



European Monitoring Centre
for Drugs and Drug Addiction



**2007 NATIONAL REPORT (2006 data) TO THE
EMCDDA
by the Reitox National Focal Point**

“HUNGARY”

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

REITOX

CONTRIBUTORS:

CSESZTREGI TAMÁS, Criminal Professional and Research Institute

CSOHÁN ÁGNES, National Centre for Epidemiology

DARÓCZY ZITA, National Focal Point

HAJNAL GYÖRGY, ECOSTAT Government Institute for Strategic Research on Economy and Society

HORVÁTH MÓNIKA CSILLA, Semmelweis University, Department of Forensic Medicine

KOÓS TAMÁS, National Institute for Drug Prevention

KOVACSICS LEILA, National Institute for Drug Prevention

KUN BERNADETTE, National Institute for Drug Prevention

KUN GÁBOR, National Institute for Drug Prevention

MÜLLER ÉVA, Ministry of Health

NÁDAS ESZTER, National Focal Point

NÉMETH ÁGNES, National Institute of Child Health

NYÍRÁDY ADRIENN, National Focal Point

PORKOLÁB LAJOS, National Institute of Psychiatry and Neurology

PAKSI BORBÁLA, Budapest Corvinus University, Behaviour Research Centre

RITTER ILDIKÓ, National Institute of Criminology

SZABÓ KRISZTINA, National Focal Point

VARGA ORSOLYA, National Focal Point

REVISED BY:

BUDA BÉLA, FELVINCZI KATALIN, KASSAI FARKAS ÁKOS, RÁCZ JÓZSEF,
SZEMELYÁCS JÁNOS, TOPOLÁNSZKY ÁKOS, ZACHER GÁBOR

TABLE OF CONTENTS

SUMMARY	5
1. NATIONAL POLICIES AND CONTEXT	7
1.1. LEGAL FRAMEWORK	7
1.2. INSTITUTIONAL FRAMEWORK, STRATEGIES AND POLICIES	9
1.3. BUDGET AND PUBLIC EXPENDITURE	10
1.4. SOCIAL AND CULTURAL CONTEXT.....	10
2. DRUG USE IN THE GENERAL POPULATION AND SPECIFIC SUB-GROUPS	17
2.1. DRUG USE IN THE GENERAL POPULATION	17
2.2. DRUG USE IN THE SCHOOL AND YOUTH POPULATION.....	17
2.3. DRUG USE AMONG SPECIFIC GROUPS	19
3. PREVENTION	21
3.1. UNIVERSAL PREVENTION	21
3.2. SELECTIVE PREVENTION	29
3.3. INDICATED PREVENTION.....	32
4. PROBLEM DRUG USE AND THE TREATMENT DEMAND POPULATION	34
4.1. PREVALENCE AND INCIDENCE ESTIMATE OF PROBLEM DRUG USERS	34
4.2. TDI – TREATMENT DEMAND INDICATOR	34
4.3. PROBLEM DRUG USERS FROM NON-TREATMENT SOURCES.....	44
4.4. INTENSIVE OR FREQUENT PATTERNS OF USE	47
5. DRUG-RELATED TREATMENT	48
5.1. TREATMENT SYSTEM.....	48
5.2. DRUG-FREE TREATMENT	51
5.3. PHARMACOLOGICALLY ASSISTED TREATMENT	51
6. HEALTH CORRELATES AND OTHER CONSEQUENCES	53
6.1. DRUG-RELATED DEATHS AND MORTALITY OF DRUG USERS	53
6.2. DRUG-RELATED INFECTIOUS DISEASES	55
6.3. PSYCHIATRIC CO-MORBIDITY	61
6.4. OTHER DRUG-RELATED HEALTH-CORRELATES AND CONSEQUENCES.....	61
7. RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES	64
7.1 PREVENTION OF DRUG-RELATED DEATHS.....	64
7.2 PREVENTION AND TREATMENT OF DRUG-RELATED INFECTIOUS DISEASES	64
7.3. INTERVENTIONS RELATED TO PSYCHIATRIC CO-MORBIDITY	65
7.4. INTERVENTIONS RELATED TO OTHER HEALTH CORRELATES AND CONSEQUENCES	66
8. SOCIAL CORRELATES AND CONSEQUENCES	67
8.1. SOCIAL EXCLUSION	67
8.2. DRUG-RELATED CRIME	71
8.3. DRUG USE IN PRISON	74
8.4. SOCIAL COSTS	74
9. RESPONSES TO SOCIAL CORRELATES AND CONSEQUENCES	76
9.1. SOCIAL REINTEGRATION.....	77
9.2. PREVENTION OF DRUG-RELATED CRIME	79

10. DRUG MARKETS	80
10.1. AVAILABILITY AND SUPPLY	80
10.2. SEIZURES	80
10.3. PRICE/PURITY	81
11. PUBLIC EXPENDITURES	84
11.1. NATIONAL ESTIMATES OF LABELLED DRUG-RELATED EXPENDITURES	84
11.2. ATTRIBUTABLE PROPORTIONS AND ESTIMATION OF NON-LABELLED EXPENDITURES	85
11.3. NATIONAL STUDIES ON DRUG-RELATED PUBLIC EXPENDITURES	88
12. VULNERABLE GROUPS OF YOUNG PEOPLE	90
12.1. CHARACTERISTICS OF THE MAIN VULNERABLE GROUPS	90
12.2. DRUG USE IN THE VULNERABLE GROUPS	91
12.3. VULNERABLE GROUPS IN TREATMENT	93
12.4. CORRELATES AND CONSEQUENCES OF DRUG USE IN VULNERABLE GROUPS	93
12.5. LEGAL BACKGROUND	93
12.6. PREVENTION AMONG VUNLERABLE GROUPS	95
13. DRUG-RELATED RESEARCH IN EUROPE.....	96
13.1. RESEARCH STRUCTURES	96
13.2. MAIN RECENT STUDIES AND PUBLICATIONS	96
13.3. COLLECTION AND DISSEMINATION OF RESEARCH RESULTS	97
14. BIBLIOGRAPHY	99
ANNEXES	101
LIST OF TABLES	101
LIST OF FIGURES	102
LIST OF MAPS	103
LIST OF ABBREVIATIONS	103

SUMMARY

Since 1 July 2006, drug affairs coordination tasks have been carried out in the Ministry of Social Affairs and Labour, at the Department of National Drug Affairs Coordination. This Department is part of the Family and Social Services Department, headed by the under-secretary responsible for social policy. A ministerial commissioner, appointed by the Minister of Social Affairs and Labour, who is responsible for drug affairs coordination, carries out the tasks of the national drug coordinator. The coordinator is the operational leader in the coordination processes, and represents Hungary in international drug policy issues. At the end of 2006, the Coordination Committee on Drug Affairs was reorganized. Under the new structure, the Committee, consisting of 10 permanent members with voting rights, meets at least 4 times a year. It is a significant change that 4 of the permanent members are not delegated by the governmental organization. The Parliament created the Ad Hoc Committee on Drug Affairs, whose task is to review the governmental measures taken on the basis of strategic aims set out in the document titled "National Strategy to Combat the Drug Problem", and to summarise and evaluate their results.

In 2006 surveys were primarily conducted among young people both at the national and local levels (this latter usually meaning the examination of drug use habits of high school students in a given city). The national level data collection was executed within the framework of the HBSC research. The results of the survey showed a slight increase of illicit drug use. The HBSC survey also proved the consumption structure characteristic of Hungarian youth, that is, the two most popular drugs are cannabis and the combined use of alcohol and pharmaceuticals – this latter mostly among girls – as was discovered in earlier ESPAD surveys as well.

The results of the survey aiming to describe the school prevention programmes implemented within the frame of the ICsSzEM-OM tender system prove that they concentrate less on the provision of knowledge, but rather put emphasis on refusal techniques and the development of self-knowledge. It is characteristic of these programmes that they are carried out with the involvement of outside experts, but the teachers of the schools also actively participate. In comparison with the results of earlier surveys, these programmes got less favourable reactions from the students regarding both interactivity and the animators' performance.

Treatment centres recorded 15,480 drug users in 2006, which means a 5% increase over the previous year. On the other hand, the number of new patients decreased by 10% (5,673 patients). The number of heroin users in treatment and injecting users has been continuously decreasing since 2000. This trend was reversed in 2006, and both the number of heroin users in treatment and injecting users increased. In 2006 again, the number of patients in treatment for cannabis use was the highest; the number of amphetamine users decreased for the first time compared to the previous year. The share of cocaine users has further increased, while the number of hallucinogen users decreased.

The health care treatment chain – similarly to the previous year – is still quite irregular and deficient in 2006. The lack of experts and the proper health care of children and youths with addiction and psychiatric problems pose serious difficulties. In the opinion of problem drug users, the two most inaccessible forms of treatment are drug rehabilitation and methadone maintenance treatment.

Examining the social consequences of drug use, we may conclude that, as in previous years, the reactions of social politics and the treatment system to the existing and newly emerging challenges are still isolated in most cases. Most evident are the initiatives of NGOs and

church organizations, whether it is about the question of housing, education, training or employment. Behind these initiatives are mostly national and international tender sources.

Based on the incidence data reported in 2006 and the HIV tests of 300 injecting drug users (IDUs) it can be concluded with a high probability, that in the Hungarian IDU population – similarly to previous years – the number of HIV infections is very low. Among people treated at specialised outpatient treatment centres and people taking advantage of low-threshold services, 28.9% HCV prevalence was measured. In 2006, the number of injectors distributed by needle exchange programmes increased by 56%, while the number of clients grew by 84%. The per capita number of injectors – implying secondary syringe exchange – that had been on the rise, decreased in 2006 for the first time since 2003. On the other hand, the number of clients has reached its highest value ever. This may mean that the programmes reach more and more drug users directly.

On the whole, the number of deaths caused by illicit drug use decreased compared to previous years, but the number of fatal heroin overdoses further increased. In 2006 deaths caused by heroin comprised 88% of all direct deaths brought about by illicit drug use. No deaths caused by amphetamines or ecstasy were reported.

In Hungary the number of reported misuse of narcotic drug offences decreased by 13.4% compared to the previous year. However, it was stable as a proportion of total criminal activity. The number of revealed offenders was 15% less in 2006 than the number of misuse of narcotic drug cases detected by the authorities. This means that every sixth offender against whom the proceedings were initiated for misuse of narcotic drugs committed at least two offences. In 2005 this ratio was 7%, and never went above that in the years prior to 2005 either. The main reason for this is the criminal legislation.

Concerning drug markets, the most noticeable change concerned ecstasy tablets, as both the number of seizures and the quantity of tablets seized has decreased significantly and tablets with low active substance content have appeared in greater amounts. The proportion of heroin and cocaine increased slightly again. The purity of drugs at street markets has changed, the extent of the change depending on the type of drug. The delta-9-THC content of herbal cannabis has been slowly but steadily increasing for years.

1. NATIONAL POLICIES AND CONTEXT

1.1. LEGAL FRAMEWORK

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

- a) Act LI of 2006 (VII. 11.)

Act LI of 2006 amended the Act XIX of 1998 on Criminal Procedure (see National Report 2006).

- b) Act CXXXII of 2006 (XII. 19.)

Act CXXXII of 2006 on the development of the health care system greatly transforms the health care system, and together with that the treatment of drug users. The aim of the Act is the further transformation and development of the health care system with the result of a more efficient, up-to-date care system with better quality and sustainable financing which system would take the local decisions into consideration as well. Regarding this, the act defines: the priority hospitals and special institutions with national tasks providing the most important services (emergency attendance, interventions requiring higher technical preparedness); their capacity (number of slots) minimal necessary for maintenance of the tasks – therefore guaranteed in the law – allocated for professional groups; and for all regions the distributable active and a chronic capacity. The Annex 1 and 2 defines the number of active and chronic – rehabilitation - slots functioning after 1st of April 2007.

- c) 132/2006 Government Regulation (VI. 15.)

The Government Regulation 132/2006 (VI. 15.) amended the Government Regulation 43/1999 (III. 3.) on the detailed rules of the financing of health care services by the Health-insurance Fund. The regulation came into force on 1st July 2006 with a serious effect on the financing.

- d) 228/2006 Government Regulation (XI. 20.)

228/2006 Government Regulation amended the 162/2003 (X. 16.) Government Regulation on the order of growing, trafficking and using plants suitable for producing drugs. The Regulation modified the legal framework of the threshold limit changes of all active substances of opium alkaloids regarded as drugs (morphine, thebaine, codeine) in industrial, culinary and decorative poppy seeds, and the usage of these kinds of poppy seeds and cannabis sativa.

- e) 262/2006 Government Regulation (XII. 20.)

The 262/2006 Government Regulation defines the detailed rules of the rate and implementation of fines imposed by the Hungarian Trade Licensing Office in processes related to drug precursors. The Office can impose a fine between 1892 EUR and 3784 EUR in its scope of authority.

- f) 1002/2007 Government Regulation (I. 18.)

1002/2007 Government Regulation on the Coordination Committee on Drug Affairs (CCDA) outlines the tasks and composition of CCDA (see subsection "Coordination arrangements, changes" for details).

g) 14/2007 Parliament Regulation (III. 7.)

14/2007 Parliament Regulation created the Ad hoc Committee on Drug Affairs, whose task is to review governmental measures taken on the basis of strategic aims set out in the document titled "National Strategy to Combat the Drug Problem", and to summarise and evaluate their results. This evaluation must contain the review of tasks carried out since Government Regulation 1129/2004. (XI. 24.) (on governmental tasks concerning the realization of aims set out in the national strategic programme on combating the drug problem) entered into force. This evaluation is based on the work carried out by the Ad hoc Committee on Drugs (an ad hoc committee that made preparations for the harmonization of the contents of the National Strategy to Combat the Drug Problem with the future Drug Strategy of the EU), which operated from April 2005 to May 2006.

h) 49/2007 Joint Regulation of the Ministry of Economy and Transport, Ministry of Health, Ministry of Justice and Law Enforcement, the Prime Minister's Office and the Ministry of Finance (IV. 26.)

49/2007 joint regulation of the Ministry of Economy and Transport, Ministry of Health, Ministry of Justice and Law Enforcement, the Prime Minister's Office and the Ministry of Finance regulates the set of data needed to be stored for the authorities carrying out their tasks concerning drug precursors and the access order of these data.

i) 38/2007 Parliament Regulation (V. 9.)

38/2007 Parliament Regulation contains the acceptance of the report on the realization of the national strategic programme to combat the drug problem and on the transparency and evaluation of the treatment-institutional framework (regarding years 2003-2005). The Regulation amended the 96/2000 (XII. 11.) Parliament Regulation on the acceptance of the national strategy to combat the drug problem. According to the amendment, the government reports on the realization of the strategic programme and the transparency and evaluation of the treatment-institutional framework evaluation to the Parliament every three years, and to the Youth, Social and Family Committee and Health Committee every year.

Law enforcement

Based on data of the Public Prosecutor's Office, 2,484 persons were sentenced for drug-related offences in 2006. These offenders committed 2,874 offences, which they were called to account for on the following legal grounds:

- 1,806 offenders were sentenced for using type offences prohibited by Section 282 and Section 282/A of the Criminal Code;
- 182 offenders were sentenced for trafficking type offences prohibited by Section 282 and Section 282/A of the Criminal Code;
- 148 persons were sentenced for offences prohibited by Section 282/B (using or trafficking type offence to the injury of a person under the age of eighteen or involving such a person);
- 348 persons were sentenced for conducts as prohibited by Section 282/C (drug-addicted persons committing a using or trafficking type offence);
- Nobody was sentenced for an offence prohibited by Section 283 (Misuse of materials used for producing narcotic drugs) of the Criminal Code.

In 2006, the following punishments and measures were inflicted upon the 2,484 persons against whom final judgements were issued:

- 923 were sentenced to imprisonment: 424 were enforceable and 499 were suspended
- 151 were sentenced to perform work in the public interest
- 771 were fined
- and individual measures were inflicted in 639 cases.

1.2. INSTITUTIONAL FRAMEWORK, STRATEGIES AND POLICIES

Coordination arrangements, changes

Since 1 July 2006 drug affairs coordination tasks have been carried out by the Department of National Drug Affairs Coordination in the Ministry of Social Affairs and Labour. This Department is part of the Family and Social Services Department, headed by the under-secretary responsible for social policy. A ministerial commissioner, appointed by the Minister of Social Affairs and Labour, who is responsible for drug affairs coordination, carries out the tasks of the national drug coordinator. The coordinator is the operational leader of the coordination processes, and represents Hungary in international drug policy issues.

It is one of the responsibilities of the Ministry of Social Affairs and Labour to operate the Coordination Committee on Drug Affairs (CCDA) as a body that makes recommendations and gives opinions to the government. The president of the CCDA is the Minister of Social Affairs and Labour and the Minister of Health.

At the end of 2006, the CCDA was reorganized. Under the new structure, determined by Government Regulation 1002/2007, the Committee meets at least 4 times a year with the 10 permanent members having voting rights. It is a significant change that 4 of the permanent members are not delegated by governmental organizations. There are 9 further temporary members participating in the meetings of the CCDA, who also enjoy voting rights, and 10 other professional members without voting rights. The temporary and professional members are invited by the president of the Committee to participate in the meeting, if any of the issues on the agenda of the meeting concerns the competence and scope of duties of the organization represented by that member.¹

The national strategy and its implementation

In 2006 and in the first half of 2007, 1129/2004 Government Regulation (XI. 24.) is still in force, and it concerns of the government's execution of the aims of the strategic programme

¹ The permanent members of the Committee: the president and co-president of the Committee, the representative of the Ministry of Justice and Law Enforcement, representative of the Ministry of Education and Culture, representative of the Ministry of Local Governments and Regional Development, Ministry of Finance and four people delegated by the NGOs representing the strategic fields of drug affairs coordination.

The temporary members of the Committee: the representative of the Ministry of Agriculture and Countryside Development, the representative of the Ministry of Economy and Transport, the representative of the Ministry of National Defence, the representative of the Ministry of Foreign Affairs, the representative of the Office of the Prime Minister, the representative of National Public Health and Medical Officer Service, the representative of the National Headquarters of the Hungarian Prison Service, the representative of the National Police Headquarters and the representative of the National Headquarters of Customs.

The expert members of the Committee: the representative of the Supreme Court, the representative of the Public Prosecutor's Office; the representative of the National Committee on Crime Prevention, the representative of the military services of national security, the representative of the Hungarian Trade Licensing Office, the representative of the Office of Health Authorisation and Administrative Procedures, the representative of the National Institute for Addictology, the representative of the National Focal Point, the representative of the National Institute on Drug Prevention, and further experts called upon by the president of the Committee.

for combating the drug problem. A new action plan will be created and a new government regulation accepted in 2007 in order to re-qualify several tasks of which terms are expired and tasks that have not been (completely) fulfilled.

1.3. BUDGET AND PUBLIC EXPENDITURE

No new information available.

1.4. SOCIAL AND CULTURAL CONTEXT

Public opinions of drug issues

The Hempseed Association held their demonstration 'Million Marijuana March' again in 2006, with the participation of 6000 people. Similarly to the experience of the previous years the event polarized the forming of opinions about drug issues, giving opportunity for participants and commentators to express their politically influenced views about the phenomenon. Substantive discussions did not rise this time either between groups with markedly different views.

Attitudes to drugs and drug users

A survey on the attitude of policemen to drugs and drug users

In 2006 a survey (Ritter 2007) was carried out on a representative sample among policemen² to sum up attitudes to drug use. The aim of the survey was to find out how policemen dealing with drug users in practice evaluate the social and criminal treatment and its means of the problem of drug use in Hungary, and how they relate to the drug using population.

According to the respondents, crimes related to drugs were ranked 5th in their seriousness from the eight types of crimes listed. (They were judged less serious than crimes against property, tax fraud, corruption and crimes committed against the elderly.) So it was not included among the most serious crimes.

To the question, "which are the types of crimes, whose offenders the respondents the most condemn", the following response was given: 3.9% condemned the offenders committing misuse of narcotic drugs, or more precisely, drug traffickers. 42.2% of respondents answered that there are offenders, whom they do not consider as criminals. According to 57.6%, all offenders committing a crime must be considered as criminals. According to the first group, who said there are offenders, whom they do not consider as criminals, one has to be the most understanding towards offenders committing failure of maintenance, causing a traffic accident and using drugs. That is, they considered these offenders as the least criminal.

According to 75.5%, Hungary is within the middle range among European countries concerning the spread of drug use. 15.6% responded that Hungary is ranked among the top 10 countries, while 7.5% placed it among the bottom 10. A significant number of policemen think that the level of drug use in Hungary is around the European average, or a little higher.

² The target group of the survey were policemen (detectives, investigators) determining the legal qualification of offences and their direct superiors (heads of departments). The sampling frame was constructed by policemen working at the county police headquarters, the two police headquarters from every county with the highest detection index, and the district headquarters of Budapest. The survey was conducted with the help of self-reporting questionnaires. 386 questionnaires were processed in the survey.

According to the survey respondents, drug use could be combated most effectively by the following means:

Table 1. Means to combat drug use

Means	%
Stricter punishment	37.0
Prevention, information	38.2
More effective control over border crossing points	4.1
Legalising certain drugs	8.5
Controlling night clubs by police raids, increasing the role of the police	9.4
Prevention, information + more explicit police presence, stricter laws + increasing personal and material means	0.6
More rational punishments and sentencing practice	4.2

Source: Ritter 2007

98.2% answered the question, asking whether drug users should be punished, that is, the willingness to answer was high. 66.9% agrees with punishing drug users. The following table contains the reasons with which people most often explained their viewpoint:

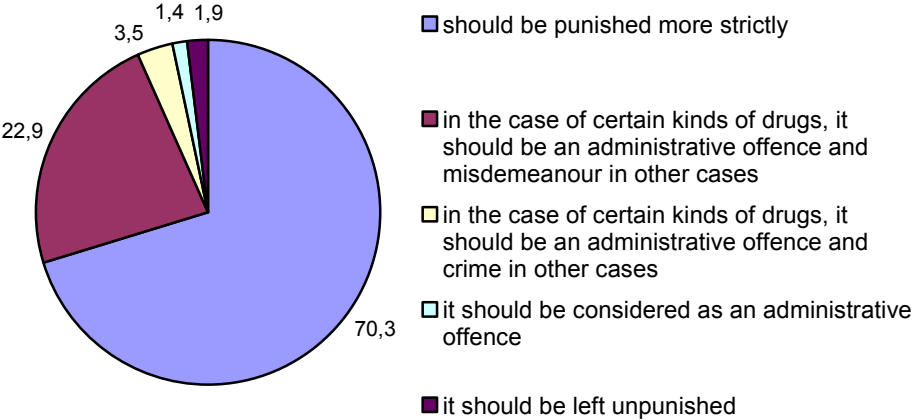
Table 2. Reasons for supporting and objecting to the punishment of drug use

Pro punishment	Contra punishment
Punishment is deterrent	It is an illness that has to be healed and treated
Drug use is a crime	People are criminalised, who should not be
There are many accessory crimes accompanying drug use	Only those people should be punished, who commit other crimes under the effect of drugs
Drug users often turn into vendors	The real problem is not solved by the punishment of users
Because of the possibility of diversion, the withholding effect of punishment cannot prevail	Diversion may help in quitting

Source: Ritter 2007

To the question asking whether drug use can be combated with the criminal justice system, 56.6 % said that it cannot.

Figure 1. How should drug use be punished? (percentage of people answering)



Source: Ritter 2007

26.4% of respondents said that these offences should only be considered as an administrative offence in the case of certain drugs, while offences related to other drugs should stay criminal offences. The complete lack of punishment was only chosen by 1.9% of

the respondents. According to 1.4% of the answers, all offences related to drug use should be treated as an administrative offence independently from the kind of the drug.

According to 50% of respondents a distinction should be made based on the type of drug, and the severity of the punishment should be adjusted to that. Contrary to this, to the question of whether there should be a distinction between drug users and the offenders in other drug-related crimes, 81.9% answered yes.

Table 3. *Police attitude to drug users*³

Statements	Average
The use of all kinds of drugs is equally harmful	3.7
If someone starts to use drugs, they will sooner or later start trafficking as well	2.8
Drugs are much more harmful than alcohol	3.8
Between drugs and alcohol the difference is that law only prohibits drug use	2.5
Drug users have weak character	3.2
It would be better if drug use were only an administrative offence	1.5
Most of the people who have ever tried drugs never become drug addicts	2.2
Drug users need to be punished	4.1
Drug users are criminals	3.0
I would not mind if a treatment centre for drug users were set up in my neighbourhood	2.6
Drug using students should be expelled from schools	3.0
The use of soft drugs should be legalized	2.5
Drug use should be punished much more strictly than it is now	3.6
Drug addicts are sick people	3.8
Only those people use drugs who cannot handle their problems	2.5
The punishment of drug use should be regulated at a lower level of law than it is now	2.4
A distinction should be made in the criminal judgement between different types of drugs	2.6

Source: Ritter 2007

Looking over the attitude scale, it is obvious that the respondent policemen in general condemn drug use, what's more, drug users (even though the illness image of addicts is recognised here as well). They do not wish to leave this behaviour unpunished, and do not agree with regulation at a lower level of law or differentiation based on the different types of drugs, either. They judge drug use to be more harmful and dangerous than drinking alcohol.

Initiatives in parliament and civil society

Between 1 July 2006 and 31 May 2007, the drug problem came up 9 times at the 67 parliamentary sessions held in this period in the form of bills, debates, interpellations and questions:

- There was a general debate on the modification of 96/2000. (XII.11.) Regulation Parliament on the acceptance of the report on the realization of the national strategic programme to combat the drug problem and on the transparency and evaluation of the treatment-institutional framework (regarding years 2003-2005)

³ According to the Likert-scale, participants had five statements to choose from: completely agrees (5), agrees (4), indecisive (3), disagrees (2), completely disagrees (1).

- The short presentation of the document titled “Annual Report 2006: The drug problem in Europe” prepared by the EMCDDA
- Changes in drug policy and the codification of the new Criminal Code
- Setting up the Ad hoc Committee on Drug Affairs and election of its members
- Drug prevention in the Hungarian Army and schools
- Combating the drug use by NGOs and churches

The drug problem appeared on the parliament's agenda more often than in the previous year (1 July 2005 – 30 June 2006). This small scale rise may also be due to the fact that the government has to make its report on the implementation of the National Drug Strategy to the Parliament every two years – and this occurred in 2006. The ratio of the drug problem appearing on the agenda and parliament meetings increased from the 10.5% observed in the previous year to 13.4% in the examined year.

A staff member of a syringe-exchange programme in Budapest asked for a criminal procedure against himself on 1st of December 2005 in the Budapest Chief Public Prosecutor's Office. The antecedent of it was the statement of the Superior Public Prosecutor (May 2005) according to which: 'illicit drug use and the assistance to it in any way or with any aim – in my point of view in all cases - refers to the suspicion of a criminal offence. In case of detecting this, law enforcement agencies are ex officio obliged to proceed'. The self-reporting - as a part of the campaign of the Hungarian Civil Liberties Union (HCLU/TASZ) - aimed to clarify the uncertain legal situation around the work of harm reduction programmes. The long-term objective of this action was to enable the clients of the programmes to possess sterile and used tools without being afraid of police proceedings and to facilitate a national agreement between the programmes and the police. The public prosecutor's office ended the investigation against the staff member of the syringe-exchange programme in June 2006 because of error in consciousness of danger for the society, but it stated the abetter behaviour.

The Act CLXX of 2005 amended to Act III of 1993 on Social Administration and Social Care declared that low threshold services – beside primary care – belong to the community based care types of addicts (see National Report 2006). The sections on low threshold care were integrated in 1/2000 (I.7.) Regulation of the Minister of Social and Family Affairs (see chapter 9.) (39/L §) amended by the 9/2006 (XII. 27.) Regulation of the Minister of Social and Labour Affairs (see chapter 9.) which sections define syringe-exchange programmes as emphasized harm reduction service. These changes resolve the above mentioned legal problem.

Media campaigns

National level

In 2006 the Hungarian Television organized a thematic week within the framework of the Week against Drug Abuse (26 June - 2 July), during which films, talks and documentaries related to the drug problem were broadcast. During the week an anti-drug spot was also broadcast on television channels, whose making was sponsored by the Ministry of Social Affairs and Labour to the amount of EUR 2,342⁴. The spot contained the messages set out below:

⁴ Based on the official midrate of the EUR for 2006 (1 EUR=264.27 HUF).

Table 4. *The content of the television spot broadcast in 2006 on the occasion of the Week against Drug Abuse*

In Hungary 11.4% of the adult population has already tried illicit drugs.
47.5% of youth living in Budapest between the ages of 17-18 have used illicit drugs.

**DRUGS ARE AMONG US.
THE DECISION IS YOURS,
BUT WE SHARE THE RESPONSIBILITY**

**26 June 2006 – International Day against Drug Abuse
We share the responsibility!**

Source: Ministry of Social Affairs and Labour

Local level

To find media campaigns organized at local level we asked for the help of the Coordination Fora on Drug Affairs (KEF).⁵ We could only identify six media campaigns based on the completed questionnaires. The effectiveness of these campaigns was not evaluated in any of the cases. Three of the campaigns were conducted on local television, two of them in local radio stations, and one of them in a local newspaper. Two communication channels (television, newspaper) were only used in one of the campaigns, however, this was rather an information campaign on the activity of local organizations.

The detailed information available on these campaigns can be found in the table below.

⁵ A questionnaire was sent out to the local KEFs with the help of the National Institute for Drug Prevention. Out of the 90 KEFs 11 answered.

Table 5. Mass media campaigns organised locally in the last 3 years

The title of the campaign	Media channels used	Geographic coverage	Target group	Duration of the campaign	Main message of the campaign	Costs (EUR) ⁶
Le(sz)állópálya – television magazine	Local television	City of Pécs	High school students, parents, teachers, experts	30 minutes of live broadcast, once a month over 10 months	Prevention approach, objective information from authentic experts, harm reduction philosophy	EUR 3784
Endangered by drugs – radio magazine	Local radio	Southern-Transdanubia	High school students, parents, teachers, experts	30 minutes of live, interactive broadcast, once a month	Prevention approach, objective information from authentic experts, harm reduction philosophy	n.a.
Series on the drug problem	A monthly cultural and news magazine	County of Győr-Moson-Sopron (except for Győr and Sopron)	Inhabitants of the county (except for Győr and Sopron)	December 2005 – May 2006	Let's face the problem, the sooner and more effectively we act, the more certain success is	EUR 1321+ EUR 114 to experts
STOPPING-PLACE Insight to the world of drugs, the possibilities of prevention and treatment. Messages from popular local personalities offering alternatives.	Radio Active, Szolnok	Within 50 km radius of Szolnok	General population	May 3 – May 24, 2007 on Thursdays in 30 minutes	You can choose another sensible way of spending your time instead of using drugs	EUR 757
Crime prevention chronicle	Terézváros TV, TÉMA (Newspaper of the 6th district of Budapest)	Budapest, Terézváros (6 th district)	General population	Continuous, once a week	Information on local crime prevention ideas and the operation of CFDA	Cca. EUR 3784 yearly
Presentation of “Together against drugs” spots to the viewers	Television	The broadcasting sector of TV Eger and its cable viewers	Mainly young people	Continuous, of varying length, in public service blocks	“Live without drugs”	n.a.

Source: Based on KEF reports

⁶ The costs in the table were calculated on the basis of the official exchange midrate of the EUR for 2006 (1 EUR= 264.27 HUF).

Conclusions

Provisions of Act CXXXII of 2006 on the development of the health care system, that entered into force on 1st January 2007 and of 132/2006 Government Regulation that entered into force on 1st July 2006 had great impact on the treatment of drug-users and on the financing of treatment. Description of those impacts may only be provided in the following year.

The Parliament established the Ad hoc Commission on Drug Affairs, whose task is to review the government's measures taken on the basis of strategic aims set out in the document titled "National Strategy to Combat the Drug Problem" and to list and evaluate the results achieved so far.

From the point of view of the drug affairs coordination, it was an important step that the CCDA was enlarged with civil delegates as full members.

Based on the attitude survey conducted among policemen, we may draw the following conclusions: 38.2% of respondents answered that drug use could be reduced through prevention and information, while 37% thinks that stricter punishment would serve the same aim. 81.9% of policemen think it necessary to differentiate between drug users and perpetrators of other drug crimes. However, the results are contradictory, because according to 56.5% of respondents, criminal law is not the right means to reduce drug use, but 70.3% still thinks that drug use should be punished more strictly. The survey did not find an explanation to resolve this contradiction, so based on these results we might draw the conclusion that policemen have no clear, definite attitude regarding drug use.

2. DRUG USE IN THE GENERAL POPULATION AND SPECIFIC SUB-GROUPS

Overview

In 2006 surveys were conducted primarily among young people, both at the national and local levels (this latter meaning the examination of drug use habits of high school students in a given city). The national level data collection was carried out within the framework of the HBSC research, which included questions regarding illicit drug use. Local level surveys were mostly conducted in the Northern Alföld (Great Plains) region on the assignment of the CFDA – similarly to last year. These surveys provided a snapshot for the development of the local drug strategy. No drug epidemiological survey was conducted among adults.

2.1. DRUG USE IN THE GENERAL POPULATION

No new information available.

2.2. DRUG USE IN THE SCHOOL AND YOUTH POPULATION

Out of the 2,877 high school students (9th and 11th grade⁷) who responded to the 2006 HBSC survey, 20.3% have already used illicit drugs, or committed pharmaceuticals and/or inhalants abuse. The rate of cannabis use is the highest among all of the illicit drugs, with 17.3% lifetime prevalence. The combination of pharmaceuticals and alcohol is the second most commonly used drug (14.7%), while the prevalence of other⁸ mentioned illicit drug use is 12.4%.

Trying cannabis once or twice has the highest prevalence rate (11%) among high school students, from which we may draw the conclusion that even though the most popular and most often used drug is herbal cannabis and cannabis resin, most of the students have only tried them as an experiment. Occasional pharmaceuticals abuse and combining pharmaceuticals and alcohol is also popular among high school students. We can also see in the case of other drugs that drug use most often just means trying it out. In the case of ecstasy and amphetamines (speed) the prevalence of 1 or 2 times' use is almost equal, while the use of hallucinogenic herbal drugs is slightly more widespread than trying LSD.

Table 6. *Frequency of drug use by type of drug*

Type of drug	Number of students (N)	Frequency of usage (%)						
		never	once or twice	3-5 times	6-9 times	10-19 times	20-39 times	40 or more times
cannabis	2,849	77.5	11.0	3.5	2.1	2.2	1.2	2.5
alcohol and pharmaceuticals together	2,852	86.9	9.2	1.9	0.8	0.8	0.3	0.2
pharmaceuticals to get high	2,858	92.3	5.2	0.8	0.9	0.3	0.2	0.2
ecstasy	2,860	93.9	3.9	0.6	0.3	0.4	0.6	0.4
speed	2,860	94.3	3.8	0.5	0.4	0.5	0.3	0.3
magic mushrooms	2,859	95.7	2.4	0.6	0.5	0.3	0.2	0.4

⁷ 15- and 17-year-olds

⁸ Ecstasy, speed, opiates, cocaine, LSD and other herbal drugs, e.g. magic mushroom belong to this group

solvent, glue	2,860	96.0	2.8	0.6	0.1	0.0	0.2	0.3
other drugs	2,320	97.5	1.1	0.3	0.2	0.2	0.1	0.6
LSD	2,843	98.1	1.3	0.1	0.1	0.0	0.2	0.1
cocaine	2,851	98.9	0.7	0.1	0.0	0.0	0.1	0.2
opiates	2,857	99.3	0.4	0.0	0.0	0.0	0.1	0.2

Source: Kovacsics, Németh

1.1% of the students marked other kind of drug use on the questionnaires. The other kinds of drugs most often mentioned were petrol and gas propellant products, patrons, certain energy drinks, coffee, or sometimes the above mentioned illicit drugs under another name (e.g. angel dust, rush, amphetamines).

In both grades the added lifetime prevalence of illicit drug use and the abuse of legal substances are higher among boys. We found the highest rate, 32.9% among boys in the 11th grade. This rate is twice as much as measured among boys in the 9th grade, and also 10% higher than the lifetime prevalence measured in their own age group among girls.

The use of all kinds of drugs is influenced by gender and age, the lifetime prevalence of the older students is higher than that of the younger ones, and the ratio of boys is higher than that of girls except for pharmaceuticals abuse.

Table 7. Distribution of the most often used illicit drugs based on gender and grade (LTP)

Type of drug	9 th grade				11 th grade			
	Male		Female		Male		Female	
	N	%	N	%	N	%	N	%
cannabis	99	13.1	65	8.4	208	30.5	127	19.0
alcohol and pharmaceuticals together	70	9.4	100	13.0	106	15.9	99	14.8
pharmaceuticals	36	4.8	60	7.8	64	9.5	59	8.8
ecstasy	42	5.6	37	4.8	52	7.7	43	6.4
speed	32	4.3	36	4.7	63	9.3	33	4.9

Source: Kovacsics, Németh

We can draw conclusions concerning the kind of drug use from recent years' prevalence data. The last year prevalence of cannabis is 15% among 9th and 11th grade students. Frequency rates for boys are higher in all cases. The members of both sexes have most often tried cannabis once or twice – 9% of the boys and 7.2% of the girls admitted this.

The aggregate last month prevalence is 6.4%. With regard to level of use, we added up use from 1-5 occasions, which roughly covers the recreational use category, when young people use herbal cannabis or cannabis resin almost every week at social occasions. Both boys and girls reached the highest rates in this category, 5.4% and 4.2%. The next class was formed so that we consolidated answer categories 6-19, while the rest were put into the last, intense user category, meaning that they used cannabis 20-40 or even more times in the past 30 days. The occasional and intense drug use among boys shows about the same rates (1.2-1.3%), which indicate regular cannabis use. This fact will require increased attention from the point of view of risk behaviour.

The age of first use can be estimated most often to be between 15-16 years of age: in the case of cannabis 70%, in the case of other drugs 75% has tried the given drug for the first time at around 15-16 years of age. The ratio of people trying drugs under 14 is less than 10% in the case of all kinds of drugs.

Based on lifetime prevalence data, the spread of drugs is highest in the capital: 30.8%. All other categories, e.g. county seats, towns, smaller villages and farms, show much lower rates. Consequently, we could say that the frequency of drug using behaviour is in direct proportion to the size of the settlement.

Except for solvents/inhalants, in all drug categories a smaller proportion of students going to grammar schools or technical high schools have ever tried any kind of drug than students going to vocational schools. While 6.5% of grammar school and technical high school students have tried pharmaceuticals to make them feel better, 11% of vocational school students done so. We may find similar percentage differences in the case of combining pharmaceuticals and alcohol. In the case of stimulants the difference is almost double, 12.2% of vocational school students have already used these kinds of drugs.

The prevalence rates of the survey conducted four years ago (Sebestyén, 2003) are in general higher than the latest data. The explanation might be that in the 2006 survey the aggregate questions regarding the use of cannabis and other illicit drugs were also adjusted based on whether the students answered the other question indicating their age at usage in accordance with the previous questions. If they indicated in one of the questions that they had used cannabis or other drugs, but answered no to the age question, or the other way around, we omitted them from the evaluation. This resulted in lower rates for both the use of cannabis and other drugs. The survey conducted four years ago was not adjusted in this way. If the data are not adjusted, the lifetime prevalence of aggregate drug use is 30.6%, and 22.5% for cannabis. If we compare these data with those from 2003, we find an increase with regard to the lifetime prevalence of all drug use.

Table 8. *Comparison with earlier results*

Lifetime prevalence rates	HBSC 2002	HBSC 2006
illicit and legal drugs together	24.3%	20.3%
pharmaceuticals abuse	9.3%	14.7%
cannabis	19.8%	17.3%
inhalants	2.1%	4.0%
ecstasy	4.3%	6.1%
amphetamines/speed	3.6%	5.7%

Source: Sebestyén 2003, Németh

2.3. DRUG USE AMONG SPECIFIC GROUPS

Hungarian Army

The complex screening system of the Hungarian Army provides information on the geographical and qualitative distribution of drug use among their ranks. This serves as a basis for creating their prevention strategy. Results are obtained in the Army's accredited drugs-examination laboratory. Medical personnel are continuously trained how to obtain urine samples, to keep registers and to apply drug quick tests.

The following table contains the results of laboratory tests conducted in 2006 in order to verify drug use from urine samples (Gachályi 2007).

Table 9. Drug screening tests conducted in the Hungarian Army in 2006

Screening test	Number of positive cases		
	Cannabis	Opiate ⁹	Amphetamines
Aptitude (N=6297)	31	35	10
Authority (N=140)	20	7	6
Prevention (N=1705)	4	10	3
Total (N=8142)	55	52	19

Source: Gachályi 2007

While no use of opiates could be detected in the previous year, in 2006 their use could be supposed in 52 cases. As a result, the distribution of the types of drugs tested among the positive cases changed significantly. The ratio of samples proving the use of cannabis was reduced by 50%, and the ratio of positive amphetamine samples also decreased somewhat. Illicit drug use was in most cases already detected at the aptitude test stage.

Conclusions

The results of the 2006 national survey showed a slight increase in illicit drug use. The HBSC survey also confirmed the consumption structure characteristic of Hungarian youths, that is, the two most popular drugs are cannabis and the combined use of alcohol and pharmaceuticals – the latter mostly among girls – as was discovered in earlier ESPAD surveys as well.

Besides this – similarly to the previous year – more and more regional surveys were conducted for analysing the local drug situation.

In the army's screening tests the use of opiates could again be detected, which implies that the earlier discovered process of opiates becoming the second most popular drugs - after cannabis - among soldiers is continuing, as opposed to the structure observable in normal population.

⁹ Opiate positivity could not be instrumentally (GC/MS) proven in all cases, so sometimes only the suspicion of consumption could be affirmed.

3. PREVENTION

Overview

Detailed information is available on school based drug prevention programmes. The database (Drug Information Portal for Professionals - www.ndi-szip.hu) that lists these programmes can be searched based on different criteria. The website is visited by more and more people every year.

We know significantly less about universal and selective prevention programmes outside schools. There has only been one attempt to survey these efforts (see National Report 2006).

In the area of workplace drug prevention, a programme to prevent alcohol and drug use was elaborated. However, its introduction has been delayed by a lack of resources.

3.1. UNIVERSAL PREVENTION

School-based prevention

The Ministry of Youth, Family, Social Affairs and Equal Opportunity (ICsSzEM) and the Ministry of Education (OM) (the former's name has since changed to the Ministry of Social Affairs and Labour) jointly issued tenders for school-based health promotion and drug prevention programmes in the amount of EUR 643,282¹⁰ in 2006.

As a result, 289 schools from 451 tender applicants won subsidies in a total amount of EUR 584,249¹¹. This means that 105,225 students in the population aged 11 to 18 participated in prevention activities under this scheme¹².

In 2006 a survey was conducted in order to outline school prevention programmes implemented in school year 2005/2006 under the tender system operated by the ICsSzEM-OM, to locate these programmes (Paksi and Demetrovics, 2005; Paksi et al. 2006a) in the national register of prevention programmes (see National Report 2004) and to evaluate them¹³.

Characteristics of programmes implemented within the frame of the ICsSzEM-OM tender

70% of interventions – matching minimum expectations of tender criteria – were of a duration of 5 hours, 17% of 6-10 hours, and another 10% dealt with students in more than ten hours. However, in 8 out of the 229 examined programmes intervention was carried out in a shorter duration than that prescribed by tender criteria.

In the programmes run in the subsidy-winning schools, prevention activities in a student group usually (in 60% of the cases) took place within an interval of 1-5 months. 20% of the programmes were shorter, while 20% of the programmes were longer than that (six or more months). The time interval of all school prevention programmes conducted in Hungary

¹⁰ Values were calculated based on the official midrate of the EUR for 2006 (1 EUR=264.27 HUF).

¹¹ Based on data from Sulinova Kht.

¹² Based on the report by the Ministry of Education

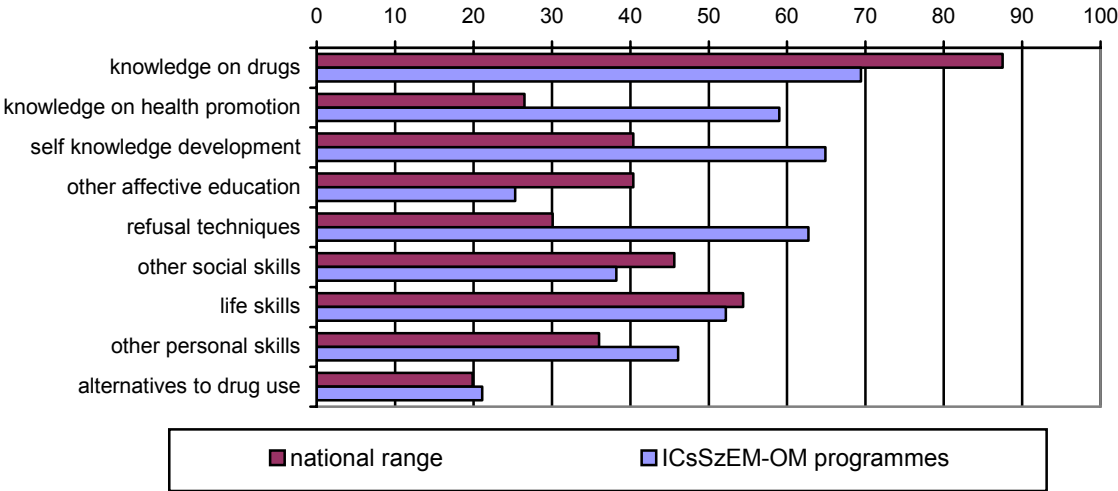
¹³ The survey was conducted by the Behaviour Research Centre of the Budapest Corvinus University. Data could be collected among the service providers, experts or professional teams carrying out interventions in 277 (88.5%) out of the 313 schools winning the tender. In the 277 schools 187 prevention professional teams were identified, out of which 64 were existing service providers in the field, while 123 were "ad hoc" teams created for the execution of the tender in the organization of the winning tenderer (school). The 187 prevention professional teams implemented 229 different prevention programmes. The following methods were applied for data collection: telephone interview, face to face questionnaire, self-reporting questionnaire, analysis of documents, face to face interview.

between 2003-2005 naturally had a wider range than that of interventions realized within the frame of the ICsSzEM-OM tender, as 25% of these programmes were run in only 1-2 hours, but these have not been included in the present tender system. However, despite the fact that the tender contained only minimum criteria with regard to the duration of the programme, not only the short term elements have been excluded from schools in the frame of the tender: among the programmes running in winning schools, programmes longer than 5 hours were much rarer than in the range of prevention programmes in general.

Regarding the syllabus, all programmes defined drug prevention objectives – in accordance with the aims of the tender. However, these objectives got different emphasis in the different programmes. A smaller part of the programmes (37.6%) defined its activity as direct drug prevention intervention; the majority (62.3%) primarily provided health promotion and only aimed to achieve drug prevention objectives indirectly. In the national range of prevention programmes ratios are reversed: the majority (75%) of programmes acting at the school drug prevention scene (also) with a drug prevention objective – directly targeting the intervened population – are direct drug prevention programmes. This shift among the programmes in the framework of the tender compared to the national range is probably mostly due to the tender criteria: “modern approaches place drug prevention within the area of health promotion”¹⁴. At the same time, nine out of ten programmes implemented under the tender directly dealt with illicit and/or licit drugs, and only 9.3% dealt with them indirectly. In the tender it was a priority to deal with licit and illicit drugs together. 94% of the programmes within the frame of the tender satisfied this criterion. They directly and/or indirectly dealt with both legal and illicit drugs.

The most common objectives of the programmes under the tender were: the provision of knowledge concerning drugs and health promotion, development of self-knowledge, and the development of refusal skills (in about 60-70% of the programmes). 40-50% of the programmes defined objectives related to life skills and/or social skills, or personal skills, but on the whole, at least two-thirds referred to some kind of skills training. Other affective education and alternatives to drug use were the least mentioned components; these were mentioned by 20-25% of the programmes.

Figure 2. The appearance of different objectives in the national range of programmes and in the prevention programmes within the frame of the ICsSzEM-OM tender system (in the percentage of programmes)



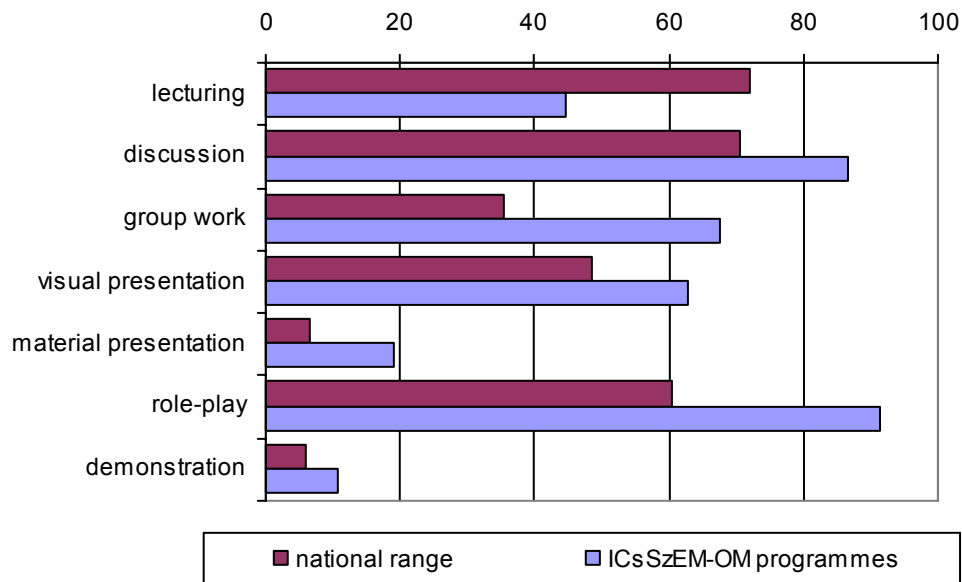
Source: Paksi et al. 2006b

¹⁴ Quote from the tender

Compared to the national range, the programmes run under the ICsSzEM-OM tender system focused more on health promotion than on information related to drug use. On the other hand, more emphasis was laid on refusal techniques and self-knowledge development. Despite the objectives set out in the tender, the development of social skills and life skills appeared to a lesser extent among the objectives, compared to the national range.

Considering the applied methods, programmes carried out within the framework of the tender system were quite diverse. The average programme applied 3.8 methods out of the 7 methods identified. In the vast majority (91%) of the programmes, methods included role plays/simulations/drama plays. Discussion was applied in a similar percentage. Group work and visual presentation were also popular; 60-70% of the programmes used these methods. These elements were included significantly more often in tender programmes even compared to programmes in the national range. On the other hand, in accordance with tender criteria prescribing interactivity, lecturing was used minimally.

Figure 3. The use of different methods in the national range of programmes and the prevention programmes within the framework of the ICsSzEM-OM tender system (in the percentage of programmes)



Source: Paksi et al. 2006b

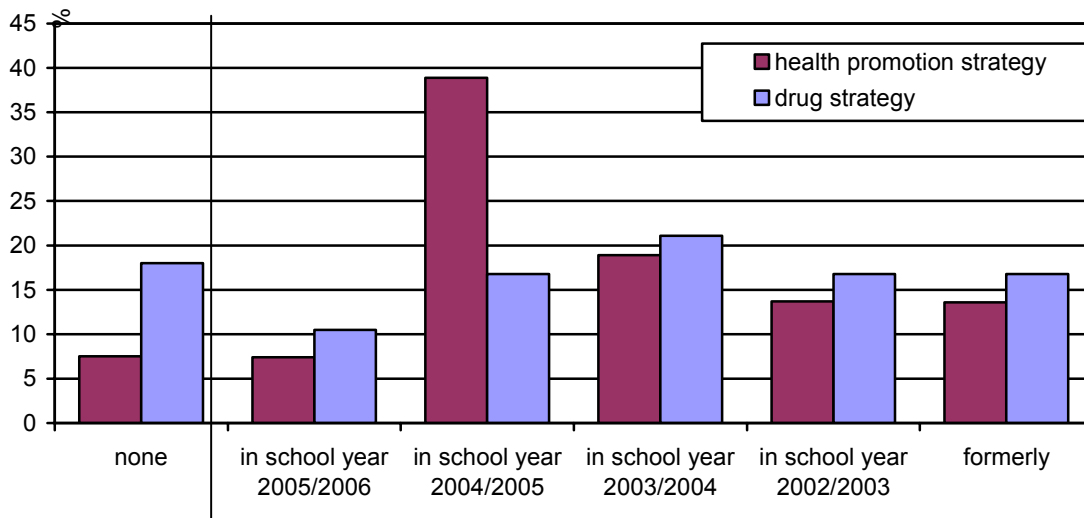
97% of tender programmes satisfied the criterion according to which “the number of students may not be more than in an average class”¹⁵ at prevention classes.

Strategies related to prevention/health promotion activities

In more than 90% of schools that won subsidies at the ICsSzEM-OM tender there was a detailed health promotion strategy, and in more than 80% a drug strategy available, which in the majority of the schools were completed prior to the examined tender year.

¹⁵ Quote from the tender

Figure 4. *Is there a health promotion or drug strategy at the schools participating in the tender, and if yes, the year it was completed (%)*



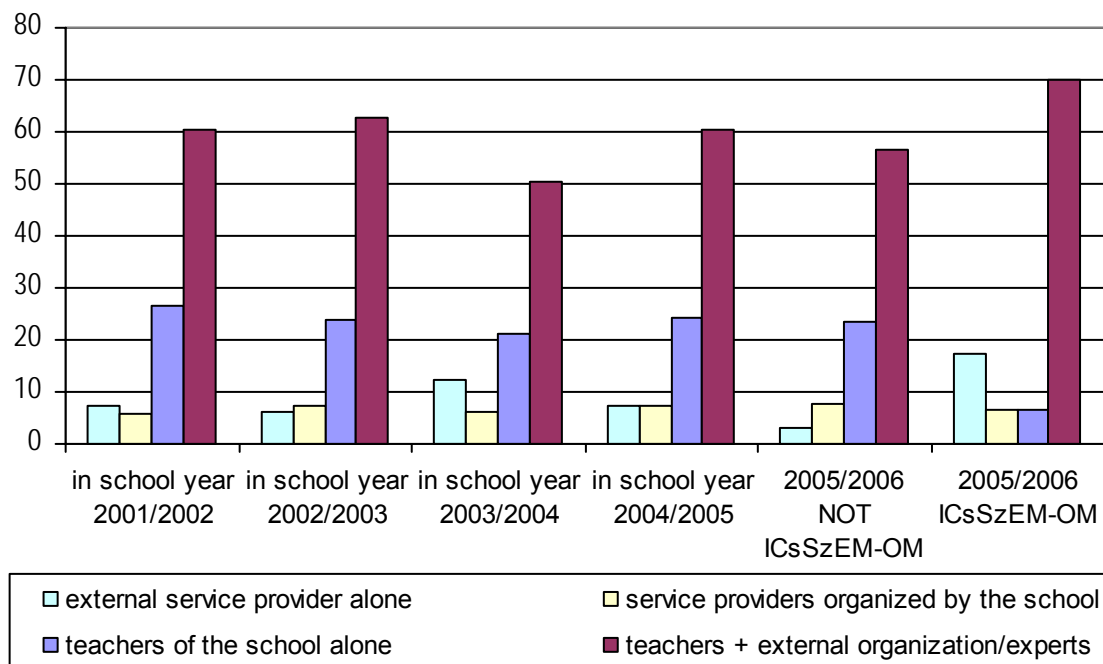
Source: Paksi et al. 2006b

The implementation of prevention activities

Prevention/health promotion activities in the ICsSzEM-OM tender system were carried out with the help of external service providers (prevention organizations and/or experts) in the vast majority (93.5%) of schools. Interventions were carried out by teachers on their own in only 6.5% of the schools. In the majority of schools engaging external service providers – in a total of 70% of the schools – teachers did however also take part in the prevention/health promotion work with the cooperation of the external service providers.

Compared to prevention work carried out in earlier years or in the present school year, but outside the tender system of ICsSzEM-OM, at schools participating in the tender teachers carried out prevention/health promotion work on their own less.

Figure 5. *Who carried out prevention activities in the past four years in tender winning schools (in the percentage of schools)?*



Source: Paksi et al. 2006b

Relationship of schools to the representatives of the health promotion institution system¹⁶

According to the survey data, schools winning the ICsSzEM-OM tender described their relationship with all the examined institutions as intensive in the field of prevention/health promotion. With regard to the intensity of the relationship, service providers carrying out prevention activities among the students, and family-care services were rated highest. The other institutions were placed in the following order (with small differences): school health service, service providers organizing further prevention training for teachers, consulting service for families at risk, institutions of the health-care system, police, social care institutions, and, lagging significantly behind, the Coordination Forum on Drug Affairs.

Process evaluation of prevention/health promotion activities among students¹⁷

According to the questionnaires answered by the participating students after the interventions, three-fourths of them participated in the whole programme, while another 14% were present for part of the programme. In total, the programmes carried out under the tender failed to reach 9.6% of the students. This rate of reaching the students matches objective participation rates registered during observations in earlier surveys aiming to evaluate prevention interventions (Paksi et al., 2002; Paksi and Demetrovics 2002).

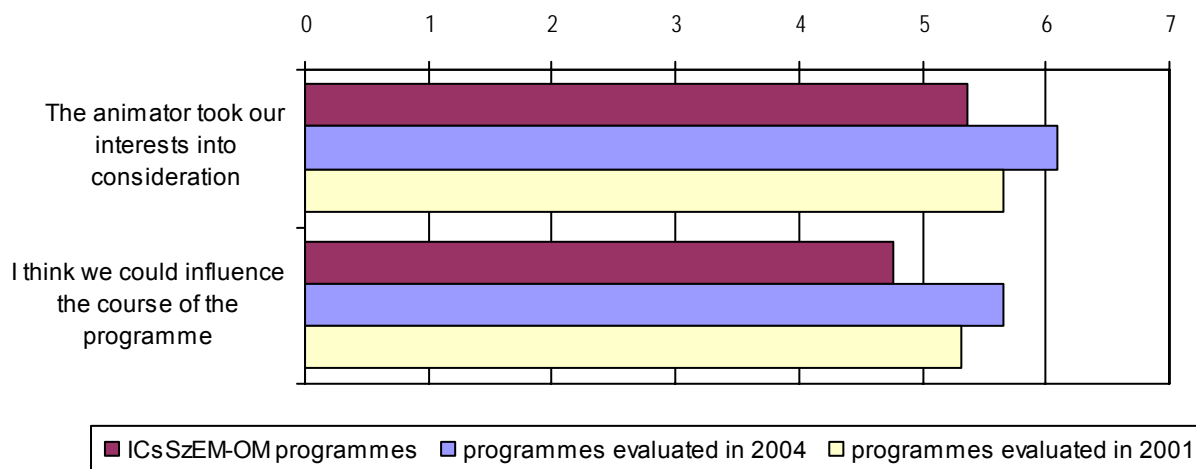
The evaluation of the level of involvement of participants, that is the interactivity of the programmes, was done – similarly to earlier surveys (Paksi et al. 2002; Paksi and Demetrovics 2002; Paksi et al. 2006a) – along subjective indicators. The programmes received a “rather favourable” classification from the participants¹⁸ of the interventions: almost three-fourths of the participants (average: 5.36, deviation: 1.76) felt that “the animator took our interests into consideration”, and half of the respondents (average: 4.76, deviation: 1.88) said that “we could influence the course of the programme”. However, if we compare these results with the results of surveys evaluating a number of Hungarian drug prevention programmes in 2001 (Paksi and Demetrovics, 2002) and 2004 (Paksi et al. 2006a), we will find that students participating in ICsSzEM-OM programmes in 2006 felt the prevention classes to be less interactive.

¹⁶ Respondents had to describe their relationship to the following institutions with the help of 5-grade scale (1 meaning no relationship at all, 5 meaning an intensive relationship): school health service, KEF, family-care service, consulting service for families at risk, social care, police, institutions of the health care system and professional organizations taking part in student intervention and teacher training.

¹⁷ The process evaluation of activities carried out among students was conducted with the help of questionnaires answered after the interventions by 3,495 students of 189 classes in 96 institutions representing the schools participating in the tender. The following subjective indicators were applied in the survey: efficiency of reaching the target group, interactivity, the actual implementation of the intervention compared to the plans, satisfaction of participants.

¹⁸ Here and in the analysis concerning the evaluation of the programmes, the answers of 3,012 students were used, who answered the question on participation in the programme, “yes, I was present for the whole programme” or, “yes, I was present for part of the programme”.

Figure 6. *The opinion of students participating in ICsSzEM-OM programmes and students participating in earlier evaluation surveys on the interactivity of prevention programmes (averages of scale point values)¹⁹*



Source: Paksi et al. 2006b

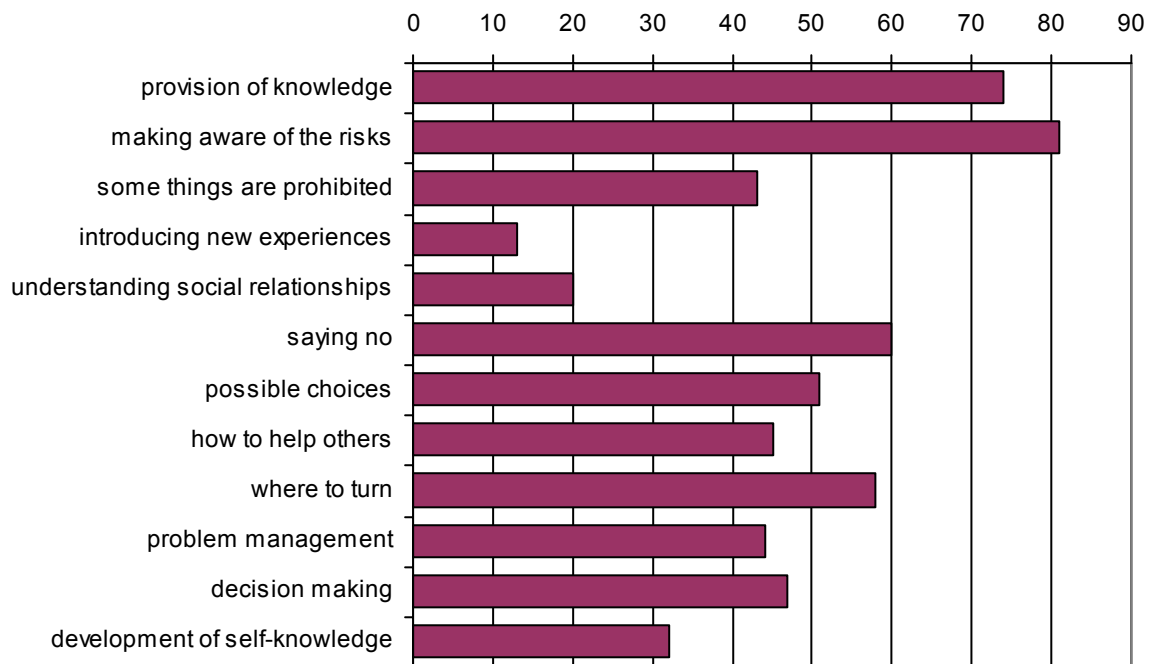
Interactivity was relatively low compared to earlier evaluation surveys, despite the fact that 98.8% of the respondents participated in a programme, which – according to its description – applied some kind of interactive technique. However, it is not known how much of the objectives related to interactivity could actually be achieved during these programmes. One explanation for the relatively low “perceived interactivity” of ICsSzEM-OM programmes may be that the implementation of the programmes was different from that planned. Based on earlier surveys (Paksi and Demetrovics, 2002; Paksi et al. 2006a) – that measured realized interactivity with objective methods as well (beside subjective indicators); both indicating different tendencies – however, there is another possible explanation. Different tendencies observed in objective and subjective interactivity indicators may imply that participants do not regard every interaction as a sign of partnership and that factors other than interactions also have an influence on partnership and perceived interactivity. (Paksi, Demetrovics 2002, Paksi et al. 2006a)

The substantial question of process evaluation is to what extent the set goals were reached and to what extent was the programme implemented according to the plans. The analysis of these questions – as the prevention classes were not observed – was carried out by comparing the objectives perceived by the participants with the objectives listed in the descriptions of the programmes received from the leaders/reference persons of the prevention teams.

Among the goals perceived by the students the most common ones were making aware of the risks and the provision of knowledge. More than 70% of the participants mentioned these. 60% of the students perceived the goals related to “saying no”, while 40-50% mentioned the goals related to the development of various skills. Considering the ratio of students reached by the programmes working with different objectives, we can say that these answers correspond to the occurrence of planned objectives (see Figure 7.). Almost 60% of the students perceived the goal of providing information on treatment services that was a priority of the tender. On the other hand, students perceived the goals related to self-knowledge in a lower ratio compared to the programme descriptions.

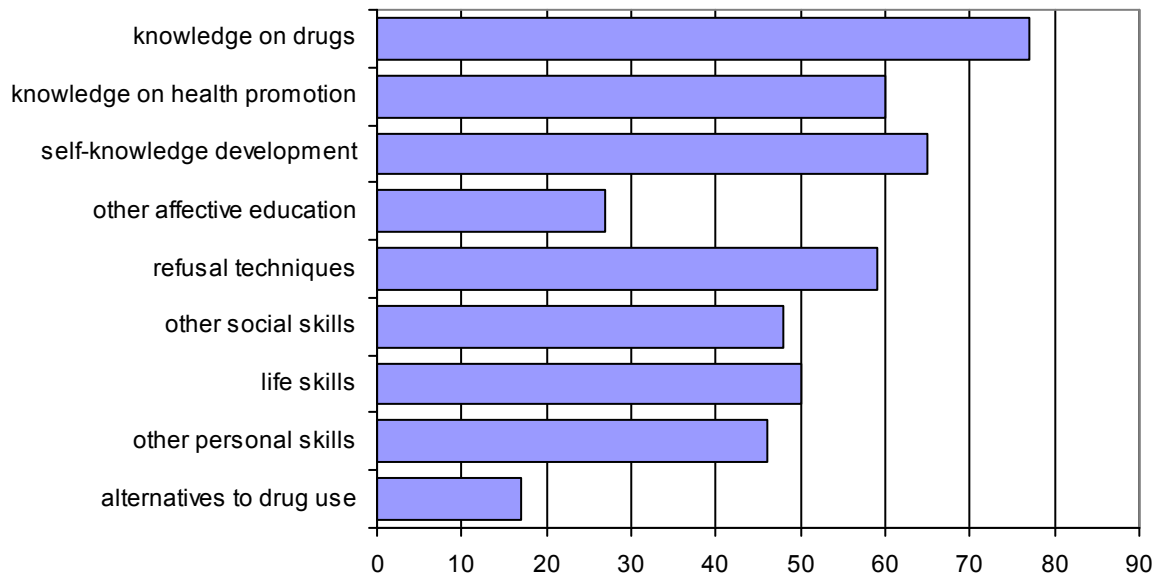
¹⁹ The respondents had to express the degree of satisfaction on a 7-grade scale, 1 meaning “totally disagree”, 7 meaning “totally agree” with the given statement.

Figure 7. Perception of different objectives among the participants of the ICsSzEM-OM tender programmes (in the percentage of participating students)



Source: Paksi et al. 2006b

Figure 8. Appearance of different goals in the descriptions of the ICsSzEM-OM tender programmes (in the percentage of participating students)



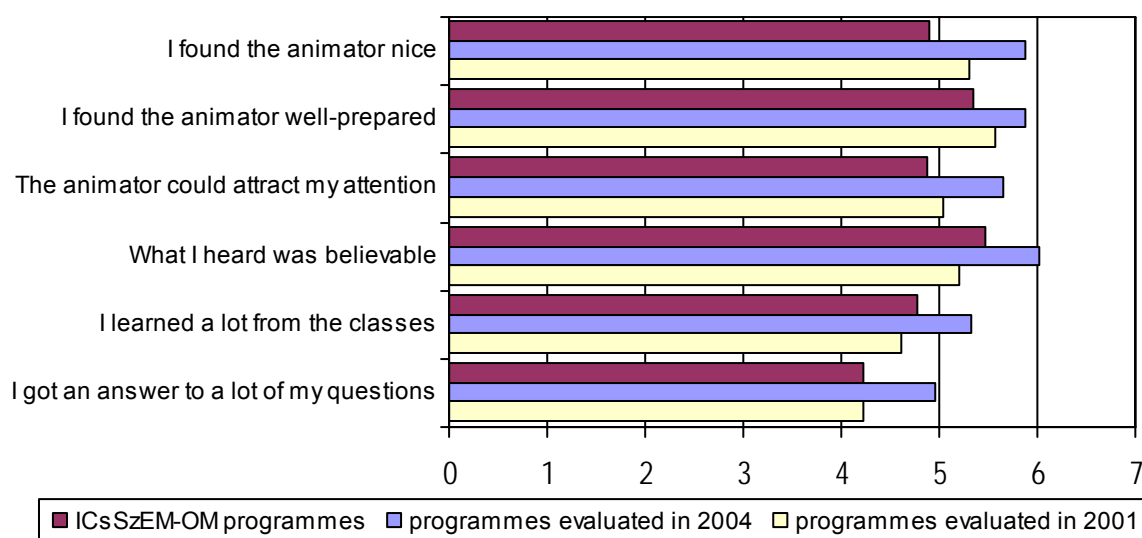
Source: Paksi et al. 2006b

The reactions of the participants and their satisfaction with the programmes were studied by satisfaction indicators. Students expressed their satisfaction with the programme and its certain dimensions – similarly to indicators applied in earlier surveys (Paksi et al. 2002, Paksi, Demetrovics 2002; Paksi et al. 2006a) – from different aspects on a seven-grade scale. The animators got “rather favourable” marks from the participants in all three examined dimensions. The most favourable reactions were received in relation to the

credibility of the classes: three-fourths of the students gave “rather positive” responses. About 70% found the animators well-prepared, and about three-fifths of the students said that the animator was nice and could attract their attention. The students were least satisfied with the information content of the programmes, despite the fact that 90% of the students asked participated in a programme whose objectives contained the provision of information concerning drugs and/or health promotion.

By comparing the results with earlier evaluation surveys conducted among prevention programmes (Paksi et al. 2002, Paksi, Demetrovics 2002, Paksi et al. 2006a), it can be concluded that animators in the ICsSzEM-OM tender programmes got less favourable reactions from the participating students, even though their overall judgement was positive. Based on the satisfaction indicators received in the other evaluation dimensions, we may say that the prevention programmes carried out under the tender on the whole do not rank among the programmes receiving the most favourable reactions from the participating students.

Figure 9. *The averages of responses given in the different dimensions by students participating in the ICsSzEM-OM programmes and respondents of earlier evaluation surveys (averages of scale point values)*



Source: Paksi et al. 2006b

Naturally, the above statements apply to all the programmes under the tender and all the students participating in the programmes. The relatively high deviation of average values (close to 2) in the different dimensions indicates that the opinion of the students was not unanimous. However, no explanatory model of appropriate strength could be created – with the help of more than 100 variables representing the characteristics of programmes, schools and participating students – to explain the opinion differences²⁰.

The outcome evaluation of prevention/health promotion activities carried out among students

The survey attempted to estimate the short-term effects of the interventions along indicators – already applied in earlier surveys – representing tender priorities and the final objectives of the drug prevention programmes. With regard to the fact that data were only collected after the prevention interventions (because of the timing of the survey), it was not possible to measure changes in the variables of objectives that occurred as a result of the prevention programmes. As a result, in the course of the outcome evaluation only the following factors

²⁰The stepwise linear regression analysis to explain the variance of the satisfaction index – created by main component analysis of variables related to the reactions of participants – did not result in a strong enough model.

could be examined: to what the extent could differences in the variables of objectives – occurring after the programme – be explained by the individual characteristics of participants, the peculiarities of the schools or rather the different characteristics of the prevention programmes²¹.

The survey tried to point out those characteristics of the programmes that have an especially beneficial effect on the realization of prevention objectives (e.g. knowledge of students, or self-efficiency).

However, based on the analyses concerning the effectiveness of programmes – except for objectives related to the provision of knowledge – no programme characteristics could be identified, that could help determine the so-called best practises, that are more effective than the average. According to the differences appearing in the perception of the students, the use of visual presentation or if the programme took place over several occasions, preferably with the involvement of a variety of animators were usually effective in transferring knowledge.

Due to the emphasis laid on the role of interactivity, researchers examined the explanatory power of perceived interactivity in a separate model for all objectives. However, the favourable effect of interactive methods was also primarily shown in reaching the objectives of knowledge provision.

Training of school drug-coordinators

Only one training for school drug-coordinators was organized in 2006 (35 teachers), because the programme had to be re-accredited last year.

Out-of-school prevention

No new information available.

3.2. SELECTIVE PREVENTION

Recreational settings

In 2006 six organizations carried out harm reduction/prevention activities in the recreational settings. Only one of the organisations introduced in National Report 2005 (Buliségély - Party help, Veszprém) did not carry out this kind of activity in 2006. Two services started their operation in 2005. The organizations typically operated in a certain town or region, with only two of the organizations participating in programmes organized in further towns, primarily at festivals. In 2006 the six organizations took part in more than 250 events, where they reached almost 28,000 youths.

Table 10. *The activity of organizations carrying out harm reduction activities in recreational settings in 2006*

Name of the programme	Geographical coverage of the programme	Year of launching the prog.	Number of staff	Relevant scenes	Service volume	Number of contacts
Party Service (Budapest)	national	1999	1 full-time coordinator, 15-30 volunteers	Parties, festivals	21	19,650 people

²¹ Stepwise linear regression was used to explain the variance of dependent variables.

Bulisegély – Party help (Pécs)	Pécs, Baranya, Southern Transdanubia region	2000	8 professional helpers	Rock, disco, alternative, university club, festivals	160	1,720 people
Mozgótárs szolgálat – “Moving partner” party service (Debrecen)	Northern Great Plain region, national	2000	3 full-time and 7 part-time experts, 46 university peer students	Festivals, university parties	27	911 people
Agria party service (Eger)	Eger and surrounding area	2004	1 project coordinator, 3 peer trainers, 12-15 voluntary peer helpers	Mainly electronic music parties, festivals	29	1,451 people
MI-ÉRTÜNK – FOR US (Békéscsaba)	Békéscsaba and surrounding area	2005	3 full-time employees, 2 volunteers, 2-5 peer helpers	Festivals	12	3,300 people
Youths for the youths – Party Service (Székesfehérvár)	Székesfehérvár	2005	1 full-time, 10 voluntary peer helpers	Rock, alternative, electronic, festivals	6	600 people

Source: Based from information received from the organizations

Besides making contact and conversation, the staff of the organizations handed out information materials and flyers to the partying youths, as well as drinks and food reducing the harms of drug use. Service providers enhanced the safer entertainment of young people with the following materials/goods: mineral water (cca. 4,500 litres), condoms (3,844), flyers (46,000), glucose, cookies, vitamins and fruit.

Roma youths

The joint peer-counsellor training programme for Roma and non-Roma youths organized by Foundation for a Clear Future took place twice (in Budapest and Salgótarján) in 2006, with 18 participants both times. After the trainings two follow-up meetings were held.

Youths visiting malls – programme ALTERNATÍVA

Population surveys of the past years (Elekes and Paksi, 2004a, 2004b; Paksi and Elekes, 2003, 2004; Dúll et al. 2006) discovered that young people often visiting malls use drugs (licit and illicit) much more often, than youths not, or only rarely visiting malls (see chapter 13.). (see National Report 2004, chapter 2.)

Based on the findings of the surveys, a new service was launched for young people in 2005 at two locations: in Budapest (Polus Center) and in Pécs (Pécs Mall). The ALTERNATÍVA office operates as a low threshold service, where youths hanging around in malls can drop in for free on every day of the week. The staff in the office offers them different programmes in the form of structured and scheduled or spontaneous group discussions, or individual consultations. Young people can also enjoy services that require less involvement, like reading newspapers, playing games, writing on the notice board, graffiti, listening to music, having tea or just chatting with each other. Group discussions mostly involve questions of self-knowledge, and issues teenagers are most occupied by, such as relationships, love, sexuality, and drug use. There are other programmes for ALTERNATÍVA’s visitors as well,

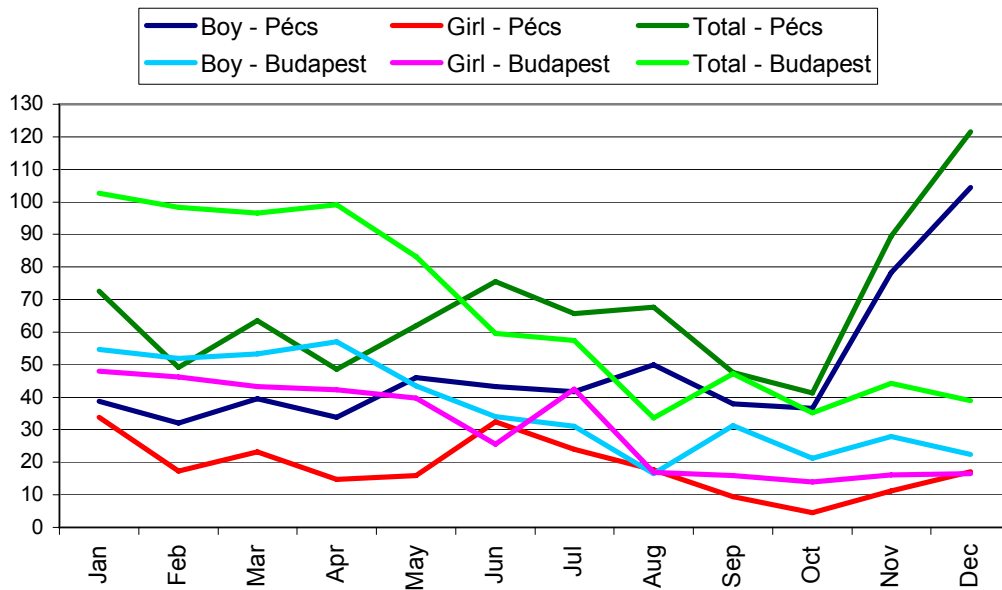
for example a film club, relaxation and yoga groups, arts and craft activities, and leisure programmes outside the mall. Besides providing low threshold services, one of the most important tasks of the counselling offices is to direct attending youths to the most appropriate health and/or social services, considering their optimal social and mental development. It is not the task of ALTERNATIVA to treat or solve the physical and mental health or the social situation of the attending youths directly. It only deals with these problems indirectly, by acting as a filter and directing youths to the right places.

In 2006 the ALTERNATIVA in Pécs was visited on average by 265 youths monthly. Many of them are returning guests, so this number of visitors does not mean that 265 different people visited the office. According to the experiences of the staff, “regulars” were initially rather from the age group 16-18 but by the beginning of 2006, more and more 12-14-year-olds became frequent visitors as well. The attendance of the Pécs office increased significantly in two months: once in June at the beginning of the summer break, and around the end of November/beginning of December. This latter increase was primarily due to a continuously growing group of teenagers above 15.

In the Budapest office on average 285 visitors were registered monthly, similarly as in Pécs. The high attendance (on average 382 visitors monthly) of the first half of the year was followed by a significant decrease (on average 187 visitors monthly) in the second half of the year. The decrease was observed at the beginning of summer. Beside the start of the summer break when youth spent more time outdoors, another reason for the decreased popularity of the office was that the management of the mall moved them into smaller premises. The smaller place available and the closing down for several weeks (because of the renovation of the new premises, the moving and financial problems) are both reasons for the decreased attendance. The “regulars” of the Budapest office are also 12-18-year-old boys and girls.

Most of the youths frequenting the Pécs and Budapest offices come from single parent families, in some cases with financial difficulties. In the living area, neighbourhood, circle of friends or acquaintances of regulars in Pécs the occasional use of illicit drugs (primarily cannabis) can be found. In the case of the visitors of the Budapest office this problem directly affects the young people. Most of them regularly smoke and occasionally – at weekend parties – drink alcohol. Some of them use cannabis and/or ecstasy too at these occasions. Problems arising among regular guests are those distinctiveness of young people. They mostly focus on self-knowledge and emotional questions: the experiences of developing and living through relationships (friendship, love), the lack of self-esteem or self-confidence. Further problems were aggressive behaviours caused by school tensions, physical looks or other shortcomings.

Figure 10. Average weekly attendance of ALTERNATIVA offices in the given months in 2006



Source: Foundation Alternativa

Drug prevention in the Hungarian Army²²

The Hungarian Army (HA) organized drug prevention trainings and programmes for its personnel in 2006. The five Regional Subcommittees of the HA held drug prevention trainings 40 times in the previous year. The trainings organized by the individual subcommittees were quite diverse (e.g. mental hygienic trainings supporting drug prevention, “Communication with Problematic Families”, drug prevention manager training with a mental hygienic approach). Almost 3,500 people participated in these trainings.

The complex lifestyle programme “Health is Your Greatest Weapon” of the Health Protection Institution of the HA ran in 5 garrisons in 2006 with about 1,600 participants. The target group of the programme was the entire staff and their family members.

Besides these, the drug prevention experts of the HA took part in several festivals and other programmes in the framework of civilian-military cooperation.

Prevention at workplace

No new information available.

3.3. INDICATED PREVENTION

No new information available.

Conclusions

The survey aiming to describe the school prevention programmes implemented within the framework of the ICsSzEM-OM tender system gives a detailed description of the differences between these programmes and the programmes in the national range of prevention programmes. They concentrate less on the provision of knowledge, they rather put emphasis on refusal techniques and the development of self-knowledge, and they apply more interactive methods. It is characteristic of programmes realized under the tender that they are

²² Based on the report by the Ministry of Defence

carried out with the involvement of outside experts, but the teachers of the schools also actively participate. In comparison with the results of earlier surveys these programmes got less favourable reactions from the students regarding both interactivity and their assessment of the animators.

In 2006 organizations offering harm reduction services in the recreational setting operated in six towns. The staff of the programmes participated in more than 250 programmes where they contacted nearly 28,000 young people. The national coverage of services provided in the recreational setting is very low; in only 4 of the 10 biggest cities is there an organization operating in this scene.

More information on out-of-school, selective and indicated prevention requires further research.

4. PROBLEM DRUG USE AND THE TREATMENT DEMAND POPULATION

Overview

Data providers apply the reporting method and format set by the Ministry of Health when reporting on drug users who enter treatment. All-inclusive TDI based data collection in 2006 was only carried out in the second half of the year.

In 2006 – similarly to the previous year – aggregated data were available on patients that received treatment. The range of institutions obliged to provide data covers practically all in- and outpatient treatment centres for psychiatric and addiction problems.²³

In the past few years, a number of amendments were made to provisions of the Criminal Code dealing with drug use and alternatives to prison (diversion programmes). Treatment demand may have been influenced by these changes, but the extent cannot be exactly determined.

4.1. PREVALENCE AND INCIDENCE ESTIMATE OF PROBLEM DRUG USERS

No new information available.

4.2. TDI – TREATMENT DEMAND INDICATOR

The data below contain the results of the National Statistical Data Collection Programme (OSAP) collected from treatment centres, similarly to previous years. This solution was necessary, as TDI system data collection was only obligatory for treatment centres from May 2006, which resulted in partial data provision for the year (see the end of this chapter for more details).

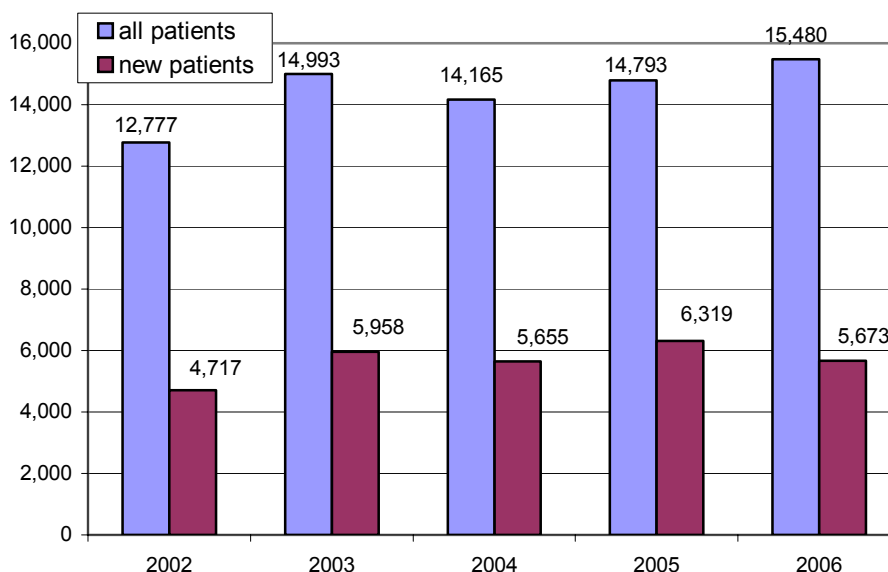
The number of patients in treatment and new patients

In 2005 the number of drug users treated grew by 4%, then in 2006 by 5% to 15,480 (TDI tables 1-2). While between 2000-2002 the number of patients fluctuated between 12,000 and 13,000, and during the following three years the fluctuation shifted up to the 14,000 to 15,000 level, in 2006 it has exceeded 15,000.

After the significant increase of 12% in 2005, the number of new patients decreased by 10% (5,673) in 2006 (ST03) and practically fell back to the 2004 level. The gradual increase observed in the long-run can be detected here as well. However, the extent of fluctuation is much greater than in the case of the total number of patients in treatment. This may probably be attributed to the definition of “new patient” based on self-assessment, which causes a significant element of uncertainty because of its subjectivity.

²³ Primary health services are not obliged to provide data. This is why a definition of “special treatment demand indicator” may be more exact.

Figure 11. The number of drug users treated in Hungary between 2002-2006



Source: Report No. 1627 by OSAP and Report No. 1211 by the Ministry of Health

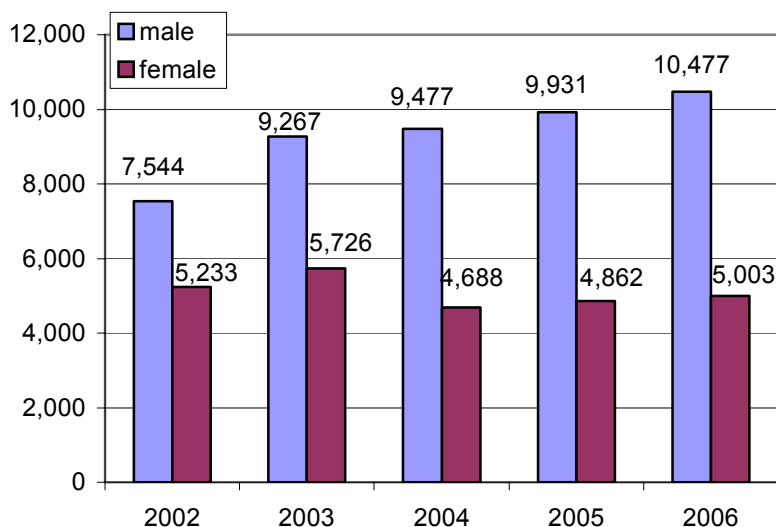
Annual fluctuations in the number of all patients and new patients and the gradual increase in treatment demand may be attributed to the amendments to the law in the past few years.

Socio-demographic characteristics

It can be seen from the graph below that the absolute number of women in treatment has increased compared to 2005.

Between 2002-2006 (similarly to previous years) the number of male patients has been higher in all drug categories, except for sedative-type of drugs. The proportion of female patients using sedatives and tranquillisers as drugs has been significantly higher every year (in 2006 3:2 "in favour of" women).

Figure 12. Breakdown of drug users in treatment by gender between 2002-2006

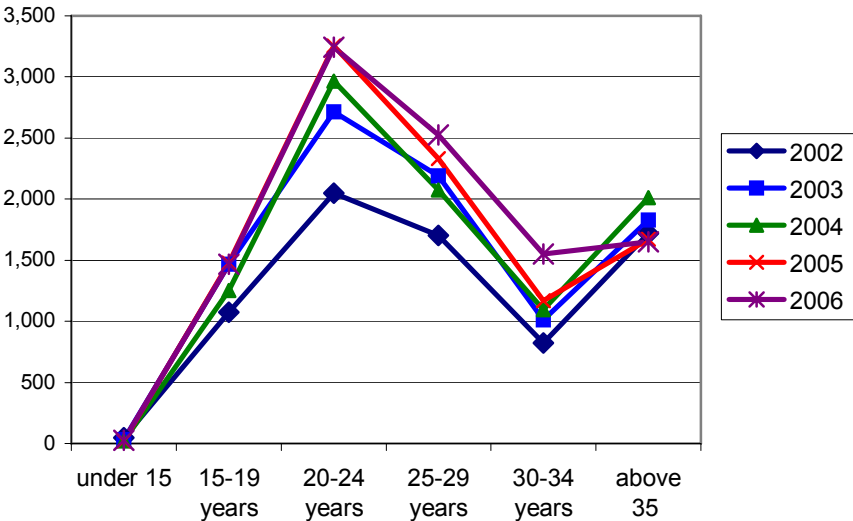


Source: Report No. 1627 by OSAP and Report No. 1211 by the Ministry of Health

Among new patients, there was a tendency similar to the one presented among all patients. The 2002-2003 peak can be found in the shifting of the ratio of women here as well, then the resettling between 2004-2006. In 2006 the number of both male (-12%) and female (-6%) patients decreased, therefore the increase in the total number of patients was not attributable to a rise in the number of new patients.

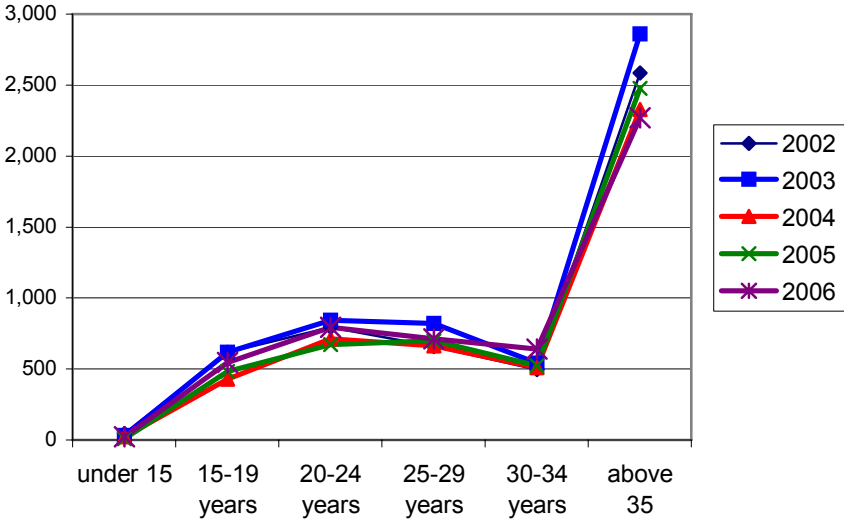
The breakdown by age among men and women shows tendencies that are consistent from year to year but different by gender. The 20-24 age group of male patients represented the largest group among all patients each year between 2002 and 2006. However, there was no increase in this group in 2006. The same age group of female patients was the largest until 2005. That is, in 2005 the 25-29 age group was the largest – though only slightly. In 2006 the frequency of the 20-24 age group of all patients became the highest again and similarly to the previous years, frequency was relatively high in other age groups as well.

Figure 13. Breakdown of male patients in treatment for drug use by age between 2002-2006



Source: Report No. 1627 by OSAP and Report No. 1211 by the Ministry of Health

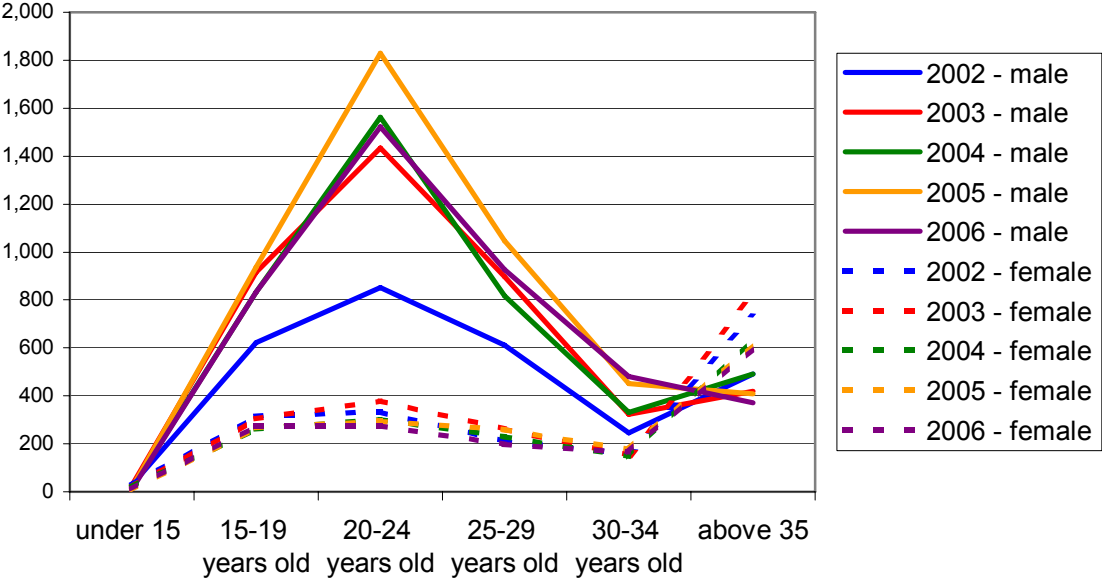
Figure 14. Breakdown of female patients in treatment for drug use by age between 2002-2006



Source: Report No. 1627 by OSAP and Report No. 1211 by the Ministry of Health

An interesting phenomenon can be observed among new patients: the frequency curve of women is becoming continuously “flatter”, and the ratio of 20-24 year olds decreases. In 2006 the frequency of the 15-19 age group was practically equal to that of the 20-24 group. In the last two years the number of men above 35 has also been decreasing, while the number of female patients in this group – however slightly – continuously increases. The difference between the two sexes in the age distribution may be due to the fact that the drugs mainly used by women – sedatives and tranquillisers, and the use of these together with alcohol (poly-drug use) result in more serious problems requiring treatment at an older age.

Figure 15. Breakdown by age among new patients between 2002-2006

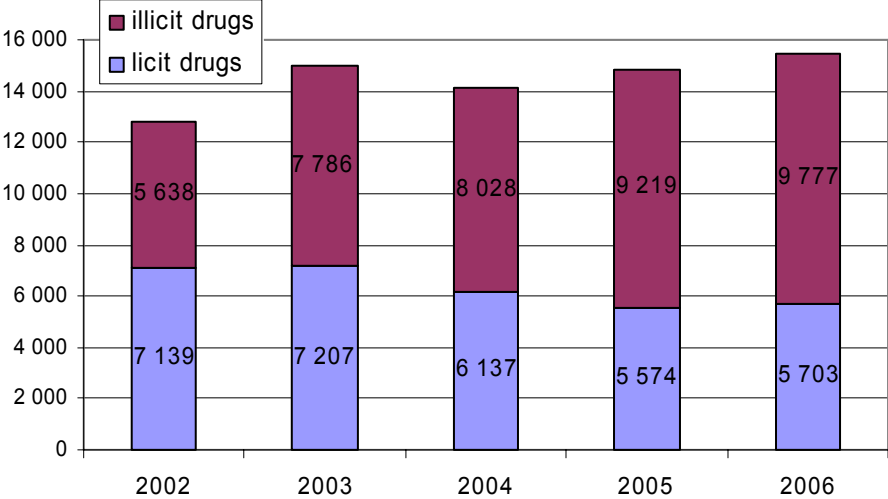


Source: Report No. 1627 by OSAP and Report No. 1211 by the Ministry of Health

Breakdown by substance

In 2004 and 2005 the number of patients using licit drugs kept decreasing, whereas the number of patients using illicit drugs increased significantly. In 2006 both the number of patients using licit and illicit drugs increased, however the ratio between illicit and licit drugs remained 2-to-1.

Figure 16. Breakdown of patients in treatment by substance between 2002-2006



Source: Report No. 1627 by OSAP and Report No. 1211 by the Ministry of Health

Despite a slight increase in the number of patients using opiates in 2005, the use of heroin and injecting drug use within this drug type continued its decline. Due to this decrease, cannabis and its derivatives became the most frequently used drugs.

In 2006 there was a significant increase in both the number of heroin users and injecting heroin users in treatment (15% in both cases). The overall increase within the opiate category was 8%, but this has not affected its earlier rank. The share of the opiates within all drugs used is presently 15%.

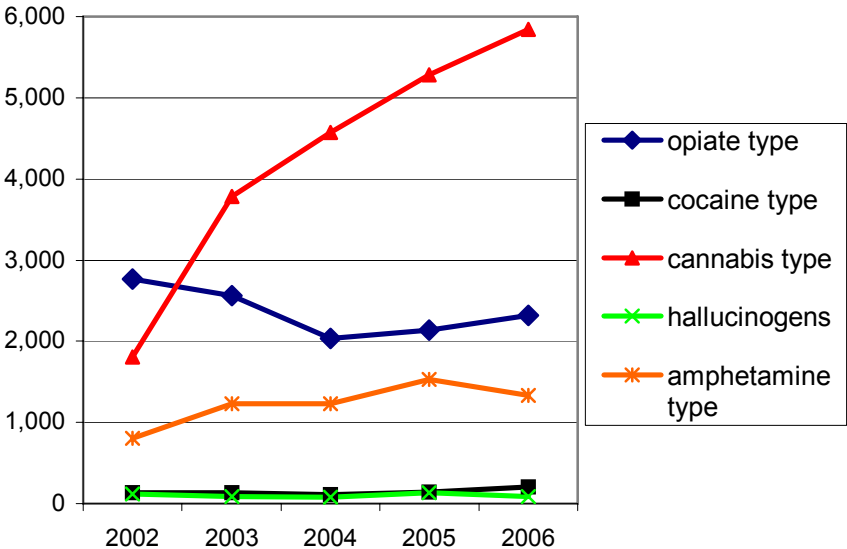
The number and proportion of cannabis users among all patients has been continuously and sharply increasing since 2002. The number of patients using cannabis grew by 21% in 2004, by a further 16% in 2005, and again by 11% in 2006. With this they amount to a proportion of 38% of all the patients in treatment.

The number of patients using amphetamine grew by a significant 24% in 2005, which was followed by a 13% increase in 2006, meaning that about 9% of all patients were amphetamine users.

Although after four years of constant decrease, the number of patients using cocaine increased by 22% in 2005, and by 48% in 2006 (from 138 people to 204), their share among all patients is still only 1.3%.

The share of patients using hallucinogens increased considerably, by 72% (from 76 to 131 people) in 2005. This was followed by a 37% decrease in 2006. As a result their share presently is 0.5%.

Figure 17. Number of patients in treatment for illicit drug use between 2002-2006



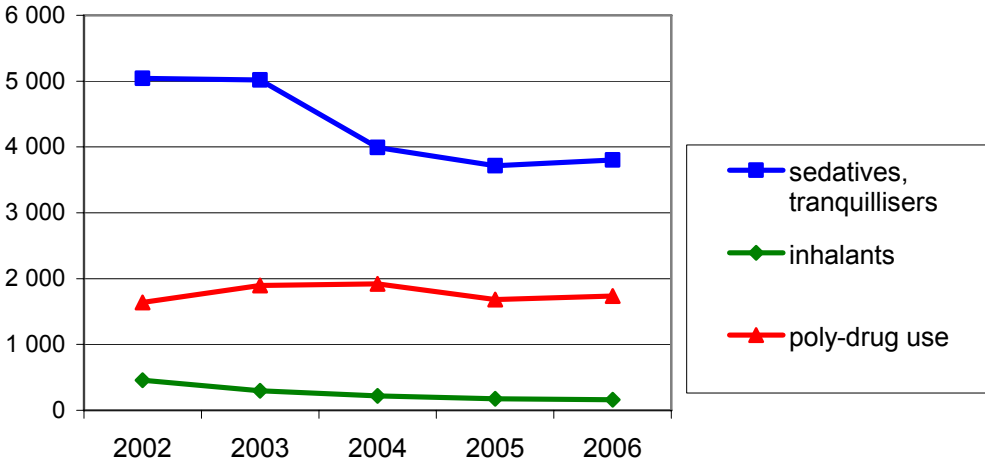
Source: Report No. 1627 by OSAP and Report No. 1211 by the Ministry of Health

The share of patients abusing sedatives and tranquillisers continuously decreased until 2005. In 2006, they still represented a share of 25% among all patients; this is the highest ratio among licit drugs.

Although the number of patients for poly-drug use (sedatives and/or tranquillisers consumed with alcohol) showed some fluctuation, it eventually remained constant in the average of the past five years' data. It represents a share of 11% among all users.

The number of patients using inhalants has constantly been decreasing and had a share of 1% among all patients in 2006.

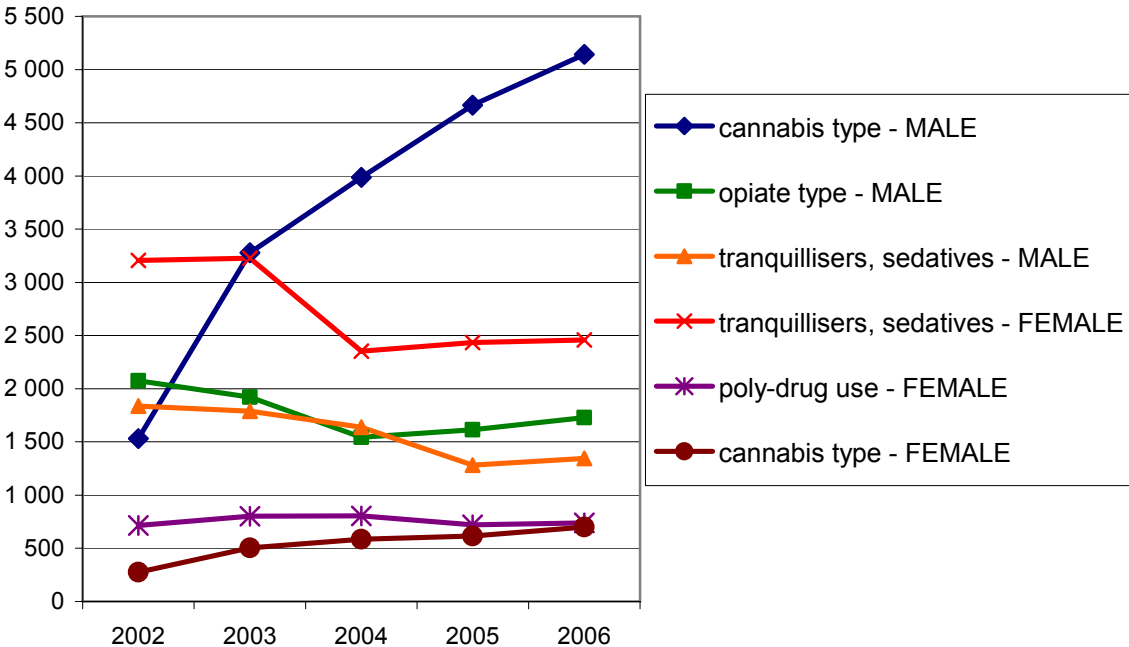
Figure 18. Number of patients in treatment for use of licit drugs between 2002-2006



Source: Report No. 1627 by OSAP and Report No. 1211 by the Ministry of Health

The following figure illustrates gender-based differences in preference for each specific drug.

Figure 19. Substances mainly used by males and females in treatment (by number of users)

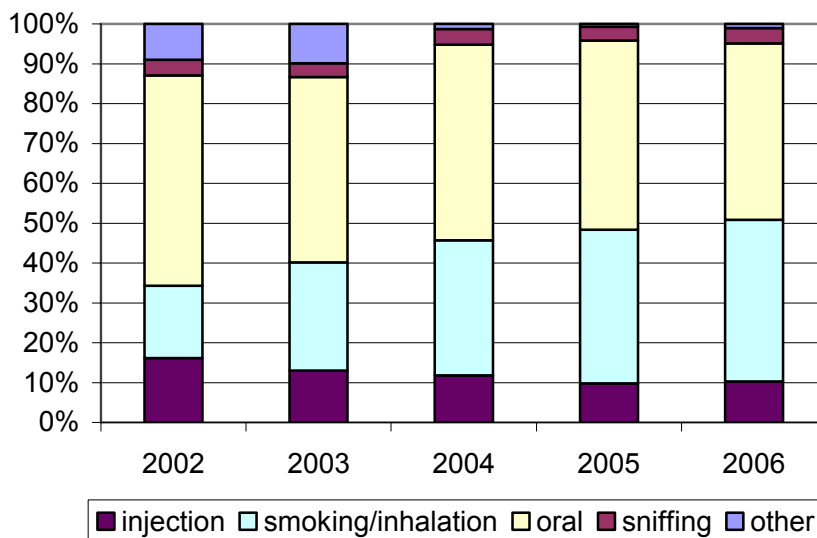


Source: Report No. 1627 by OSAP and Report No. 1211 by the Ministry of Health

Breakdown by route of administration

The routes of administration have significantly changed among patients in treatment in the last few years. Injecting drug use was decreasing steadily until 2005, nearly halving compared to the 2001 level. Conversely, there was a 10% increase in 2006, primarily due to the repeated increase in injecting heroin use. Between 2002 and 2006 smoking/inhalation increased significantly, becoming 2.7 times more frequent. This underlines the rapid upsurge of cannabis use. The share of oral administration of drugs (eating/drinking) stayed practically the same in the past 5 years. This is still the most common route of administration among patients, which is in accordance with the large shares of sedatives, tranquillisers and poly-drug use. The frequency of sniffing increased in 2006 compared to the previous year.

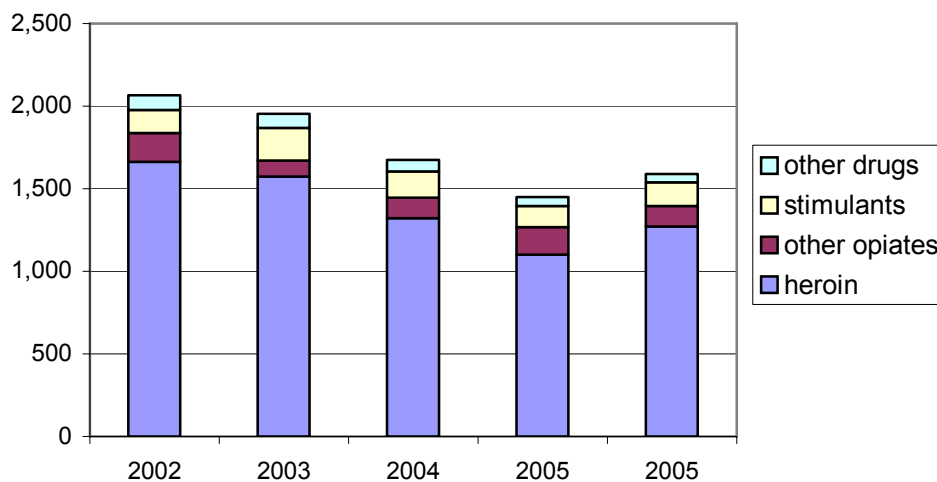
Figure 20. Breakdown of patients by route of administration between 2002-2006



Source: Report No. 1627 by OSAP and Report No. 1211 by the Ministry of Health

Injecting drug use was decreasing between 2002-2005. On the other hand, there was a 10% increase in 2006. The primary reason in the background of the increase is the 15% rise in the number of injecting heroin users in treatment. Injecting use of other substances has been practically stagnating.

Figure 21. Breakdown of injecting drug users in treatment between 2002-2006

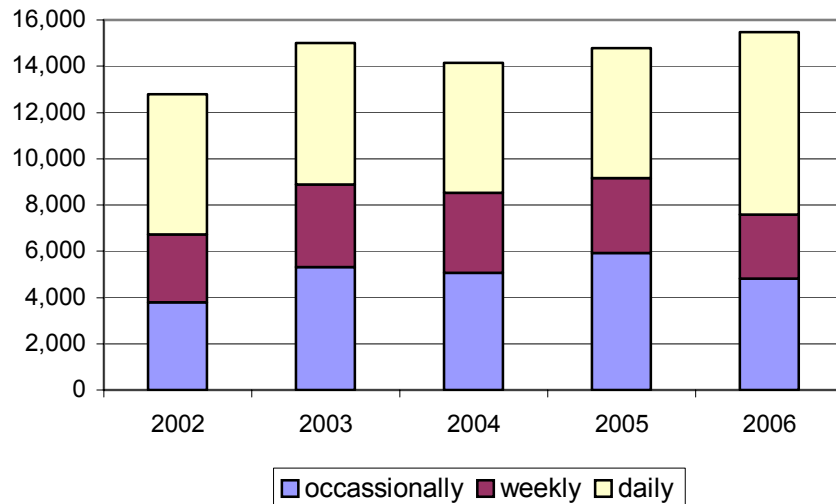


Source: Report No. 1627 by OSAP and Report No. 1211 by the Ministry of Health

Breakdown by frequency of use

The breakdown of the frequency of use among patients shows a mixed picture. The number of all occasional users in treatment has been increasing, but in 2006 decreased by 19%. The number of those using drugs on a weekly basis decreased steadily over the last three years. As regards the number of those using drugs on a daily basis, a decreasing tendency could be observed in general until 2005, apart from slight annual fluctuations. On the other hand, there was major increase in 2006, which was mainly due to the tripling of daily consumption of benzodiazepines.

Figure 22. Breakdown of patients in treatment by frequency of use (19 cases are unknown in 2004)

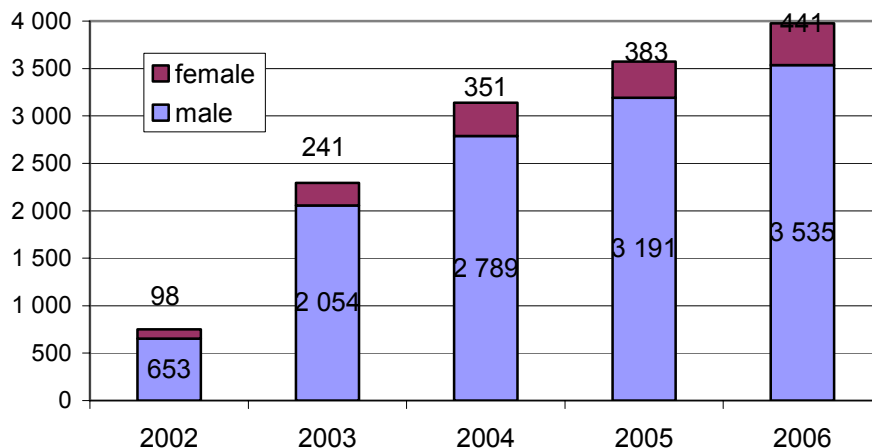


Source: Report No. 1627 by OSAP and Report No. 1211 by the Ministry of Health

Changes in the number of patients in drug diversion programmes

A break-through increase occurred in the number of patients in diversion programmes in 2003, when their number increased by 206%. This increase continued in the following years as well, however, in a decreasing extent. This phenomenon may probably be attributed to the amendment of the Criminal Code. The number of patients in diversion programmes increased by 15% in 2005, and by a further 13% in 2006. In 2006, 3,976 persons started diversion programmes.

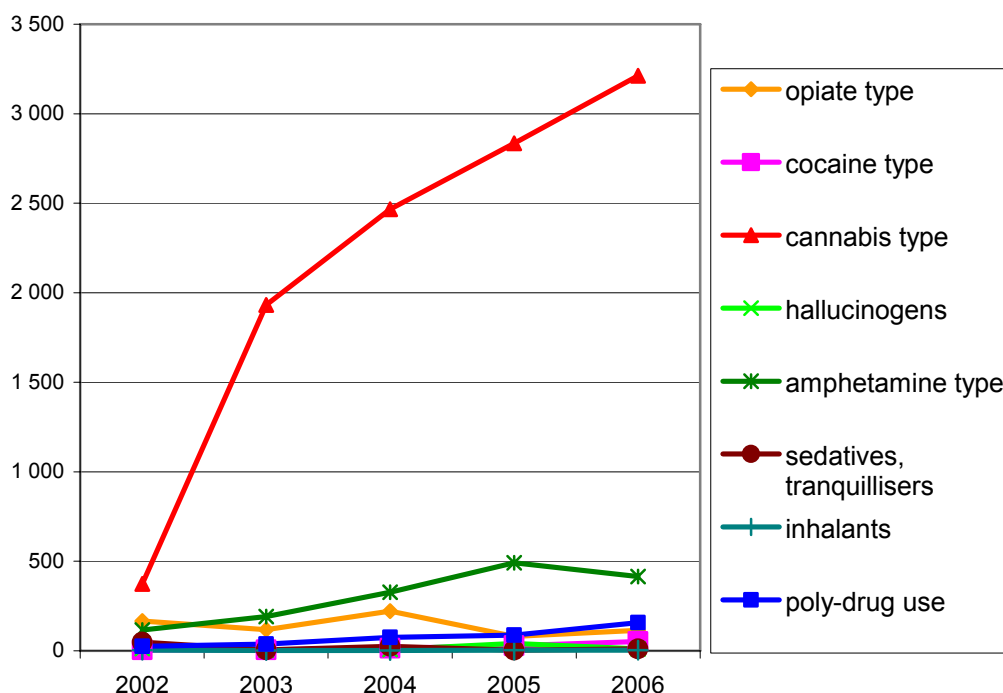
Figure 23. Number of patients in diversion programmes between 2002-2006



Source: Report No. 1627 by OSAP and Report No. 1211 by the Ministry of Health

The major increase from 2003 is due to the outstanding rise in the number of cannabis users in diversion programmes.

Figure 24. Breakdown of patients in diversion programmes by drug type



Source: Report No. 1627 by OSAP and Report No. 1211 by the Ministry of Health

We should also mention that the number of patients in diversion programmes for drug use increased for every drug type in 2006, except for hallucinogens and amphetamines.

Overview of available TDI data

The origin of analysed data

The analysis below is based on the TDI database of the National Institute for Addiction (OAI). It does not contain data from the annual aggregate reports of treatment centres (so-called "old" OSAP reports).

The relevant act prescribes TDI data collection for the concerned service providers since May 2006. This implies that presently available data cannot be considered of full value with regard to annual statistics, as they are only partially available for the first half of 2006.

The data in the database have been selected by the OAI. In Hungary the TDI database has been amended with an "in diversion"²⁴ module, which includes persons who participated in treatment as an alternative to criminal proceedings. This resulted in three statistical tables. The first one contains the data for clients *outside diversion*, the second contains the data of participants in *diversion programmes*, and the third is a *national aggregate* statistics. Separate examination is necessitated by the differing composition of the two populations.

²⁴ Since the modification of the Criminal Code by Act II of 2003 (1 March 2003), there is a possibility in the case of "misuse of narcotic drugs" for certain offenders determined by the act to avoid punishment. Section 283 of the Criminal Code determines the cases in which the offender cannot be punished provided that they undertake to participate in a treatment for drug addiction for at least 6 months continuously, in another treatment for drug use, or in a prevention-information service and they can verify this with documentation. The classification based on the seriousness of addiction is effectuated by the psychiatrist or addiction experts or clinical psychologist of the given institutions. (Source: <http://qvism.gov.hu/index.php?id=827>)

The present chapter is to be considered experimental, therefore only the most significant details are presented from the annual statistics.

Characteristics of clients outside diversion

According to available TDI data one-third of clients did not enter diversion treatment. According to the data, 50% participated in treatment for the first time, 45% had been previously treated, but the treatment was interrupted for at least 6 months. For the remaining 5% there was no reliable information with regard to earlier treatment. The male:female ratio of clients in treatment is generally 4:1.

The most frequently used substance among people starting treatment is cannabis (42%). This ratio among people receiving treatment for the first time is two-thirds. In the case of this second group stimulants are in the second place (mainly amphetamines), while the third most common reason for treatment is opiate use, primarily heroin. In the case of men, cannabis use as a reason for treatment is much more common, than among women. This phenomenon corresponds with other epidemiological data.

Among clients outside diversion programmes, the second most frequent reason for treatment is opiates, amounting to 25% of all treatment needs; the third and fourth reasons are stimulants and sedatives, each with a 10% share. The remaining amounts are accounted for by cocaine (3%) and other drugs (8%) meaning inhalants and hallucinogens.

Among men, cannabis use is the most frequent reason for entering treatment, especially in the minor (15-19) and young adult (20-24) categories. Cannabis is also the most frequent reason for entering treatment among women, but not as prominently as in the case of men. Among women, the ratio of clients entering treatment because of the use of tranquillisers and sedatives (especially benzodiazepines) is higher. The third most common reason is opiate use, primarily heroin.

Another important datum is the age at which they start using drugs. Early drug use predicts serious problem drug use later.

50% of all men entering treatment for heroin use started using drugs before the age of 19. In the case of amphetamine users this ratio is two-thirds, while among cannabis users it is 77%. These latter two data are also similar among patients entering treatment for the first time (34 and 79%). Male heroin users among patients in treatment for the first time belong to an older age group. The above-mentioned ratios are very similar among women as well.

As for the frequency of drug use, among men there is practically no difference in intensity between the total patient population and patients in treatment for the first time. Regarding heroin use, the ratio of regular/intensive use in both groups is 78-80%, the ratio of intensive amphetamine users is around 50%, while the share of weekly/daily cannabis users is 35-40%. In case of women, the data of patients in treatment for the first time cannot be interpreted conclusively, because of the low number of cases.

Secondary drug use is also worth mentioning, from which we can conclude that in the case of heroin users the most common secondary drug is cannabis among all patients treated, but the use of stimulants and alcohol is also frequent. Among clients who marked stimulants as primary substance, the use of cannabis as a secondary drug is very high. Based on the data, this relationship is true the other way around as well.

Socio-demographic data

60% of patients treated for the first time come from the 15-24 age group.

45% of all patients in treatment live with their parents; in the case of new patients this ratio is 56%. According to the data, the housing circumstances of the majority (85-90%) of clients in treatment (both new and old patients) are stable.

About one-third of all patients work, one-third is unemployed, and about 20% are students (this latter ratio is almost 40% among new patients). For further socio-demographic data of clients in treatment outside diversion programmes, see chapter 8.

Characteristics of clients in diversion programmes

According to TDI data in the database of the OAI, 90% of patients participating in diversion programmes are men, both in the group of all clients, and new clients. 74% of clients in diversion enter treatment for the first time. Almost half (44%) of all the patients belong to the 20-24 age group.

Among clients in diversion the ratio of injecting drug use is less than 10%. The most frequently used primary drug among clients in diversion is cannabis, 82% among all patients treated. This ratio is about two times higher than among clients outside diversion programmes (where it was 42%). The situation is similar among patients in diversion who enter treatment for the first time. Here 84% use cannabis as the primary drug, while this ratio among first-treated patients outside diversion programmes is 63%. Among women in diversion the ratio of cannabis as a primary drug is much lower than among men; about two-thirds of women use cannabis. The use of stimulants makes up 25% of all cases. The same ratio among men is about 10%. The ratio of opiate and cocaine users is very low (2-3%).

Among clients in diversion the date of first drug use falls between 15-19 years of age among almost 70% of men, while the ratio in this age group among women is 80%. Secondary drug use is similar to that of clients outside diversion.

Socio-demographic data

Two-thirds of clients participating in diversion live with their parents, and the housing circumstances of about 90% are stable. Almost 50% work regularly; one quarter are students.

4.3. PROBLEM DRUG USERS FROM NON-TREATMENT SOURCES

A survey was conducted in the spring of 2006 (Márványkövi et al. 2006), which targeted problem drug users²⁵ in Budapest, who either did not enter treatment or ended up at health care institutions after at least one year (directly before being questioned). The aim of the survey was to discover the hindrances and difficulties that hamper problem drug users outside treatment in accessing health and psycho-social services and needle-exchange programmes.

49 men and 18 women were included in the sample²⁶. The average age of the sample was 27.4 years. The ratio of age groups 18-24, 25-29 and above 30 was about even. Three-fourths of the interviewees declared themselves to be of Hungarian origin, while one quarter were of Roma origin. The sample was homogeneous regarding education: more than half did not have a high school degree. The average number of grades completed was 10. It is also characteristic of the sample that three-fourths did not have a regular job, and/or supported themselves from odd jobs. Only four of them were married and 35 of the drug users did not have a partner at the time of questioning. The ratio of people living with their parents or living in sublets or somebody else's apartment was approximately equal.

The data of the survey further point out that problem drug use may be accompanied by committing – not only drug-related – crimes. 43 of the clients in the sample had had a criminal proceeding initiated against them, and 20 of them had been in prison (for 2.2 years on average). In the case of more than a third of the interviewees the proceeding was started for the use, supplying or offering of drugs, and almost in the same number of the cases for crimes against property (as well).

²⁵Has been using opiates or amphetamines 3-4 times a week for at least 3 years.

²⁶The researchers accessed the interviewees with two methods: the snowball method (started at four independent points), or sampling with a treatment place/service provider basis. As a result, 67 problem drug users were interviewed.

Almost all of the problem drug users in the sample have tried one of the three problem drugs (heroin, cocaine, amphetamines). Except for one of the interviewees, all of them used cannabis, 45 of them used cocaine, 63 used amphetamines, and 61 used heroin. The age of trying heroin, cocaine or amphetamines was almost identical (19-20 years), and the date of first use and the beginning of regular use practically coincided. During the 30 days, and also the 48 hours preceding the interview, most people used heroin or cannabis. Almost two-thirds used various drugs in this period, and almost all of them injected one of the problem drugs. The average length of their drug career was 7.6 years. Shared paraphernalia use, that is, the risk behaviour related to injecting drug use, was common (admitted by 46), and so was sexual risk behaviour. Medium level drug addiction was characteristic of the sample.

The results of the survey cast light on the relationship between treatment demand and the ratio of people entering treatment. Half of the sample have already participated in some kind of treatment, or have partaken in psychological or labour counselling. The demand for services of needle exchange programmes (low-threshold services) is high among problem drug users – this is rather true for interviewees in better health. Their majority have received sterile needles or paraphernalia through a low-threshold organization – mainly needle exchange programmes.

Treatment demand occurs with a higher probability among problem drug users who have earlier entered some kind of treatment, or have friends who are injecting drug users²⁷.

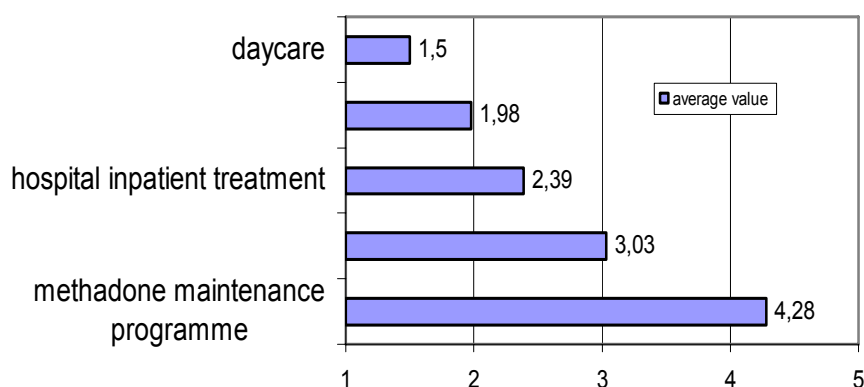
During the 30 days preceding the interview, 11 participants had received some kind of health care treatment²⁸, most of them having been hospitalised. During the previous year, more than half of the problem drug users sought treatment of their general practitioner as well, but only seven of them declared that they received further specialised care on the referral of the general practitioner. The ratio of those who received dental care is relatively high (28 people). Visiting a treatment centre for sexually transmitted diseases or dermatology is much less characteristic (8 and 9 people respectively). 53 of the interviewees participated in various screenings (HIV, hepatitis, tuberculosis), which were usually carried out at higher threshold institutions.

The most inaccessible forms of treatment, according to the opinion of the surveyed users, are drug rehabilitation and methadone maintenance treatment. The demand for methadone maintenance treatment among interviewees is higher than the present enrolment ratio.

²⁷ The authors give the following explanation: "The earlier history of treatment, as a factor influencing (enhancing) needs in a positive way, can be explained with the socialization effect of earlier treatments: if there is a problem, one has to ask for treatment. Also, the given person knows where and how they can ask for treatment. This kind of role of injecting drug user friends may indicate peer effects in the initiation of treatment, but indirectly it may also denote an impaired psycho-social situation, that is, social exclusion when only injecting friends are left." Márványkővi et al 2006.

²⁸ Health care treatments used: inpatient, outpatient, rehabilitation, methadone maintaining, day-care.

Figure 25. Judging the difficulties of entering certain treatment centres



Source: Márványkövi et al. 2006

The opinion on drug rehabilitation is partly understandable, as the motivation of problem drug users to quit and live without drugs is not always strong enough to actually go through all the steps leading to rehabilitation. The high demand for the needle exchange programme may imply the same thing. The opinion on methadone maintenance treatment is different; this harm reducing treatment should be more easily accessible. However, other data from the survey confirm its inaccessibility. The members of the sample judged the conditions of entering treatment more difficult in the case of more serious addiction.

Table 11. Factors hindering treatment in the two most "isolated" treatment forms: reasons mentioned

Drug rehabilitation (N=30)	Times mentioned
There are too few institutions with too few places	13
The wait is too long	8
Proper drug use record is needed	3
User must be in lucid mental state at admission	3
Methadone maintenance (N=43)	Times mentioned
The wait is too long/there are too few places	26
It is hard to fulfil the conditions	6
Treatment expectations are too strict	6
Financial burden / too expensive	2
It also depends on whether one is liked / subjective	2

Source: Márványkövi et al. 2006

Most of the interviewees had access in case of need to outpatient treatment in the 12 months preceding the survey. The participants thought - in all kinds of treatment except for outpatient treatment - that the reason for entering treatment originates in institutional reasons.

The participants who required needle exchange services said that in most of the cases they received the necessary sterile needles.

Table 12. Accessibility of treatment

(N=67)	Outpatient (N=14)		Inpatient (N=12)		Rehabilitation (N=10)		Day-care (N=6)		Methadone (N=22)		Total (N=41)	
	N	%	N	%	N	%	N	%	N	%	N	%
Yes	6	42.9	2	16.7	0	0	2	33.3	2	9.1	10	24.3
No, not always	8	57.1	10	83.3	10	100	4	66.6	20	90.9	31	75.7
Total	14	100	12	100	10	100	6	100	22	100	41	100

Source: Márványkövi et al. 2006

The experts asked perceive the problems of the treatment system in the lack of continuity in the treatment chain, and often the unorganised nature of accessibility of treatment. However, they think that the greatest problems in accessing treatment are the motivation of clients and the danger of relapse caused by their relationships (drug using friends).

4.4. INTENSIVE OR FREQUENT PATTERNS OF USE

No information available.

Conclusions

Treatment centres recorded 15,480 drug users in 2006, a 5% increase on the previous year. On the other hand, the number of new patients decreased by 10% (5,673 patients). The number of heroin users in treatment and injecting users had been continuously decreasing since 2000. This trend was reversed in 2006, and both the number of heroin users in treatment and injecting users increased. In 2006 again, the highest number of patients in treatment were in for cannabis; since 2002 cannabis has been the “leading” drug type. The number of amphetamine users decreased for the first time in 2006. The share of cocaine users has also been growing, but the number of hallucinogen users decreased. The ratio of the former among all the patients in treatment now exceeds 1%; the ratio of the latter is less than 0.5%. Among patients in diversion programmes the number of cannabis users has been the highest since 2003.

5. DRUG-RELATED TREATMENT

Overview

Concerning drug-related health care, an increase in the number of clients could be detected in 2006. Institutional frameworks have not essentially changed. Outpatient treatment is still heterogeneous, while inpatient treatment is usually carried out on the basis of psychiatric care.

The financing of health care and the operation of the institutions was significantly influenced – besides output volume restriction – by the 132/2006. (VI. 15.) Government Regulation, which came into force on 1 July, 2006. This act modified the 43/1999. (III.3.) Government Regulation on the detailed rules of financing health care services from the Health Insurance Fund. The modification of multipliers from 1 July 2006 induced a significant reduction in the financing of professionally qualified intensive rehabilitation psychiatry. Above this, differently from practises of previous years, financing on the basis of output volume in 2006 was defined by 95% of the accounted total output without degression of year 2005, using points system in case of specialised outpatient and weighted points system in case of inpatient treatment. This calculation method was introduced to limit the possible growth of turnover in volume of activity of health service providers, and in many cases it led to a decrease in the number of used services compared to previous volumes.

Act CXXXII of 2006 on the development of the health care system passed by the Hungarian Parliament greatly transforms the health care system, and together with that the treatment of drug users. However, as the act was only passed at the end of 2006, we will only be able to assess its effects next year.

5.1. TREATMENT SYSTEM

Health care

The health care treatment of drug users is still free similarly to previous years; social security covers the treatment as a subjective right. At the same time, there are institutions where patients are treated free of charge, but the operation of the institution is not financed by the Health Insurance Fund, but by the church or the local government. An example is the new outpatient treatment centre of the Blue Point Specialized Outpatient Treatment Centre in the 3rd district of Budapest, which currently operates on local government funds. The treatment centre essentially started operations in September.

The table below shows the number and proportion of drug users (including abusers of pharmaceuticals and inhalants) in different institution types of the health care system in 2006.

Table 13. *The distribution of drug users treated in health care based on institution type in 2006*

Type of institution	All patients		New patients	
	number	%	number	%
Addiction treatment outpatient centres	3,557	22.98	1,247	21.98
Specialised outpatient treatment centres	6,505	42.02	2,856	50.34
Child and youth psychiatric care centres	32	0.21	20	0.35
Psychiatric care centres	415	2.68	246	4.34
Psychiatric and addiction-treatment inpatient departments	4,971	32.11	1,304	22.99
Total	15,480	100.0	5,673	100.0

Source: Report No. 1211 by the Ministry of Health

The above data also indicate that the largest ratio of drug patients were treated at specialised outpatient treatment centres in 2006 as well. As long as outpatient treatment is confined to the various care centres and outpatient treatment centres, there is practically no alternative – with one exception - to psychiatric and addiction wards for inpatient treatment.

Professional trainings

In 2006 the Ministry of Health organized a professional training programme concerning the early recognition of the drug problem, for heightening the sensitivity of professionals working in the field of basic and specialized healthcare, and a training programme for pediatricians on child and teenage therapeutics from a budget of HUF 10 million received from drug affairs coordination. The programme was implemented by the National Institute for Addiction.

Professional protocols

In 2006 the National Institute for Addiction initiated the preparation of professional protocols on preliminary status assessment, methadone treatment, cannabis addiction, amphetamine addiction, opiate addiction and the treatment of children of pregnant women using drugs.

Social care

The detailed rules of the operation of low-threshold services were determined in Regulation 3/2006. (V. 17.) of the Ministry of Youth, Family, Social Affairs and Equal Opportunity, which amended Regulation 1/2000. (I. 7.) of the Ministry of Social and Family Affairs on the professional requirements of employment in social institutions, its personal and material requirements, and the professional tasks and operation requirements of social institutions offering personal care.

Rehabilitation centres welcome clients from all over the country. Their distribution is very uneven. The number of institutions carrying out drug rehabilitation in 2006 was 13. According to data available the average utilization of slots is very diverse: in certain institutions it is around 70-80%, while others operate at 100% utilization with waiting lists.

The financing of drug rehabilitation centres originates from two sources: the National Health Insurance Fund (OEP) finances the health care service, while a social normative is determined for the financing of social care.

In 2006 the Ministry of Health supported the inclusion of two institutions carrying out drug rehabilitation to the OEP: The Paraklisz Anti-drug Foundation (13 slots) and the Kovácsszénája Drug Rehabilitation Home (16 slots). With regard to the fact that Act CXXXII of 2006 on the development of the health care system appoints the Regional Health Affair Councils to make local decisions, the two drug rehabilitation homes can only be included in 2007 if the concerned Regional Health Affair Councils support their inclusion in the course of preparing their proposals on the division of their capacities.

Geographical differences in treatment

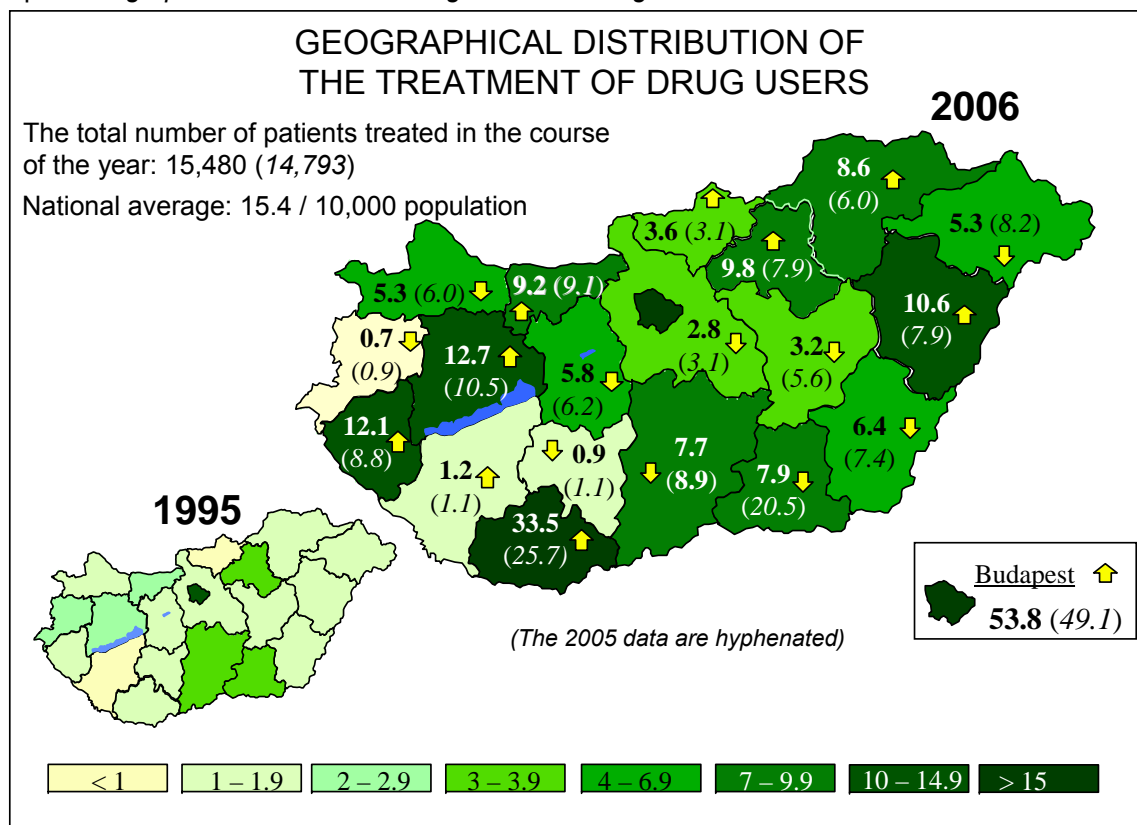
The data regarding geographic distribution in the present health care drug statistics are related to the location of the institution carrying out the treatment in all cases. The specialised outpatient treatment centres carry out sub-special, progressive treatment within specialised care, which means that patients are often referred to them by institutions with general psychiatric and/or addiction profiles too, if they are located relatively close by. As a result the region covered by a specialised outpatient treatment centre may cross county boundaries. The best example of that is the situation of County Pest surrounding the capital, Budapest: in the period between 2002-2006 the number of patients treated / 10,000

inhabitants increased every year in Budapest, while it stayed practically the same in County Pest.

Despite the development efforts of the Ministry of Health, there are counties in Hungary where there is no specialised outpatient treatment centre. In 2006 all together 21 specialised outpatient treatment centres (of which 6 are found in Budapest) provided primary outpatient care for clients, but addiction treatment outpatient centres, the specialised outpatient centres and the TÁMASZ network still play a very important role. In 2006 there were 453 out- and inpatient care units taking part in the medical treatment of clients.

In counties Pest, Tolna and Somogy the specialised outpatient treatment centres of the capital and neighbouring counties and the psychiatric/addiction wards of the given county provide treatment for the patients. In 2006 there was a difference in the number of drug users per the number of inhabitants in the region of the treatment centres between the eastern and western part of the country: this ratio has increased west of the Danube but decreased east of it.

Map 1. Geographical distribution of drug users receiving treatment in 2006



Source: Report No. 1627 by OSAP and Report No. 1211 by the Ministry of Health

One of the most seriously deficient area of addiction is still the health care treatment of children and youth struggling with addiction, which has serious deficiencies in both the area of inpatient and outpatient treatment. In 2006 the treatment of children and youth was primarily carried out by 36 child- and youth care centres, and a few specialised treatment centres. There are great inequalities among the care centres in terms of how well equipped they are and the number of experts available to them. Ten institutions provided child and youth inpatient treatment in 2006. The distribution of the institutions around the country is very uneven.

Diversion Programmes

The modification of the act on Criminal Proceedings effective from 1 July 2006 makes it possible for offenders of minor drug-related crimes entitled to diversion to participate in one of the diversion programmes already in the police investigation phase of the proceedings. Earlier it was only possible to add the time spent in the treatment programme to compulsory diversion time beginning from the date of the release of the public prosecutor's resolution. This modification means that the long wait until the release of the public prosecutor's resolution (which could take months) ceases, and the persons entitled to participate in a diversion programme can enter treatment programmes within 1-2 weeks from the beginning of the criminal proceedings.

The number of drug users in diversion programmes increases continuously: in 2006 3,976 people started the treatment at one of the health care service providers. The number of people taking part in the prevention-information service was 3040.

In 2006, there were 46 service providers in the country offering preventive-consulting services. The majority of them were operated by NGOs or local governments.

5.2. DRUG-FREE TREATMENT

Inpatient treatment (active and chronic)

According to the data of the National Health Insurance Fund, 5 addiction wards were in operation in the country in 2006 with a total of 216 slots, while further 55 psychiatric departments provided treatment with 3,965 slots.

Considering that most of the drug patients in inpatient treatment are cared for in psychiatric wards, it is difficult to get an overview of capacities (and especially of capacities available for drug using patients).

Outpatient treatment

Two new outpatient treatment centres were opened in 2006 in Budapest. One is the new institution of the Blue Point Specialized Outpatient Treatment Centre, which began operations in September 2006, and is presently financed by the local government. The other one is operated by the Drug Prevention Foundation, opened its gates on July 4th in the 15th district and is currently financed by district and ministry funds.

5.3. PHARMACOLOGICALLY ASSISTED TREATMENT

Substitution treatment

Eight outpatient treatment centres provide substitution maintenance treatment to clients. 3 of them operate in the capital, and there is one centre at each of the following places in the countryside: Veszprém, Pécs, Gyula, Szeged and Miskolc. 853 clients entered the methadone programme in 2006. More than 78% of them participated in the programme in Budapest. There is also a long waiting list in several locations because of the output volume restriction.

Table 14. *Number of participants in methadone treatment in 2006*

Jász Street	Buda	Soroksár	Veszprém	Pécs	Gyula	Szeged	Miskolc
410	118	144	11	42	20	62	46

Source: Jász Street Drug Outpatient Treatment Centre

Table 15. *Monthly distribution of participants in methadone treatment*

Jan.	Feb.	Mar.	Apr.	May	June	July	Aug	Sept.	Oct.	Nov.	Dec.
461	446	459	458	490	455	429	436	442	414	435	430

Source: Jász Street Drug Outpatient Treatment Centre

Withdrawal treatment

In the case of overdose, patients are usually taken to the detoxification ward, or in an optimal case, to the emergency room. In 2006 there were two detoxification wards in the capital. The emergency internal medicine ward of the Péterfy Sándor Street Hospital also took an active role in detoxification. Detoxification in the countryside is primarily provided by emergency rooms and casualty wards.

Conclusions

On the whole, it can be concluded that the health care treatment chain – similarly to the previous year – is still quite irregular and deficient in 2006. Considering the number of clients, there are great differences between the capital and the other parts of the country.

The lack of experts and the proper health care of children and youth with addiction/psychiatric problems are serious deficiencies. In the framework of social care only a few programmes exist that facilitate complex reintegration and re-socialization.

6. HEALTH CORRELATES AND OTHER CONSEQUENCES

6.1. DRUG-RELATED DEATHS AND MORTALITY OF DRUG USERS

In 2006 data on drug-related deaths in Hungary again were collected on the basis of reports prepared within the framework of the National Statistical Data Collection Programme (OSAP). Data were corrected by experts of the National Institute of Forensic Medicine. Data were provided by the Institutes of Forensic Medicine, County Police Headquarters and the National Institute of Forensic Medicine. We define drug-related death as death caused by direct intoxication, i.e. direct overdose, and indirect drug-related death by nature or violence.

Direct overdoses

National data

The number of deaths due to illicit drug use further decreased in 2006 compared to previous years. While the number of deaths caused by overdose was 34 in 2004, and 28 in 2005, 25 persons died due to overdose in 2006. However, a change can be observed in the types of drugs involved. (ST 05, ST 06)

Table 16. *Number of direct drug-related deaths in 2006*

	Male	Female	Total
Heroin	21	1	22
Methadone	0	0	0
Other opiates	1	1	2
Hallucinogens	0	0	0
Amphetamines	0	0	0
Ecstasy (MDA, MDMA, MDE, MBDB, 4-MTA)	0	0	0
Cocaine	1	0	1
Illicit drugs total	23	2	25
Solvents, inhalants	10	1	11
Sedatives/tranquillisers	80	95	175
Poly-drug use	5	2	7
<i>Total</i>	141	102	243

Source: National Institute of Forensic Medicine

The number of fatal heroin overdoses has increased, from 8 in 2004, to 13 in 2005, and 22 in 2006. As a proportion of total deaths due to illicit drug use heroin has almost doubled (in 2005 they accounted for 46%, while in 2006 for 88% of all cases). Heroin overdoses were only reported from the territory of Budapest this year. It is not yet known what is behind this increase in the number of deaths (and non-lethal overdoses, see chapter 6.4) by heroin. According to the available data neither the price, nor the purity of heroin has changed significantly in the previous period.

Two morphine overdoses were recorded nationwide, one of them a suicide (County Pest), the other the result of accidental overdose (County Borsod). Lethal intoxications caused by amphetamines or ecstasy totally disappeared from the statistics compared to 2005. The number of cocaine overdoses was again very low in 2006, similarly to previous years (1 case was registered from County Pest).

The mean age at death related to heroin use was 28.8 years. The victim of the accidental morphine overdose was a man from the 35-39 age group, while the person committing suicide was a woman over 55. The only person overdosing on cocaine was a man from the 30-34 age group.

The number of deaths because of the overdose of sedative/tranquilliser-type substances remained practically the same as in 2005, while the number of deaths related to the use of solvents/inhalants increased compared to the previous year. There were two butane overdoses among inhalant-related deaths in 2006. This cause of death was first recorded in the capital in 2002, then there were 2 similar cases in 2003 and 1 in 2004. There is no information on butane-related deaths from other parts of the country.

The highest number of drug-related deaths was recorded in Budapest (152 deaths) followed by the counties of Pest and Borsod (16 deaths), Bács-Kiskun (12 deaths), Vas (11 deaths) and Győr-Moson-Sopron (10 deaths). The counties of Baranya, Hajdú and Tolna did not report any overdose cases related to either licit or illicit drug use. In the gender-based breakdown of drug-related deaths, no significant differences can be observed between the counties.

Indirect drug-related deaths

Indirect death related to opiates occurred in one case in Budapest, and it happened in connection with a road traffic accident (run over by a train). Cocaine was present in 2 cases in County Győr-Moson-Sopron, and in 1 case (suicide by gunshot) in Budapest. Cannabis positivity was reported from Counties Bács-Kiskun and Békés, in both cases related to road traffic accidents. Amphetamine positivity was reported from Budapest in two cases. One of the cases was a suicide by hanging where MDMA was also found besides amphetamines in the organs of the deceased. The other case was a carbon-monoxide poisoning where THC was discovered besides amphetamines.

Table 17. *Indirect drug-related deaths among cases of deaths caused by violence*

	Male	Female	Total
Opiate	1	0	1
Cocaine	2	1	3
Cannabis	2	0	2
Amphetamines	2	0	2
Sedative/tranquilliser	6	6	12
Total	13	7	20

Source: National Institute of Forensic Medicine

According to the data from Budapest, autopsy was performed in the case of one known drug user, whose death was attributable to natural causes.

In the course of HIV, HCV, HBV and syphilis testings run in the case of deaths related to drug use in Budapest HCV positivity was discovered in 10 cases, while HBV vaccination could be proven in 5 cases. 8 out of the 10 HCV positive persons died of heroin overdose, while the two other persons died violent indirect deaths. Neither HIV nor syphilis positivity was found this year.

Mortality and causes of deaths among drug users

No information available.

6.2. DRUG-RELATED INFECTIOUS DISEASES

In 2006 the data referring to the reported HIV/AIDS cases among injecting drug users (IDUs) and the incidence of acute HBV and HCV cases in Hungary – similarly to previous years – originate from the national registry of infectious patients operating in the National Centre for Epidemiology and the surveillance database.

The Ministry of Health provided the funding for measuring the incidence of infections related to drug use (HIV, HBV, HCV) in Hungary in the form of project financing according to the 2006 decision of the Coordination Committee on Drug Affairs. As a result new examination methods were also applied. Between 15 November and 30 December 2006, 300 IDUs were examined for the first time in Hungary in the frame of a multi-centric examination in a test where blood drawn from the fingertip was dried and then screened for HIV, HBV and HCV.

The collection and analysis of data referring to diagnostic HIV, HBV and HCV tests carried out in the laboratories of the National Public Health and Medical Officer Service (ÁNTSZ) among IDUs, originating from the reports of the county institutions of ÁNTSZ was continued. However, following the structural transformation of ÁNTSZ, these data are incomplete, and they are not recommended for use for surveillance purposes.

HIV/AIDS

In 2006, 80,168 HIV tests were performed. 81 newly revealed HIV positive cases were reported, thus the incidence of HIV infections (8 cases/million inhabitants) was lower compared to the year before (10,5 cases/million inhabitants). The mode of infection was only known in two-thirds of the newly registered HIV cases. This year no HIV infections were discovered among people in the IDU risk group. No newly diagnosed AIDS patients were reported among IDUs, either.

Table 18. *Distribution of registered HIV positive persons by risk groups*

	2002	2003	2004	2005	2006	Total
Homo/bisexual	35	34	45	55	38	207
Heterosexual	26	18	13	21	14	92
Haemophiliac	0	0	0	0	0	0
Transfusion recipient	0	0	0	0	0	0
Injecting drug user	1*	1*	2*	2**	0	6
Nosocomial	0	0	0	3*	0	3
Maternal	0	0	0	2	0	2
Unknown	16	10	15	23	29	93
Total	78	63	75	106	81	403

* Imported cases, ** Together with imported cases

Source: National Centre for Epidemiology (Csohán et al. 2007b)

Acute Hepatitis B

In 2006, 83 acute infections were reported, 30.3% less than in 2005. The annual incidence was 83 cases/100K population/year.

The frequency of acute hepatitis B has been decreasing in recent years – probably together with newly acquired symptom-free infections – due to compulsory teenage vaccination. The transmission route was known in 34.9% of all cases. There were no IDUs among patients in the known risk groups (ST9 N4 Results HBV notif).

Table 19. Number and proportion of IDUs among reported acute HBV-cases

Reported acute HBV infections			
Year	Number	IDUs	
		Number	%
2002	159	6	3.8
2003	143	7	4.9
2004	131	6	4.6
2005	119	1	0.8
2006	83	-	-

Source: National Centre for Epidemiology (Csohán et al. 2007b)

Acute Hepatitis C

29 acute Hepatitis C cases were reported in 2006 as opposed to the 22 cases reported the previous year. However, this number is still lower than the average number of cases reported in the previous 10 years (51). 4 patients were infected through injecting drug use. The ratio of patients in identified risk groups is 51.7%.

The patients were all men belonging to the age group of 25-34. Two of the acute hepatitis C patients who were also injecting drug users lived in Budapest, while the other two lived in County Borsod-Abaúj-Zemplén. (ST9 N2-Results HCV notif)

Table 20. Number and proportion of IDUs among reported acute HCV patients

Reported acute HCV infections			
Year	Number	IDUs	
		Number	%
2002	42	3	7.1
2003	30	2	6.7
2004	40	11	27.5
2005	22	1	4.5
2006	29	4	13.8

Source: National Centre for Epidemiology (Csohán et al. 2007b)

Prevalence of HIV, HBV and HCV infections among IDUs

In June 2006 the Ministry of Health concluded an agreement with the National Centre for Epidemiology (NCE) to realize the task called "Nation-wide extension of screening programmes, with regard to the provision of the conditions for cooperation between the local ÁNTSZs and NGOs". The prevalence of infectious diseases related to injecting drug use (HIV, HBC, HCV) was surveyed in line with that.

The test's innovation was that a dried blood sample (drawn from the fingertip) was used for the first time in Hungary for screening purposes. The use of the dried blood sample made feasible the collection of samples from 300 confirmed injecting drug users within six weeks.

Four treatment centres and two needle exchange programmes in Budapest, and in the countryside three specialised outpatient treatment centres and a youth drug centre participated in the survey. (ST9 DBS study P1 Methods)

Table 21. Organizations participating in the survey of HIV, HBV, HCV prevalence

	Name of the organization	Number of tested clients
Budapest	Drug Prevention Foundation	55
Budapest	Blue Point Specialized Outpatient Treatment Centre	20
Budapest	Nyíró Gyula Hospital Specialised Outpatient Treatment and Prevention Centre	50
Budapest	Hungarian Interchurch Aid Addiction Centre, Soroksár	15
Budapest	Baptist Aid Street Front syringe exchange service	20
Budapest	National Psychiatry and Neurology Institute	15
Gyula	Independent Association, Gyula	15
Miskolc	Semmelweis Hospital, Specialised Outpatient Treatment Centre, Miskolc	20
Pécs	Specialised Outpatient Treatment Centre, Pécs	55
Szeged	Youth Drug Centre, Szeged	35

Source: National Centre for Epidemiology (Csohán et al. 2007a)

The above institutions offered the opportunity of screening to people declaring themselves IDUs, or who could recall ever using injecting drugs. Selection of patients was conducted according to the case definition of the EMCDDA²⁹.

The samples were taken by the staff and volunteers of specialised outpatient treatment centres and NGOs based on a preliminary training. The collection of blood samples was effectuated on a voluntary basis, but the person supplying the sample had to reveal some of their identification data, which made the creation of the so-called generated code³⁰ used in TDI possible.

The blood was drawn from the fingertip with the use of a lancet, and then the filter paper containing the blood drops was enclosed in a specially sealed plastic bag and transferred to the laboratory. HIV tests were carried out in the Microbiological Research Group (MRG) of the National Centre for Epidemiology, while the HBV and HCV tests were conducted at the Hepatitis and Molecular Virology Department of the National Centre for Epidemiology³¹.

The drug users were informed of the results of the tests. In the case of a positive result, those infected with HBV or HCV were given the appropriate information regarding the necessary steps to stop the spreading of the illness and where they can turn for further medical care.

²⁹ EMCDDA case definition: Protocol for the implementation of the EMCDDA key Indicator, Drug-related Infectious Diseases (DRID) Version 6 October 2006, Target group and inclusion criteria for surveys, p. 11

³⁰ The generated code does not make retrospective identification possible, but its use helps avoid the entering of duplicates into the database.

³¹ For HIV screening purposes the Murex HIV Ag/Ab Combination ELISA (Murex Biotech Limited) test was applied (Judd et al 2003), and the samples giving a reactive result were controlled by two other, combined ELISA tests also suitable for the demonstration of virus antigens: Vironostika HIV Uni-Form II. Ag/Ab (BioMerieux), and Genscreen Plus HIV Ag-Ab (Bio-Rad). If it seemed necessary, INNO-LIA HIV I/II Score (INNOGENETICS) Line Immuno Assay, operating on the principle of immunoblot, was also carried out.

The presence of HVB was determined with the demonstration of HBsAg, while HCV infection was determined with the demonstration of HCV antibodies. Both examinations were effectuated with ELISA technique. To confirm positive results of anti-HCV, Line Immuno Assay technique was applied.

In the case of HCV, the HCV Ab Screening ELISA kit manufactured by DiaPro, INNOTEST HCV Ab IV kit manufactured by Innogenetics and Bioelisa HCV kit by Biokit were used. Anti-HCV positive results were verified by INNO-LIA HCV Score tests by Innogenetics.

Results and conclusions

In the examination period (between 15 November and 31 December 2006) 300 IDUs were contacted, their data registered and blood samples taken at 10 specialised outpatient treatment centres and needle exchange stations operated by NGOs.

In the laboratory tests, reliable results could be released regarding HIV and HBV infection due to the applied methods in the case of all 300 people. On the other hand, in the case of antibody tests conducted in order to detect HCV infection, in 13 cases the result was inconclusive, therefore these cases were excluded from processing.

All 300 samples were negative for HIV, that is – similarly to previous years – no HIV positive person was found among the participating IDUs. HCV antibodies were detected in 83 people (28,9%), and HBV surface antigens in 4 cases (1,3%). All 4 HBV virus vectors were proven to be positive for HCV antibodies as well.

Table 22. Breakdown of HIV, HCV, HBV infected IDUs by age group

Age group		People tested for the presence of HIV antibodies		People tested for the presence of HBsAg antigen			People tested for the presence of HCV antibodies		
		number	positive	number	positive number	positive %	number	positive number	positive %
< 25 years	Male	27	0	27	0	0.0	27	9	33.3
	Female	18	0	18	0	0.0	18	4	22.2
25-34 years	Male	142	0	142	1	0.7	137	35	25.5
	Female	32	0	32	1	3.1	30	5	16.7
> 34 years	Male	64	0	64	1	1.6	60	19	31.7
	Female	17	0	17	2	5.9	15	11	73.3
Total	Male	233	0	233	2	0.9	224	63	28.1
	Female	67	0	67	2	3.0	63	20	31.7
	Male + Female	300	0	300	4	1.3	287	83	28.9

Source: National Centre for Epidemiology (Csohán et al. 2007a)

There were 233 (78%) men and 67 (22%) women in the sample. More than half of the sample were in the 25-34 age group (174 people, 58%), while people above 35 comprised 27% (81) of the sample, and the smallest was the age group below 25, with 45 members (15%).

The 28.9% HCV prevalence measured among IDUs in 2006 almost completely equals the results of similar surveys conducted in 2001 and 2003 in Hungary. The highest prevalence was detected among people above 34, in their case 40 out of 100 drug users were infected. The prevalence of the age group below 25 turned out to be 28.9%, while 23.9% of the 25-34 age group was HCV infected. (ST9 DBS study P2SerPrev HCV)

On the whole, no significant difference could be observed between the infection ratio of men and women, however, the prevalence among women over 34 was very high, more than two times higher (73.3%) than the average prevalence value.

The chance of becoming HCV infected also depended on how long they had been injecting drugs. Four intervals could be selected as the term of injecting drug use: (<2 years, 2-4 years, 5-9 years, >10 years). 9 people out of the 300 could not say when they started to inject drugs. Almost half (146 people, 48.7%) of the people providing samples declared that they had been injecting drugs for more than 10 years. 26% (78) of the people in the examination said that they had been injecting drugs for 5-9 years, 13% for 2-4 years, and only 9.3% had been injecting drugs for less than 2 years.

In the group of those IDUs, who had been using drugs for more than 10 years, 39.7% were HCV infected. The ratio of infection was correlated with increasing time of injecting drug use. No HCV-infected people were found in the group injecting drugs for less than 2 years. The infection ratios also point out that drug users injecting drugs for more than 10 years have a 2.2 times higher chance of acquiring HCV than those who have not been using injecting drugs for such a long period of time (2-5 years).

Table 23. Breakdown of HCV, HBV positive IDUs by term of injecting drug use

Term of injecting drug use	People tested for the presence of HBsAg antigen			People tested for the presence of HCV antibodies		
	number	positive number	%	number	positive number	%
< 2 years	28	0	0.0	26	0	0.0
2 - 4 years	39	0	0.0	39	7	17.9
5 - 9 years	78	1	1.3	78	21	26.9
>10 years	146	3	2.1	136	54	39.7
Total	291	4	1.4	279	82	29.4

Source: National Centre for Epidemiology (Csohán et al. 2007a)

Out of the 83 HCV-positive people, 80 drug users declared themselves opiate users. The table below shows that among opiate using IDUs, HCV infection is four times more frequent than those who did not inject opiates.

Table 24. Breakdown of HCV, HBV positive IDUs by the type of drug

Type of drug	People tested for the presence of HBsAg antigen			People tested for the presence of HCV antibodies		
	number	positive number	%	Number	positive number	%
Opiate	260	3	1.2	248	80	32.3
other. not opiate	40	1	2.5	39	3	7.7
Total	300	4	1.3	287	83	28.9

Source: National Centre for Epidemiology (Csohán et al. 2007a)

As for Budapest and the countryside, we may state that 60 out of the 162 samples from Budapest proved to be positive for HCV, which is equal to 37%. By comparison, only 18.4% of the samples from the countryside tested positive for HCV (23 samples out of 125). Two of the four HBsAg-positive people were screened in Budapest and two in Pécs. (ST9 DBS study P2SerPrev HBV)

Table 25. Geographical breakdown of HBV and HCV screenings and the ratio of positive cases (2006)

Region/city	People tested for the presence of HBsAg antigen			People tested for the presence of HCV antibodies		
	number	positive number	%	number	positive number	%
Budapest	175	2	1.1	162	60	37.0
Szeged	35	0	0.0	35	8	22.9
Pécs	55	2	3.6	55	14	25.5
Miskolc	20	0	0.0	20	0	0.0

Gyula	15	0	0.0	15	1	6.7
Countryside total	125	2	1.6	125	23	18.4
Total	300	4	1.3	287	83	28.9

Source: National Centre for Epidemiology, 2007 (Csohán et al. 2007a)

HIV, HBV and HCV prevalence among IDUs according to tests taken in the regional laboratories of ÁNTSZ

The eight county institutes of the National Public Health and Medical Officer Service have been providing data on the results of HIV tests conducted among IDUs since 2000, and of HBV and HCV screenings since 2003. The number of tests decreased compared to previous years, despite the fact that AIDS consultation offices operate in every county, where the HIV and HCV screening of IDUs is free of charge. (ST9 P1prev)

HIV screening was conducted in the case of 69 people, 57 IDU men and 12 women in the above-mentioned eight counties. All of the results were negative. (ST9 P2prev HIV)

HBsAg screening was conducted in the case of 55 people, 47 men and eight women in the above-mentioned eight counties. No HBV vector person was detected. (ST9 P2prev HBV)

HCV antibody tests were effectuated in the case of 47 IDUs, 42 men and five women in the above-mentioned eight counties. Three people were found with HCV infection. The low positivity rate is not representative of the IDU population in Hungary. (ST9 P2prev HCV)

Table 26. *The results of serology tests carried out in the laboratories of the regional institutes of ÁNTSZ aiming to detect HIV, HBV, HCV infection among IDUs*

Age group		People tested for the presence of HIV antibodies		People tested for the presence of HBsAg antigen			People tested for the presence of HCV antibodies		
		number	positive	number	positive number	positive %	number	positive number	positive %
< 25 years	Male	13	0	10	0	0.0	11	1	9.1
	Female	3	0	2	0	0.0	2	0	0.0
25-34 years	Male	36	0	34	0	0.0	28	2	7.1
	Female	8	0	6	0	0.0	3	0	0.0
> 34 years	Male	8	0	3	0	0.0	3	0	0.0
	Female	1	0	0	0	0.0	0	0	0.0
Total	Male	57	0	47	0	0.0	42	3	7.1
	Female	12	0	8	0	0.0	5	0	0.0
	Male + Female	69	0	55	0	0.0	47	3	6.4

Source: National Centre for Epidemiology (Csohán et al.2007b)

Tuberculosis and drug use

In 2006 three drug users were found with tuberculosis during screenings.

The most frequent risk factors were alcohol addiction and homelessness. Living alone is also a significant risk factor. The prevalence of tuberculosis among the homeless is twelve times higher than the average. It is a major problem in the capital, where almost every third person infected with tuberculosis is homeless. (Jónás et al. 2007)

Table 27. Risk factors identified among tuberculosis patients in 2006

Risk factor	Number of patients	% of patients
Alcohol addict	342	18.1
Homeless	187	9.9
Contact person	82	4.3
Immigrant	13	0.7
Health care worker	27	1.4
Lives alone	120	6.3
Diabetes	63	3.3
Steroid treated	12	0.6
Closed community	54	2.9
Drug user	3	0.2
HIV infected	2	0.1
Other risk factor	410	21.6
No risk factor	833	44
Incidence:	1,894	113%*
Total:	2,148*	

* More factors could be chosen from among the risk factors, that is why the total is higher than the number of patients

Source: Epidemiology and operation data of the pulmonology institutions in 2006

Screening for infectious diseases in prison

934 tests for HIV were carried out in prisons, no positive cases were found. Hepatitis tests were carried out in the course of blood donations previously but there were no blood donations in prisons in 2006. 9 positive cases were diagnosed on the evidence of symptoms.

6.3. PSYCHIATRIC CO-MORBIDITY

No new information available.

6.4. OTHER DRUG-RELATED HEALTH-CORRELATES AND CONSEQUENCES

Drugs intoxications

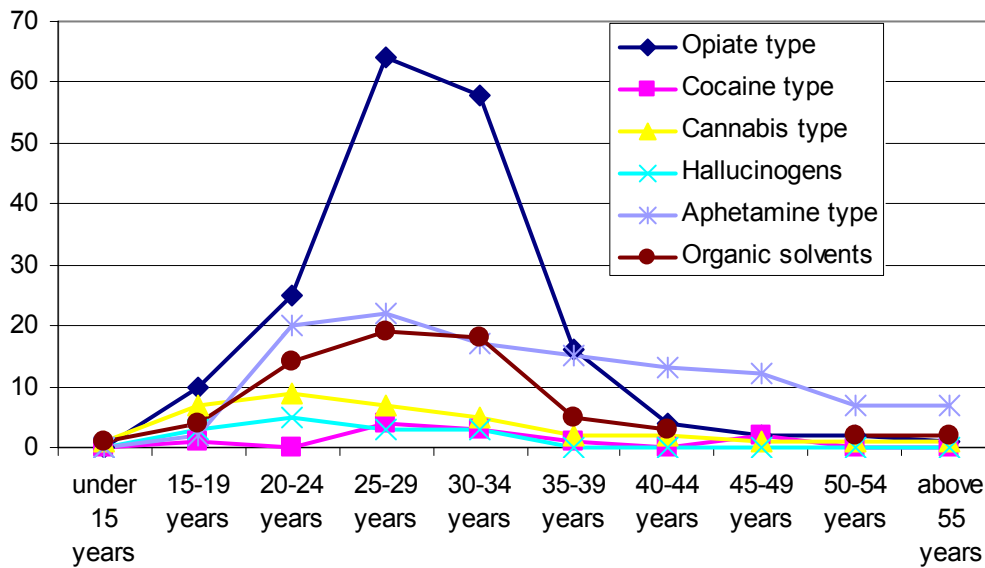
Data collection related to drug intoxications is performed in two ways. On the one hand, with the help of the "Intoxication report from the health care system" report form set out in Annex 12 of Regulation 44/2000. (XII. 27.) of the Ministry of Health, and on the other hand in the framework of data collection No. 1627 by OSAP and No. 1211 by the Ministry of Health. The data are processed by Health Toxicological Information Service of the National Institute of Chemical Safety; however, the data originating from the two sources are handled separately, as their overlaps are not known. In the present subchapter we present the data from data collection OSAP 1627 on the "Report on drug users and their treatment" generated at the Clinical Toxicology Department of the Péterfy Sándor Street Hospital during the last three years. It is true that this report only contains data from one hospital, but in Hungary this is the only clinical toxicology department, therefore all drug intoxication cases are transported here from Budapest and its environs.

It can be said about drug intoxications in 2006 (358 men, 234 women) that the largest proportion of patients were admitted for opiate use, and within that, the use of heroin was the most frequent (140 men, 43 women). Opiates are followed by amphetamines, but here the

exact type of the drug was not known in 66% of the cases. While amphetamine-type non-lethal overdoses were more frequent among men (33 men, 20 women), ecstasy overdose was more common in women (6 men, 32 women). Six times more men than women had to be treated for the overdose of cannabis-type drugs (36 men, 6 women), and there were no intoxications caused by hallucinogens among women (14 men).

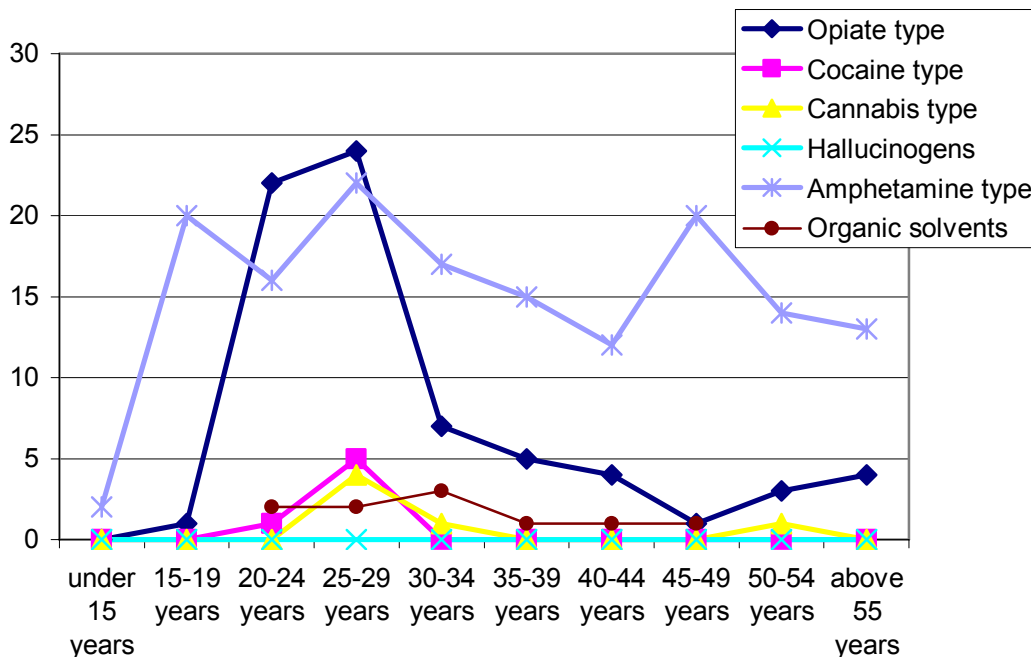
Among both men and women most of the non-lethal drug overdoses happened in the 25-29 age group. On the other hand, the second most affected age group was different among men and women. While among men the older, 30-34 age group was the second most affected, among women it was the younger, 20-24 age group.

Figure 26. Breakdown of men treated at the Clinical Toxicology Department of the Péterfy Sándor Street Hospital for drug intoxication by age group (N=426)



Source: Report No. 1627 by OSAP and Report No. 1211 by the Ministry of Health

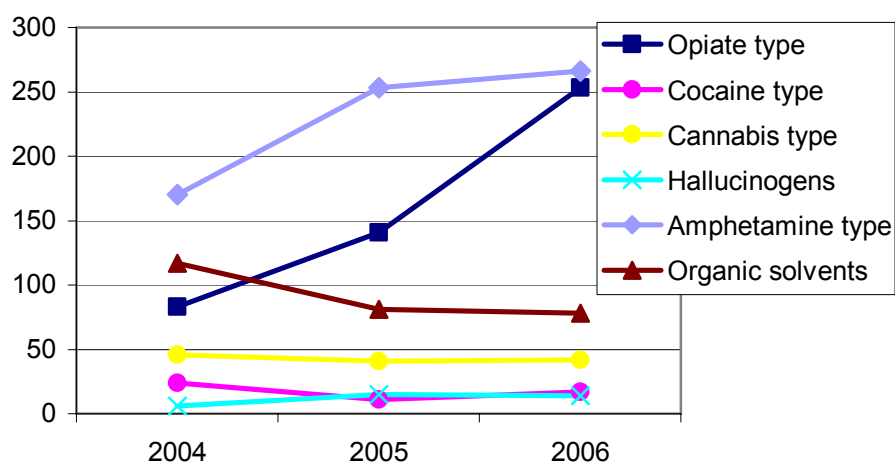
Figure 27. Breakdown of women treated at the Clinical Toxicology Department of the Péterfy Sándor Street Hospital for drug intoxication by age group (N=244)



Source: Report No. 1627 by OSAP and Report No. 1211 by the Ministry of Health

Regarding the trend in intoxication cases in recent years, we have observed an increase in the total number of cases, but there were significant differences among the individual drug types. The greatest increase can be observed in the number of non-fatal opiate intoxications, with heroin as the main drug (46 cases in 2004, 102 in 2005 and 183 in 2006). Even though the increase in the number of fatal heroin intoxications is somewhat less than the increase in non-fatal heroin intoxications, the trends follow similar pattern. The number of intoxications caused by cannabis-type drugs was steady during the previous years, while the increase rate of the number of amphetamine intoxications slowed down. However, amphetamine is still by far the leading cause of intoxications. A decrease can only be observed in the case of organic solvents/inhalants.

Figure 28. The number of patients treated for drug intoxication at the Clinical Toxicology Department of the Péterfy Sándor Street Hospital between 2004 and 2006



Source: Report No. 1627 by OSAP and Report No. 1211 by the Ministry of Health

Conclusions

On the whole, the number of deaths caused by illicit drug use decreased compared to previous years, but the number of fatal heroin overdoses further increased. In 2006 deaths caused by heroin accounted for 88% of all direct deaths brought about by illicit drug use. No deaths caused by amphetamines or ecstasy were reported.

Based on the incidence data reported in 2006, and the HIV test results of 300 injecting drug users (IDUs), it can be concluded with a high probability, that in the Hungarian IDU population – similarly to previous years – the number of HIV infections is very low. The 28.9% HCV prevalence measured among people treated at specialised outpatient treatment centres and among people taking advantage of low-threshold services calls attention to the importance of HCV prevention.

According to intoxication data from Budapest, the number of non-fatal heroin intoxications further increased, having become four times higher than in the last three years (46 cases were registered in 2004, 102 in 2005 and 183 in 2006). Besides opiates, the number of amphetamine overdoses also increased. On the other hand, a decrease was observed in the number of intoxications by solvents/inhalants.

7. RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES

7.1 PREVENTION OF DRUG-RELATED DEATHS

No new information available.

7.2 PREVENTION AND TREATMENT OF DRUG-RELATED INFECTIOUS DISEASES

Syringe exchange programmes

Thirteen organisations operated syringe exchange programmes in 2006, of which four were located in Budapest. The geographical distribution of the organizations in the countryside has not changed either since last year. Although the outreach work did not operate in the Pándy Kálmán Hospital in Gyula in 2005 because of financial problems, it re-started in 2006.

Injecting drug users have the option of turning to two fixed NSPs in Budapest and four in other cities. In the scope of these six programmes 102,981 injectors³² were distributed, representing a 75% increase on the previous year. This increase is shared between the turnover of needles and syringes of the programmes run by the Blue Point Specialized Outpatient Treatment Centre and the Drug Prevention Foundation, Budapest. (The fixed syringe exchange programme – Café Contact – of the Blue Point Specialized Outpatient Treatment Centre moved to the 8th district of Budapest during 2006.) The number of needles and syringes distributed in other cities varied from 90-475. The proportion of needles and syringes returned by clients was 52.3% in fixed-location syringe exchange programmes across the country.

The turnover at vending machines increased by 9% in 2006: 22,090 needles and syringes were distributed in the five programmes (one in Budapest). During the year, 1,002 needles and syringes were found in special waste containers placed in the vicinity of selected vending machines, which is almost two times as many as in the previous year.

Two services continued to provide mobile syringe exchange in Budapest. The number of needles and syringes distributed tripled (16,689 pieces), and the return rate increased to 89%, which is the second largest ratio since 2003 (102%). The increase in the number of needles and syringes distributed is probably due to the fact that one of the service providers directs drug users met during street outreach programmes to their mobile bus and other locations, and in the case of the other service provider, clients sometimes return hundreds of used syringes and leave with just as many sterile injectors.

The number of street outreach programmes facilitating the discovery of hidden injecting drug users and making syringe exchange available to them has increased from five to eight (three programmes in Budapest, five in the countryside). This increase is attributable to the (re)start of the programmes of the Blue Point Specialized Outpatient Treatment Centre in Budapest, and the INDIT Public Foundation and the Pándy Kálmán Hospital in Gyula in the countryside. These programmes distributed 22,763 injectors, which is more than last year, but still the second lowest number since 2003. The return rate decreased again drastically to 55.4%, reverting to the rates of 2003 and 2004.

The data indicate that clients returned more syringes to the workers of street programmes in 2005 than in 2006. It can also be observed that the number of injectors distributed and returned+collected by mobile syringe exchange buses increased. Therefore it is possible that clients visiting street programmes switched to the mobile syringe exchange in 2006.

³² Injector: needle + syringe

Table 28. *Injector and client turnover data of syringe exchange programmes, 2003-2006*

	Fixed syringe exchange	Mobile syringe exchange	Street outreach	Syringe vending machine	Total
2003					
Distributed	19,600	682	28,970	2,415	51,667
Returned (+collected)	7,984	695	15,081	5	23,764
Exchange rate	40.7%	101.9%	53.1%	0.2%	46.5%
Number of clients	490	37	424	-	951
Number of contacts	2,321	912	426	-	3,659
2004					
Distributed	30,649	2,870	38,742	7,510	79,771
Returned (+collected)	18,739	2,370	21,384	65	42,558
Exchange rate	61.1%	82.6%	55.2%	0.8%	53.4%
Number of clients	561	82	471	-	1,114
Number of contacts	3,665	1,590	1,007	-	6,262
2005					
Distributed	58,804	5,500	20,823	20,263	105,390
Returned (+collected)	32,941	3,722	15,343	496	52,502
Exchange rate	56.0%	67.7%	73.7%	2.4%	49.8%
Number of clients	440	131	388	-	959
Number of contacts	5,172	2,148	1,380	-	8,700
2006					
Distributed	102,981	16,689	22,763	22,090	164,523
Returned (+collected)	53,907	14,789	12,613	1,002	82,311
Exchange rate	52.3%	88.6%	55.4%	4.5%	50.0%
Number of clients	900	232	636	-	1,768
Number of contacts	6,013	3,117	1,758	-	10,888

Source: *Reitox National Focal Point*

The total number of needles and syringes distributed increased by 56% in 2006 compared to the year before, and the exchange rate reached 50% again. According to the data, 1,768 clients were involved in NSPs, an 84% increase. The number of injectors per capita – an indicator implying secondary exchange - decreased for the first time since 2003, from 110 needles and syringes in 2005 to 93 injectors per capita in 2006. This may mean that the service providers reached more and more clients directly. The number of client contacts was 10,888, an increase of slightly more than 25%. This change is due to the increase in the number of client contacts of fixed and mobile programmes (see above).

Counselling, screening

The organizations participating in the syringe exchange programme provide counselling and information (e.g. on safer drug use and safe sex) in the form of flyers or on demand in the form of fixed or street outreach programmes. The majority (ten) of the organizations carry out HIV and/or HCV screening individually or in cooperation with the local ÁNTSZ. At organizations operating the methadone programme the annual HIV and HCV screening is compulsory for all participants.

7.3. INTERVENTIONS RELATED TO PSYCHIATRIC CO-MORBIDITY

No new information available.

7.4. INTERVENTIONS RELATED TO OTHER HEALTH CORRELATES AND CONSEQUENCES

The prevention of road accidents related to drug use

Hungary participated in the TISPOL international road monitoring campaign eight times in 2006. The monitoring aimed to roll back drink and drug driving two times (in June and December); the name of these campaigns was "Alcohol & Drug Action". The monitoring covered the whole territory of the country and lasted two days at a time. All of the main police departments and the Highway Police participated in the campaign, which lasted eight hours a day. In June substances indicating drug use were detected in urine samples (with the help of quick tests) in three cases, while in December there was no positive result.

Interventions concerning drug-using pregnant women and their children

In 2006 the Sober Babies self help group was created, which is the informal community of women who consume(d) any kind of licit or illicit drugs during pregnancy. The group gives no professional advice. One can keep in touch with the group anonymously, it has no formal membership, asks for no personal data and charges no membership fee.

Conclusions

According to the data of syringe exchange programmes, the per capita number of injectors decreased in 2006 for the first time since 2003. On the other hand, the number of clients was the highest ever. This may mean that the programmes reach more and more drug users directly, that is, an increasing number of clients are involved in the treatment system.

8. SOCIAL CORRELATES AND CONSEQUENCES

Overview

In Hungary there have been no surveys in the recent past, nor are there any in progress now, that could highlight the main characteristics and changes of the chapter below in depth. There are, however, surveys and data that touch upon the main questions of the sub-chapters, even if they do not cover them totally. This chapter contains the results of these surveys and the practical experiences acquired in the given field.

By the entering into force of Regulation of the Ministry of Health, Social and Family Affairs 76/2004. (VIII. 19.) on the detailed rules of the determination, collection and processing of certain sectoral (health, professional) data not suitable for identification the circle of activities obliged to report was widened by TDI and the diversion report systems.

The new data provision obligations give a possibility of providing systematic and uniform, therefore comparable data on clients requiring treatment, participating in the treatment/care system or the system of diversion and clients taking advantage thereof.

8.1. SOCIAL EXCLUSION

In the present chapter we shall present the change in the extent of social exclusion of drug users – except for information on prostitution – based on the TDI database. As the law has only required TDI data collection since May 2006, the data rendered by the concerned service providers cannot be considered of full value for annual statistics. We must note that not all service providers fulfilled all requirements set out in the act despite the reporting obligation. We have to take this into consideration when analysing the presented data, and also the fact that drug users (especially problem drug users – Márványkövi et al. 2006.) do not always make it into treatment.

In 2006 the TDI data of 1,472 clients were reported³³ by the service providers to the OAI (for a detailed description of the characteristics of the clients in treatment, see chapter 4.2). Most questionnaires were filled out by the 25-29 age group (360), followed by the 20-24 age group (337). A significant part of the sample comes from the 15-19 age group (251 people), and almost in the same ratio from the 30-34 age group (234 people). The mean age is 28.5 years. The majority of people in the database are men with 78.3% (1,152 people), while women comprised 21.4% (315 people).

As for drug use, we can say that the most characteristic substance as a primary drug is cannabis (41.4%), which is followed by opiates (by far, mostly heroin) with 24.9%. 10.2% of the sample used sedatives and tranquillisers as a primary drug. The use of all other substances was below 10%.³⁴

Homelessness

In the TDI questionnaire four answer choices are given for the question concerning living status ("Where do you currently live?") as follows: (i) stable accommodation, (ii) unstable accommodation, (iii) in institutions (prison, clinic), (iv) not known/missing³⁵. The four categories are not sufficient to compare data substantially with the results of earlier surveys. If, based on the 2006 data, we arbitrarily consider the people in category (ii) as homeless –

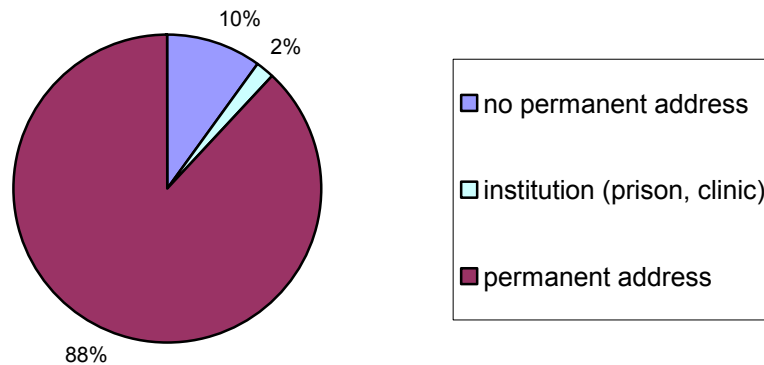
³³ It does not contain the data of people entering treatment through diversion.

³⁴ Cocaine (total) 2.71%, stimulants (total) 9.71%, hallucinogens (total) 0.74%, inhalants 2.1%, other substances (total) 8.22%. The use of crack is the least characteristic in the sample.

³⁵ In 47 cases out of the 1,472 the housing circumstances were unknown.

that is, that they have lost their housing temporarily or permanently, then they would make up 9.9% of the sample (141 people).³⁶ We can suppose that this percentage would be lower if the data were more differentiated, and hence that there is no close correlation between drug use and homelessness.

Figure 29. *Living status among clients in treatment*

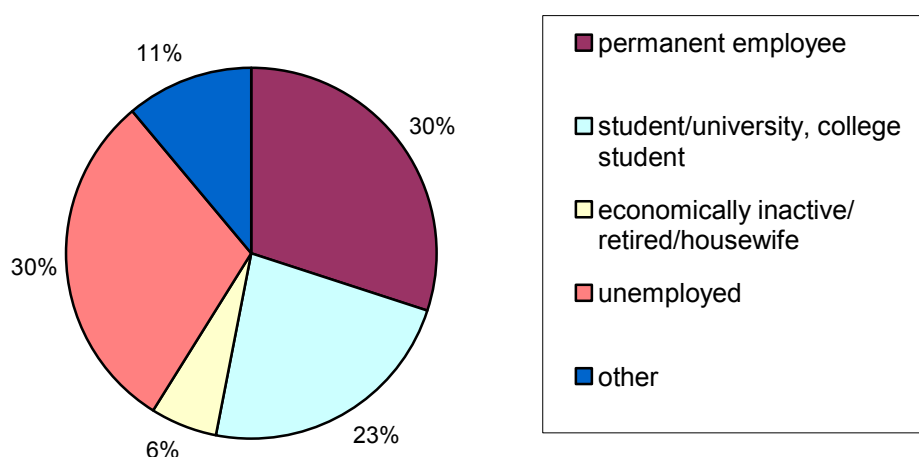


Source: OAI

Unemployment

According to TDI data, 30.1% (422) of the people entering treatment had jobs³⁷. The proportion of the unemployed is almost the same, 29.9% (418 people). In earlier surveys (Vingender 2006, Ladányi, Forrai 2006) the ratio of the expressly unemployed was 27%, which is significantly higher than the national average unemployment rate. If we suppose that a significant portion of problem drug users has no access to treatment, and unemployment is high among them, then the actual unemployment rate of the TDI database is probably even higher.

Figure 30. *Work status among clients in treatment*



Source: OAI

³⁶ This rate is 1.5% (3 people) in the qualitative survey of Vingender (2006) In the survey by Ladányi E., Forrai E. (2006) 7.5% of the participants declared themselves homeless, that is they live in the street or other public premises.

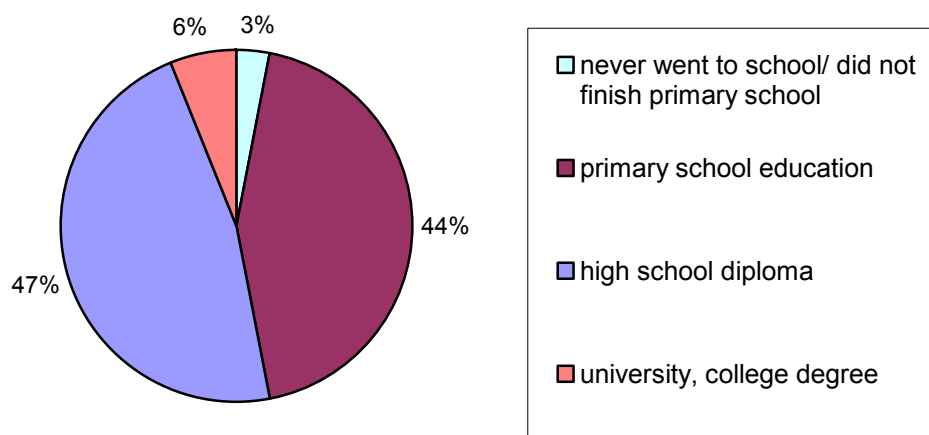
³⁷ In 72 cases out of the 1,472 work status was unknown.

Education levels

According to the data, the highest completed educational level for 43.6% of people in treatment is primary school education. 2.6% never went to school or did not finish primary school. 5.7% (79 people) finished college or university, while 48% (661 people) have a high school diploma.³⁸ 22.6% of participating drug users (316 people)³⁹ was a student at the time of filling out the questionnaire.

Based on earlier surveys (Vingender, 2006) it seems that there is no significant change in educational data compared to 2005.

Figure 31. *Highest level of completed education among clients in treatment*



Source: OAI

Social network

Based on the 2006 TDI data, 46.7% of patients entering treatment (665 people) live with their parents.⁴⁰ Considering the mean age (28.5 years), this rate is quite significant. It may seem that a parental environment offers some kind of security, at least regarding housing, but it probably also means a bastion of natural support for many.

The surveys of Vingender I. (2006) and Ladányi E., Forrai E. (2006) aimed to prove this hypothesis. While 52.6% of the participants of Vingender's survey live with their parents, this rate is 45.4% in Ladányi and Forrai's survey. In this latter survey, to the question "*Is there a person to whom you can turn for help and support, with whom you can talk about your problems?*", the participants indicated a close family member at the highest rate (69.6%).

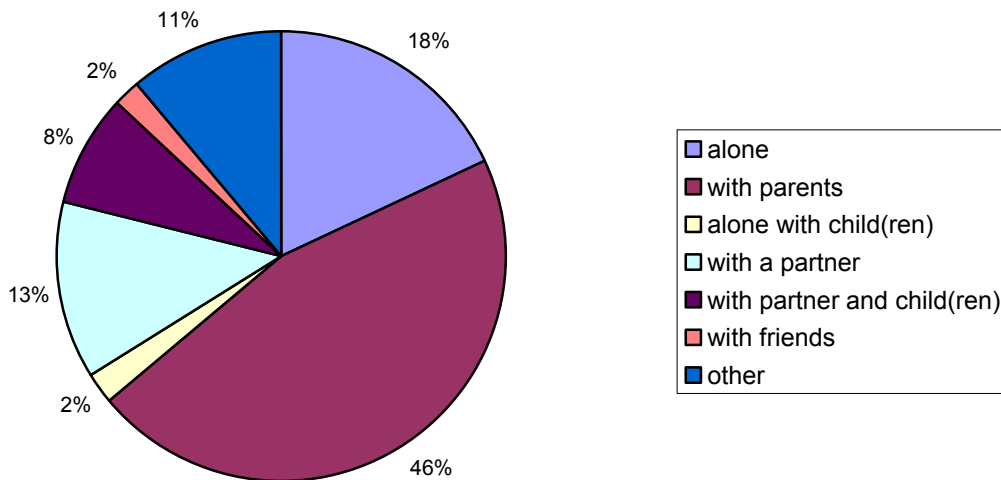
On the other hand, a large portion of the participants live alone (252), or together with a partner (179 people). A partner relationship may also have supportive value from a social point of view.

³⁸ In 96 cases out of the 1,472 education level was unknown.

³⁹ The status of student could be indicated under the question concerning work status, where in 72 cases out of the 1,472, work status was unknown.

⁴⁰ In 48 cases out of the 1,472 family status was unknown.

Figure 32. *Family status of clients in treatment*



Source: OAI

Prostitution

In the beginning of 2006 a survey was conducted with the title “Focus on the basic rights of prostitutes – background survey for the educational programme and legal aid service”⁴¹ (Juhász, Csíkvári 2006). 37 prostitutes were involved in the survey, with whom in-depth interviews were conducted.⁴²

The results of the survey indicate that there is drug use among prostitutes questioned in the survey, especially in the case of prostitutes working on public premises. Some women reported occasional and less risky drug use⁴³, but some in the sample, admitted to being daily injecting heroin users. Some of them fell into prostitution for the money necessary to acquire drugs.

According to the opinion of policemen questioned in the survey, drug use among prostitutes is a real, but not overwhelming problem. They mostly encountered the problem when the prostitutes start to use drugs if the pimp induces them.

⁴¹ The survey was supported by the “Actions in support of civil society in the Member States which acceded to the European Union on 1st May 2004” programme of the European Commission, Directorate-General Justice, Freedom and Security designed to support the NGOs of the acceding countries. The applicant of the tender was the Hungarian Prostitutes’ Interest Protection Association.

⁴² The survey is not representative. In the course of the survey 35 interviews were conducted with 37 prostitutes. Also, as an amendment, 15 experts concerned in this field were interviewed (10 policemen from Budapest and County Pest, two lawyers and the president of the Association, a further three lawyers, a teacher working at an orphanage and a social worker).

⁴³ They mostly reported – non-injecting – use of cannabis and amphetamines. Only one prostitute reported earlier cocaine use.

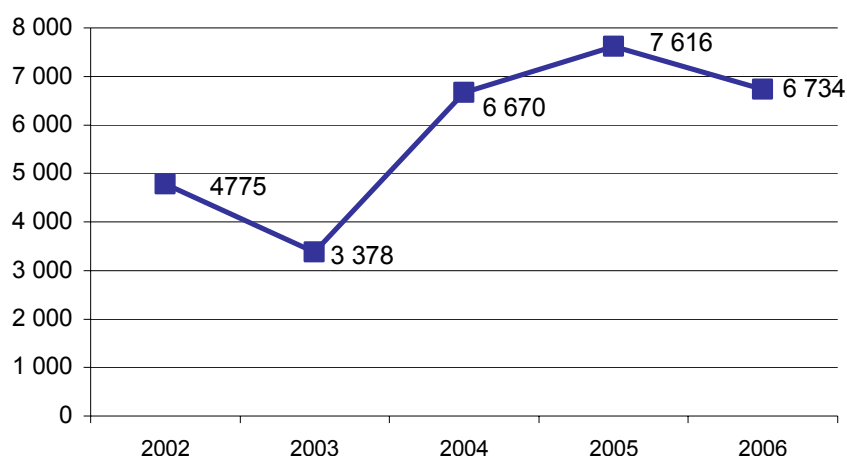
8.2. DRUG-RELATED CRIME

The task of the Uniform Criminal Statistics System of the Police and the Public Prosecutor's Office (ERÜBS) is the statistical collection of data on Hungarian crime. The data below refer to acts where the criminal proceedings were finished in 2006.

Drug offences

The number of revealed cases concerning the misuse of narcotic drugs decreased by 13.4% compared to 2005.

Figure 33. *The number of revealed cases concerning the misuse of narcotic drugs*



Source: ERÜBS

This decrease cannot be accounted for by any legal changes. It is possible that the investigating authority's interest in and/or capacity for uncovering these offences decreased somewhat.

Misuse of narcotic drug offences made up 1.6% of total crime activity in 2006. This rate does not indicate the full extent of crime related to drugs (e.g. crimes committed by drug users in order to acquire drugs, other organized crime).

Date of offence

Regarding the date when the offences were committed we get the following picture:

Table 29. *Revealed offences of misuse of narcotic drugs by the date of the offence*

Year of offence	Number of cases	%
2006	1 184	17.6
2005	3 819	56.7
Before 2005	1 731	25.7
Total	6 734	100

Source: ERÜBS

The crime data indicate clearly the ratio of cases initiated and finished in the same year decreased significantly since before 2004 (the rate was around 30% then) due to the modifications of the Act on the Criminal Code and the Act on Criminal Proceedings in 2003. (In 2004 the rate was 14.4%, in 2005 20.6%, and in 2006 17.6%). This implies that proceedings initiated because of misuse of narcotic drugs take longer and longer compared

to earlier regulation. Considering the cases initiated in 2006, investigation was only closed in the same year in roughly every sixth case.

Perpetrations

Offences involving the activities “production, manufacturing, acquisition, possession, importing” of narcotic drugs which include most often personal use, made up 89.8% (90.9% in 2005) of all revealed drug offences. Compared to that, supply-related criminal acts (denoting offering, supplying, distributing, trafficking narcotic drugs) do not even account for one-tenth (7%) of all reported offences. A significant proportion of misuse of narcotic drug offences is constituted by demand-related behaviours, especially offences committed by occasional users.

Offenders

The number of reported offences of misuse of narcotic drugs decreased by 13.4% compared to 2005. The number of offenders committing misuse of narcotic drugs decreased by 23.7%.

In the following sections, the socio-demographic characteristics of those offenders who committed misuse of narcotic drugs are examined according to the 2006 criminal statistics (independently from the fact whether they were punishable or not).

Breakdown by gender

90.4% were male and 9.6% were female among offenders committing misuse of narcotic drugs in 2006. This ratio has been constant for years.

Breakdown by age

Table 30. *Breakdown of offenders committing misuse of narcotic drugs by age in 2006*

Age groups	No. of cases	%
Child (0-14 years)	17	0.3
Underage (14-18 years)	836	14.6
18–24 years	3166	55.4
25–30 years	1190	20.8
31–40 years	439	7.6
41–50 years	60	1.0
51–60 years	11	0.2
Above 61 years	6	0.1
Total	5725	100.0

Source: ERÜBS

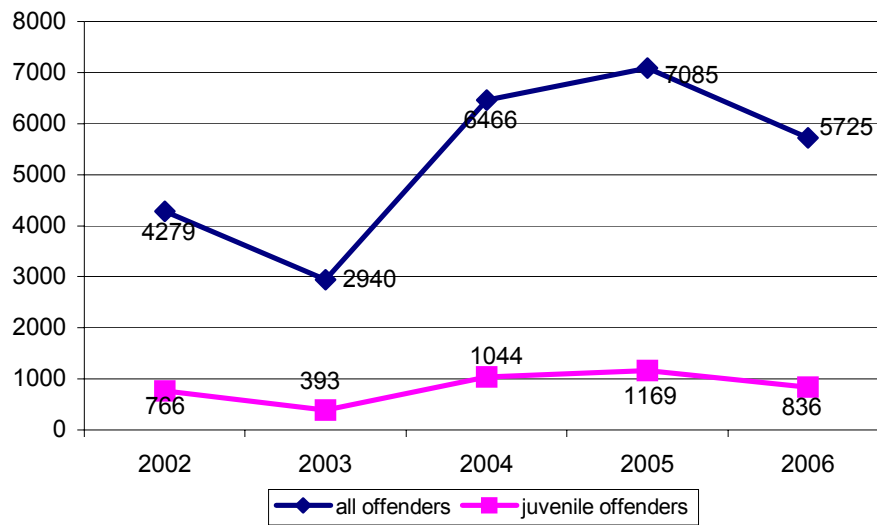
In 2006 the breakdown of offenders committing misuse of narcotic drugs by age did not change significantly compared to 2005.

Juvenile offenders

In 2006, juveniles made up 9.1% of all offenders in Hungary. While the proportion of juveniles among all offenders increased somewhat in 2006 compared to 2005 (8.7%), it decreased by 1.9% among offenders committing misuse of narcotic drugs. The number of juvenile offenders who committed misuse of narcotic drugs was 836 in 2006. They represented 14.6% of all offenders committing drug-related crimes.

While 91% of offenders committed the drug-related crime at or before age of 30 in 2006, this rate does not reach 60% among perpetrators of other crimes.

Figure 34. Number of offenders committing misuse of narcotic drugs



Source: ERÜBS

Breakdown of offenders by education

50.0% of drug misuse offenders had finished primary school, 24.6% had completed a vocational school and, 22.6% secondary school, while the rate of people with college or university degrees was 1.6% in 2006.

No significant change can be detected for years in the breakdown of offenders committing misuse of narcotic drugs by education.

Breakdown by previous convictions

In 2005, 33.8% of reported offenders who committed misuse of narcotic drugs had been previously convicted. A major portion of these offenders were drug-addicts, and their previous offences were also related to drug use or the acquisition of drugs.

Most offenders committing misuse of narcotic drugs (66.2%) had never been convicted before. This rate is higher than in other crime categories.

18.5% of the perpetrators were repeat offenders (i.e. had committed another criminal act in the last 3 years).

Consequent crime – offences committed under the influence of narcotic drugs

The rate of those who committed an offence under the influence of narcotic drugs or other psychoactive substances decreased by 22.7% (to 3209) in 2006 compared to the year before. The explanation for this may be the decrease in the number of offences of the misuse of narcotic drugs, as most perpetrators (70.8%) committed misuse of narcotic drugs. That is, a proceeding has been started against this many offenders (also) because they were under the influence of narcotic drugs. This rate was 76.2% in 2005, so a clear decrease can be detected here as well.

Regarding major crime categories: when, 14% of offenders committed property offences, 3.5% committed traffic offences, 3.2% committed offences against another person and 2.2% committed disrupting the peace under the influence of narcotic drugs or other psychoactive substances. It should be noted that the rate of traffic offences committed by persons under the influence of drugs increased by almost 2%.

Suspension of accusation

In 2006 the number of closed suspensions of accusation against offenders of misuse of narcotic drug crimes was 3175 (55.5%). This is 1237 less than in 2005, when the ratio of suspensions of accusation was 62.3%.

In 2006 this legal institution was applied in the case of 7338 offenders (which is 5.6% of all offenders). Most often it was imposed on offenders of misuse of narcotic drugs, in 43.2% of all cases when accusation was suspended (in 2005 54%).

While in 2004 50% of offenders committing misuse of narcotic drugs participated in suspension of accusation, this rate was 62.3% in 2005. In 2006 we returned to the 2004 level in many ways, regarding both the number of offences of misuse of narcotic drugs and the number of closed suspensions of accusation (55.5%).

Therefore we may state that in 2006 the frequency of applying this legal institution in the case of offenders of misuse of narcotic drugs decreased.

The real reason for this decrease is that Act LI of 2006 amended Act XIX of 1998 on Criminal Proceedings (see National Report 2006, chapter 1.), and the amendment makes it possible for the suspects to start participating in some form of diversion after the commission of the crime, but before the suspension of accusation. This participation means the offender is no longer punishable, regardless of when the suspension of accusation occurs.

The number of patients treated as an alternative for criminal proceedings also further increased (see chapter 4.2). Only the time of beginning treatment has changed, thus the frequency of suspension of accusation decreased in cases of misuse of narcotic drugs.

8.3. DRUG USE IN PRISON

In 2006 drugs were found in 21 cases in prisons, 23 persons were involved. Cannabis derivatives were found in most cases, pills containing amphetamines in some cases and cocaine and morphine on one occasion. The drugs were hidden in packets or in the cells.

8.4. SOCIAL COSTS

No information available.

Conclusions

Available TDI data imply that in the case of drug users the primary help and support relationships are those with direct family members and friends. Regarding housing, the family house offers the greatest level of security. Comparing the answers of drug users in the sample with earlier and present statistical data, it seems that most drug users had finished primary school. There is still no close correlation between drug use and homelessness. A significant segment of the examined population does not have regular work, which significantly affects their ability to support themselves.

In examining the relationship between drug use and prostitution, we must rely on assumptions and the opinions of experts because of the paucity of research data. We can say that drug use is present among prostitutes, and it is also verifiable that prostitution is present among drug users, but at present we do not know the exact rates, the reasons for these activities or the dynamics of change.

In Hungary the number of reported misuse of narcotic drug offences decreased by 13.4% compared to the previous year. However, as a proportion of total crime it was practically constant (1.7% in 2005, 1.6% in 2006). The number of revealed offenders was 15% less in

2006 than the number of misuse of narcotic drug cases detected by the authorities. This means that every sixth offender against whom the proceedings were initiated for misuse of narcotic drugs committed at least two offences. (In 2005 this ratio was 7%, and never went above that in the years prior to 2005 either). The main reason for this is the criminal legislation.

9. RESPONSES TO SOCIAL CORRELATES AND CONSEQUENCES

Overview

In Hungary the treatment of addicts is mainly carried out within the regulatory and institutional framework of the social and health sectors. In 2006, the two responsible ministries (ICsSzEM and FMM) were merged, thus creating the Ministry of Social Affairs and Labour (SzMM). Following the merging of the two ministries, the SzMM became responsible for drug affairs coordination⁴⁴ (see chapter 1.2).

Regulations, professional concepts

- Act III of 1993 on Social Administration and Social Care (hereafter Social Act)
- 1/2000 (I.7.) Regulation of the Ministry of Social and Family Affairs on the professional tasks and operational conditions of social institutions providing personal care
- 188/1999. (XII.16.) Government Regulation on the authorisation of social and village guardian services providing personal care, and authorisation of social services ventures
- 239/2006. (XI.30.) Government Regulation on the managed territorial equalisation system of the social, child welfare and child protection services in 2007

The amendments of the Social Act set out in Act CLXX of 2005 (namely the listing of low-threshold services for addicts within the framework of public services) necessitated the professional modification of related regulations as well. With the amendment of the Social Act, low threshold services were defined in the law, and also the normative support of low threshold service providers became possible. The proper harmonization of the legal background was necessary in both cases.

1/2000. (I. 7.) Regulation of the Ministry of Social and Family Affairs and 188/1999. (XII.16.) Government Regulation were amended according to the above. The amendments included:

- the change in the requirements concerning the professional programme of public services⁴⁵:
the professional programme of public services must contain the mode of cooperation with health care service providers
- the headcount limits of public services⁴⁶:
the service provider providing public services must have capacity for the treatment of at least 40 persons, except for low threshold services
- the definition of low-threshold services⁴⁷:
“The low-threshold treatment of addicts is a service based on outreach work, and anonymous and voluntary participation, whose aim is to reduce the harm caused by addiction, to counter situations endangering life and to initiate and support a new lifestyle.”
- the services that can be provided during the low-threshold treatment of addicts⁴⁸
- the minimum number of services that must be provided during the treatment⁴⁹.

⁴⁴ 170/2006. (VII. 28.) Government Regulation on the tasks and scope of authority of Minister of Social and Labour Affairs.

⁴⁵ Based on Regulation 2/2006. (IV. 14.) of the ICsSzEM. Entered into force on 22 April 2006.

⁴⁶ The 188/1999. (XII.16.) Government Regulation, this modification entered into force on 1 January 2007. The modification was set out in the 325/2006. (XII. 23.) Government Regulation.

⁴⁷ Based on Regulation 9/2006. (XII. 27.) of the SzMM. Entered into force on 1 January 2007.

⁴⁸ Based on Regulation 9/2006. (XII. 27.) of the SzMM. Entered into force on 1 January 2007.

⁴⁹ Based on 9/2006. (XII. 27.) Regulation of the SzMM. Entered into force on 1 January 2007.

“The institutions and service providers providing low-threshold services for addicts... must provide at least two of the determined services.”

- the conditions of entering treatment⁵⁰:
“During the low-threshold treatment of addicts, anonymity has to be ensured in all cases, no personal data are to be taken, certified or registered, and no personal treatment plan is to be prepared. The service cannot be denied based on the lack of abstinence or symptoms or behaviours arising from the addiction.”

As part of the amendment, the rules concerning qualifications of those providing the services became stricter. Accordingly, persons employed as community workers or community coordinators must have certification related to community psychiatric services by the starting date of their employment. The only exception to this rule is if the person to be employed has already started the training and will finish it in the given year.

The legal background of the normative financing of social service providers is determined by the act on the national budget. Act CLIII of 2005 was amended on 13 February 2006. The earlier system of awarding normative support was reformed fundamentally by the act.

As a result of the legal amendments, institutes run by NGOs with licence are not entitled to receive normative state financing automatically during the year. Before the awarding of the normative, they have to ask for incorporation from the SzMM because of the managed territorial equalisation system.

Among the services eligible for support are community services, including the community and low-threshold treatment of addicts.

According to the regulation, a service qualifies as a new service “if the operating institute or its legal predecessor did not receive normative state support in December 2006”.

We must note that even though the low-threshold treatment of addicts was not available in 2006 as an independent service (the modifications of the Social Act in this regard entered into force on 1 January 2007), the effective provisions of Regulation of the Ministry of Social and Family Affairs 1/2000. (I. 7.) made it possible for low-threshold service providers to finance their activity within the framework of the public treatment of addicts from state norms to some extent.

9.1. SOCIAL REINTEGRATION

One may experience serious deficit at both ends of the treatment chain: at low-threshold services, considered as first step; and at re-socialization as finalization of the treatment process, including: employment, aftercare, training, education and housing. Good examples and practices can be found in these areas – mainly the results of civil initiatives – but these fields still require development.

Housing

Apart from the above, no significant change occurred regarding housing compared to 2005. In the system of services for the homeless, the treatment of addicts has been explicitly added at a national level. Alcohol and pharmaceutical abuse are the main addictions problems appearing in the treatment system. Still, experience is that drug users who also have an addiction problem, but are willing to stay clean – even if for a short period (for example for one night in a shelter) – are admitted and supported by all levels of the treatment system, depending on the extent of motivation and preparedness.

⁵⁰ Based on 9/2006. (XII. 27.) Regulation of the SzMM. Entered into force on 1 January 2007.

As a result, professional workshops operated within the coordinator system of the Budapest Methodological Centre of Social Policy and its Institutions (BMSzKI) in 2006 on a monthly basis on addiction, housing, employment and welfare homes.

Besides being the regional methodological centre for homeless services in the Central Hungarian Region, BMSzKI also provides half of the available rooms for the homeless in Budapest. Besides several types of shelters it also operates a temporary rehabilitation home (66 people) for addicts (Győri 2006).

Education and training

The Belvárosi Tanoda Foundation continued their innovative EQUAL programme titled "...being about lost by life..." aiming at the complex care of addicts. In 2006 a total of 346 people participated in the programme, 70% men. Regarding the breakdown of participants by age, 54% were under 25, while the remaining 46% belonged to the age group 25-45.

Training programmes open for, but not expressly started for drug users⁵¹

The programme titled "A chance for your future" of the SEED Foundation for Small Enterprise Economic Development operated from the end of 2003 until the end of 2006.

During these three years, the programme provided financial assistance and mentoring for about 60 Romas in Budapest under the age of 40. The evaluation of the programme is still under way, therefore no exact data are available yet. However, it is already clear that a significant share of the participants acquired competitiveness-enhancing knowledge (language, computer skills), or new professions opening new (employment) opportunities. Besides many other partners, the Blue Point Specialized Outpatient Treatment Centre also took part in the realization of the programme.

Employment

With the modification of the Social Act, the (social) employment of clients in an institutional legal relationship (e.g. rehabilitation home) became possible in the form of work rehabilitation or employment focusing on development and preparation of clients.

Another important change is that the system of financial support is linked to assisting employment. People claiming regular social aid are required to participate in an adaptation programme. With the help of the adaptation programme even those can enter the labour market, who previously could not take advantage of the services offered by labour offices due to deficient social skills or health condition.

The 'Integrated alternative education and employment programme for disadvantaged people, especially addicts' of the Philanthropic Foundation operated from 1 February 2005 to 30 November 2006. The programme had a national scope and during its term it aimed to increase the employment chances of 24 people through education, employment and psycho-social support. Its target audience were addicts, disabled persons, Romas and women. The financial source for the realization of the programme was provided through a HEFOP⁵² tender.

The first sober café (Café Ultra) was opened in Pécs in July 2006 as a result of the cooperation of the Milestone Foundation, the INDIT Public Foundation and several self help groups. Café Ultra is a meeting place for people in the process of quitting and at the same time a protected work place for people leaving a rehabilitation centre.

⁵¹ Regarding the below-mentioned programmes, we do not have data on the number of drug users taking advantage of their services.

⁵² HEFOP (Human Resources Development Operative Programme) is part of the National Development Plan which lay the foundations for the utilization of funds received from the EU Structural Funds between 2004-2006.

The provision of basic social services

In order to foster the re-socialization and reintegration of addicts, the SzMM supported this area with HUF 50 million in the form of tenders in 2006. Mainly NGOs undertook to realize this aim. On the whole, 23 sponsored programmes started operations in 2006: five in the field of education and training, seven in the field of employment, six in housing and another five programmes in other fields of social reintegration.

The establishment of the National Equality Network began in 2004 in Hungary. Under this programme Equality Coordination Offices (Houses of Equal Opportunity) were set up. The aim of the network is to support programmes fostering social reception and chance provision for underprivileged and disadvantaged social groups (Romans, disabled persons, children, women, the elderly). The House of Equal Opportunity in Eger opened on 7 October 2005. It started its programme titled "Busted" in 2006 together with the county prison, where – on the average – 10-12 female prisoners belonging to the 35-40 age group participated weekly. The programme organized small group training in skills development and self-knowledge as well as drug prevention classes for the prisoners, aiming to support a drug free lifestyle for them, to reduce the chance of relapse and of the risks of drug use.

In December 2006 the magazine called "Packet", published by Hungarian Baptist Aid's Street Front Programme was released in 1500 copies in Hungary, with a target audience of problem drug users. The magazine is intended to be published regularly. Its aim is to channel information mainly to heroin users – concerning treatment centres, legal background, up-to-date news on the treatment of drug addiction, interesting facts, peer accounts – that may be useful in their every day lives.

9.2. PREVENTION OF DRUG-RELATED CRIME

No new information available.

Conclusions

Examining the social correlates and consequences of drug use we may conclude that similarly to previous years, the answers of social politics and the treatment system to the existing and newly emerging challenges are still isolated in most cases. Mostly we can talk about the initiatives of NGOs or church organizations, whether on the question of housing, education, training or employment. Behind these initiatives are mainly national and international tender sources. This is adjusted by the lawmakers through the modification of the law in certain cases based on prior experience.

10. DRUG MARKETS

Overview

There were no institutional changes related to drug seizures or drug analysis in 2006. All seized substances which raise suspicion that they may be drugs, are analysed by the Department of Organic Chemistry and Analysis Experts Department of the Criminal Professional and Research Institute (BSzKI), as well as by five regional drug-analysis laboratories.

10.1. AVAILABILITY AND SUPPLY⁵³

It has been discovered in the last two years that criminal groups operating via the "Balkan route" - mainly linked to heroin smuggling - also take part in the smuggling, vending and production of synthetic drugs.

According to experiences of 2006, the organization and conspiracy level among the groups smuggling and vending synthetic drugs has increased, and a stable circle of Hungarian offenders has formed (mainly in the Netherlands). Division of labour within the organization has further differentiated: functions have evolved for providing means, organization, courier, storage, wholesale and retail sales functions.

10.2. SEIZURES

The data in the analysis below include drugs found and seized (by the Police and the Customs) in Hungary in 2006. (ST13)

Table 31. *Number and quantity of seizures of illicit drugs*

Type of drug	2005		2006	
	seizures	quantity	seizures	quantity
Herbal cannabis (kg)	1707	161.6	1540	266.5
Cannabis plant (pieces)	43	811	50	3529
Cannabis resin (kg)	86	12.9	67	3.0
Heroin (kg)	108	237.8	144	131.1
Cocaine (kg)	89	7.6	113	7.3
Amphetamines (kg)	355	27.743	368	21.81
Methamphetamine (kg)	5	0.107	11	0.013
Ecstasy (tablet) /MDMA, MDA, MDE/	366	234582	145	138278
LSD (dose)	14	560	13	2148

Source: BSzKI

In 2006 – similarly to previous years – the most common active substances were delta-9-THC, amphetamines, MDMA, heroin and cocaine.

The frequency of amphetamines became second in 2006, preceding ecstasy.

⁵³Based on a report of the National Bureau of Investigation

The most well-known drugs are followed by ketamine regarding frequency, which is also known as “I-dust” on the Hungarian black market. It is characteristically seized in small amounts, since 2003-2004 consistently 30-50 times every year.

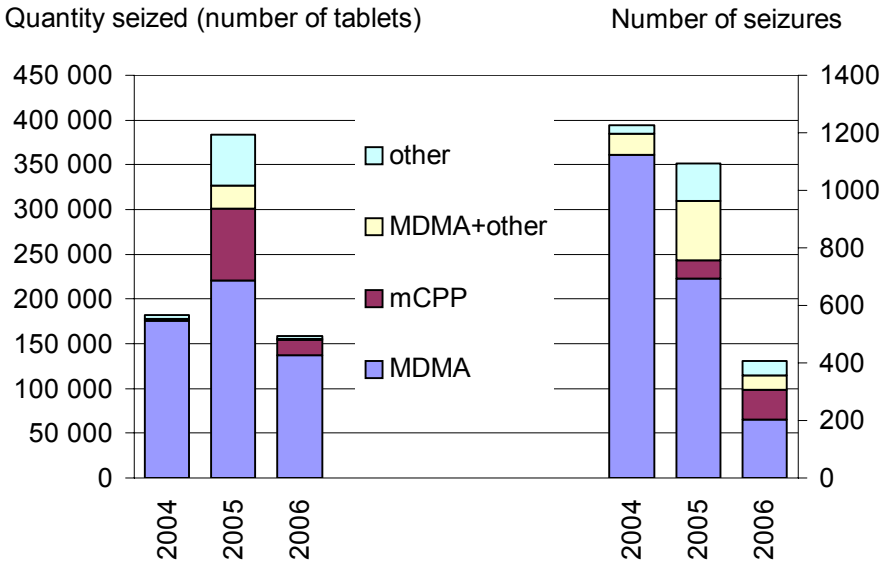
In 2006 pure methamphetamine-hydrochloride (“ice”) was seized twice, while pure MDMA-hydrochloride once in smaller amounts. These active substances had not been seized in a pure form in Hungary before.

Besides illicit drugs, we also have to mention the uncontrolled substance GBL (Gamma-Butyrolactone). Having entered the body, GBL becomes Gamma-Hydroxybutyrate (GHB), a compound which qualifies as an illicit drug. GBL was seized once each in 2002 and 2003, in 2005 three times, while in 2006 11 times in the total of 300 grams, which implies that the misuse of this substance is spreading.

The number of seizures of heroin, cocaine and amphetamines has been increasing continuously in recent years. Even though there was no significant change in the number of seizures, the quantity of seized herbal cannabis and cannabis plant increased significantly compared to the two previous years.

There was a significant decrease in the seizures of ecstasy-type tablets – in both the number of seizures and the quantity of tablets. The quantity of seized tablets did not decrease proportionally with the number of seizures, but this is due to the fact that most of the pills (more than 70%) originated from one large seizure in 2006.

Figure 35. The number of seized ecstasy-type tablets and seizures



Source: BSzKI

10.3. PRICE/PURITY

Price of drugs at street level

Similarly to previous years, in 2006 the price of drugs at street level was assessed on the basis of questionnaires completed by drug users.

The survey showed some changes in the rate of answers compared to 2005. Most people could again provide information regarding herbal cannabis, but more people had information

on the price of amphetamine than ecstasy. This fact confirms other changes in different areas of the drug problem (more amphetamine seizures, etc.), which imply that amphetamines has become more widespread on the drug market. (ST16)

Table 32. Price of drugs at street level in EUR⁵⁴

EUR	Lowest	Highest	Most common	Average	Number of responses
Cannabis resin (gr)	6.5	10.4	8.5	8.4	63
Herbal cannabis (gr)	6.1	9.8	8.4	8.0	91
Heroin (gr)	38.7	62.8	48.4	50.8	49
Heroin (packet)	15.2	21.7	17.4	18.5	39
Cocaine (gr)	46.0	88.0	56.3	67.0	55
Crack (gr)	48.4	60.5	48.5	54.5	9
Amphetamines (gr)	9.1	13.0	11.3	11.0	79
Ecstasy (tablet)	2.9	6.7	4.8	4.8	74
LSD (dose)	7.4	11.6	9.4	9.5	46
Methadone (20 mg)	4.1	8.1	6.8	6.1	30
Methadone (5 mg)	1.6	3.5	2.4	2.6	20

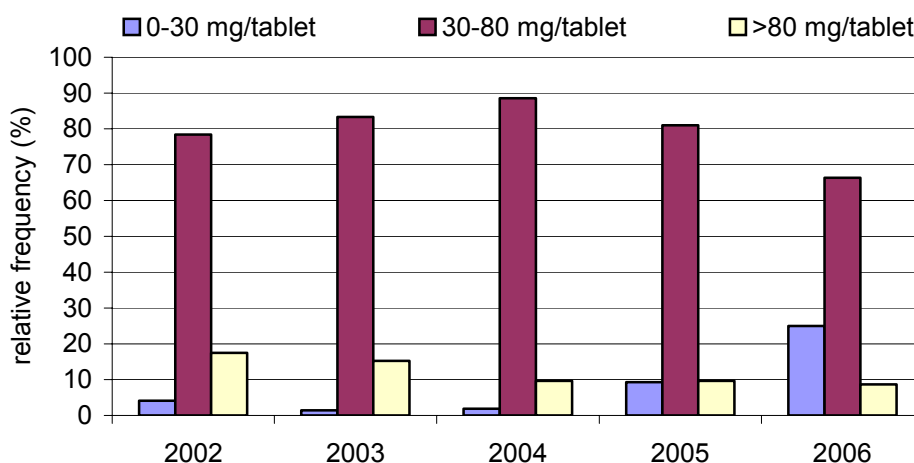
Source: National Focal Point 2007

Changes that occurred compared to prices reported in 2006: there was a decrease in the average price of cannabis resin, cocaine, amphetamine, ecstasy and LSD, while heroin (gr) became more expensive compared to the average price last year.

Purity

The active substance content of drugs has changed the most in the case of tablets. Besides MDMA, the frequency of tablets containing mCPP is also still significant, but in the quantity of tablets seized, tablets containing MDMA made up a larger share of seizures in 2006 as well. Among these tablets the frequency of tablets containing less MDMA-basis than the average 30-80 mg/tablet increased significantly. (ST15)

Figure 36. The change in the active substance content of tablets containing MDMA



Source: BSzKI

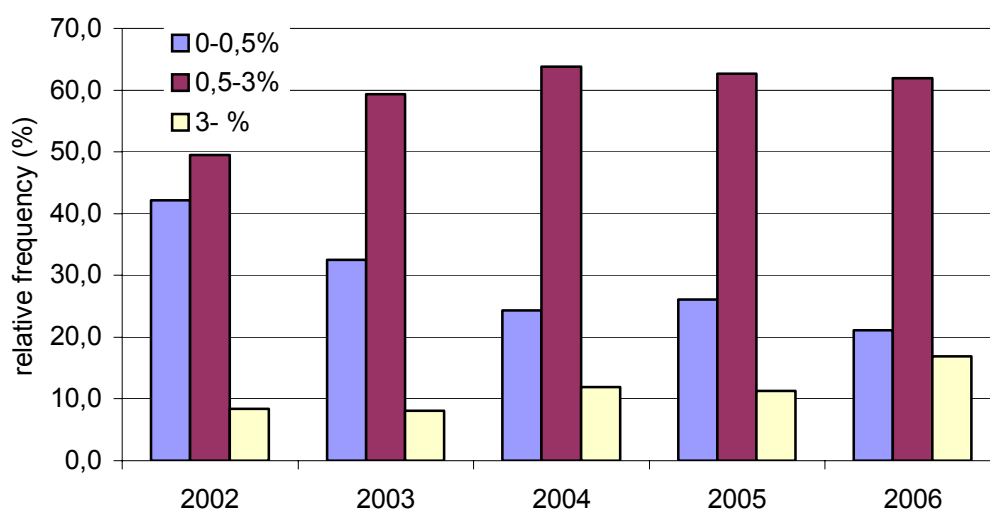
⁵⁴ The prices in the table were calculated on the basis of the official exchange midrate of the EUR for 2006 (1EUR = 264.27 HUF).

Among powders containing heroin that were seized in large quantities – typically in the form of 0.5 kg packages – there were several seizures of the low (around 10% heroin-basis) concentrate characteristic of more diluted street samples. (ST14)

No bigger cocaine shipment was seized in 2006. In the case of smaller seizures, the 30% cocaine-basis concentration was most common. However, measured active substance contents cover the whole spectrum of 10-80% concentration. (ST14)

In the case of seized herbal cannabis, the ratio of substances with lower (<0.5%) active substance contents is decreasing, while the ratio of substances with active substance contents higher than the average (0,5-3%) has been continuously increasing for years. (ST14)

Figure 37. Delta-9-THC content of seized herbal cannabis and cannabis plant



Source: BSzKI

Conclusions

The greatest change can be detected concerning ecstasy tablets, as both the number of seizures, and the quantity of tablets seized has decreased significantly, and products with low active substance content have appeared in a great amount. The proportion of traditional drugs (heroin, cocaine) increased slightly again. The purity of drugs on the street has changed, the extent of change depending on the type of drug. The delta-9-THC content of herbal cannabis has been slowly but firmly increasing for years.

11. PUBLIC EXPENDITURES

11.1. NATIONAL ESTIMATES OF LABELLED DRUG-RELATED EXPENDITURES

The starting point for estimating the so-called labelled drug-related expenditure items is, according to the Guidelines, the comprehensive budget document (year-end report). In Hungary this report is part of the Law on the Implementation of the Budget of the Republic of Hungary; for the year 2005 this can be found in Annex 1 of the Law 2006/XCIX.

Before proceeding to identify the labelled expenditure items two methodological remarks are necessary.

- (1) The budget report lists expenditure items mostly according to the administrative unit in which they occurred. Occasionally there are items which can be assigned not to organizational units but to programmes or policies; in general, however, information on substantive, functional aspects is missing. Therefore labelled items amount only to a marginal percentage of actual drug-related expenditure.
- (2) The Budget Law includes all expenditure of (i) central government organizations, (ii) social security funds, as well as (iii) general and earmarked transfers for the local and territorial self-governmental sector. It does not, however, provide actual, exhaustive information on expenditures of local and regional self-governments themselves. Therefore, labelled drug-related expenditure items (possibly) present in the budget reports of individual local and territorial self-governments fall outside the scope of the Budget law, and thus of the current exercise.

Table 33. *Labelled drug-related expenditure items in the Law on the Implementation of the Budget for 2005*

Item	Million HUF	Thousand EUR ⁵⁵	Govt. level	COFOG group	Function (Reuter 2006)
Reduction of individual and social damage resulting from drug addiction (ICsSzEM)	24,7	99,6	Central	10.7 (Social exclusion n.e.c.)	4. Harm reduction
Prevention programme (ICsSzEM) *	202,8	817,6	Central	7.4 (Public health services)	1. Prevention
HU-2002-180-05-02 KEF capacity building (ICsSzEM - Support for PHARE and accession related programmes) *	16,6	67	Central	7.4 (Public health services)	1. Prevention
Total	244,1	984,2			

Source: Hajnal 2007

* These items cannot be unequivocally classified neither according to the COFOG nor according to the Reuter (2006) classifications scheme. On the basis of expert judgement it seems, however, that the dominant element of these activities is prevention. Therefore they were classified accordingly.

It is interesting to note that the actual figures (shown in the table) are substantially smaller than the ones originally foreseen by the budget plan.

⁵⁵ The amounts indicated in the table were calculated according to the official exchange midrate of the EUR for 2005 (1EUR = 248.05 HUF).

11.2. ATTRIBUTABLE PROPORTIONS AND ESTIMATION OF NON-LABELLED EXPENDITURES

Overall expenditures

The below table presents the figures for COFOG Functions 3 (Public order and safety) and 7 (Health) for 2005.

Table 34. *Total expenditure for COFOG Functions No. 3. and 7. in 2005*

COFOG function	Million HUF	Thousand EUR⁵⁶
COFOG 3 – Public order and safety	453,969	1,830,151
COFOG 7 – Health	1148,312	4,629,356

Source: Ministry of Finance, Division of Budget and Fiscal Policy

Methodological remarks relating to the estimation of drug-related budget expenditure

The method of estimation foreseen by the EMCDDA Reporting Guidelines rests on the following logic:

- Drug-related expenditures are estimated as the sum of sub-totals calculated for seven separate functional areas (falling within the broad functions of COFOG 3 and 7). These areas will be specified later.
- The starting point of the estimation is the total expenditure of the functional area at hand. These budget figures are compiled and reported by all EU Member States – including Hungary – according to the same COFOG methodology.
- However, only a small percentage of these group totals are related to the drug problem. Therefore so-called attributable proportions – reflecting the percentage of drug-related activities within all group activities – have to be estimated. On this basis the drug-related proportion of total group expenditures can be estimated.

In mathematic form:

$$TotalDrugExp = \sum_{i=1}^7 GroupExpenditure_i \times AttributableProportion_i$$

where

- TotalDrugExp denotes total drug-related budget expenditure;
- i: ranging from 1 to 7, is the index for COFOG functional groups mentioned above;
- GroupExpenditure_i denotes the total budget expenditure for the ith COFOG group;
- AttributableProportion_i denotes the attributable proportion applicable for the ith COFOG functional group.

It can be seen that the key precondition of successful estimation is identifying and using a sufficiently good measure of attributable proportion.

Attributable proportions can, theoretically, be calculated in an infinite number of different ways. The crux of the problem is – also highlighted by the research conducted in 2006 (see National Report 2006, chapter 1.) – is that, in the Hungarian context, such numbers don't exist as such; moreover, they cannot either be calculated on the basis of available data in an exact manner.

Thus the problem is to produce the best possible estimations within the limits set by the availability of relevant data/information. This estimation is inevitably less than perfect; its quality can vary in a broad range, according to the scope and quality of available data.

⁵⁶ The amounts indicated in the table were calculated according to the official exchange midrate of the EUR for 2005 (1EUR = 248.05 HUF).

Acquiring such data is, however, time-consuming and expensive since it requires substantial field research.

In the view of this it is important to note that the scope of the present work involves an important limitation. Namely, the estimation of attributable proportion has to be based on data and information already available from the 2006 research project referred to earlier.

Drug-related expenditure in the field of public order and safety

This COFOG function includes the following functional groups:

- COFOG 3.1 Police Service. This corresponds to the item “F03.b (Rend és közbiztonság)” in the document titled „Államháztartás funkcionális mérlege”.
- COFOG 3.3 Law courts. This corresponds to the item „F03.a (Igazságszolgáltatás)”.
- COFOG 3.4 Prisons. This corresponds to the item „F03.d (Büntetés-végrehajtási igazgatás és működtetés)”.

The below table shows the estimation of drug-related expenditure for the above three functional groups. Estimations are made on the basis of different available attributable proportions. The structure of the table is as follows.

- The table consists of three sections with identical structure. These sections correspond to the three COFOG functional groups mentioned above.
- The starting point of the calculation is the budget total for the functional group at hand. This figure is followed by different measures of attributable proportion (denoted as “Attributable proportion 3.x.y”). These measures are the results of the 2006 research.
- The actual figures for the various measures of attributable proportion stem, likewise, from the research conducted in 2006.
- The third and fourth column of the table shows (in HUF and in EUR) the drug-related budget expenditure calculated using different measures of attributable proportion.
- Judging the quality of the different estimations – and thus the applicability of the envisaged measures of attributable proportion – is made possible by comparing the resulting drug-related expenditure figures with those resulting from the 2006 research. Using the results of this previous research as a benchmark is justified by the fact that those figures were estimated with a method reflecting the institutional and data-related specificities of the Hungarian context to an extent much larger than does the EMCDDA Reporting Guidelines⁵⁷. These “benchmark-estimates” can be found in the rows labelled “alternative estimate”.

Table 35. *Estimation of drug-related expenditure in the field of public order and safety using different measures of attributable proportions (2005)*

Item	%	Million HUF	Thousand EUR ⁵⁸
COFOG 3.1 – Public order and safety		259,394	1,045,733
Attributable Proportion (3.1/a): Number of criminal acts	1.58	4,098	16,520
Attributable proportion (3.1/b): Number of criminal acts, w/o those closed as “uncleared”	2.74	7,107	28,651
Attributable proportion (3.1/c): Criminal cases closed	1.93	5,006	20,181

⁵⁷ The method of the 2006 research put much less emphasis on the requirement of methodological standardization and the resulting international comparability. Thus it is of course by no means “better” in any sense than the one foreseen by the Guidelines; rather, it seeks to fulfil partly different requirements.

⁵⁸ The amounts indicated in the table were calculated according to the official exchange midrate of the EUR for 2005 (1EUR = 248.05 HUF).

Alternative estimate (for the Police and the Customs and Finance Guard)		3,729...4,458	15,033...17,972
COFOG 3.3 – Law courts		10,7971	435,279
Attributable Proportion (3.3/a): Number of criminal acts	1.58	1,706	6,877
Attributable proportion (3.3/b): Number of criminal acts, w/o those closed as “uncleared”	2.74	2,958	11,925
Attributable proportion (3.3/c): Criminal cases closed	1.93	2,084	8,401
Alternative estimate		487...520	1,963...2,096
COFOG 3.4 – Prisons		37,047	149,353
Attributable proportion (3.4/a): Number of new inmates	2.46	911	3,672
Attributable proportion (3.4/b): Average number of inmates.	5.08	1,882	7,587
Alternative estimate		1,790...1,912	7,216...7,708
Total (using the Guidelines method) *		7,686	30,985
Total (on the basis of the 2006 research)		6,006...6,890	24,212...27,776

* Calculated on the basis of attributable proportions resulting in the smallest deviation from the benchmarks

Source: Hajnal 2007

Some comments to the figures seem justified:

- The best estimates – i.e. those approaching the estimates of the 2006 research to the largest extent – are marked with dark background.
- In the group of Law courts (3.3) the deviation from the benchmark is remarkably large (more than threefold). The reason of this is that processing criminal cases amounts to a relatively modest proportion (about 15%) of the total activity of law courts. Therefore the – apparently – “best” estimate resulted not from attributable proportion measure criminal cases closed, although, conceptually, this is a much more relevant indicator of workload and of expenditure. Instead, the best estimation was made using the measure “number of criminal acts”. However, it has to be noted that this peculiarity is only attributable to the temporal dynamics of (i) new criminal cases and of (ii) criminal cases reaching the judicial phase. Thus it seems that, on the longer run, attributable proportions for law courts should – despite the results reported in the above table – be estimated on the basis of closed criminal cases.
- Although to a much lesser extent, but we have a similar situation with regards to the police expenditures (COFOG 3.1) where, again, a measure of attributable proportion which is conceptually less adequate proved – at least this time – to be the most “successful” one.
- Finally, with regard to the prison expenses it can be seen that the best measure is clearly the one based on the average number of inmates. However, the reporting system of the Hungarian National Correction Service does not report such data; instead, they had to be estimated on the bases of available data using a relatively complex model.

Health expenditures

This function includes the following COFOG functional groups:

- 7.1 Medical products, appliances and equipment; this forms a subset of the item „F05.e (Egyéb egészségügy)” in the Hungarian reporting system. According to

additional data supplied by the Ministry of Finance in 2005 this figure amounted to 370,840 million HUF (1,495,021 thousand EUR).

- 7.2 Outpatient services corresponds to item „F05.b (Háziorvosi és gyermekorvosi szolgálat)” plus item „F05.c (Rendelői, orvosi, fogorvosi ellátás)”.
- 7.3 Hospital services corresponds to item „F05.a (Kórházi tevékenységek és szolgáltatások)”.
- 7.4 Public Health services corresponds to item „F05.d (Közegészségügyi tevékenységek és szolgáltatások)”.

Within the scope of the current work it was not possible to propose and calculate measures of attributable proportion for any of the above four expenditure groups. Therefore it was not possible to give estimations for drug-related expenditure in the above areas either.

The reason for this is that the 2006 research relied, unlike to “top-down” approach employed in the functional area of public order and safety, a bottom-up approach. That is, most elements of the health expenditure was calculated directly on the basis of the national data base of the National Health Insurance Fund (OEP) including, in theory, full details of each and every service transactions occurring in the national health system. Since this exercise resulted directly in financial figures it did not supply natural/in-kind measures of service volume which could now be used to calculate attributable proportions.

Irrespective of this difficulty, it is important to emphasize that at the time of preparing the National Report a general, overarching reform programme of the entire Hungarian health insurance and service provision system is underway. It is foreseen that as part of this reorganization the OEP will, at least in its present form, cease to exist. Funding of health services will be overtaken by a number of new insurance companies partly owned by private investors. Consequently, it is highly probable that the current data and reporting system of the OEP – also used for the 2006 research – will be replaced by other, not-yet-known information systems.

Nevertheless, the below table summarizes the total expenditures of the four COFOG functional groups.

Table.36. *Total expenditures for the health-related COFOG functional groups (2005)*

COFOG item	Million HUF	Thousand EUR⁵⁹
COFOG 7.1 Medical products, appliances and equipment	370,840	1,495,021
COFOG 7.2 Outpatient services	212,919	858,371
COFOG 7.3 Hospital services	463,394	1,868,148
COFOG 7.4 Public health services	48,480	195,444

Source: Ministry of Finance, Division of Budget and Fiscal Policy

11.3. NATIONAL STUDIES ON DRUG-RELATED PUBLIC EXPENDITURES

In Hungary only one research estimating the drug-related public expenditures has been conducted so far. The adopted methodological guidelines were worked out in 2005. It considered the available data sources according to the international methodology. The study was finalized in 2006. The main results, methods and references can be found in the National Report 2006, chapter1. (The detailed methodology paper of this research has been sent to the EMCDDA.)

⁵⁹ The amounts indicated in the table were calculated according to the official exchange midrate of the EUR for 2005 (1EUR = 248.05 HUF).

Conclusions

Labelled drug-related budget expenditures identifiable on the basis of the national budget report is, only a small fragment of total drug-related budget expenditures for the same year. On the basis of applying the methodology foreseen by the EMCDDA Reporting Guidelines the total amount of drug-related expenditures in the field of public order and safety is 12-28% higher than the benchmark set by the 2006 research. There was a particularly large deviation with regards to the expenses of the judiciary. Drug-related budget expenditures in the field of health services (COFOG 7.1-7.4) were, within the scope and the limits of the current work, impossible to estimate.

It is probable that the method of estimation foreseen by the Guidelines would have been largely impossible to apply even if extensive new field research were possible. Irrespective of this problem, the overarching reform of the Hungarian health service system underway is likely to alter all currently existing data sources and systems. Therefore it is impossible to foresee at this point to what extent the Guidelines will be applicable in the Hungarian context in the longer run.

12. VULNERABLE GROUPS OF YOUNG PEOPLE

International studies focussing on drug prevention have identified several risk factors that may play a role in the formation of dangerous drug use patterns and social exclusion. Vulnerable groups can be identified on the basis of several factors. It is, however, important that causality proven by research should be present between the presence of the given factor and the formation of the drug problem. The members of the vulnerable groups are addressed with selective prevention interventions. EMCDDA specifies the following groups as vulnerable to drug use: young people living in child protection care, school dropouts, children from families struggling with drug and/or alcohol problems, homeless youths, youth living in socially disadvantaged neighbourhoods, ethnic groups, party/festival goers, children from vulnerable families (alcohol, drugs, poverty).

12.1. CHARACTERISTICS OF THE MAIN VULNERABLE GROUPS

From among the vulnerable groups identified by international literature and by the National Strategy, the number of young people living in child protection care is available: in 2005⁶⁰ 17,456 children (9,172 boys, 8,135 girls, 149 foreigners) were placed temporarily at the Local Child Care Offices or taken into temporary or permanent child care, out of whom 585 had special needs. This number includes all three categories of children with special needs (see below); therefore it cannot be determined exactly how many of them struggle with problems caused by alcohol, drug or other psychoactive substances.

Act XXXI of 1997 on the protection of children and child welfare administration defines vulnerability as follows: vulnerability is a state arising as a result of a behaviour, negligence or a circumstance that hinders or impedes the physical, intellectual, emotional or moral development of the child. According to the data of child guardian authorities, in 2005 the number of vulnerable minors was 223,594 in Hungary.

The act specifies three cases in which the child must be provided special care. These are the following: children struggling with a serious personality development disorder or displaying serious psychotic or neurotic symptoms, an offender under 14 displaying serious integration disorder or serious antisocial behaviour, and children abusing alcohol, drugs or other psychoactive substances. However, these groups are not separated in the statistics prepared by the child guardian authorities.

Table 37. *Number of vulnerable minors registered by child guardian authorities between 2001-2005*

	2001	2002	2003	2004	2005
Number of vulnerable minors registered on 31 December of the given year	249,928	235,673	232,381	225,365	223,594
Environmental	50,700	46,875	50,219	49,365	50,229
Behavioural	25,584	27,824	26,475	31,120	35,014
Financial	166,363	153,297	144,700	135,897	126,291
Health	7,281	7,677	7,987	8,983	9,060

⁶⁰ Data of 2006 were not available at the time of preparing the National Report

Out of the total number of vulnerable minors	vulnerable also because of the alcoholism of the parent	25,674	25,743	25,643	24,914	23,444
	vulnerable also because of housing conditions	27,562	29,726	31,754	32,470	30,578
Number of families in which vulnerable minors live		107,437	104,271	102,241	99,584	98,304

Source: Report on family, child and youth protection, Ministry for Social Affairs and Labour (2006)

In 2005, 296 children were taken into temporary care because of the addiction of their parents. They were put up at temporary homes for families in most of the cases. On the whole, the addiction of the parent or the child was the reason for taking the child into temporary care in only 3.8% of the cases.

Table 38. Breakdown of children in temporary care by the root cause inducing admission, 2005

	substitute parents	temporary child home	temporary family home	total	%
Life conduct problems of the parents	32	444	795	1,271	15.8%
Health problems of the parents	37	158	81	276	3.4%
Health problems of the child	3	21	43	67	0.8%
Addiction of the parents	19	112	165	296	3.7%
Addiction of the child	0	7	0	7	0.1%
Housing problems of the parents, crisis accommodation	5	48	500	553	6.9%
Housing problems of the parents, becoming homeless	30	190	1,423	1,643	20.4%
Housing problems of the parents, unsatisfactory housing conditions	16	248	1,102	1,366	16.9%
Abuse (physical, sexual, emotional)	5	86	1,044	1,135	14.1%
Justified absence of parent or foster parent	57	51	52	160	2.0%
Family conflict	8	178	694	880	10.9%
Behavioural problems of the child	9	149	28	186	2.3%
Other	7	103	114	224	2.8%
Total	228	1,795	6,041	8,064	

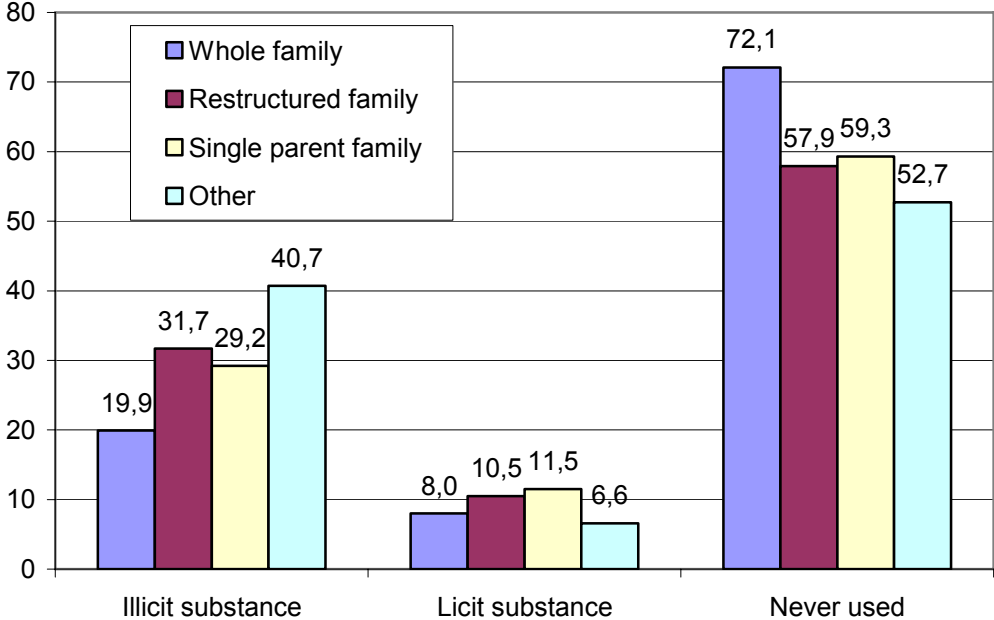
Source: Report on family, child and youth protection, Ministry for Social Affairs and Labour (2006)

12.2. DRUG USE IN THE VULNERABLE GROUPS

We have given account of surveys examining the drug use of groups considered vulnerable to drug use in previous Reports. The surveys targeted the following vulnerable groups: children with mental problems (see National Report 2006, chapter 11.), young people in state welfare care, Roma youths (see National Report 2005, chapter 2.), boys living in reformatories and youth attending electronic music parties (see National Report 2004, chapter 2.).

The ESPAD surveys examine the relationship between drug use of young people and family background variables (Elekes, 2005). According to the results of the 2003 ESPAD survey⁶¹, missing school because of truancy showed a significant correlation with the indicators of drug use in the case of both boys and girls. Examining family structure, it became obvious that intact families have a protective effect against the use of both licit and illicit drugs, while young people growing up without one of the biological parents are more vulnerable.

Figure 38. Breakdown of using licit and illicit substances by family structure (%)

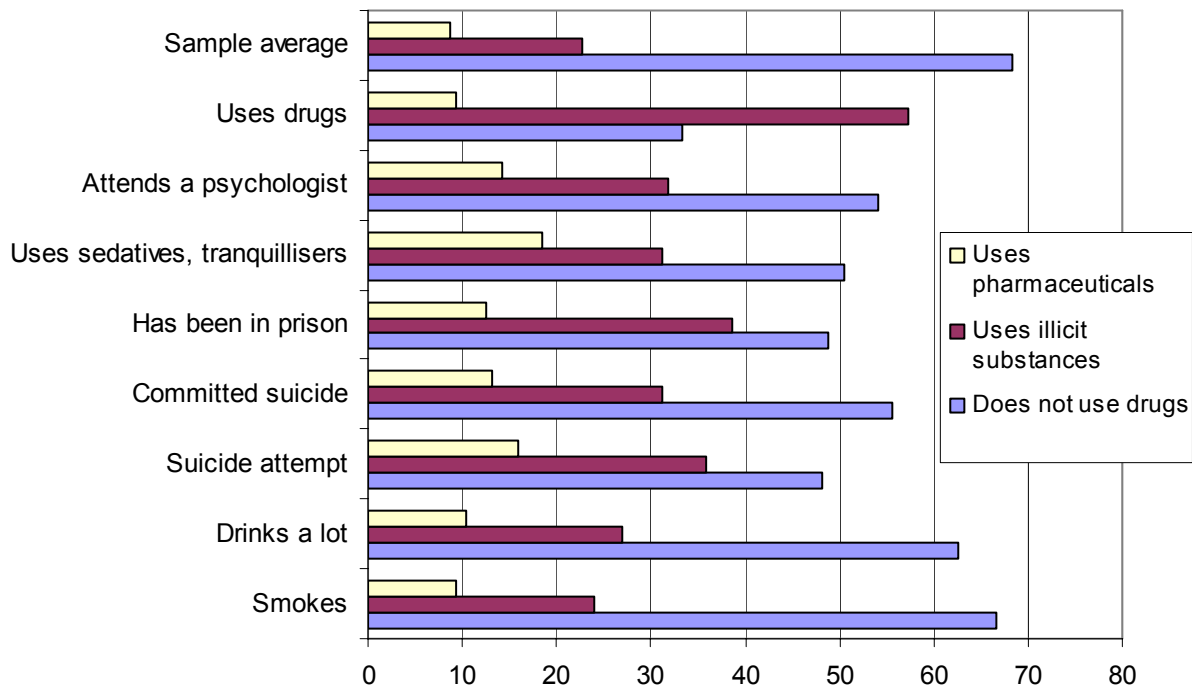


Source: Elekes 2005

Further family background factors were also identified that had a significant correlation with the drug use of young people, like the strength of parental control, substance use of elder siblings, and the presence of different deviances in the family. The following figure shows drug use patterns among young people in relation with the deviances of the other members of the family.

⁶¹ The survey was conducted by the Behaviour Research Centre of the Budapest Corvinus University based on a national representative sample stratified by the type and location of schools in the 8-10 grades. The gross sample size of the 16 year old students was 3,167 of persons and the net size of 2,677 persons. Data collection was carried out according to ESPAD standards with self-reporting method in classes.

Figure 39. Breakdown of drug use patterns by deviances present in the family (%)



Source: Elekes 2005

Smoking in the family has the least effect on the drug use habits of young people, however, every deviance increases the probability of using licit or illicit drugs to some extent. As for illicit drug use, the children of drug using parents seem to be the most vulnerable.

12.3. VULNERABLE GROUPS IN TREATMENT

No information available regarding the vulnerability of young people and individuals entering the health care system for treatment because of drug use.

There are two foster homes offering special treatment for young people being raised in child protection care struggling with psychoactive substances or displaying serious antisocial symptoms, in which a total of 32 young people (16+16) can be accommodated. However, both institutions only admit boys.

12.4. CORRELATES AND CONSEQUENCES OF DRUG USE IN VULNERABLE GROUPS

No information available.

12.5. LEGAL BACKGROUND

Act XXXI of 1997 on the protection of children and child welfare administration determines the objectives, range and special forms of specialized child protection services in case of vulnerability (see National Report 2006, chapter 11.).

The National Strategy⁶² identifies the twelve most important scenes of prevention; one of them is "Groups at risk, risk conditions". Here the following vulnerable youth – and adult – groups are specified:

- children with multiple disadvantages,
- children of alcoholic parents,
- truants, loafers, street kids,
- psychologically troubled children, teenagers (psycho-pathological conditions in adolescence, problem behaviours, long-term hospital treatment in childhood or absence from home),
- children and youngsters receiving specialised care from child protection living with foster parents or in orphanages,
- youths and adults currently in or recently released from penitentiary institutions.

The Strategy specifies the institutions of child protection and the groups of Roma population as separate scenes.

The Strategy lays down several objectives concerning the vulnerable groups.

Long-term objectives:

Raising the awareness of families to enable them to recognise and manage drug problems. Families exposed to a high risk of drug use should be assisted with family-friendly welfare policy instruments.

Development of workplace drug policies, and extension of the drug-free workplace program. In hazardous workplaces, drug use should be prevented also by introducing inspections with a view to protecting the employee and the workplace community and ensuring safe performance of work; special workplace-based preventive treatment programs should be launched for drug users and those with psychological or social risks.

Medium-term objectives:

The health promotion programs containing drug prevention modules should cover as wide a range of the Hungarian youth as possible. Here we name only the most important and, at the same time, largest groups, where drug prevention has a particularly important role to play: those participating in public and higher education, dropouts, the unemployed young, those at risk for other psycho-social reasons.

Short-term objectives:

Survey and assessment of the institutions. Today, a very large number of state, municipal, voluntary and church organizations deal with drug users or youths endangered by drug use, with or without expressed reference to such activity. (...) Presumably, it is not possible to survey the entire institutional system, but the screening of at least a representative segment is necessary.

Surveys concerning the prevalence of drug use among the young and its monitoring. It is necessary to conduct surveys in higher education and among the high-risk youth detailed above, and to repeat them from time to time in order to follow the changes.

Reinforcement of local community initiatives: development of special programs for the young at risk, collection of such existing programs and getting experts acquainted with them.

(Treatment) programs for high-risk or special populations. Organization of special programs enabling long-term care in various institutional forms (inpatient, outpatient, aftercare, community, psychiatric and rehabilitation) for those struggling with other psychiatric problems (dual diagnosis, co-morbidity).

⁶² National Strategy to Combat the Drug Problem, 2000

12.6. PREVENTION AMONG VUNLERABLE GROUPS

We do not yet have as detailed information on the selective prevention activities targeted at vulnerable groups as that concerning school programmes (see National Report 2006, chapter 3.).

The Drug Information Portal for Professionals (www.ndi-szip.hu) contains the description of 12 programmes targeting vulnerable groups. The programmes in the database mostly offer alternatives of spending free time for disadvantaged young people struggling with behavioural problems. However, they also include two programmes that are organized by certain institutions for their inmates (Mother Protection Foundation, Peace Orphanage of the Local Government of Budapest).

Conclusions

The groups of young people vulnerable to drug use identified by international literature can also be found in Hungary. However, identifying and collecting information on them is often difficult. According to available research data it can be concluded, however, that the prevalence values of illicit substance use are generally higher in the vulnerable groups. Further research is needed, on the one hand, to get to know the characteristics of these groups better, and on the other hand, to be able to develop proper programmes for these groups on the basis of the results.

13. DRUG-RELATED RESEARCH IN EUROPE

13.1. RESEARCH STRUCTURES

Drug-related research in national policy

The national drug strategy dedicates an individual chapter to the importance of monitoring. Additionally, each pillar (community and cooperation, prevention, treatment and harm reduction, supply reduction) lists the research topics needed for situation analyses and intervention evaluation.

However, mainly epidemiological researches were conducted in the last 5 years. Researches estimating the consequences of drug use or follow up studies are still missing. We can rarely find surveys assessing the effectiveness of interventions. On the one hand it is caused by the efforts for initial situation analyses; on the other hand it is due to the lack of resources and expertise. It follows that survey type researches have long-time tradition in Hungary but only a few studies using qualitative techniques have been carried out so far.

Relationship between research and policy

The demand for applied researches and the questions that need answers are usually defined by drug policy. But - beyond reports or conference lectures - research results are relatively rarely taken into account in political decision-making or come to practice as specific interventions. Nevertheless two counter-examples must be mentioned. The output of the first research is the complex database of school-based prevention programmes (see National Report 2004, chapter 3.). The second one focused on the substance use, beliefs and prevention needs of the youth visiting shopping centres (see National Report 2004, chapter 2.). The intervention strategy has been developed and the ALTERNATÍVA programme has been implemented according to the results, consequences of the survey (see chapter 3.2.).

Main national structures for drug-related research

The main coordination body and at the same time sponsor of the Hungarian drug-related researches is the ministry responsible for drug coordination, currently the Ministry of Social Affairs and Labour. Researches are financed in open tendering. The budget frame varied between yearly 75.500EUR and 188.700EUR in the last 5 years.⁶³ The maximum available amount per research was 3.800 – 11.300EUR. Research programmes of high priority and of primary importance (i.e. ESPAD, national adult population surveys) are financed individually from the ministry resources. Most researches are conducted by researchers or research groups working at universities.

13.2. MAIN RECENT STUDIES AND PUBLICATIONS

Main recent studies since 2000

- national adult population surveys 2001, 2003 (see National Report 2004, chapter 2)
- ESPAD 2003 (see National Report 2005, chapter 2)
- “Lights and shadows” – risk factors, prevention needs and possibilities, research series between 2002-2006 (see National Report 2004, chapter 2, 3)
- estimates for drug-related public expenditure (see National Report 2006, chapter 1)

⁶³ Values were calculated based on the official midrate of the EUR for 2006 (1EUR=264.27 HUF).

Peer-reviewed scientific journals

Drug-related publications of the Hungarian researchers published in international journals in 2006:

Gyarmathy VA, Neaigus A, Ujhelyi E, Szabó T, Rácz J (2006): Strong HIV and hepatitis disclosure norms and frequent risk behaviours among young Hungarian drug injectors. *Drug and Alcohol Dependence*. 2006; 82 (Supplement 1): S65-S69.

Rácz J (2006): Questions on the interpretation of drug users' autobiographies in a country in the "early" phase of drug use. *Contemporary Drug Problems* 33/Spring 99-122.

Pikó B (2006): Adolescent smoking and drinking: The role of communal mastery and other social influences, *Addictive Behaviours*, Volume 31, Issue 1 102-114

13.3. COLLECTION AND DISSEMINATION OF RESEARCH RESULTS

Information flows

Since its establishment (2004) the Hungarian National Focal Point has been collecting all research reports conducted in Hungary with the involvement of the above mentioned ministry in this process. Furthermore it explores drug-related researches at local level, financed from different resources, through the National Public Health and Medical Officers Service system, although their scale is negligible. The full text research reports can be found in the FP. The summaries are published in the national reports. Surveys irrelevant for the NR are published in the monthly newsletter. Besides, the FP makes proposals for tendering towards the drug coordination, appointing the areas that need studying. In some cases the FP conducts individual researches (i.e. selective prevention programmes, drug prices at street level) or initiates researches (i.e. recreational drug use, drug-related public expenditures).

National scientific journals

At present there is only one scientific journal focusing specifically on the illicit drug problem in Hungary, called *Addiktológia* (*Addictologia Hungarica*) www.addiktologia.hu

The main topics are: addiction medicine, epidemiology, prevention, drug-related infectious diseases, treatment, book and conference reviews. It has an international scientific committee beside the Hungarian scientific board. It is a peer-reviewed journal. The abstracts are published in Hungarian and in English, as well.

Other national scientific journals of social sciences which sometimes publish drug-related researches analysing certain aspects of the problem: *Psychiatria Hungarica*, *Magyar Pszichológiai Szemle*, *Új Pedagógiai szemle*, *Demográfia*, *Esély*.

Other means of dissemination

The electronic database of researches financed by the drug coordination is being uploaded. It is expected to be fully accessible on the Drug Information Site for Professionals (www.ndi-szip.hu) by the end of this year. The ministry and the sponsors in general (i.e. local governments) usually published the research results on their websites in the last couple of years. In some cases research reports or their abstracts can be found on the websites of individual researchers or research groups. Furthermore, the publication series for professionals edited by the National Institute for Drug Prevention gives another possibility to publish the most important research reports in printed form. Moreover, the research results

are regularly communicated at drug-related conferences. The results of national surveys are also presented in the meetings of the Coordination Committee on Drug Affairs.

Conclusions

The overwhelming majority of drug-related researches in Hungary are drug epidemiology studies measuring the spread of drug use in different populations. The most frequently used methodology is the survey technique. Surveys with national samples rarely analyse the context of substance abuse or behaviour disorders or explore the determining factors behind these. Researches estimating the consequences of drug use or the efficiency of interventions are almost totally missing although the drug coordination (as the main sponsor) encourages the study of these fields through tendering. The main reasons for that are the lack of expertise and the long-term funding schemes. Publications of the Hungarian researchers are relatively rarely published in international scientific journals. They rather publish in the only national drug-related scientific journal or in the publication series for professionals.

14. BIBLIOGRAPHY

Csohán, Á., Dudás, M., Győri, Z., Minárovics J., Rusvai E., (2007a). A hazai intravénás droghasználattal összefüggő fertőzések (HIV, HBV, HCV) 2006-2007. évi prevalenciájának vizsgálata. Országos Epidemiológiai Központ Beszámoló a 2006. évi tevékenységről

Csohán, Á., Kaszás, K., Lendvai, Gy. (2007b). Az intravénás kábítószer-használat révén terjedő fertőző betegségek helyzetéről- Országos Epidemiológiai Központ. Unpublished thesis.

Elekes, Zs. (2003). A drogfogyasztás elterjedtsége és a fogyasztásra ható társadalmi tényezők az iskolában tanuló fiatalok körében. Demográfia, 2005 48 (4) 345–374.

Elekes, Zs., Paksi, B. (2003). A középiskolások drogfogyasztása 2003-ban Budapesten. Helyzetkép és tendenciák. Addiktológia 3 (3) 308-331.

Elekes, Zs., Paksi, B. (2004a). Európai középiskolás kutatás az alkohol- és drogfogyasztásról. Magyarországi projektbeszámoló. OTKA Research report, Budapest.

Elekes, Zs., Paksi, B. (2004b). *A felnőtt népesség alkohol- és drogfogyasztása 2003-ban*. NKFP Kutatási zárójelentés, Budapest. Paksi, B.; Elekes Zs. (2003): A középiskolások drogfogyasztása 2003-ban Budapesten. Helyzetkép és tendenciák. Addiktológia 3 (3) 308-331.

Elekes, Zs., Paksi, B. (2004c). A felnőtt lakosság droghasználata – különös tekintettel a nagyvárosi fiatal felnőttekre. Magyar Addiktológiai Társaság V. Országos Kongresszusa, Balatonfüred.

Gachályi, A. (2007). 2005. évben végzett szűrővizsgálatok. MH EVI Toxikológiai Kutató Osztály, Kábítószer Vizsgáló Laboratóriuma. Unpublished thesis.

Győri, P. (2006). Országjelentés 2006. Jelentés a magyarországi hajléktalanügyi statisztika alakulásáról a Hajléktalanság Európai Kutatóközpontja részére.

Hajnal, Gy. (2007). A kábítószerrel kapcsolatos költségvetési kiadások alakulása 2005-ben: Az EMCDDA 2006. évi Útmutójának magyarországi alkalmazási lehetőségei. Unpublished thesis.

Jónás, J., Barsiné Fodor, K., Kiss, P., Péterfiné Türgyei, M. (2007). A pulmonológiai intézmények 2006. évi epidemiológiai és működési adatai. Országos Korányi TBC és Pulmonológiai Intézet

Judd ,A., Parry, J., Hickman, M., Mc Donald, T., Jordan, L., Lewis, K., Contreras, M., Dusheiko, G., Foster, G., Gill, N., Kemp, K., Main, J., Murray-Lyon, I., and Nelson, M. (2003). Evaluation of a modified commercial assay in detecting antibody to hepatitis C virus in oral fluids and dried blot spots. Journal of Medical Virology 71 49-55

Juhász, J., Csikvári, J. (2006). Középpontban a prostituáltak alapvető jogai - háttérkutatás az oktatási programhoz és jogsegélyszolgálathoz. Available: www.pantarhei.org.hu, www.prostituáltak.hu.

Ladányi, E., Forrai, E. (2006). Szociális szolgáltatások és kábítószer-fogyasztók. ICsSzEM kutatási beszámoló. Unpublished thesis.

Márványkövi, F., Melles, K., Dr. Rácz, J. (2006). A kezelésbe és tücserébe jutás akadályai. Addiktológia 2006 (4) 319-341.

Nemzeti Stratégia a Kábítószer-probléma visszaszorítására, 2000

OAI (2007). TDI adatbázis 2006. Unpublished data.

Paksi, B., Demetrovics, Zs. (2002). A prevenció gyakorlat megismerése. A budapesti középiskolai drogprevenció programok felmérése és értékelése. Szakmai forrás sorozat. 2. L'Harmattan. Budapest.

Paksi, B., Demetrovics, Zs., Czakó, Á. (2002). Az iskolai drogprevenció programok értékelése I. A programok teoretikus és szervezeti háttere, valamint a kivitelezésének vizsgálata. Addiktológia (1) 15-37.

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

Paksi, B., Demetrovics, Zs., Nyírády, A., Nádas, E., Buda, B., Felvinczi, K. (2006a). A magyarországi iskolai drogprevenció programok jellemzői. Addiktológia.

Paksi, B., Demetrovics, Zs., Bozsonyi, K., Erdélyi, I. (2006b). A közoktatási intézményekben a 2005. évi, ICSSZEM-OM támogatásával folyó iskolai egészségfejlesztő-drogmegelőzési tevékenység értékelésére irányuló kutatás, monitoring rendszer kialakítása. Research report. Available: <http://www.uni-corvinus.hu/index.php?id=p5100111>

Ritter, I. (2007). Rendőrök a kábítószer-fogyasztásról. Unpublished thesis.

Sebestyén, E. (2003). Illegális szerhasználat. In: Iskoláskorú gyermekek egészségmagatartása. Aszmann, A. (ed.). Országos Gyermekkegészségügyi Intézet. Budapest.

Tájékoztató a család, gyermek- és ifjúságvédelemről 2005. év, Szociális és Munkaügyi Minisztérium 2006.

Vingender, I. (2006). Adalékok a droghasználat társadalmi mintázatához. Addiktológia 5 (3) 161-190.

http://www.seed.hu/cikkek/segelyhelyett_1

ANNEXES

LIST OF TABLES

Table 1. Means to combat drug use.....	11
Table 2. Reasons for supporting and objecting to the punishment of drug use	11
Table 3. Police attitude to drug users.....	12
Table 4. The content of the television spot broadcast in 2006 on the occasion of the Week against Drug Abuse.....	14
Table 5. Mass media campaigns organised locally in the last 3 years.....	15
Table 6. Frequency of drug use by type of drug.....	17
Table 7. Distribution of the most often used illicit drugs based on gender and grade (LTP) ..	18
Table 8. Comparison with earlier results.....	19
Table 9. Drug screening tests conducted in the Hungarian Army in 2006	20
Table 10. The activity of organizations carrying out harm reduction activities in recreational settings in 2006	29
Table 11. Factors hindering treatment in the two most "isolated" treatment forms: reasons mentioned.....	46
Table 12. Accessibility of treatment.....	46
Table 13. The distribution of drug users treated in health care based on institution type in 2006.....	48
Table 14. Number of participants in methadone treatment in 2006	52
Table 15. Monthly distribution of participants in methadone treatment	52
Table 16. Number of direct drug-related deaths in 2006.....	53
Table 17. Indirect drug-related deaths among cases of deaths caused by violence.....	54
Table 18. Distribution of registered HIV positive persons by risk groups	55
Table 19. Number and proportion of IDUs among reported acute HBV-cases	56
Table 20. Number and proportion of IDUs among reported acute HCV patients.....	56
Table 21. Organizations participating in the survey of HIV, HBV, HCV prevalence.....	57
Table 22. Breakdown of HIV, HCV, HBV infected IDUs by age group.....	58
Table 23. Breakdown of HCV, HBV positive IDUs by term of injecting drug use	59
Table 24. Breakdown of HCV, HBV positive IDUs by the type of drug	59
Table 25. Geographical breakdown of HBV and HCV screenings and the ratio of positive cases (2006).....	59
Table 26. The results of serology tests carried out in the laboratories of the regional institutes of ÁNTSZ aiming to detect HIV, HBV, HCV infection among IDUs	60
Table 27. Risk factors identified among tuberculosis patients in 2006.....	61
Table 28. Injector and client turnover data of syringe exchange programmes, 2003-2006 ...	65
Table 29. Revealed offences of misuse of narcotic drugs by the date of the offence	71
Table 30. Breakdown of offenders committing misuse of narcotic drugs by age in 2006	72
Table 31. Number and quantity of seizures of illicit drugs.....	80
Table 32. Price of drugs at street level in EUR	82
Table 33. Labelled drug-related expenditure items in the Law on the Implementation of the Budget for 2005.....	84
Table 34. Total expenditure for COFOG Functions No. 3. and 7. in 2005	85
Table 35. Estimation of drug-related expenditure in the field of public order and safety using different measures of attributable proportions (2005).....	86
Table 36. Total expenditures for the health-related COFOG functional groups (2005).....	88
Table 37. Number of vulnerable minors registered by child guardian authorities between 2001-2005	90
Table 38. Breakdown of children in temporary care by the root cause inducing admission, 2005.....	91

LIST OF FIGURES

Figure 1. <i>How should drug use be punished? (percentage of people answering)</i>	11
Figure 2. <i>The appearance of different objectives in the national range of programmes and in the prevention programmes within the frame of the ICsSzEM-OM tender system (in the percentage of programmes)</i>	22
Figure 3. <i>The use of different methods in the national range of programmes and the prevention programmes within the framework of the ICsSzEM-OM tender system (in the percentage of programmes)</i>	23
Figure 4. <i>Is there a health promotion or drug strategy at the schools participating in the tender, and if yes, the year it was completed (%)</i>	24
Figure 5. <i>Who carried out prevention activities in the past four years in tender winning schools (in the percentage of schools)?</i>	24
Figure 6. <i>The opinion of students participating in ICsSzEM-OM programmes and students participating in earlier evaluation surveys on the interactivity of prevention programmes (averages of scale point values)</i>	26
Figure 7. <i>Perception of different objectives among the participants of the ICsSzEM-OM tender programmes (in the percentage of participating students)</i>	27
Figure 8. <i>Appearance of different goals in the descriptions of the ICsSzEM-OM tender programmes (in the percentage of participating students)</i>	27
Figure 9. <i>The averages of responses given in the different dimensions by students participating in the ICsSzEM-OM programmes and respondents of earlier evaluation surveys (averages of scale point values)</i>	28
Figure 10. <i>Average weekly attendance of ALTERNATIVA offices in the given months in 2006</i>	32
Figure 11. <i>The number of drug users treated in Hungary between 2002-2006</i>	35
Figure 12. <i>Breakdown of drug users in treatment by gender between 2002-2006</i>	35
Figure 13. <i>Breakdown of male patients in treatment for drug use by age between 2002-2006</i>	36
Figure 14. <i>Breakdown of female patients in treatment for drug use by age between 2002-2006</i>	36
Figure 15. <i>Breakdown by age among new patients between 2002-2006</i>	37
Figure 16. <i>Breakdown of patients in treatment by substance between 2002-2006</i>	37
Figure 17. <i>Number of patients in treatment for illicit drug use between 2002-2006</i>	38
Figure 18. <i>Number of patients in treatment for use of licit drugs between 2002-2006</i>	39
Figure 19. <i>Substances mainly used by males and females in treatment (by number of users)</i>	39
Figure 20. <i>Breakdown of patients by route of administration between 2002-2006</i>	40
Figure 21. <i>Breakdown of injecting drug users in treatment between 2002-2006</i>	40
Figure 22. <i>Breakdown of patients in treatment by frequency of use (19 cases are unknown in 2004)</i>	41
Figure 23. <i>Number of patients in diversion programmes between 2002-2006</i>	41
Figure 24. <i>Breakdown of patients in diversion programmes by drug type</i>	42
Figure 25. <i>Judging the difficulties of entering certain treatment centres</i>	46
Figure 26. <i>Breakdown of men treated at the Clinical Toxicology Department of the Péterfy Sándor Street Hospital for drug intoxication by age group (N=426)</i>	62
Figure 27. <i>Breakdown of women treated at the Clinical Toxicology Department of the Péterfy Sándor Street Hospital for drug intoxication by age group (N=244)</i>	62
Figure 28. <i>The number of patients treated for drug intoxication at the Clinical Toxicology Department of the Péterfy Sándor Street Hospital between 2004 and 2006</i>	63
Figure 29. <i>Living status among clients in treatment</i>	68
Figure 30. <i>Work status among clients in treatment</i>	68
Figure 31. <i>Highest level of completed education among clients in treatment</i>	69
Figure 32. <i>Family status of clients in treatment</i>	70
Figure 33. <i>The number of revealed cases concerning the misuse of narcotic drugs</i>	71

Figure 34. <i>Number of offenders committing misuse of narcotic drugs</i>	73
Figure 35. <i>The number of seized ecstasy-type tablets and seizures</i>	81
Figure 36. <i>The change in the active substance content of tablets containing MDMA</i>	82
Figure 37. <i>Delta-9-THC content of seized herbal cannabis and cannabis plant</i>	83
Figure 38. <i>Breakdown of using licit and illicit substances by family structure (%)</i>	92
Figure 39. <i>Breakdown of drug use patterns by deviances present in the family (%)</i>	93

LIST OF MAPS

Map 1. <i>Geographical distribution of drug users receiving treatment in 2006</i>	50
---	----

LIST OF ABBREVIATIONS

ÁNTSZ - National Public Health and Medical Officers Service
BSzE - Association of Safe Entertainment Venues
BSzKI – Institute for Forensic Sciences
KEF – Coordination Forum on Drug Affairs
ICsSzEM – Ministry of Youth, Family, Social Affairs and Equal Opportunity
ISM – Ministry of Youth and Sports
KKB – Coordination Committee on Drug Affairs
ERÜBS – Uniform Police and Prosecutors’ Criminal Statistics
ESzCsM – Ministry of Health, Family and Social Affairs
ETTSZ - Health Toxicological Information Service
EüM – Ministry of Health
GyISM – Ministry of Children, Youth and Sports
MH – Hungarian Army
MH- EVI – Hungarian Army’s Health Institute
MKCS – National Centre for Epidemiology, Microbiology Laboratory
NDI – National Institute for Drug Prevention
NIH - National Institutes of Health, USA
OAI – National Institute for Addiction
OEK – National Centre for Epidemiology
OEP – National Health Insurance Fund
OM – Ministry of Education
OSAP – National Statistical Data Collection Program
OTH – Office of the National Chief Medical Officer
OTKA – National Scientific Research Found
SzMM – Ministry of Social Affairs and Labour