



Country report on New Psychoactive Substances in Hungary

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1 NPS definition according to the Hungarian Medicines Act (Act XCV of 2005)

New psychoactive substances as substances or groups of compounds recently appearing on the market that have no medicinal use and that, due to their effect on the central nervous system, are suitable for altering a person's state of consciousness, behaviour or senses, and therefore represent a threat to public health similar to the substances listed in the illicit drug and psychotropic substance schedules.

2 Drug policy frameworks

Hungary's first national drug strategy was approved by the National Assembly at the end of 2000, the implementation started in 2001. This strategy was meant for a 9 year period, it expired at the end of 2009. By that time a thorough evaluation of the first National Drug Strategy had been carried out and based on these findings a new strategy was developed and approved by the National Assembly for the period of 2010-2018. The implementation of this strategy did not start at all as a new government came into force in 2010 and its understanding of the drugs phenomenon was different from that of the previous period. A long 'strategy-less' phase started which lasted for 3 years. After social and public administration consultations, the National Assembly approved it (National Assembly Decision 80/2013 (X.16)) with the title 'National Anti-drug Strategy 2013–2020, Clear consciousness, sobriety, and fight against drug crime'. The National Anti-drug Strategy determines targets for the period of 2013 and 2020. Besides recognising the necessity of handling the personal and social risks and damage in connection with drug use, its main objective is the reduction of the use of illicit substances with the help of targeted, community-based interventions. The National Anti-drug Strategy desires to achieve this objective through wide-ranging prevention activities, by strengthening a recovery-oriented approach and reintegration in the field of the care and treatment of drug addicts, by the more effective application of crime-prevention and crime-fighting interventions in the field of supply-reduction, and through strict action against trafficking.

"The strategy uses five basic values (Right to life, human dignity and health; Personal and community responsibility; Community activity; Cooperation; Scientific basis) to determine the general and concrete objectives in the following fields: Health development and drug prevention; Treatment, care, recovery; Supply reduction."(National Report, 2015, p. 8.)

The Policy Programme (Action plan) development and approval was a labour and time demanding process as its approval by political decision makers took more than two years (it was approved by the government at the very end of 2015, 2010/2015 (XII. 29) Governmental decree), consequently no budget and proper guidance was given to the field for the implementation of the current National Anti-drug Strategy.

3 Legislative framework & implementation¹

3.1 Characteristics of drug legislation

The new Criminal Code (hereinafter: Btk.) accepted by the National Assembly on 25 June 2012 entered into force on 1 July 2013. Chapter XVII of the Btk. (Criminal offences against health) provides regulations in connection with illicit drugs in six statutory definitions:

¹ Based on the National Report written by the National Focal Point for the EMCDDA.

- drug trafficking;
- possession of narcotic drugs;
- inciting substance abuse;
- aiding in the manufacture or production of narcotic drugs;
- criminal offences with drug precursors, and
- misuse of new psychoactive substances.

The statutory definition of drug trafficking (Art. 176-177) includes the offering, supply, distribution and trafficking of illicit drugs, as well as providing material assistance to these perpetrations. The law punishes the basic case with a term of imprisonment of between two and eight years.

Perpetrations involving the possession of illicit drugs (Art. 178-180) include producing, manufacturing, acquisition, possession, import, export of illicit drugs and transporting them through the territory of the country. The punishment for the basic cases is imprisonment for a term of between one to five years. The Btk. separately names illicit drug consumption, the punishment for which is the same as the punishment for the acquisition of a small amount.

The Btk. orders the offense of inciting substance abuse (Art. 181) (a person over the age of eighteen years who persuades or who attempts to persuade a minor to engage in the consumption of a substance or agent that has a narcotic effect and that is either classified as an illicit drug or not) to be punished by imprisonment of up to two years.

“The Btk. contains the cases and conditions of alternatives to criminal procedure (quasi compulsory treatment, hereinafter QCT) (Art. 180) which, according to the Hungarian criminal law system, are given as grounds for exemption from culpability. The text of the law states that if a person who produces, manufactures, acquires or possesses a small amount of illicit drug for own consumption or who consumes illicit drugs ‘is able to present a document before being sentenced in the first instance to verify that he/she has participated in treatment for drug addiction, treatment of other conditions with drug use or a preventive-consulting service’ then he/she may not be punished. The QCT may be initiated either in the prosecution or the court phase of the criminal proceedings. The possibility of QCT is not available for those persons who undertook QCT in the two years previous to the perpetration of the offence or whose criminal liability has been determined in a drug trafficking or drug possession case.” (National Report, 2015. p.13- 14.)

3.2 Control of new psychoactive substances

The rapid appearance of the new substances forced Hungarian decision-makers to elaborate a new monitoring and risk-assessment system, which can be used to provide the appropriate information to make responsible decisions regarding the control of designer drugs.

Act XCV of 2005 (hereinafter: Medicines Act) lays down the framework of the new legislation, while Government Decree 66/2012 (IV. 2) (hereinafter: Government Decree) determines the processes and the responsible institutions in connection with the reporting of new psychoactive substances, their preliminary assessment, their scheduling and risk assessment. The Medicines Act defines ‘new psychoactive substances’ as substances or groups of compounds recently appearing on the market that have no medic-

inal use and that, due to their effect on the central nervous system, are suitable for altering a person's state of consciousness, behaviour or senses, and therefore represent a threat to public health similar to the substances listed in the illicit drug and psychotropic substance schedules, and so with respect to this, in the past the Government, currently the minister responsible for health, classified them as such materials in a decree. The Medicines Act and the Government Decree created a new schedule (Annex 1 of Decree no 55/2014. (XII. 30.) of Ministry of Human Capacities) for the new psychoactive substances, which contains both individual compounds and compound groups (through this providing both a list of individual compounds and a generic approach).

According to the Medicines Act and the Government Decree, if the EMCDDA sends a notification about a substance on the basis of Council Decision no 2005/387/JHA, the National Centre for Addictions subjects it to a special preliminary assessment to determine whether the substance may be included in the list. In order for a substance to be included in the schedule of new psychoactive substances it must be proved that the Hungarian authorities and professional institutions have no knowledge of any data that refers to the medical use of the substance indicated in the notice, and that excludes that the substance poses a similar risk to public health as the substances included in the schedule of illicit drugs and psychotropic substances.

The individual compounds included in the schedule of new psychoactive substances must be subjected to a risk assessment within one year of their inclusion in the schedule. Depending on the result of the risk assessment, the compound must be transferred to the list of psychotropic substances (one of the schedules of Act XXV of 1998) or to Schedule D of the Government Decree. If there is insufficient data available to complete the above risk assessment according to the findings of the expert body, the classification of the new psychoactive substance may be extended for a further year. This risk assessment obligation is not applicable for compound groups, which remain in the schedule of new psychoactive substances until at least one of the substances in the group complies with the conditions for the preliminary assessment. Activities defined by the relevant legislation in connection with new psychoactive substances may only be performed in possession of a permit issued by the state administration body for health.

“The Btk. contains a section entitled ‘Misuse of New Psychoactive Substances’ (Art. 184, 184/A-D), which follows the structure of the previous articles, but regulates the offences related to new psychoactive substances with more lenient punishments. The aggravated cases of the new regulation are essentially the same as those relating to illicit drugs, however, it does not include perpetrations with a substantial quantity. The lenient cases relate to perpetration with a small amount, the upper limit of which is 10 grams with respect to the total amount of the given substance. The punishable acts also include acquisition and possession of new psychoactive substances as long as the amount exceeds the small amount. It was not the purpose of the legislators to establish the criminal liability of users of new psychoactive substances, therefore consumption is not punishable, nor is acquisition and possession of a small amount.” (National Report, 2015. p.14)

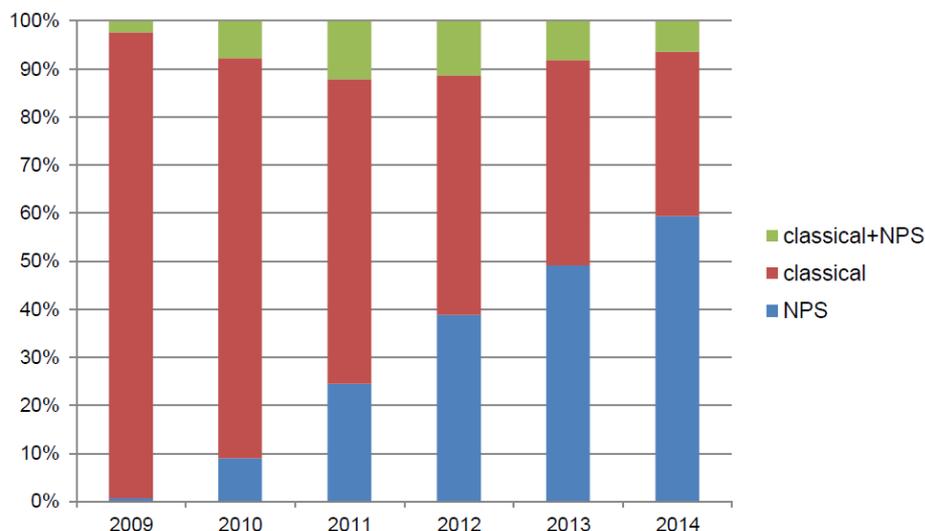
4 NPS drug market description²

During 2010–2014 new psychoactive substances completely restructured the Hungarian drug market. Following the large-scale increase in the amount of mephedrone available in the summer of 2010, the

² Based on the National Report written by the National Focal Point for the EMCDDA.

proportion of the new psychoactive substances as compared to the classical drugs rose continuously. In 2014 the new psychoactive substances constituted nearly 60% of all police seizures.

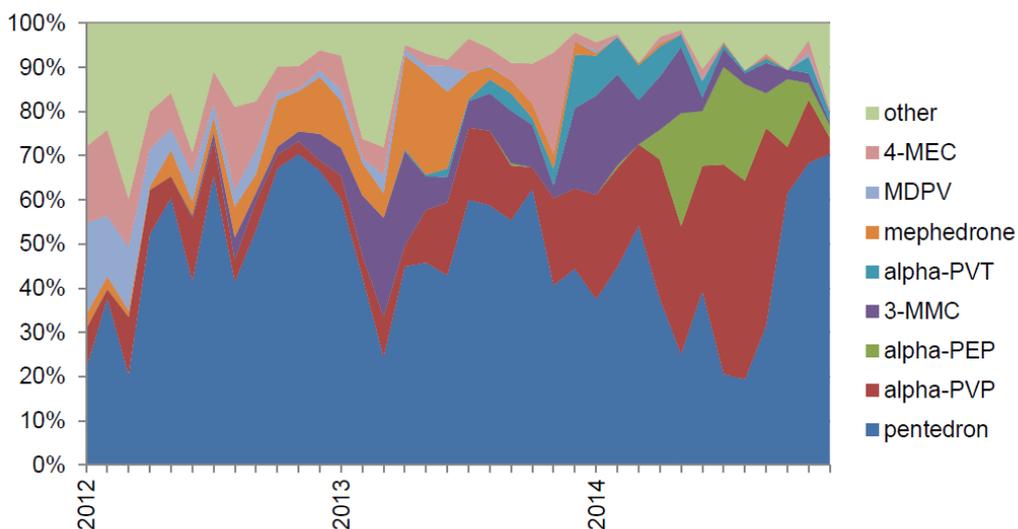
The frequency of occurrence of 'classical' and NPS (%) among substances seized between 2009-2014



Source: BSZKI 2015

The share of two large groups of the new substances, cathinone derivatives and synthetic cannabinoids was the largest in the seizures. Cathinones are usually distributed in the form of powders. The most frequent active substances were: mephedrone in 2010 (Kapitány-Fövény et al., 2013), 4-MEC and MDPV in 2011 (Csák et al., 2013), and pentedrone from 2012. During 2014 the proportion of alpha-PVP in the seizures rose significantly for a time, but by the end of the year it was pentedrone again that was the most characteristic substance.

The frequency of occurrence (%) of cathinone derivatives (proportion of cases when the active substance was detected) in the substances, broken down by month between 2012-2014

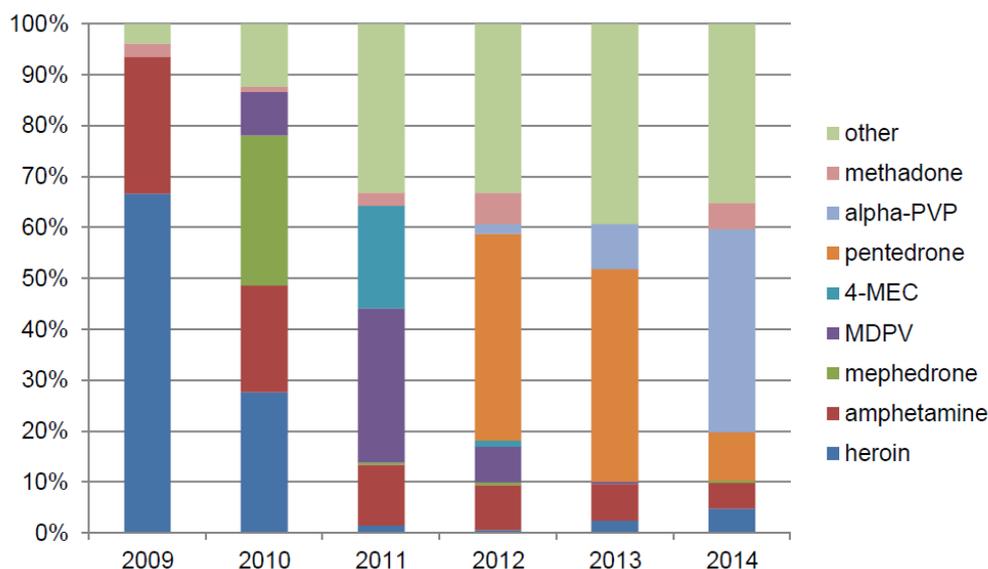


Source: BSZKI 2015

On the basis of the active substances detected in/on injecting drug use related equipment subjected to laboratory testing, it is possible to monitor trends in the types and prevalence rates of substances injected by IDUs.

The tendency experienced in the previous two years continued, heroin and amphetamine, which had been dominant before 2010, were each detected in just 5% of the cases. In the majority of the cases cathinone derivatives were detected on the examined items, however, among these it was not pentedrone that was the most frequent (9.5%) any more, but alpha-PVP (39.9% of the cases). In 35% of the cases several active substances were present, or other active substances occurring with less frequency were identified.

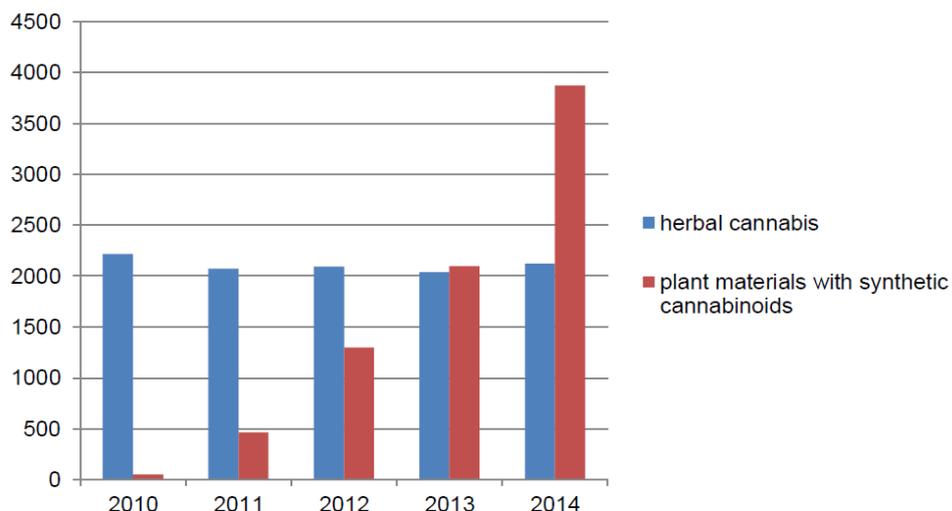
Prevalence of active substances (%) detected in/on injecting drug use related equipment between 2009-2014



Source: BSZKI 2015

Since autumn 2010 there has been a continuous rise in the seizures of plant material impregnated with synthetic cannabinoids. The number of seizures of the products known as 'herbal', 'bio weed' or 'sage' in 2014 was nearly double the number of seizures of herbal cannabis.

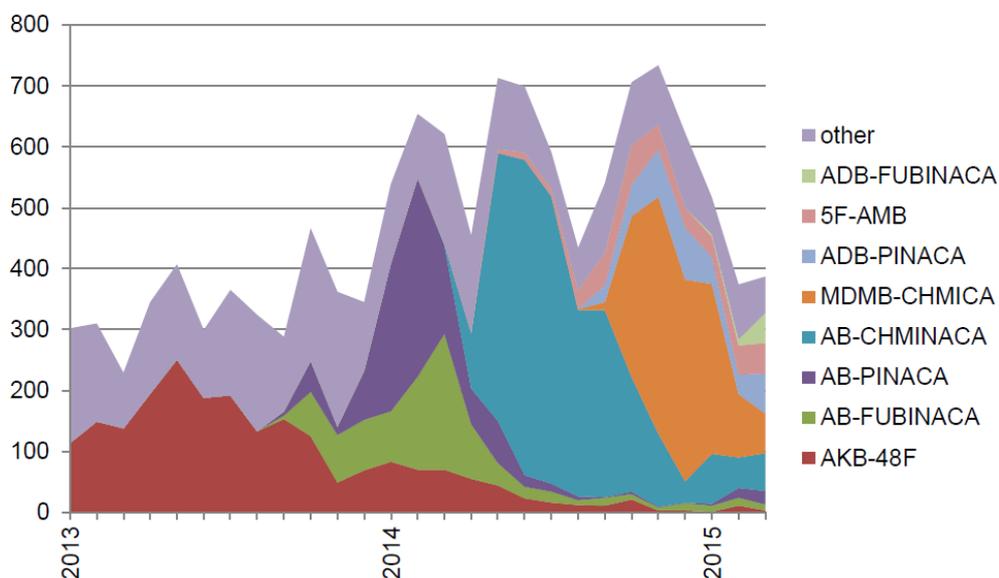
The number of seizures of herbal cannabis and plant materials treated with synthetic cannabinoids between 2010-2014



Source: BSZKI 2015

The range of active substances found in the products follow the changes in legislation dynamically, in individual periods characteristically 1–2 dominant active substances can be found on the market. After the individual active substances become regulated, usually within 1–3 months, their occurrence drops significantly and their places are taken over by new active substances that are not yet regulated. The most frequent active substance during 2014 was AB-CHMINACA.

The frequency of occurrences (N) of synthetic cannabinoid compounds (number of cases when the active substance was detected), broken down by month between 2013 and the first quarter of 2015 (National Report, 2015. p.103- 106.)



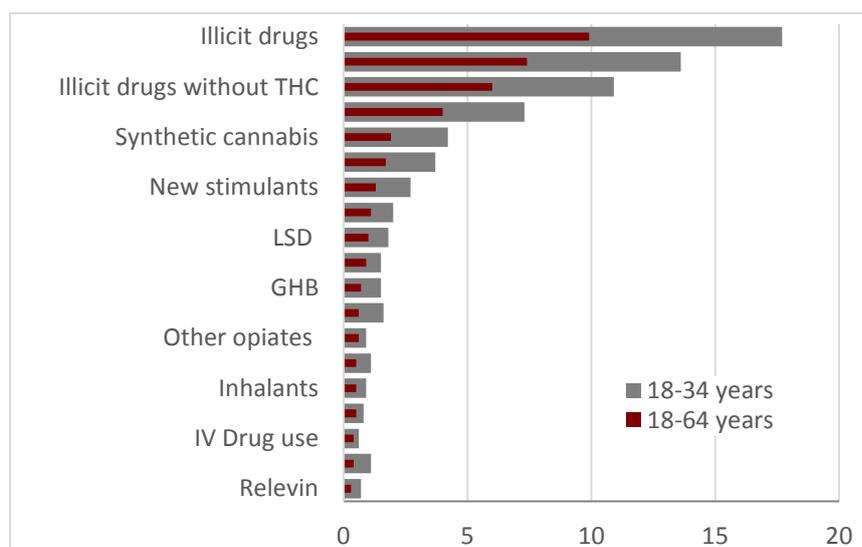
Source: BSZKI 2015

5 NPS demand side description

5.1 NPS and other drug use in the adult population

The last but one adult population survey on drug use which followed international/European standards was carried out in 2007 (Paksi et al, 2009). In that survey no special information was gained on new psychoactive substances. A survey with agreed methodological properties on drug use in the Hungarian adult population was implemented in 2015 March – April. Data from this survey has not yet been published. The table below shows our preliminary data on prevalence estimates (Felvinczi, et al, 2015; Paksi et al, 2015).

Life time prevalence rates according to substances



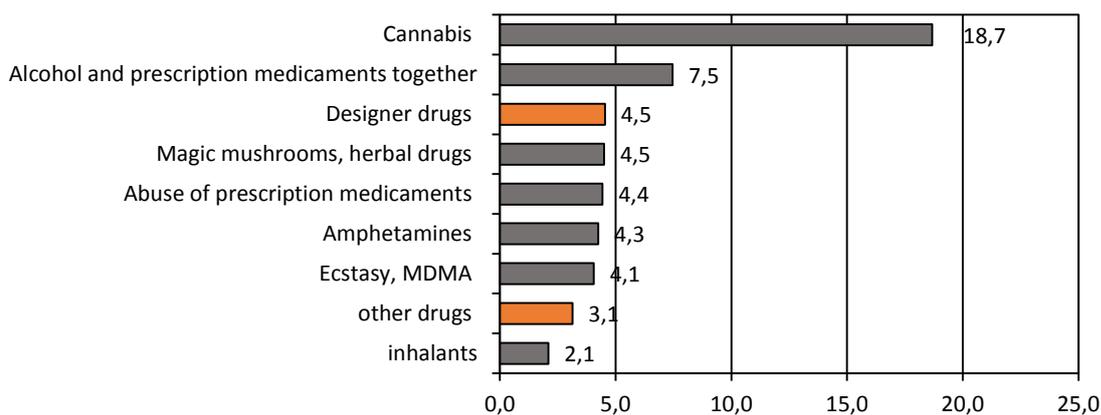
Source: Katalin Felvinczi, Anna Magi, Zsolt Demetrovics, Borbála Paksi, 2015

5.2 NPS and other drug use among young people

Since 1986 and 1993 Hungary participates in two international research series (HBSC since 1986, ESPAD since 1993). In both of them data collections are carried out in every fourth year. Both researches are working with national probabilistic sample therefore national trends and international comparisons can be carried out (Elekes 2009; Paksi, 2009; Aszmann, 1997; Németh et al, 2011; Németh, Arnold 2015)

The HBSC study covers different thematic areas relevant from the perspective of health behaviour, among them smoking, drug and alcohol use. The last data collection within the context of HBSC was carried out in 2014. The preliminary findings regarding the life time prevalence rates can be seen in the table below. From the data it can be seen that the new psychoactive substances are becoming more and more popular in the target population.

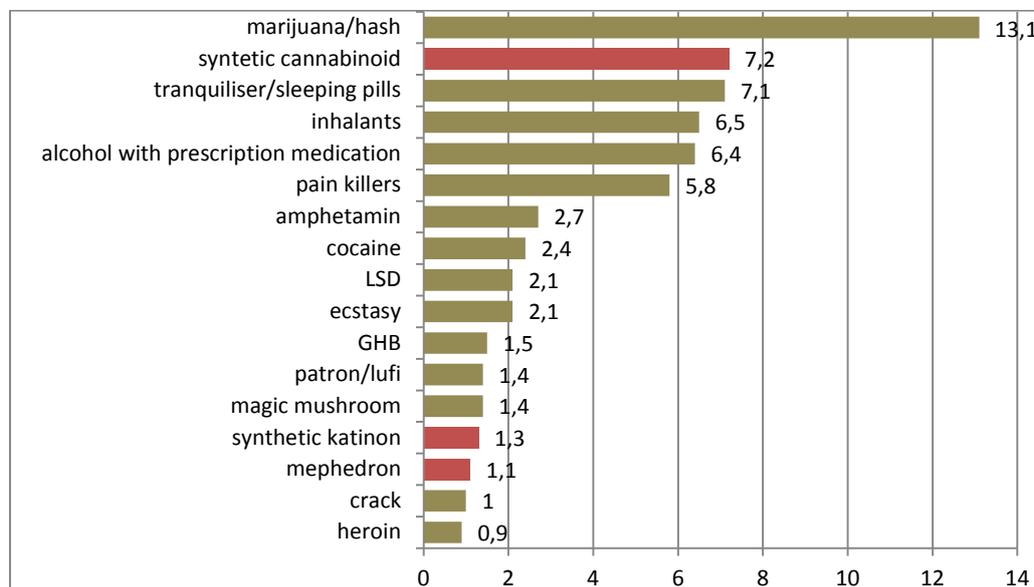
Life time prevalence rates (%) according to substances, grades 9–11



Source: Németh, Arnold, 2015

„The main purpose of ESPAD – as it can be read on the project’s website, <http://www.espad.org/> – is to collect comparable data on substance use in Europe among 16 year old students, in order to monitor trends within as well as between countries.” Hungary joined this initiative at the very beginning and since then participated in all data collection flows. The last one took place during the spring of 2015, therefore at the moment we have just some very preliminary data. From the data shown below it can be seen that one of the NPS (synthetic cannabinoids) is the second most popular substance used by young people in the country. (New psychoactive substances are coloured with orange yellow.)

Life time prevalence rates (%) among 16 years old school children, 2015



Source: Elekes, Nyírády, 2015

5.3 NPS use among injecting drug users³

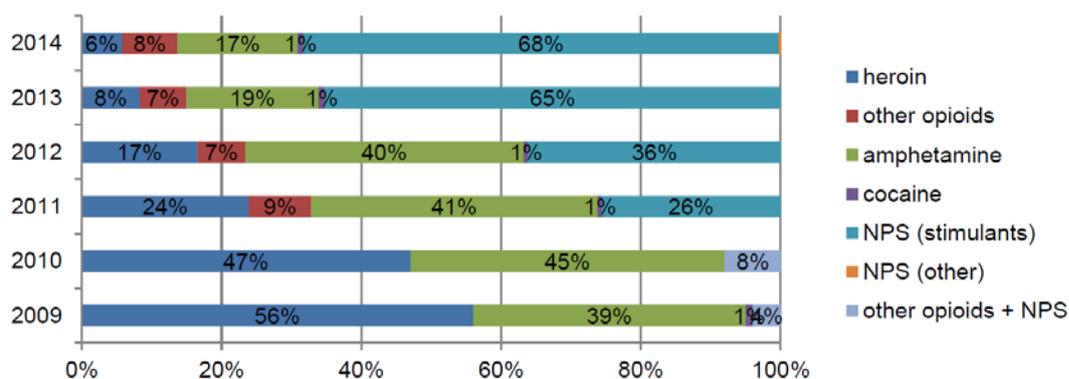
With regard to the primarily injected substance, it can be said that while in the past it was heroin and then heroin and amphetamine that were the typically injected substances, today the most popular substances are designer stimulants (primarily synthetic cathinones). This pattern change can be observed in the data of several routine data collections.

On the basis of NSP (needle syringe programme) data (Tarján 2015b), the appearance of new psychoactive substances (NPS) in 2010 completely transformed the structure of injecting drug use patterns characteristic of the previous years: While in 2009 fewer than 44%¹⁴ of IDUs attending NSPs primarily injected stimulants, this proportion had risen to 86% by 2014.

The proportion of those injecting classical stimulants, mainly amphetamine, was around 40% between 2009-2012, however, by 2013 this figure had dropped to 19% and remained at this level in 2014 (17%). The proportion of those injecting cocaine is negligible among IDUs attending NSPs.

The increase of NPS (mainly synthetic cathinones) injecting pushed out heroin from 2010 and then even amphetamine from 2013: While in 2010 fewer than 8% of NSP clients used designer stimulants, in 2014 this was the primarily injected substance for 68% of them. (National Report, 2015 p. 28.) A research (Kapitány_Fövényi et al, 2015) carried out on a clinical sample suggests that among injecting drug users a higher percentage of psychiatric disorders, symptoms can be observed than among non-injecting ones.

Breakdown of NSP clients by primarily injected drug between 2009-2014



Source: Tarján 2015b

“In 2010 the dominant injected designer stimulant was mephedrone, in 2011 it was MDPV, and since 2012 the substance with the street name ‘penta crystal’ has been in first place. Among designer stimulants, the use of ‘penta crystal’ decreased slightly in 2014 as compared to previous years; in spite of this it is still the most widespread designer stimulant. The substance with the street name ‘music’ had only just appeared in 2013, but by 2014 it had become the second most frequently injected NPS.” (National Report, 2015, p. 29.)

³ Based on the National Report written by the National Focal Point for the EMCDDA.

6 NPS related prevention activities

6.1 Prevention

There are no special prevention, drug demand reduction interventions which target NPS use. In the following part the general features and the organisational structure of prevention and wider drug demand reduction interventions will be presented.

6.2 Organisational structure of prevention activities

The vast majority of prevention activities is financed either by the central government or by the local municipalities. The financial conditions of these organisations is very unpredictable as the main source of the available financing is the different grant schemes provided by the state budget or by the European Structural Fund. Consequently prevention service providers are not able to ensure the sustainability of their activities. Professional guidance and support are supposed to come from the national drugs coordination (National Drug Prevention Coordination Department of the Ministry of Human Capacities) and the so called background institutions. A quality assurance system (system of professional certification) was put in place in 2013; according to the legislation just those programmes could be functional in the school setting from September 2013 which were able to successfully obtain this certificate. As most of the service providers were not prepared for this system, a very small number of them could get this certificate. Due to these circumstances less than 10 programmes were legally available in the 2013/2014 school year.

As far as targeted/selective prevention programmes are concerned the financing is very similar to school-based universal prevention programmes: unpredictable and insufficient. There is no quality assurance in place at all.

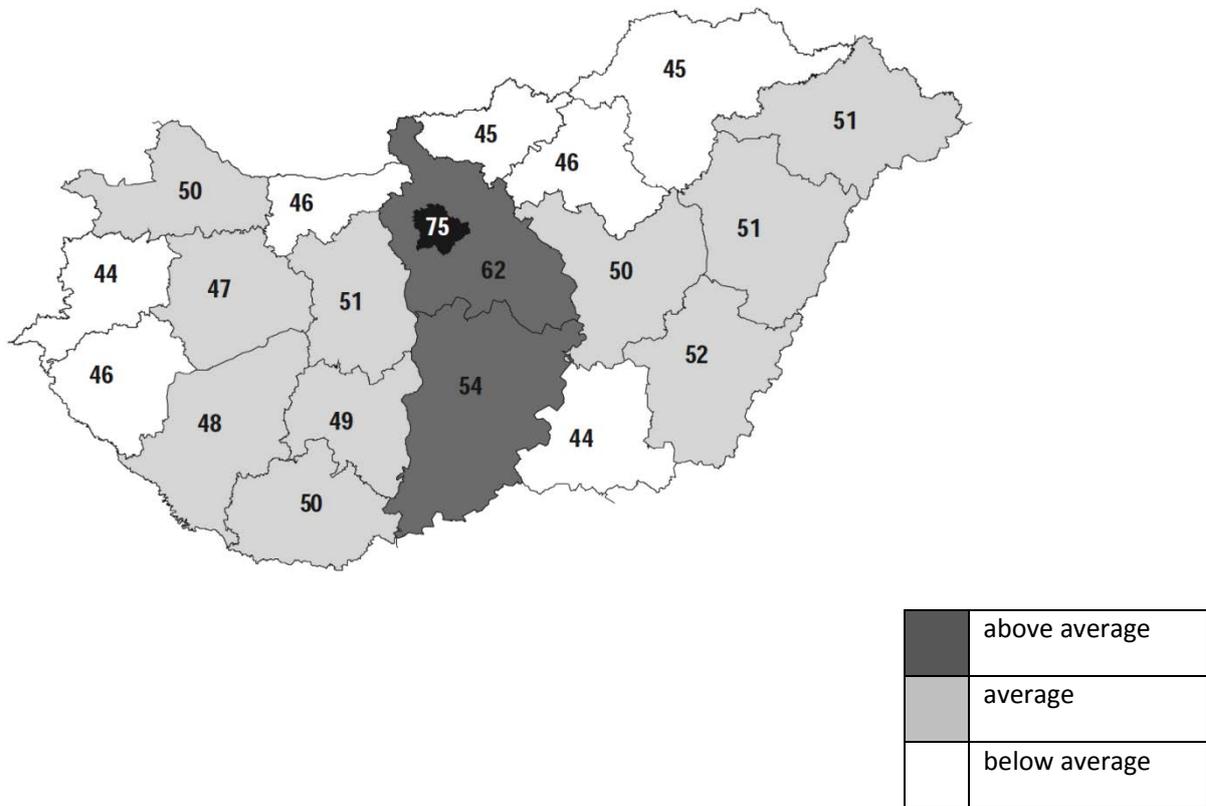
In general, we can say that there is no properly organised training/education for prevention professionals and due to the fact that the institutional system which previously was meant to support the professional development of prevention service providers was demolished (the National Institute for Drug Prevention was reorganised, well-educated staff members were fired) and the financial resources narrowed dramatically throughout the drug field, the conditions of quality prevention work are fairly disadvantageous. Furthermore, the research activities also became critically rare; as far as prevention programmes are concerned actually we do not know how many service providers are still active, what kind of programmes do they offer, how many individuals are they able to cover.

According to earlier studies, (Paksi et al 2010) most of the prevention service/programme providers implemented universal prevention programmes in the school setting. The vast majority of these organisations are NGOs whose financing came from the central government or from the local municipalities. Organisations which implement targeted prevention programmes mostly outside the school setting, were either NGOs or state/government owned-operated professional organisations.

In comprehensive quantitative researches covering the period prior to 2009, we explored the availability and the content of school-based universal drug prevention programmes (Paksi, et al, 2006; 2007; 2009, 2010). The main objective of the research was to get a clear picture of the number, geographical distribution, target group, thematic focus and applied methods of the actually functioning prevention interventions. In the period prior to 2009-2010 quite a large number of prevention programmes was available; approx. 280 programmes offered their services. Almost 3/4 of them targeted the final population (school-aged children) and the rest focused on mediators (teachers and/or peers).

During this period no qualitative research was carried out to check the views of professionals related to the perceived availability of these interventions, but from the map below the geographical distribution of the prevention programmes can be seen based on their headquarters.

Number of prevention programmes targeting the final population in different counties of Hungary (school year of 2001-2002)

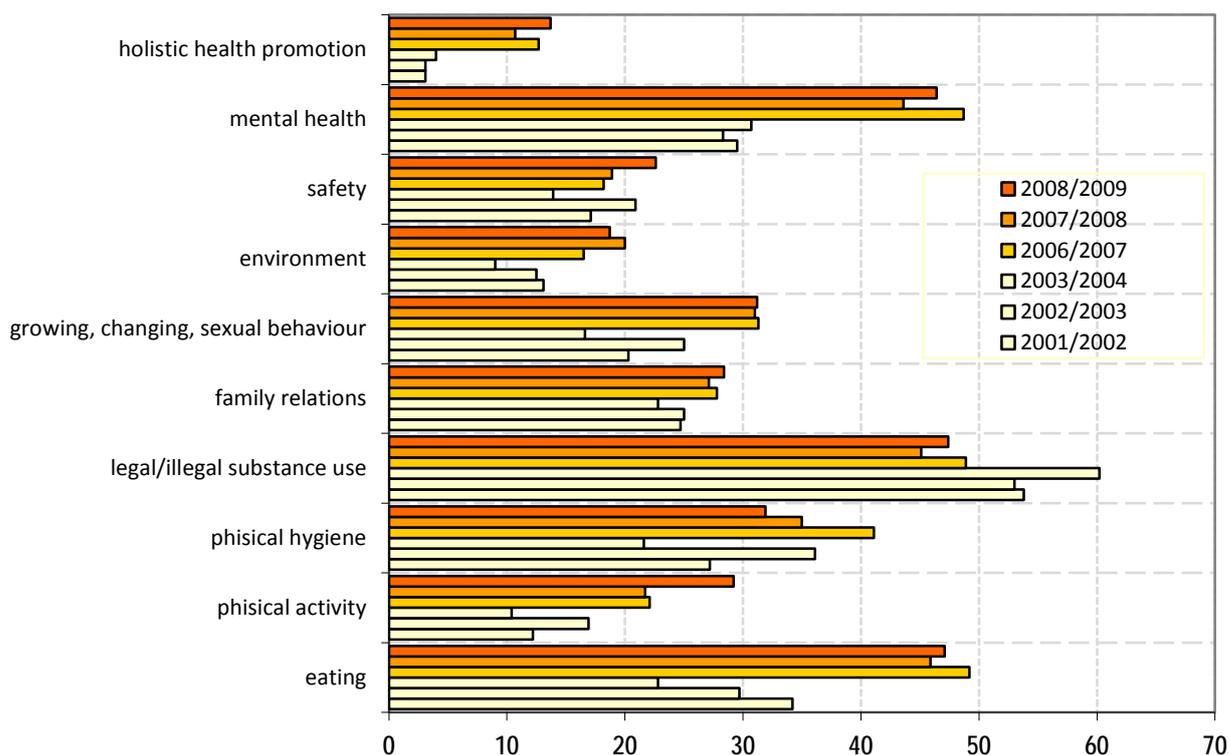


Source: Paksi et al, 2010.

From this map we can see that there was no equal distribution of school-based prevention programmes in the country, the middle of Hungary was in a better situation as far as the number of the programmes was concerned. Other data which informed us about the number of individuals covered by the different programmes gave a much more balanced picture; it means that even if a fewer number of programmes were available in some settlements they were able to cover a bigger number of individuals with the same programme.

The below graph shows how the thematic focus of the different school-based prevention interventions in those years when we could systematically explore the activities of the service providers.

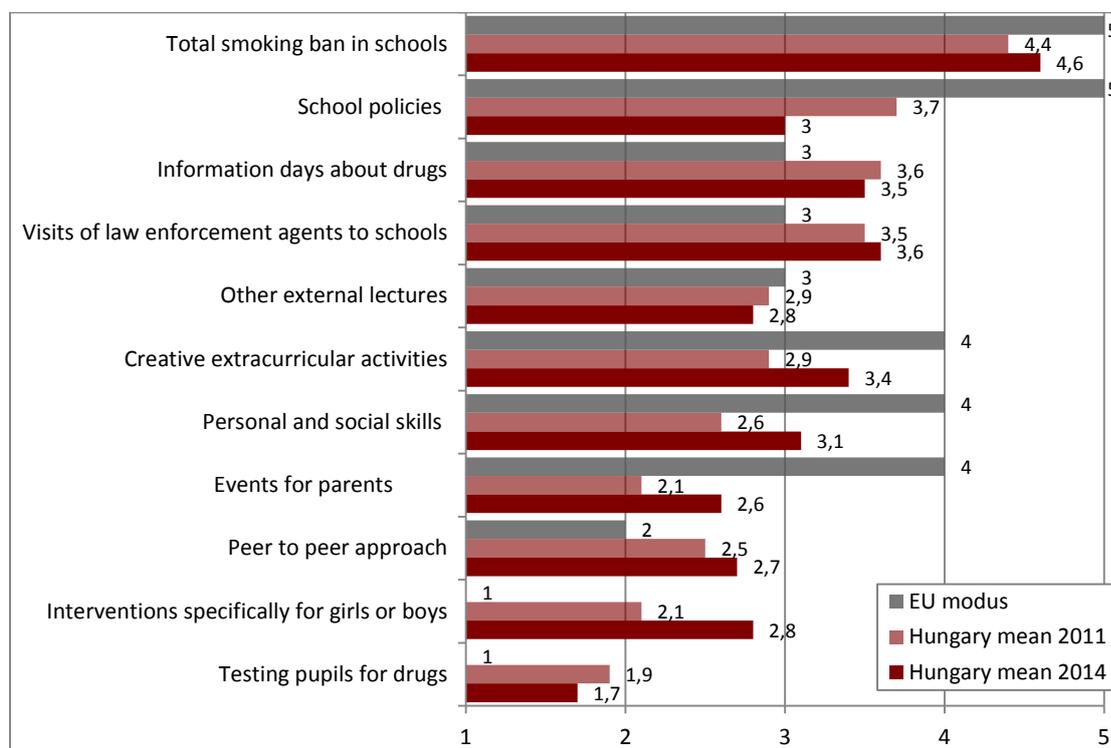
Thematic focus of school-based prevention interventions in 2001-2003 and 2006-2009 in %



source: Paksi et al, 2009

As it was mentioned before, due to the changes in the coordination mechanism and in the drug policy focus of the Hungarian government, no systematic quantitative data collection was carried out to explore the features and availability of prevention programmes. To meet the expectations of the professional organisations active in the field, qualitative data collections were carried out – covering the year of 2011 and 2014 - in 2012 and in 2015 to explore the perceptions of field experts related to the availability and thematic focus of prevention activities (Paksi, Magi, 2013; Paksi, Felvinczi, 2015).

The availability and content of different prevention interventions in the school setting, based on the experiences of filed experts on a five point scale: 1=no provision, 2=rare provision, 3=limited provision, 4=extensive provision, 5=full provision



Source: Paksi, Felvinczi, 2015

The graph provides the opportunity to compare the perceptions of professionals for the year of 2011 and 2014 and also to see the differences between Hungary and the EU member states (data characterising the EU are from the EMCDDA and are based on professional views of experts – structured questionnaires). It can be seen that in most cases Hungary is very much different from the EU average, there are a few programme types where the perceived availability is far worse than in other EU countries. Those programmes which are supposed to have very limited impact on behaviour have a higher availability in Hungary (information days about drugs, law enforcement agents at schools), whilst creative extracurricular activities, personal and social skills development, events for parents and school policies are much less available than in other EU countries.

6.3 Treatment and Care⁴

The inpatient and outpatient treatment of drug users is a shared task of the healthcare system and the social services system. The treatment of drug users and the operation of the treatment system are coordinated and monitored by the State Secretariat for Social Affairs and Social Inclusion and by the State Secretariat for Health of the Ministry of Human Capacities (EMMI) with the help of its professional background institutions and consulting bodies.

⁴ Based on the National Report written by the National Focal Point for the EMCDDA.

Numerous forms of inpatient and outpatient treatment and treatment units for the treatment of drug users are accessible all over the country. The demand for specialised outpatient treatment of drug addicts was acknowledged in the 1980s and it was then that the first services were set up.

The treatment is generally provided by public institutions operated by the state or local governments (hospitals, clinics) and by non-profit organisations run by churches and NGOs. With regard to the present treatment possibilities, there are no specialised treatment programmes targeted at the users of individual substance types, instead programmes target the users of all substance types or addictions or psychiatric problems in general. An exception to this is opioid substitution treatment (hereinafter OST), which has been available in Hungary since 1994 for substance users struggling with opioid addiction for an extended period.

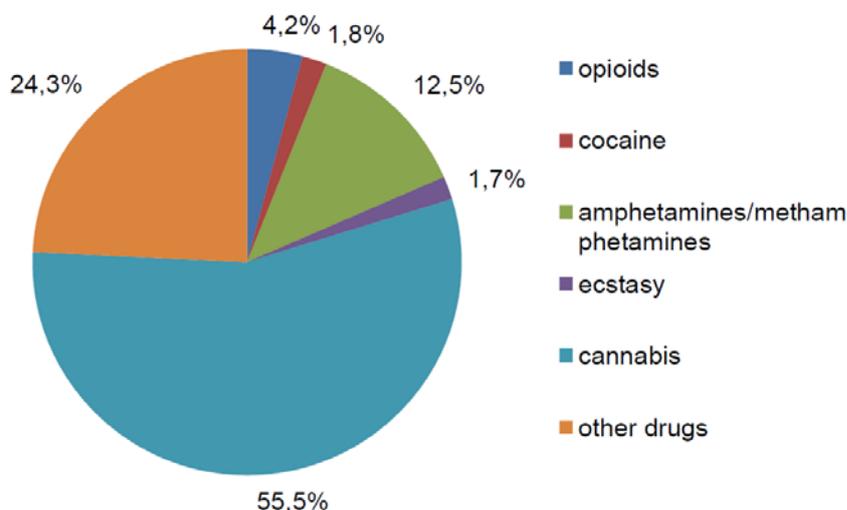
A significant determinant of the treatment system in Hungary is the legal possibility of treatment/preventive interventions that may be used as an alternative to criminal procedure (quasi compulsory treatment; hereinafter QCT). The majority of entering treatment are linked to this (60% in 2014).

“Drug treatment is not a separate category neither within the social nor the healthcare systems; in general they belong to the group of treatment modalities related to addiction and psychiatric problems. This makes it difficult to monitor the treatment possibilities, capacity and utilisation. Reliable data about the field is available from the drug treatment (TDI) and OST data collection, which are suitable primarily for describing the characteristics of the clientele. On the basis of these sources, the greatest problem is posed by cannabis use, most users start treatment because of this. The consequences of the spreading of new psychoactive substances (hereinafter: NPS) can be seen indirectly from the treatment data and more directly from the market and NSP data, which can be observed in the changes of injecting drug use and treatment demand as well. In parallel with this, the decrease in the use of heroin and the relative stability of treatment demand linked to amphetamine can be observed.” (National Report 2015, p. 49.)

6.4 Key treatment related data and proportion of treatment demands by primary drug

“The 90 treatment units providing drug treatment and reporting to the TDI reported a total of 4688 clients entering treatment in 2014. 3120 of the clients entered drug treatment for the first time in their lives. The majority (55.5%) of those starting treatment due to drug problems – similarly to previous years – started a treatment programme because of cannabis use. 12.5% started treatment because of amphetamine use. Opioid use was the reason for starting treatment to a less significant extent (4.2%). The proportion of cocaine and ecstasy users was under 2% each. Nearly one quarter (24.3%) of treatment entrants indicated the use of other (non categorisable) substances as their primary substance.” (National Report 2015, p.55.)

Breakdown of treatment demand by primary drug (2014; %; N=4688)



6.5 Harm reduction services⁵

Needle/syringe programmes (NSP)

During the major part of last year, the service structure established through the 3-year-long (2012-2014) fixed funding did not change, in 2014 3148 service providers operated NSPs in 21 cities, which covered 14 counties and all the 7 regions (Tarján 2015b). However, it is important to highlight that in the second half of 2014 the two largest NSPs in Budapest had to close down as a consequence of local governmental decisions. The Kék Pont Alapítvány terminated its needle/syringe programme in district 8 in August and the Drogprevenációs Alapítvány stopped its service in district 13 in November.

In 2014, 30 fixed locations with NSPs operated in the country, 15 organisations performed street outreach work, 1 organisation operated a mobile NSP, and in 4 cities IDUs could purchase syringes from syringe vending machines.

11 organisations operated two types of programmes, this in all cases was street outreach attached to a fixed location NSP. Four service providers operated three different programme types, and 15 service providers only had one type of NSP service, which was mostly a fixed NSP.

In 2014, NSPs distributed a total of 460,977 sterile syringes, the number of returned and collected syringes was 296,716.49. The exchange rate was 64%. As restrictions on the number of syringes that could be distributed/exchanged per contact that was introduced in the previous two years at the larger service providers remained, it is probable that a significant proportion of the used syringes not returned to the programmes – primarily in the capital – were reused or shared (HNFP 2015). In 2014, 4,442 IDUs used NSP services on a total of 41,535 occasions. 1,844 new clients were registered by the programmes in the course of the year. On average 102 syringes were distributed and 67 returned per client, the mean number of contacts per client was 9 in the year in question.

⁵ Based on the National Report written by the National Focal Point for the EMCDDA.

According to the breakdown by programme types, the majority of syringes were distributed and collected by fixed location NSPs. In 2014 the data originating from this programme type formed 83% of the total national turnover if the number of distributed syringes is considered.

Syringe and client turnover data of NSPs in 2014

	fixed location	mobile NSP	street outreach	syringe vending machine	total
distributed	381,992	58,655	14,125	6,205	460,977
returned (+collected)	226,560	57,995	11,188	973	296,716
exchange rate	59%	99%	79%	16%	64%
number of clients	4,096	231	115	-	4,442
number of new clients	1,652	141	51	-	1,844
number of contacts	38,184	2,055	1,296	-	41,535
number of NSPs*	30	1	15	4	31

**The same NSP can run several types of programme at the same time, so the number of NSPs per programme type is not equal to the total number of NSPs.*

Source: Tarján 2015b

On examining geographical distribution, NSPs located in Budapest had the decisive proportion of both the number of distributed/returned and collected syringes and the number of clients/contacts (the rates varied between 86-89% in respect of the individual indicators) in 2014 as well. Due to the closures in 2014, the share of the Kék Pont Alapítvány and the Drogprevenció Alapítvány (the terminated programmes) of the national NSP turnover was examined. According to the data of 2014, in spite of this being an incomplete year for the two organisations, 40-60% of the number of distributed/returned and collected syringes and the number of clients/contacts can be attributed to these 2 organizations.

“Beside sterile syringes, most NSPs provide counselling on safe injecting (23 out of 27 reporting organisations). The majority of NSPs provide alcohol pads, condoms and vitamins. Sterile filters and mixing containers were available at less than half of the locations. Nearly a third of the organisations provide sterile injecting equipment in pre-assembled packages. (Tarján 2015b).” (National Report 2015, p. 82-83.)

7 Conclusions

Based on the data reviewed in the previous parts we can say that New Psychoactive Substances play a crucial role in articulating the drug situation in Hungary. According to recent epidemiological research it can be stated, that these substances are becoming more and more popular mostly among young people. In some cases NPS are the second most popular substances. Compared to other EU countries the intravenous administration of NPS is a constantly growing, especially among clients representing marginalised, poor economic status social groups.



There are no special prevention and/or treatment and care programmes related to these substances. In general we can say that the prevention system made a few steps back, thus the perceived coverage and the perceived availability of promising interventions are fairly low.

General characteristics of the system is that financial resources are insufficient for covering the needs of different type services, interventions; partly due to financial shortages there are no large scale and systematic researches.

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