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HUNGARIAN CIVIL LIBERTIES UNION

HARM REDUCTION PROGRAMS IN HUNGARY

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Foreword

This is the first time the Hungarian Civil Liberties Union has undertaken to publish a volume of articles on Hungarian drug policy in English. The present volume focuses on harm reduction; the writers of the articles pursue two related aims: they try to describe the present state of harm reduction services in Hungary, on the one hand, and to identify the causes of why certain other forms of harm reduction have not yet been introduced in this country, on the other.

Before 1989 the cultural policy of the Communist government was defined by a threefold classification according to what was colloquially referred to as 'the three "t"-s'. These are derived from the identical first letters of the Hungarian words for 'prohibited', 'tolerated' and 'supported'. Works and authors favored and deemed politically correct by the Communist powers were to be 'supported', works and authors disfavored or positively persecuted by them were to be 'prohibited'. To make matters less perspicuous and less straightforward, there was a third category, that of 'tolerated' cultural artists and products. These were neither explicitly prohibited by the power centers, nor were they welcome or supported; straddling the two poles of existence and non-existence, they were trying to stay alive under conditions of uncertainty .

If we apply this threefold classification to the topic of the present volume, approaches to the drug problem that depart from methods which have previously won full recognition, namely harm reduction services and schemes, we can describe the present situation of these activities as lying somewhere between what is tolerated and what is supported. We cannot say that they are merely tolerated, but they are not receiving from official decision-makers in drug policy the amount of financial support they deserve. On the other hand, the prohibition of services based on harm reduction approach is clearly a thing of the past, as most of the services offered to reduce the individual and social harm caused by drug use and often by bad anti-drug laws, are rendered against a background of powers and entitlements secured by legal instruments.

As far as the worst aspects of the drug problem are concerned, Hungary has been on the lucky side in comparison with other countries of East and Central Europe: in respect of the spread of HIV, the situation of Hungary simply cannot be compared with the literally tragic drug situation in successor states of the former Soviet Union. On the other hand, the Hungarian example, the problems and the situation of harm reduction services can certainly serve as a basis for conclusions and lessons for other countries in the East and Central European region. Despite the numerous differences, these countries still have much in common.

What is certainly common to the state of drug policy in the former socialist countries is that the populations of these countries are hardly familiar with harm reduction services. Even if harm reduction schemes are officially supported by a given state, the population of the country is likely to know little or virtually nothing about the immense advantages these activities can produce. It might not be an immodest claim to say that the present booklet, like all publications on harm reduction, is itself an instrument of harm reduction: it tries to alleviate the harm that is bound to result from insufficient familiarity with, and less than proper recognition of, an approach to drug policy which is based on and itself produces up-to-date scientific results: the policy of harm reduction.

January of 2003
Budapest

CHAPTER 1

The Background to Harm Reduction in Hungary: Legislation and Drug Policy

PREHISTORY

While many Hungarians are still unfamiliar with the meaning of the expression 'Harm Reduction', the new approach to matters of drug policy associated with the phrase has gained some ground both in thought and practice since the early, 1990s, or perhaps more palpably the mid-1990s. As will be apparent from later chapters in this volume, the notions of a needle exchange service or of methadone treatment were no longer new to professionals dealing with drug patients in Hungary in the 1990s. By contrast, it was not until much later that official drug policy – if there is such a thing in this country – began to take recourse to harm reduction schemes as a means for dealing with certain aspects of the drug problem. The progress made by those applying harm reduction methods has been far from undisturbed and has often been impeded by considerations of partisan politics, as is the case in this country with almost any problem that is related to the drug issue.

The left-wing government in office between 1994 and 1998 was the first after the political transformation to approach the drug problem on the basis of comprehensive professional considerations. Parliament set up its Case Committee of Drug Affairs with the task of elaborating a short-term and a long-term strategy for settling the drug problem. Ready by the spring of 1998, the document entitled 'National Drug Strategy' clearly conveyed a sense of resolve to introduce harm reduction not merely as a theoretical label but as a real instrument to be put to actual use in the implementation of drug policy schemes[1]. The scheme enunciated in the National Strategy set itself the objective of making low threshold services available to a wide circle of the drug user population. It aimed at offering intravenous drug users regular access to needle exchange schemes, a few of which were already running on a modest scale at the time, with plans not only for providing more of them but also for providing a greater variety of them including such arrangements as mobile and street exchange etc. Another aim was to make methadone substitution treatment wide-spread. A further positive feature of the strategy was the fact that it did not only put together a list of what was to be achieved but also spoke in straightforward terms about funding. From a distance of five years we can now safely claim that the Strategy's treatment of harm reduction services as important instruments of drug policy was perfectly commensurate with the actual extent to which these methods are adequate to reduce the individual and social harm caused by intravenous and other drug use.

This draft could have set the course of domestic drug policy for several years if it had not been for political changes which ensued soon after its inception. Only a month after the Strategy had been completed, the general elections lead to a change in the government and the ascending right-wing coalition made it fairly clear that the philosophy underlying its drug policy was radically different from that of its predecessor and that it was not going to rely on the Strategy. It is small wonder that the Strategy ended up in a drawer to collect dust, losing all hope of becoming real for a time no one could then predict.

As far as the history of harm reduction schemes is concerned, needle exchange projects already in operation at the time of the political changes continued into the late 1990s, but their efficacy was dif-

1. National Drug Strategy 1998.

ficult to measure. Chapter IV. of the present volume offers a glimpse of this history, so in the present connection I would like to confine my attention to the problems of measurability. Firstly, the services offered under those schemes made their way to very few drug users. The situation is aptly expressed by the statistically confirmed fact that until the spring of 2002 there was only one needle exchange service with rather restricted opening hours in Budapest, the countries capital, which is inhabited by two million people, and that, with the exception of a handful of very small-scale attempts, there was no mobile or street needle exchange. Secondly, the situation in country towns was even less favorable, with needle exchange services there running even less efficiently.

When we think of the low incidence of HIV infection among Hungarian drug users, the explanation for these data which look very favorable in Eastern and Central European comparison, has to be sought somewhere else in view of the obvious fact that needle exchange schemes were not wide-spread and widely accessible in the 1990s and indeed are not wide-spread even today. The intravenous use of drugs, especially heroin, however, was markedly present in that period and was continuously on the increase[2]. If, then, intravenous drug use had reached measurable proportions and if, on the other hand, low threshold services were not wide-spread, what could have been the cause of the negligible number of HIV carriers in the domestic intravenous drug user population as compared either with the same indices in Western European countries or in countries of East and Central Europe at more or less the same level of development? Perhaps no answer to this question can be precise enough to dispel all doubts. But one of the unmistakably important causes must have been the fact that Hungary has never had a “Drug Paraphernalia Act”. Throughout the 1980s and 90s sterile injection equipment was available to everyone at pharmacies, a certain number of which were open even at night. This favorable fact was offset by the possibility that, if a police identity check happened to reveal that someone was carrying injection equipment, this could have served, and indeed can still serve, as a basis for criminal prosecution for illegal drug use. Still, the fact remains that in contrast to quite a number of countries, sterile syringes have always been freely available without restriction in Hungary. By no means accidentally, government schemes for the further development of harm reduction services presently in the pipeline are envisaging a role to be played by pharmacies via the Chamber of Hungarian Pharmacists[3], and one version of these plans, which are expected to be implemented in 2003, envisages the installment of needle exchange automata outside pharmacies.

2. Report on the State of the Drug Problem in Hungary, Ministry of Youth Care and Sports, Budapest, 2000.

THE 1999 AMENDMENT: A RESTRICTIVE DRUG LAW

After the Drug Strategy elaborated in 1998 fell a victim to the political change at the top level, the new government came up with its own version of a Drug Strategy in the summer of 2000. The publication of the new drug strategy, however, was preceded by a modification to the provisions of the Criminal Code on ‘drug abuse’ which became effective on March 1, 1999. The new legislation was unmistakably stricter than the instrument it had been designed to replace. It was described by the government spokesman as ‘the strictest Drug Act in Europe’ in the fall of 1998[4]. The most important changes from the point of view of drug users can best be grasped with the help of a comparison with previous relevant legislation. While under the old rules if someone had been found using a lesser amount of drugs, at a certain stage in the criminal procedure he or she was offered the choice between letting criminal proceedings pass through on the one hand or undergoing a continuous, six-month therapy (’diversion’), on the other. The new legislation, which became effective in March 1999, withdrew

3. National Strategy for Fighting Back Drug Consumption, Budapest, 2000.

4. HCLU Booklets on Drug Policy. On the Road toward Stricter Measures, Budapest, 2000.

this choice from all suspects but drug addicts[5]. Originally introduced in 1993, the previous system of 'diversion' was widely available until 1999. Interestingly, while the official response to demands for wide decriminalization, or even to demands for the decriminalization of offences related to soft drugs, always referred to the fact that Hungary had signed international agreements which forbid decriminalization and prescribe the punishment of drug offenders as obligatory, no reference was made to the fact that the idea of diversion is also expounded and recommended in international documents. One of the UN Conventions which are constantly referred to[6] expressly allows governments to apply the milder alternative punishment of diversion with those guilty of smaller drug offences, while upholding the principle that drug offenders are to be punished. This kind of escape from punishment was restricted only to persons who could prove the fact that they were drug addicts. The criminal law practice of the past four years has shown that it is by no means easy or simple to classify drug users into the neat categories of 'drug addict' and 'occasional drug users'[7].

The lawyers of the legal aid service of the Hungarian Civil Liberties Union have had the opportunity to deal with a number of cases in which patients with several years of intravenous heroin use behind them, i.e. patients who are certain to be deemed dependent by any addictologist[8], are still classified as 'not addicted' to their accustomed drug as a result of the official examination conducted by the forensic medical expert, the official with the exclusive entitlement to decide about 'drug addiction' or 'no drug addiction'. Under the system presently in effect, forensic medical experts have practically complete discretion in deciding whether someone should be punished or have the choice to go into therapy.

Another aspect of the 1999 modification affected harm reduction schemes in their functioning and those who work in facilities offering such services. Previous legislation punished drug consumption without elevating the word 'consumption' into the formulation of the law, i.e. although the expression 'consuming drugs' was not part of the wording, using drugs counted as a criminal offence. Under Hungarian criminal law before 1999, as was the case in the criminal law practice of several other countries, the use of drugs was punished via punishing the acquisition and possession of drugs. Thus, for instance, if someone came under suspicion of drug consumption in the course of some police action, and the suspect admitted consuming drugs, he or she was punishable. Since, however, only acquisition and possession were named as pieces of offensive conduct in the law, the suspect was called to account for acquisition or possession, on the supposition that one cannot have been consuming drugs without previously acquiring and/or possessing them. Urine tests showing traces of an illegal drug in the organism resulted in the same facts, namely it was assumed that the person must have acquired and possessed the drug before consuming it. This system of rules had been in operation since the introduction of the Criminal Code in 1978 and had never posed a problem to those in the administration of justice or to citizens. Most members of society were aware that consuming drugs was de facto a criminal offence. In bold contrast to this, the new legislation introduced in 1999 incorporated the phrase 'consuming drugs' in its description of varieties of offensive conduct. The government argued that making consumption part of the law was 'a clear message' which it was necessary in the fight against drugs to convey to the public[9]. They argued, on rather a poor ground, that criminalizing consumption through the criminalization of acquisition and possession was not acceptable because it was not a clear idea for society that the law was prohibiting something that it did not mention. The word 'consumption', then, became part of the wording of the law as of March 1, 1999.

5. HCLU Booklets on Drug Policy. On the Road toward Stricter Measures, Budapest, 2000.

6. The Vienna Convention signed in 1988.

7. HCLU Booklets on Drug Policy. The Fruits of Prohibition, Budapest, 2001.

8. HCLU Booklets on Drug Policy. On the Road toward Stricter Measures, Budapest, 2000.

9. See the ministerial justification given for Act LXXXVII/1998.

This innovation was of some consequence for harm reduction services. Under Hungarian criminal law someone who assists someone in the realization of some criminal act is himself liable to be punished for the offence of complicity. Obviously, as long as acquisition and possession count as criminal offences but consumption is to be persecuted only de facto, not de iure, the question of someone rendering harm reduction services being punishable makes no sense at all. Since e.g. associates on a needle exchange service are not assisting the drug user in the acquisition or possession, only perhaps in the consumption of drugs. If consumption is explicitly mentioned in the law – and this is still the case at the moment these lines are written down – the situation is more complicated. After all, the social worker providing the drug user with sterile needles is assisting the drug addict in his or her consumption of drugs and thus falls under the category of the Criminal Code which defines 'an accessory [as] a person who purposefully assists another in the commission of some criminal offence.'

This possibility does not arise in connection with methadone treatment. Under Hungarian criminal law someone will be guilty of drug abuse only if he or she abuses some substance 'in violation of some authoritative prescription'. Although methadone, as long as it comes into someone's possession without a physician's description, is indeed to be judged on the same terms as illegal drugs, the complicity described above does not come into consideration if the medicament has been ordered by a person authorized to do so, since such a person has done so in accordance with authoritative prescriptions.

Supposing, on the basis of the above, associates of needle exchange services were punishable in Hungary today, why then have there been no criminal proceedings against persons working for such schemes in the past four years? It is obvious that needle exchange, an ineluctable part of harm reduction activities, was relatively well-known and recognized by leading police officers and politicians in the late 1990s. Although the familiarity of these important officials with these services did not necessarily mean that those engaged in the administration of the services were given the support their activity deserved by the leading officials in drug policy, it did mean that high-ranking police officers in decision-making positions understood the seriousness of the harm from which drug users and society were being relieved by these schemes. At the same time, there is another, perhaps even stronger explanation why such criminal proceedings were not started, and this the very concept of a criminal offence as it is defined in Hungarian criminal law. A criminal offence is any act forbidden and threatened by a sanction by the law which 'poses a danger to society'. If someone is to be liable for some prohibited act, he or she has to have committed an act that is a danger to the society. Conversely, if an act involves no danger to society, this fact is a reason which will exclude punishability. Now although the staff of a needle exchange service assist drug users in consumption by providing them with sterile needles, they are not only not committing an act that poses a hazard to society, but are positively protecting the society from danger, namely the danger of a transmission of hazardous diseases by shared needles. If, then, such a case were made out as a ground for starting criminal proceedings against some member of such a staff, the court would in all probability acquit the indicted social worker . The complicated legal constellation will not, it seems, be valid much longer to present us with an at least theoretical predicament. The newest legislation, to become effective as of March 1, 2003, will again make drug consumption punishable via acquisition and possession, but this will be discussed at some length later on.

THE HUNGARIAN NATIONAL DRUG STRATEGY ON HARM REDUCTION

After the National Drug Strategy elaborated in 1998 was shelved for the political reasons outlined above, the new government embarked on the task of drawing up its own new drug strategy. As a first step, the new government set up a new ministry, the Ministry of Youth Care and Sports, which was to play a significant part in the handling of the drug problem. The new ministry comprised the vice state secretariat responsible for coordination in drug policy, headed by Ákos Topolánszky (the interview he gave can be read in Chapter IV.). Although the stricter provisions on drugs became effective as early as the spring of 1999 and the modification proposal was ready for discussion in the spring of 1998, it was not until the summer of 2000 that the new Drug Strategy was presented to the government and not until December 2000 that it was presented to the Parliament. Nobody questioned the professional justification for the fundamental aims and means expounded in the Strategy. This is reflected in the fact that the parliamentary resolution on the Strategy was accepted unanimously, without a dissentient vote by the Hungarian parliament, which is so often divided on almost all issues. What did give reason for criticism was the timing and the legal environment. The timing was criticized because the presentation of the Strategy came exactly two years after the announcement of the stricter drug laws. One of the chief arguments against the proposed modification to the Penal Code in the fall of 1998 was the idea that it would be a mistake to change only the law in the absence of a comprehensive drug strategy. The other criticism was that the comprehensive and long-term plan for drug action was elaborated without any apparent consideration of the extent to which it was at odds with the context of the legal rules in which it was to be embedded, for better or for worse. There was the Strategy on one side, with its emphasis on preventive projects and the importance of education and the provision of information, and the 'Strictest drug law in Europe' with the young people terrified on the other side, with no indication whatsoever about how the two could be reconciled to get a workable system.

In the spring of 2002 the political situation changed and the new government announced a new modification to criminal legislation on drugs. These changes – to be discussed in some detail later – did not involve a change in drug policy attitude as radical as is claimed by both a number of citizens and the present opposition. First of all, nothing was done to modify the validity of the National Drug Strategy. Having been endorsed with unprecedented consensus in late 2000 by Parliament, there was no reason not to leave it in force as the document which sets the direction for further action. Secondly, rather unusually in the practice of Hungarian state administration (in which new governments usually appoint their own partisans to leading posts) Ákos Topolánszky, 'the Hungarian Drug Czar', remained in his post. The debate that went on about drug policy in the fall of 2002 seems, in retrospect, to have been about one particular aspect of the drug problem, namely the modification of certain instruments of criminal law. It remains to be seen how the official who stood up for severe criminal sanctions in drug matters will act as a 'coordinator' in the new legal situation, but one thing is certain: the National Drug Strategy has greater affinity with the underlying spirit of the legal instruments to be introduced in 2003 than with the instruments presently in force.

One might wonder what the Strategy says specifically about harm reduction schemes. The document expounds the concept of harm reduction rather briefly, noting, however, that 'harm

reduction methods in groups of intravenous drug users exposed to HIV and Hepatitis represent the only effective and cost efficient preventive method: the special interventions practiced as part of harm reduction often save the lives of chronic drug users who have no motivation to give up and can prevent severe possibly fatal diseases, while the long-term goal of complete freedom from drugs is not given up.' The Strategy tells us that harm reduction methods – outreach work, needle exchange schemes and maintenance treatment – are applied in all countries of the European Union and that the EU's anti-drug action plans for 2000–2004 emphasize the importance of establishments which offer such services. The Strategy also refers to the statements made by the WHO's European Office and East and Central European anti-AIDS initiatives launched by UN[10] all of which emphasize the importance of and justification for further developing these schemes.

That these services are to be supported and improved is not disputed, then. There are no more specific details concerning needle exchange schemes in the Strategy. By contrast, the subject of maintenance treatment is discussed in more specific terms. The Strategy emphasizes the urgency of establishing and running at least one maintenance treatment center in every region on the short term (regrettably, the document does not define 'short term'). As is described in Chapter II., maintenance treatment is no longer offered in only one or two places in this country. In the past two years, however, the developments described by the Strategy as desirable have not been realized. As a result, although the number of maintenance services has risen, the proportion between those receiving maintenance treatment and illegal opiate users continues to fall far below the level measured in Western Europe, and it is hardly rising.

Today the only substance with which maintenance treatment is available is methadone, despite the fact that treatment with other substitutive substances (such as LAAM, buprenorphine) has been available in other counties for a long time now, as is indicated in the Strategy itself. The Strategy therefore proposed extending the professional protocols for methadone treatment (see Chapter II.) to these medicaments. Regrettably enough, nothing has been done in this area in the past two years, although perhaps it is realistic to demand, as some do, that we should first attain to the level at which therapeutic establishments are capable of receiving the clients registering for methadone treatment at the moment.

All in all, the term 'harm reduction' is repeatedly used in the Strategy and the importance of such schemes is emphasized. At the same time, a seemingly minor point deserves some reflection. The section of the document which describes harm reduction schemes emphasizes twice that the client's abstinence from the drug is not to be aimed at 'in the first phase of contact-making'. In other words, what is argued is not that these schemes are called for because there are drug users who cannot or do not want to give up and in their case treatment may last for many yeas or a whole life. It is argued that abstinence is not a priority aim in the beginning phase of the treatment. We can only hope that this approach will become more flexible in time. Of greater importance, however, is the question of the extent to which the measures proposed will be implemented in actual practice. Will there be needle exchange services which succeed in reaching a wide enough circle of drug users? Will the proportion of opiate users receiving maintenance treatment rise significantly? And last but not least, will it be possible to introduce harm reduction schemes which, though not even mentioned in the strategy, have already been adopted as means of drug policy in countries which take harm reduction seriously?

10. E.g. the meeting the subsequent agreement in Geneva and Kiev in the fall of 1999.

A NEW-OLD LAW, OR RIGOR RECEDING

Based on a decision made in the Hungarian Parliament on December 23, 2002, new legal rules on drugs will become effective on March 1, 2003. The modification is the new government's response to the tightening of drug legislation introduced by the previous government four years ago. The government majority of votes endorsed a legal rule which embodies measures similar to those embodied in the law before 1999 rather than novel solutions. Accordingly the term 'consuming drugs' will be removed from the wording of the law from 2003 and drug use will be punishable as a de facto act mediated by acquisition and possession. This will put an end to the contradictory legal constellation in which associates of certain harm reduction services were in principle punishable for what they were doing. In the early phase of drafting the idea was raised of explicitly incorporating in the law a provision which would state flatly that associates of services offering needle exchange and maintenance treatment were 'not punishable' for the kind of activity they pursue. The Hungarian Civil Liberties Union expounded its view on the question – arguing that it would not be a good idea to include such a formulation in the text of the law.– and it was accepted. The argument was, firstly, that if the word 'consumption' is removed from the wording, the problematic situation mentioned above is removed with it and there is no need for the extra clause. Secondly, if the Penal Code contains such a definition, this may easily give the impression that these activities have only recently been removed from the realm of illegality which would show these activities in a bad light, as it were. It is good news for the cause of harm reduction that the definition will not be incorporated into the text of the law.

The most important difference in the new legal instrument will be its reintroduction of the alternative of diversion into therapy for all drug consumers who have committed only the offence of consumption or some other drug-related conduct of lesser weight (such as the transfer of drugs for purposes of shared consumption). In other words, criminal proceedings against all such drug consumers will be lifted if they undertake and complete a continuous six-month therapy. This arrangement is by no means a novelty: it was part of the law which was in force from 1993 until 1999. If casual drug users are identified by police, they will have to show proof of completion of an educational and advisory course rather than medical therapy, as in their case drug use rarely ever leads to health problems. In the course of the social debate carried on in the fall of 2002 the therapeutic profession unanimously supported the idea of diversion. They argued that it was a fundamental interest that young people who come into contact with drugs should come into the purview of the therapeutic network as soon as possible[11]. Legislators supported the wide availability of diversion by arguing that in a modern democratic state the interest in making the criminal law into an ultima ratio cannot be allowed to outweigh the interest in motivating drug users to enter the network of institutions which is designed to help them.

The proposed modification to drug legislation unleashed a violent political storm which produced an endless series of announcements and claims from politicians from all sides. Perhaps characteristically of the Hungarian style of political debate, although the demand for decriminalizing drug consumption (i.e. abolishing the punishability of drug consumption) was never even implicitly made, politicians on the other side of the divide, in discussing the modification, spoke of the dangers inherent in legalizing drugs. A recapitulation of these arguments is perhaps less worthy of our attention now than a review of what has been left out of the new legal instrument. It is certain that the disappearance of the word 'consumption' from the text notwithstanding, drug consumption will continue

11. See the statement made by the Hungarian Association of Narcologists and the Professional Association of Drug Outpatient Clinics.

to be a criminal offence. Equally certainly, the new legal rule entering into force in March 2003 like its predecessors, will not make any distinctions between various illegal drugs. In other words, the absence of any distinction between marijuana and heroin will remain both with regard to consumers and dealers.

We can safely conclude that the new legal instrument will not be a step toward liberalization or decriminalization. The progress that has been made is only relative.

DIFFICULTIES ATTENDING THE IMPLEMENTATION OF HARM REDUCTION SCHEMES

While we can say that the legal background for needle exchange services and methadone treatment is secured, and that we are likely to witness some improvements in these services in the near future, harm reduction schemes still tend to run into serious difficulties in practice. It is immensely important that harm reduction services should be immune from interference by authorities for the prosecution of crime in general and from harassment by the police in particular. First of all, there is a fact which must be acknowledged as a fact: any kind of police action affecting these services is likely to reduce the number of clients who are willing to seek help with them. How can one be expected to attend a needle exchange establishment in the knowledge that the policemen in the car just outside the building are watching out for just the kind of person he or she is? How can one be even supposed to keep one's trust in treatment establishments in the knowledge that other drug patients have had their data in the establishment registers made available to police?

Another fact about harm reduction schemes is that under Hungarian health care law harm reduction services are not legally distinguished from traditional forms of provision for drug patients. Harm reduction services differ greatly from traditional forms of treatment which have always been premised on a presumed willingness to achieve abstinence, but there are no legal rules specially tailored to the former. While the legal rules for health care do not make a distinction between what are two radically different kinds of treatment, a little reflection shows how serious problems are generated by this state of affairs in connection with e.g. the activities of authorities investigating crime. Needle exchange service facilities and methadone treatment facilities are often attended by a great number of drug users who do not wish to give up using illegal drugs, or not at the time of treatment, in any case. Now, consuming drugs is a criminal offence in Hungary, and over 75% of drug-related criminal proceedings are initiated against consumers[12] (as opposed to e.g. dealers etc.). That is to say, sadly enough, that police are making the greatest contribution to reducing the demand for drugs. It is not surprising then, with no legal rules applying specifically to the manner in which harm reduction services are to operate, that associates of these services have often had to face police intervention in their work. Establishments offering harm reduction services often receive requests from police for information usually about details of a client's treatment who is involved in some stage of criminal proceedings. Such requests for information are not necessarily, and not always, against the law. For instance, the diversion therapy mentioned above may be administered as part of methadone treatment, in which case the police is entitled to acquire data certifying a certain individual's completion of a certain type of therapy. Reports from our colleagues in the legal aid service show that police requests are often made for information that goes far beyond the fact of the client's completion of the six-month therapy as prescribed by the legal alternative, to no less than e.g. the full medical records. A further problem that adds to the complexity of the situation is that under a legal rule introduced in the fall of 1999 police, when investigating a case of drug trafficking, are

12. See Ildikó Ritter, op.cit.

entitled to acquire data even about persons who have never been subject to criminal proceedings before. The problem this gives rise to is that the mere consumption of a drug also counts as an act related to drug trafficking and thus police have, in principle at least, unrestricted powers to acquire data about therapeutic facilities. Fortunately, a change in relevant criminal legislation, to become effective as of March 1, 2003, will put an end to this situation, and after that time those committing only the act of drug consumption or other lesser offences will be removed from the purview of this rule and will enjoy more extensive protection. As far as requests from authorities are concerned, reports of such requests for information about patients by police or the competent attorney's offices – made face-to-face or over the phone! – continue to be relatively frequent in harm reduction establishments in the country, HCLU uses every opportunity to repeat publicly that lawful requests of this kind can only be made in writing, with an indication of the reasons for and the purpose of the request.

On the whole, then, while harm reduction schemes are clearly described in the National Drug Strategy as parts of official drug policy, they continue to have to engage in an almost day-to-day fight with external influences which threaten to undermine them at vital points of their functioning. Cooperation with the police and guaranteed immunity from police intervention are still too often a consequence of the competent police officer's favorable turn of mind, or of the local police chief's attitude to harm reduction rather than an unquestionable manifestation of respect for the valid law on the part of police. It hardly needs to be emphasized that 'respect', as opposed to personal tastes and preferences, is what harm reduction services need, and that this respect must mean more than just appropriate funding: it must mean positive steps on the part of state authorities which will guarantee immunity for the establishments and protection for the clients.

HARM REDUCTION SCHEMES AND THE LAW

In what follows we will review the legal instruments which provide the foundations for the running of harm reduction services already in operation. We will also try to examine possible ways of introducing further schemes which are in operation in other countries but are not yet established in this country.

Needle exchange and methadone schemes present the most clear-cut picture. The professional guideline elaborated by the Professional College of Psychiatry, which sets out the main rules of methadone treatment including rules of dosage, and indication, was elevated into a legal rule in the spring of 2002, which put an end to the semi-illegal (or semi-legal) practice that had been carried on for so many years. Under the legal rules introduced in spring 2002, patients have been entitled to get their medicament free of charge with the state financing treatments in accordance with the modified social security legislation. Under the old system one had to obtain permission to receive the treatment and once the permission had been acquired the patient had to pay for it. As far as needle exchange services are concerned, their professional rules were also laid down by the Professional College of Psychiatry.

Harm reduction services not yet in operation in Hungary must not be left out of account. The present legal environment would clearly exclude the introduction of some, but even those that would not conflict with the present legal conditions have not been introduced.

Heroin maintenance schemes are becoming more and more common in those Western European countries which are leaders in terms of harm reduction. Originally operated only in Switzerland but now being piloted in countries such as Germany, Holland and Great Britain these

projects are primarily targeted at clients with a long history of drug use who drop out of traditional projects or are unwilling to take part in them, and report rather promising results both in terms of a reduction in drug-related crime and in terms of the clients' state. Such projects will have to wait quite a few years to be introduced in this country. On the one hand, a great many more opiate consumers would have to be involved in methadone treatment to gauge the demand for such a maintenance service, this being the only way to find out the percentage of all opiate dependents who outrun the capacity of maintenance schemes actually available. At present however there is an even more serious hindrance in the way of the introduction of such an experiment. In order for heroin to be made available on prescription to those in need of it, heroin would have to be registered as a medicament in the first place. This substance is a prohibited drug and its medical use is not allowed on any terms or under any conditions. The partial legalization of heroin is certain to be a slow process: if we think of the length of time it took for the official procedure of licensing the use of methadone to go through, we cannot have ardent hopes of seeing heroin maintenance in the near future.

The question of Safe Injection Rooms is not as straightforwardly decidable as that of heroin maintenance. On the one hand, there are no injection rooms in Hungary today. On the one hand, the law at present prohibits anyone from assisting anyone in drug use in this way but, on the other hand, the furnishing and running of such a room would certainly not count as 'dangerous to society' by the criterion discussed above, the purpose of such a room being to put an end to the open drug scene and to promote safer drug use and thereby the protection of drug patients as well as society. As a matter of fact, the topic of Safe Injection Rooms is raised briefly in the 2002 issue of the annual assessments of the state of the drug problem which are issued by the ministry responsible for drug affairs[13]. Although the publication acknowledges Safe Injection Rooms as a workable and useful form of harm reduction, it states that 'In Hungary there is no such injection center and the prospects for the establishment of such in the near future seem poor.' Under the new legislation which will become effective in March 2003 however there will be no obstacle in principle to the introduction of this kind of services. Because the provision of a sterile needle and a medically safe environment provides no assistance in the acquisition or possession of drugs. It cannot be reasonably doubted that there is a need for such centers, at least in the capital. The study on street outreach work described in Chapter III. clearly evidences the existence of an open drug scene. Another serious problem which can be successfully tackled with the help of Safe Injection Rooms is the problem of deaths resulting from an overdose on drugs. Although the data gathered in Hungary reveal a much more favorable situation in this country than in the cities of Western Europe, the annual 20-30 heroin overdose deaths in Budapest (most of which occurs in some public place) cannot and should not be played down. Analyzing the drug situation in the capital in the spring of 2002 the competent committee of Budapest Municipality concluded that the establishment and maintenance of Safe Injection Rooms is worthy of serious consideration. Another professional study[14], which received greater publicity than the previous one, reached the similar conclusion that, in view of the existence of the open drugs scene and the lethal overdoses, the possibility of establishing such a center in the capital should be seriously explored. Certainly, this will not be legally excluded from March 2003. At the same time, previous negotiations with the police and agreement on terms of operation are an absolute precondition of the successful functioning of such an establishment. If leading police officials with responsibilities in matters of drugs accept the need for this form of intervention and guarantee immunity for these

13. Report on the State of the Drug Problem in Hungary, Budapest, 2002.

14. Ildikó Ritter, An Examination of the Impact of the 1998 Modification of Rules of the Penal Code on 'Drug Abuse'. National Institute of Criminology, Budapest 2002.

scenes of safer drug use on condition of the observance of legal rules, then the project will be able to run successfully. If by contrast police view these facilities as a convenient places where to look for possible targets for police proceedings, then there is absolutely no point in launching such establishments at all. In principle, hopes that the prosecuting authorities will not adopt a negative attitude to the idea do not seem to be entirely vain, since most scenes of needle exchange are tolerated rather than harassed by the police.

Another important instrument of harm reduction, in use in e.g. Great Britain or Holland, is the legally guaranteed opportunity for drug users to have their drug medically examined. This gives users a chance to know what substance they are using, and makes it possible to identify drugs which contain an ingredient of hazardous additional material. Last but not least, it also gives the authorities a chance to form a clear idea of the state of the black market, the ingredients and quality of substances available there. There are no services of this kind in this country. Their introduction is impeded primarily by two factors. First of all, the persons who offer such services necessarily acquire and briefly – for the time of the examination – possess drugs, so they commit an offence. This would probably be the less serious problem since the absence of the more important criterion, namely danger to society (their conduct, too, is useful rather than harmful) would not result in actual punishment administered to them. In Western Europe, these services are rendered in places and at events (discotheques, festivals, events of youth interest) where regular or casual drug users turn up in great numbers. In view of the fact that police in Hungary have liked to launch large-scale raids at places of entertainment supposedly attended by drug users, it is unlikely that an owner of such an establishment could be easily found who would be prepared to admit such schemes within the walls of his establishment. There is an undeniable element of hypocrisy about the situation since, as several surveys[15] have recently shown, these establishments are scenes of heavy drug use. In my view these services if introduced would be answering an existing need. At the same time their introduction had better be preceded by some adjustment in the legal background, or at least a set of directives for the police.

Several countries have recently reduced the strictness of their legislation relevant to cannabis derivatives either by changing legal instruments or by making application less strict. Judging cannabis by standards different from those applied to other illegal drugs is itself a kind of step taken in the direction of harm reduction since such regulation has a favorable effect both on the demand and on the supply side of the drug market. If the state permits or at least tolerates the consumption and/or limited marketing of cannabis, it expresses a judgement that it deems the consumption of these drugs less dangerous and therefore in some sense more favored than that of other illegal drugs. Such legislation is unlikely to be introduced in Hungary in the near future. The members of the Hungarian Socialist Party, the greater political force in the government coalition, who have responsibilities in drug affairs, have announced several times recently that they do not support any distinction between the various illegal drugs. What this means is not only that they would disapprove of a proposed liberalization or quasi-legalization of cannabis. It means that they do not find a distinction between drugs in terms of degree of dangerousness desirable. At the same time, professionals dealing with the drug problem have repeatedly urged Parliament to consider seriously a different set of legal rules on cannabis. Although far from being a step toward liberalization in the near future, a remark made by the Hungarian Minister of Justice in an interview given in September 20002 was a message of some importance: in response to a question about the liberalization of soft drugs the

15. In: Zsolt Demetrovics (ed.), 'The World of Synthetic Drugs', Animula, Budapest, 2000.

Minister of Justice said he did not think it a viable idea under the present conditions primarily because Hungarian society would find it hard to acquiesce in such a political decision. In contrast to statements made so far by Hungarian politicians he was not talking about the gateway drug theory or trying to make out a case from the poor mental hygienic condition of the Hungarian population: he admitted publicly that the question was too sensitive to be raised. Nobody knows to what extent this judgement reflects the facts as they really are. In any case, the results of an opinion poll conducted in November 2002[16] are rather revealing. They reveal that 80% of the population would say 'no' to the free marketing of cannabis derivatives, while the network of coffee shops in this country would now be accepted by 14% as opposed to the 6% measured in 1999 and the 10% measured in 2000.

16. Conducted by the Medián Public Opinion Research Agency.

CHAPTER II

Methadone substitution treatment in Hungary

INTRODUCTION

Methadone (6-dimethylamino-4-4-diphenyl-heptanon-3) was discovered by Max Bockmühl and Gustav Ehrhard in Germany in 1941. Originally called 'Hoechst 10820', then re-named polamydon and finally methadone, the substance was examined for its pain-killing and spasmolithic effects in Germany during World Waar II. Research into these effects of methadone started in the late 1940s in the United States, and the first scientific report on observations concerning the methadone-based treatment of heroin addicts was also made in the United States. In 1965 Dole and Nysvander published an article which reported their finding that treatment with methadone decreased drug users' craving for their drug and blocked the euphorizing effect of the average heroin dose, all of which resulted not only in the users' ability to give up using heroin but also in a significant improvement in the patients' psycho-social situation generally.

Methadone was first used in the treatment of heroin addicts in the United States in the early 1960s. First taken over in Northern and Western Europe, then in Australia, Israel, later in Southern Europe, and finally, in the 1990s, in East Europe as well, the introduction of methadone schemes is being considered more and more seriously today by government officials in developing countries in Asia, South America and Africa.

In the second half of the 1990s several international organizations were speaking highly of the benefits of substitution schemes. Recommendations for the running of such schemes were put forward by the National Health Institute of the United States in 1998, the WHO in 1999 and by EMCDDA in 2000.

AN OVERVIEW OF THE PRESENT INTERNATIONAL SCENE

European Union

Nearly all EU member states reported the expansion of methadone maintenance treatment between 1995 and 2000. From 1993 to 1999 the number of drug users receiving methadone treatment in these countries almost tripled, reaching an estimated 300 thousand in 2000. The proportions between registered opiate addicts and those under methadone treatment vary between 30-75%. The most important objectives set out in EU's agenda for the period between 200 and 2004 – actually the EU's Drug Strategy – include plans for the reduction of harm caused by drug use and more particularly the expansion of substitution treatment in the region covered. At the same time, protocols for methadone treatment vary from one country to the other within the EU. Including guidelines specifically concerning treatment, EMCDDA's 'Euro Methadone Guidelines' were published exactly with the purpose of unifying schemes.

As early as 1992, almost 800 centers in the United States were offering methadone therapy to an estimated number of 120 thousand patients. At the same time there are differences between states: some states run no methadone programs at all, while other states no less than 80% of intravenous drug users are receiving methadone therapy.

Easily accessible and up-to-date methadone schemes are also available in Australia where an estimated 20 thousand persons are receiving this kind of treatment at present.

The past five years have also seen a growth in the choice of substances available for purposes of substitution, which have come to include buprenorphine (Denmark, UK, Belgium, France, Italy, Finland), slow-release morphine (Austria), and LAAM (Denmark, Germany, Spain, Portugal).

The political transformation in East and Central Europe unleashed a significant increase in the number of heroin users, which resulted in the recognition of the importance of methadone schemes. At present, Slovenia runs 19, Poland 15, and the Czech Republic 8 centers for methadone treatment, while Lithuania and Croatia (where methadone is available also on prescription from general practitioners, in addition to availability at clinics for drug addicts) also boast a relatively well-developed institutional network for methadone therapy.

Often run the form of pilot projects, methadone treatment in the other countries of East and Central Europe is available only in one or two isolated centers or hospital wards. In Slovakia substitution treatment is available only in the capital but even so the number of its patients – 380 – outruns the total number of patients receiving such treatment in Hungary.

All countries in East and Central Europe now have introduced legislation on methadone treatment and methadone schemes in these countries are being elaborated.

Efforts to work out a protocol for substitution treatment in Russia are being assisted by the WHO.

A SURVEY OF THE PROFESSIONAL AND LEGAL SITUATION IN HUNGARY

Facilities Which Offer Methadone Treatment

The history of methadone treatment in Hungary began 13 years ago. Administered by Dr. Sándor Funk to an Englishman who was working in Hungary at the time and had been receiving methadone treatment for several years, the first methadone (Depridol) treatment was registered at the Addictology Department of Nyírő Gyula Hospital in 1989. Until 1989, the year when the treatment was stopped, the therapy was available at this particular hospital department and was asked for by an increasing number of Hungarian citizens.

In 1989 a pilot project of this kind was launched by Dr. István Cserne at the Drug Outpatient Clinic of Nyírő Gyula Hospital in Klapka and Jász utca using, in the beginning phase, codeine and dihydrocodine derivatives as substitutes. The use of methadone was initiated at the same department in 1992, which is the center providing for the greatest number of patients at present. Other scenes of pilot methadone treatment, directed by Dr. Péter Rigó, were certain departments of the National Institute of Psychiatry and Neurology. The year 1995 marked a major stage in the development outside Budapest: in that year the Drug Outpatient Clinic in the town of Pécs in the South of Hungary started using methadone in the treatment of opiate addicts. A similar scheme was launched at the Drug Outpatient Clinic in Veszprém, another country town, in 2000, and in the town of Gyula in 2002.

At present the following establishments offer methadone maintenance treatment in Hungary:

1. Budapest (Nyírő Gyula Hospital Jász utca Drug Outpatient Clinic)
2. Gyula (Drug Outpatient Clinic)
3. Pécs (Drug Outpatient Clinic)
4. Vezsprém (Drug Outpatient Clinic)
5. Balassagyarmat Addictology Department (Dr. Ildikó Kadosa)
6. OPNI (Dr. Péter Rigó)

The Professional Background

In 1992 Dr. Sándor Funk summarized his professional experiences in a brief study of methadone treatment. The first 'Conference on Methadone' was organized by the Methodological Center and Outpatient Unit for Drug Prevention in 1994 with the participation of the head physicians of centers treating drug patients, who reported their experiences in this field. At a conference on addictology held in 1997 several specialists collaborated in drafting a professional proposal for methadone treatment. In the same year, having realized the importance of methadone treatment, the Professional College of Psychiatrists invited professionals active or interested in the area to what became a 'consensus conference' which resulted in the drafting of its statement called 'Professional Guidelines for Methadone Treatment', which was finally ratified by the College in 1998. These fundamental principles were re-discussed and confirmed by the College in 1999. Until early 2001, methadone therapy was applied in observance of these guidelines. In February, 2001, the Ad Hoc Committee of the Professional College (including Dr József Csorba, Zsolt Demetrovics, Dr Judit Honti and Dr János Szemejácz) worked out a revised version of the statement, which was then endorsed by the College. In the fall of 2001 the Scientific Health Care Council accepted the guidelines issued by the College, with minor modifications.

The past few years have also seen the publication, in Hungarian, of a modest number of summaries and articles as well as the giving of professional lectures on methadone treatment in particular and harm reduction in general. Professional interest in the subject has grown considerably. In March 2001 Psychiatria Hungarica (the professional journal of the Hungarian Psychiatric Association) published an article entitled 'Assessing and Regulating Methadone Treatment', which was the first detailed and comprehensive study on the subject in Hungarian. In October 2001 'The Hungarian Manual of Methadone Treatment', edited by Dr József Gerevich, was published as a result of the efforts of the Council of the Professional Association of Drug Outpatient Surgeries.

The Legal Background

In 1993 the Budapest department of the State Public Health Office, having recognized the increasingly alarming growth of the drug problem, gave its official sanction to the use of medicaments with an ingredient of methadone in the treatment of patients suffering from dependence on opiates. The then head of the National Health Service emphasized the point that methadone treatment was to be given for the purpose of improving the general state of health of the population and overcoming and preventing addiction. The leaders of the two Drug Outpatient Clinics which were then legitimately operating submitted requests at the relevant offices of the National Health Service for permissions for long-term methadone treatment. The subsequent granting of permissions meant the official recognition of methadone treatment in Hungary.

In November 2000 the National Institute of Pharmacology issued a permission (7691/01) for marketing the tablets 'Methadone-EP 5 mg' and 'Methadone-EP 20 mg', both indicated for addiction to opiates. (Depridol, the medicament with a methadone ingredient previously used was registered as a pain-killer.)

On December 5, 2000 Parliament ratified the drug strategy called 'National Strategy for Fighting Back the Drug Problem', which meant, among others, the acceptance of the idea of applying and developing of methadone schemes. The National Strategy made the following statements concerning substitution treatments: 'Substitution treatments (methadone, buprenorphine, LAAM). The application of the synthetic drug methadone (Depridol) for therapeutic purposes is internationally accepted and the most wide-spread substance for opiate addicts. Its therapeutic use is permitted for pur-

poses of detoxification and short as well as long-term maintenance treatment. In view of the spread of somatic complications and infectious diseases transmitted by blood ((primarily Hepatitis C and, as can be expected in light of international experience, HIV) and in order to prevent other individual and social harm (e.g. crime) caused by drug consumption, it is expedient to introduce methadone maintenance treatment in Hungary. There is already a professional statement about the question which describes the way in which the treatment is to be introduced in a few national centers on the basis of a well-defined set of indications for heroin addicts. It is expedient to extend this protocol to other substitutes in view of the fact that today other substances (such as buprenorphine and LAAM, also synthetic opiate derivatives) are being used in an increasing number of establishments. For the short term the setting up and running of at least one maintenance treatment center for every region is called for. The mid-term goal is to build up a network of such centers at the county level.'

On March 13, 2001 a conference was held with the participation of all parties concerned (the Health Ministry, the Ministry of Youth Care and Sports, the Drug Regulation Department of National Police Headquarters, the State Public Health Office, the National Social Security Fund, the National Institute of Addictology, the representatives of Drug Outpatient Clinics, representatives of pharmaceutical companies) to discuss terms of the regulation and financing of methadone treatment. The participants agreed that in consideration of the national strategy the next task was to improve methadone treatment, and to systematize the legal and financial background. The representatives of all competent authorities participating promised to take measures toward a settlement of the legal and financial matters in two months. Despite this commitment it took over a year for the methodological circular to be officially published in the Health Care Gazette. This shows that the declarations on the part of many of the participants may have reflected an intention to seem intent on solving the problems rather than a real resolve to do so by making the effort required for its success.

On April 25, 2002 the Methodological Circular on methadone treatment was officially published in No 9 of the Health Care Gazette (see Appendix 1), which meant that the cause of substitution treatment had finally risen to full-scale public recognition from an underground existence which had lasted 13 years.

On May 12, 2002 the rules for the funding of methadone treatment by the National Health Care Fund were published in No 10 of the Health Care Gazette. (See Appendix 2.). This meant that the medicament had become completely subsidized, i.e. free of charge for patients.

When writing the history of the gradual acceptance of methadone treatment in Hungary one cannot remain silent about some of the more sinister episodes which have accompanied this process: the criminal procedure started against Dr Sandor Funk, head surgeon of addictology, a few years ago, the ban on methadone substitution treatment introduced by the National Chief Public Health Officer in October 2000 and the reports to the police against the heads of outpatient surgeries which were offering methadone treatment, all of which affected the professional, legal and social acceptance of maintenance treatment rather unfavorably.

THERAPEUTIC PROTOCOLS

At present methadone is applied according to three therapeutic protocols in Hungary.

1. Short detoxication treatment which involves a quick-paced reduction of the dose, lasting a maximum of 30 days. The treatment aims at detoxication, independence of opiates to be attained as quickly as possible.

2. Long-term detoxication treatment with a slower-paced, gradual reduction of methadone dose, usually applied with patients with a relatively long history of dependence on opiates. The length of this therapy varies from a month to six months. and it aims at a state of independence of opiates.

3. Substitution (long-term maintenance) treatment, with the dose of methadone kept the same for a long period of time because attempts to reduce it invariably lead to a relapse. Substitution treatment may go on for several years. It is indicated for populations of opiate addicts with whom independence of opiates is not a realistic, attainable goal within the foreseeable future.

Statistical Data

Statistical data on methadone treatment have been available since 1989, thanks to the national data base run by the Drug Outpatient Clinic in Jász utca.

Between 1990–1992 Codein was used at the Jász utca Clinic as a substitute. The Codein scheme has a yearly average of 25-30 patients. From 1992 the Depridol tablet (active ingredient: methadone) was used as a substitute until the registration of Methadone EP.

At the Jasz utca Drug Outpatient Clinic methadone maintenance treatment was administered to
32 patients in 1992,
31 in 1993,
34 in 1994,
33 in 1995,
31 in 1996
34 in 1997
32 in 1998
32 in 1999
and 89 in 2000.

Our center has been receiving the national data since April 2001. The following chart shows us the total number of those receiving maintenance treatment, and of those receiving detoxication treatment, in a monthly breakdown.

Report

On patients receiving methadone treatment between April 2001–May 2002.

Months	Veszprém		Pécs		Budapest		Total	
	Maintenenance	Detoxication	Maintenence	Detoxication	Maintenance	Detoxication	Maintenence	Detoxication
April	6	-	8	4	59	18	73	22
May	7	-	8	4	54	15	69	19
June	6	-	8	9	56	22	70	31
July	7	-	10	8	62	15	79	23
August	7	-	10	5	58	18	70	28
September	9	-	10	6	60	18	79	24
October	8	-	10	6	71	19	89	25
November	10	-	11	5	67	17	88	22
December	13	-	12	5	67	13	92	18
January	9	-	12	6	89	11	110	17
February	9	-	12	3	81	26	102	29
March	9	-	12	5	87	29	108	34
April	9	-	14	7	87	19	110	26
May	9	-	16	4	99	16	124	20

Since August 1, methadone treatment has been applied at the Drug Outpatient Clinic in the town of Gyula, where 13 patients received the treatment until October, 2002. The number of patients involved in methadone treatment has gradually risen at the Jasz utca Drug Outpatient Clinic since May 2002. The number of registered patients in October 2002 was 152.

It is evident from the data that the number of those Hungarians who are participating in one of the schemes is still rather low. The proportion of those who are receiving methadone treatment to those officially registered as dependent on opiates is 2-2,3%, which is far below the average recorded in the European Union (50%), but unfortunately below the indices reported from neighboring countries as well, such as Slovenia (24%) or the Czech Republic (19%).

With the legal and financial background of substitution treatment now completely clarified it is to be expected that the area will undergo major development. in the near future. The government is planning to start, in the capital, several methadone centers as well as, following successful examples from other countries, a methadone bus service and, last but not least, the National Drug Strategy set the goal of starting this kind of therapy in major regional centers (Szeged, Miskolc, Sopron). Plans for the much longer term envisage involving the system of provision doe by family doctors and chemists in methadone treatment so that methadone substitution schemes may reach out to a wider circle of those who would be better off with them than without. A scheme of this kind to be operated by the Addicts' Center run by Hungarian Oecumenic Charity Service is expected to be started in 2003.

Despite all these developments and prospects those working in the profession often feel that the aftereffects of long illegality, the tough resistance of certain professionals and the indifferent attitude on the part of several government officials continue to pose a great hindrance to the necessary development in this field getting under way. We still often come across the opinion that methadone treatment is a 'necessary evil' which is, to a limited extent, tolerated in this country. This very opinion, however, reduces the chances of getting across to society the oft-repeated message that methadone is a therapeutic means which serves the interests of society and which is unquestionably worth improving.

APPENDIX 1.

The Methodological Recommendation of the Professional College of Psychiatry on the Guidelines of Methadone Treatment (from: Health Care Gazette, No.9, April 25, 2002).

General Remarks

These guidelines were elaborated at the consensus-building conferences organized by the Professional College of Psychiatry

The idea underlying these guidelines is that long-term methadone substitution treatment is a form of therapeutic intervention which can be thought of as a symptomatic treatment of a chronic disease of opioid addiction, a therapy aimed at removing the organism's want of some opioid (substitution or diabetes model), and a medical intervention aimed at reducing further harm to patients regularly consuming opioids (the model of harm reduction). Methadone is the agonist agent of exogenous drugs with opioid content and its favorable pharmacological properties allow it to be applied for a

long period of time running, if necessary, to several years or decades. Long-term methadone substitution treatment is part of the tertiary prevention of drug addiction (prevention model).

There are two kinds of methadone treatment: 1. Methadone detoxication, 2. Long-term methadone substitution treatment.

1. Detoxication Through Methadone

Methadone detoxication takes place in two phases. In the first phase the opioid drugs with a short-term effect consumed by the patient are substituted by orally administered methadone with a longer effect. In the second phase the patient's dose of methadone, which is individually determined, is gradually reduced to nil possibly within a month, ideally in ten days, and maximally within six months.

2. Long-term Methadone Substitution Treatment

Hungary has recently seen the emergence of a stable population of opioid consumers who are in need of a long-term administration of methadone. In formulating and promulgating these guidelines the present meeting of representatives of Hungarian psychiatry and addictology wish to declare that we are hereby adopting a method of therapy for the above-mentioned population, which has been internationally tested, accepted and recognized.

An important fact about opioid consumers in need of long-term methadone treatment is that complete abstinence from opioids is an unattainable goal in their case.

The head of the establishment offering methadone therapy periodically (every six months) starts a project aimed at motivating patients to undertake to achieve a state of abstinence.

The Professional Requirements On Long-term Methadone Substitution Treatment are:
- professional control
- indication
- institutional framework
- efficacy control
- health insurance subsidies
- technology and safety of administration
- dosage

I. Professional Control

Decisions on long-term methadone substitution treatment are made by a team consisting of three members of the professionals working at the therapeutic establishment on the basis of considerations concerning previous history, clinical state, drug history and the patient's psycho-social situation. Two members of the team are required to be medical specialists; a medical specialist outside the establishment staff may be involved in the decision-making , if necessary. The third member of the team is an associate with higher education qualifications (a physician specialized in addictology, psychiatrist, family doctor or other qualified physician, psychologist, social worker, or consultant). Long-term methadone substitution treatment is indicated and conducted by a psychiatrist or adictologist after

completion of a special course (see Appendix). Every third month, a committee consisting of medical specialists from surgeries offering methadone treatment supervises the efficacy of treatments in progress and the necessity, or otherwise, of maintaining indication.

2. Indication

Several (at least three) years of evidenced dependence on opioids. Age above 18.

Dropping out of several repeated attempts at achieving abstinence on abstinence-oriented treatment programs. Repeated relapses in drug use ('relapse' means that consumption returns to the original level at which it was before achieved abstinence).

3. Institutional Framework

It is advisable to undertake to offer long-term methadone substitution treatment at drug outpatient units (methadone therapy clinics) where conditions in terms of personnel, equipment and safety are appropriate and where methadone treatment forms part of a complex addictological treatment regimen.

Alternatives for Medical Units Offering Methadone Therapy

- special methadone therapy center functionally related to psychiatric and addictological services
- methadone therapy department functioning as an organizational unit of a complex addictological service
- drug outpatient Clinic

4. Registration

Patients receiving long-term methadone substitution treatment are registered by the addictological service units engaged in methadone treatment. Registration is done in accordance with effective legal rules on drug security.

In addition, each long-term methadone substitution treatment begun at the unit is reported to the regional head addictologist.

The patients' data are entered into the national register on the basis of the public anonymity code. The register is run by the Jasz utca Drug Outpatient Clinic. The head of this establishment sends the national data and the quantity of methadone used per month to the director of the National Institute of Addictology and the Chief Pharmaceutical Officer.

5. Efficacy Control

Long-term methadone substitution treatment is a medical intervention which is administered subject to strict professional rules and which has to be supplemented by complex psychosocial intervention. An analysis of psycho-social factors is an ineluctable part of an assessment of efficacy. The psychological phenomenon of dependence must be approached by applying different techniques (e.g. group therapy, counseling etc.). After treatment has started, a reduction in the patient's drug consumption and some improvement in his/her psychosocial situation can be expected. It is advisable to monitor the quantity of drugs in the patient's organism by periodically administering random

urine tests (at least four times a year) as well as to ascertain the extent of social reintegration (work, studies, family life). The aim of drug monitoring is to serve as a means to make the treatment more effective rather than to check upon the patient's or the physician's achievement. Testing should be based on random samples, but it is suggested in every case in which the patient is suspected to be using drugs during the substitution treatment.

6. Health Insurance Funding

The detailed rules for subsidies are set out in the relevant legal provisions.

7. Technique and Safety of Administration

It is suggested that methadone should be administered exclusively in the form of a liquid (solution, suspension, tablet or powder dissolved in liquid). The first principle of administration is that the methadone should not possibly get into the patient's hands. Administration, therefore, has to take place daily and arrangements must be made in order that the substance should be administered in the presence of health care staff on bank holidays also.

Continuous and regular control is necessary during the entire period of the treatment.

For safe administration methadone should be stored at the methadone therapy units. Conditions of safety are to be created in accordance with effective legal rules on drug safety.

8. Dosage

It is up to the physician's judgement to determine daily doses of methadone on the basis of considerations specific to the particular patient. The dose to be determined is the minimum daily quantity sufficient to achieve the desired substitution result. In light of international experience (including the experience of Hungarian specialists) the average daily dose is 50-150 mg. The necessary minimal dose is built up by biological titration lasting several days by administering gradually increasing doses (according to the recommendation of international protocols 30+5 mg on the first day, increased by 5-10 mg each day.) Whether the appropriate level has been reached must be determined through clinical examination (psychic status, vegetative parameters), exploration, urine test and hetero-anamnesis.

9. A separate guideline is going to be laid down for the treatment of opioid dependent pregnant women, their newborn, those below 18 years of age and opiate dependent patients suffering from HIV, Hepatitis B or Hepatitis C.

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CHAPTER III

Social Work With Homeless Drug Users in the Street

The Experiences of the 'Street Front Section' of the Baptist Charity Service: December 2001–July 2002

This study presents the activity of the Street Front Section of the Baptist Charity Service, a form of organized social work which aims at reaching homeless drug users. Homeless drug users can, indeed, be described as especially difficult or problematic drug users with multiple disadvantages.

One of the foremost aims of this study is to offer the reader a vivid description of the way these people live, the problems they have come to wrestle with, and possible ways of handling their problems.

In Hungary there is no tradition of street social work with drug users, there is no protocol for it and, as a result, there are no descriptive studies. Street social work with homeless drug users, therefore, poses an entirely new challenge and is an entirely new area of activity.

In our work we started from the assumption that the subculture of Hungarian drug users had already forged its own identity, i.e. that, like in many other countries, there is a subculture of drug users which is marked by unmistakable characteristics of its own. Our work, then, is premised on the fact that drug consumption is a real part of society which involves risks and causes individual as well as social harm.

We have not the slightest intention of raising questions of moral judgment on matters related to drugs and the ideological issues surrounding the question whether a drug free society can be achieved. Drug users, in our understanding, are not criminals, nor victims, nor wretched creatures who have turned their back on God. In our eyes, they are simply human beings, ordinary people who live among us. neither better, nor any worse than ourselves. The only difference being that they have problems. These problems may be transitory, long-term, they may even last a whole life, they may be negligible, serious, severe or even fatal, and they may be stoppable or unstoppable. One thing is sure amidst this diversity: these struggling people must be given a helping hand, and in most cases this helping hand really can help.

FOUNDATIONS OF THE SOCIAL WORK IN THE STREET WE DO

Abstinence is not a precondition of being entitled to receive our services. Most problematic drug users are unable, or unwilling, to stop using drugs. One must wait patiently till it happens. Regular contact and the reduction of harm resulting from drug use may save lives because most drug addicts seriously want to give up using drugs once or twice a year. If the street worker happens to be present on such an occasion, his or her mission may come to be completed.

One can get rid of dependence on drugs but one cannot get rid of HIV, the hepatitis virus or a criminal record. Harm reduction as part of street social work thus aims at preventing HIV, hepatitis and criminal activity, achieving safer drug use and a more healthy lifestyle, preventing deterioration of state of health and the improving the drug users' quality of life.

The following could be the slogans which convey these aims:

If you use drugs, do it in a clean way, without infecting yourself and others
If you use drugs, choose the less risky methods
If you use drugs, choose the less hazardous substance

The goal, task and means of social work in the street among drug users are similar to those of street work with other target groups. The abilities and skills required are also identical to those indicated in guidelines for social work in general.

What is unique about street social work among drug users lies in its goals. These are to reduce the individual and social harm caused by drug use and to prevent an open drug scene from establishing itself. To some extent, therefore, street social work with drug users has a role to play and a task to fulfill which are different from those of the work done with other target groups.

Street social work among drug users, then, is a professional social service offered independently in the street which targets individual drug users and groups of drug users who have no institutional contacts and are not institutionally provided for. The methods of this kind of work include

1. early contact-making
2. getting to know the actual problems
3. early initiation of treatment, harm reduction, regular keeping of contact
4. integration into the network of provision.

Activities which are really available to us for the purpose of achieving these goals include the classic one called 'outreach' in the streets and mobile needle exchange schemes. Both services can function effectively only if they are conducted on an anonymous and voluntary basis. Another important requirement is that the drug users targeted by social work should feel safe in availing themselves of the service. It is a task for politicians and the police to create and maintain institutional conditions which will foster such an atmosphere of trust.

Street social work and needle exchange schemes are also designed to prevent an open drug scene from establishing itself. An 'open drug scene' is any place where drug consumption and all the related phenomena become concentrated in one particular, open public place. The emergence of an open drug scene, and its effects on hundreds, sometimes thousands of problematic drug users, is a phenomenon only too well known from the recent history of major Western European cities including Frankfurt, Barcelona, Maastricht, and Zurich. As a result of the first attempts to wind up open drug scenes, prisons got filled up, yet the open drug places could not be eradicated. Then, in the late 1980s and the early 90s, the city authorities came up with low threshold services which suited the demands of problematic drug users: street work, heated rooms during the day, drug users' rooms, needle exchange, hostel for the homeless, substitution therapy, and protected employment schemes. In short: services which were not premised on abstinence.

The Hungarian situation is different. Prisons are not yet full of drug users and although there are not thousands of problematic drug users swarming round certain public places, politicians are not yet fully aware of the extent to which severe measures of criminal law only suppress the outward manifestations of drug-related problems without solving them and thereby make it more difficult to handle and control them.

There is an increasing number of places in the capital, Budapest however, where problematic homeless drug users live in deserted, derelict houses, caves, summer cottages and stairways. There are also definite places where open drug use is a regular occurrence, e.g. roofs, lonely corners of parks, underpasses, certain parts of low income housing estates.

Although the numerical indices of drug use in public places cannot be compared to those of drug use in the above-mentioned cities of Western Europe before the introduction of harm reduction measures, open drug consumption is undoubtedly present in Hungary. The regular helping presence of street social workers may prevent the spread of various infections and viruses and the growth of the target group. The street social worker is often the drug users' only contact with the world from which he or she once started out. so one of the most important functions of the street social worker is mediation. The street social worker may mediate between

- the individual and his/her immediate environment
- individual demands and the opportunities offered by resources and helping organizations
- the given subculture and actors in the social policy and drug policy line
- the given subculture and society at large

Beyond their role as mediators, street social workers also have other roles. These include

- problem-solving: cooperative effort with the client according to definite rules
- offering consolation and support: often the street social worker is the only person who will listen to the drug user
- enabling: many of our clients think – often driven by despair – that they will never be able to give up
- teaching: there is no such thing as safe drug use, drug use will always involve some risk, but a more healthy way of life, safer drug use and e.g. safer sex are attainable goals and learnable forms of conduct
- representing: most problematic drug users are unable to manage their affairs on their own, so they need to have their own interests represented by someone else
- influencing: facilitating personal development
- mirroring: making it possible for the drug user to face the realities

All this adds up to what is called the helping role. Ideally, the helping role comprises all the above skills.

The Tasks of Street Social Work Include

- protection of life through donations of food and clothes, needle exchange and prevention of HIV and hepatitis
- regular contact, providing motivation to give up or adopt a more appropriate lifestyle
- strengthening the sense of responsibility
- drawing attention to possibilities and abilities
- strengthening problem-solving, problem-handling and decision-making abilities
- mapping the network of contacts
- provision of information

- facilitating social integration
- furthering the maintenance of family and social relationships
- assistance in handling finances
- assistance in the conduct of everyday life
- reduction of prejudices
- prevention of crime
- individual handling of cases, managing of social affairs

In street social work with problematic drug users abstinence can be set as a long-term goal only. The primary goal is not to achieve immediate abstinence. It is to try and improve the client's eating habits, get him/her to take time to get things sorted out in his or her life, and to make him/her feel a bit better.

In summary, helping activity among problematic drug users primarily aims at the protection of life and may last until the previously defined goal (harm reduction, securing of donations gifts, substituting lost documents, restoring family relationships, settling of individual personal problems, finding employment, finding housing, rehabilitation etc.) is achieved, or longer. It is primarily in his role as a helper with individual cases and with tasks involving contact with offices that the social worker can achieve these aims.

What we describe as 'individual handling of cases' is a form of help which is tailored to the individual's needs and given situation and is based on skills involved in the street social worker's usual roles and tasks. It involves social liaising which is closest to the role of mediator, i.e. is an intervention with the aim of acquiring the external resources and support which the person is entitled to receive.

Street social work done among problematic drug users, like social work with other target groups, cannot be conceived of without a cooperative background of institutions.

STREET WORK IN PRACTICE

For the first six months, we financed our outreach activity from our own resources. After that this part of our activity was supported by the Budapest Municipality, and after that by the Ministry of Child and Youth Care and Sports and the Ministry of Health, Social and Family Affairs. We launched our mobile needle exchange scheme in September 2002. It would be too early to summarize the experiences we have had in this part of our activity.

Our first step was to try and find partners. We contacted a group of street social workers in the town of Tatabánya who had great experience , the leading officials of Budapest Police Headquarters and the Civil Guard, we signed a cooperation agreement with the Civil Drug Prevention Foundation and the street workers of the Blue Point organization, and built up a relationship of close cooperation with the Shelter Foundation.

Our street workers always work in pairs. Equipped with mobile phones, they can easily make arrangements on the spot.

Stages in the Street Work We Do

- Preliminary Mapping of the Budapest Drug Scene

In September 2001, in cooperation with our partner organizations we started mapping the areas in Budapest where homeless drug users could be expected to be found. We sought out and visited

the most likely spots of such activity and arranged for the constant presence of some of our associates in these places. We looked for signs of drug consumption such as thrown-away medicine bottles, wrappings, phials, plastic bags with traces of glue sniffing, bottles of diluent, syringes, spoons, burnt beer cans and, last but not least, the people in need. We searched through low-rent housing estates, deserted areas of the city, underpasses, railway stations and the major parks. We searched through caves, shanties, uninhabited derelict buildings, cellars and in public places.

We did find groups and individuals who were using drugs and were in need of everything (clothes, shoes, food, accommodation, hospital treatment, rehabilitation, human relationships, money, care and something to do), but were ready to give up any of them to satisfy their utmost need for the drug.

At the same time we started our teamwork and worked out its professional foundations.

- Securing regular presence in the places identified

We started our outreach service in October 2001 with the help of a staff of five street workers, trying to secure regular presence and the possibility of making contact with us in the places previously identified. Profiting from the contacts we already had we tried to reach out to new patients. This process is still going on.

We distribute food, hot tea, vitamins clothes and food in the places we regularly visit.

- Reducing the individual and social harm caused by drug consumption

- Provision of information about the short and long-term effects of various drugs, drug-related risks, harm, infections (AIDS, hepatitis, skin infections) the way they can be reduced or avoided, the access to drug aid establishments, establishments offering help to the homeless, and their services, safer drug use, safer sex and healthier way of life.
- expert collection of refuse syringes

- Crisis Intervention

The majority of disadvantaged difficult homeless drug users live in deserted ruinous houses, out-of-the-way places, tents, caves, in dangerous conditions. Their lives may also be threatened by overdose on drugs. The regular presence of street social workers in these places makes possible even instant intervention in situations posing a life hazard.

In our work we often meet with glue sniffers who have suffered burning injuries. The enjoyment of organic diluents by naked lights (smoking, cooking) may also pose a life hazard.

- Establishing a Helping Relationship

Establishing a helping relationship is one of the aims of street social work. One of the conditions of the helping relationship is regular contact-keeping and cooperation. The helping relationship organizes itself along the demands of individual case handling and liaising between the problem person and social institutions.

- Facilitation of entry into various helping establishments

The greatest success in street work is to secure for the person access to a helping establishment – such as a public bath, a needle exchange scheme, a drug outpatient surgery, hospital, rehabilitation

center, legal aid service, homeless hostel, the information center for the homeless, a protected job, the employment center, the job agency etc. – or to effect the person's reunion with his or her family.

A CHARACTERIZATION OF THOSE USING THE SERVICE

Our clients are people with no hope or a conception of the future. They do not normally have a job so they eke out a day-to-day existence from begging, sorting through garbage bins, forging prescriptions, prostitution, drug distribution and petty thieving. Most of them gang together in groups of 2-5 or 10-15, and spend their days and nights together. We have more or less regularly found young persons with apparently orderly family backgrounds stringing along with these groups.

We also have clients who sniff primarily organic diluents and live alone usually in caves, deserted derelict buildings or stair-halls. In addition to their dependence on the substance, many of them have some sort of psychiatric illness. Many of our clients had grown up in state-run child care establishments who partly or completely without a family background. Homelessness may also result from a highly problematic relationship with the client's family, but such a strained relationship may sometimes be the result of the patient's drug consumption.

These groups of homeless drug addicts are held together strongly by the sense of a common fate and a common life situation. The most strongly desired aim in this atmosphere is to 'freak out' as hard as possible and to share the personal experience of one's situation and addiction with the equally addictive mates rather than to stop and live free of drugs. The members therefore confirm each other in their commonly undertaken trips rather than in stopping. All groups have some leading personality, usually loud 'big mouths' with extravagant habits who are indispensable for the existence of the group because of their skill in forging prescriptions, getting the stuff and organizing the social life of the group. They can rarely be found in a sober state and we often hear them say 'we can't be helped any more'.

Most of our clients have tried to commit suicide several times.

The internal cohesion of the groups and the forceful influence of key figures thus make it very difficult for group members to drop out or to stop. This difficulty is exacerbated by the further fact that these people think of official establishments which offer treatment (hospitals, rehabilitation homes, reintegration establishments) as beyond their reach. As one of our clients put it: 'no ID, no health insurance card, no appropriate clothing or toilet requisites, because there's no money, no cigarettes, because they cost money, because there's a waiting list, and because I don't know what to do afterwards, come back to the streets'.

99% of our clients have no contact whatsoever with helping establishments. The remaining 1% use the services offered by needle exchange schemes.

All in all, our clients are difficult drug users with multiple disadvantages. The defining characteristics of their situation are serious dependence, both physical and mental, insufficient nutritional and hygienic condition, prostitution, infections (TB, HIV, hepatitis, skin infections, financial and social problems, loss of old friends and relationships, a sense of life as a haphazard succession of events, an altered state of consciousness, impaired ability to work, unemployment, stress, depression, a variety of psychiatric problems, literal pennilessness, homelessness, and criminality. The attainment of an

altered state of consciousness, i.e. the trance caused by drugs, has become a primary need, a part of their personality, their metabolism, and their everyday life.

These people are more than simply homeless. The multiple nature of their underprivileged status is a result of the fact that their addiction deprived them long ago of the ability to initiate action when they want something and to see to getting it, and, on the other hand, the fact that the institutional network serving the homeless or the drug addicts is unable or unwilling to undertake to deal with the special mixture of problems and disadvantages their lives present.

Our clients often complain of maltreatment by policemen, and of negative discrimination due to their status as homeless, in hospitals and rehabilitation centers.

DRUG USING HABITS, STATE OF HEALTH

Homeless drug users typically use several kinds of drug together at the same time. The most frequent combinations used by these addicts are organic diluents and alcohol, alcohol and medicaments, opiates and medicaments, all of which is often supplemented by marijuana, heroin and amphetamines. We have found only one or two instances of the use of cocaine. Our clients find it relatively easy to switch from one substance to the other, depending on what they can get.

Sharing syringes and needles is common practice among our clients. 90% of our clients are infected with hepatitis, and one of them claims to be HIV infected. “I am normally the last to stab” he told us with a wry smile.

Tuberculosis, like the deep abscesses resulting from intravenous drug use, are also common. The state of health of our clients is further characterized by malnutrition, the lack of hygiene and a variety of skin diseases and parasites.

COOPERATION

We have had very different impressions of the willingness of our clients to cooperate with us. This willingness depends as much on their actual state of mind as on their motivation. It is impossible to conduct a helping conversation or mediate between the client and some office when the client is fighting withdrawal symptoms, ‘freaking out’, totally under the influence of a drug, trying to get his daily dose or hungry.

At one extreme we have a politoxicomane patient who besides receiving food and clothes donations, asked us to help him replace his lost personal documents but we have been unable to even start the replacement procedure because he either did not turn up at the time arranged or we found him in a state which made cooperation impossible.

At the other end of the scale we have had a young male homeless heroin addict with whom we were able to make the first steps in the helping relationship after the very first conversation. Our client then successfully completed a detoxication treatment at a hospital, and is now in a rehabilitation center and in regular contact with us.

ESTABLISHING AND MAINTAINING RAPPORT, WORKING METHODS

Lack of trust and a sense of rejection is a common experience with new clients. But the distribution of donations and the influence of contacts we already have are a great help in taking the edge off these manifestations.

Generally speaking, the members of our target group, after a certain degree of trust has been built up, are happy to see us visiting them, happy to receive our gifts and more willing to ask help with their various practical problems.

In one case we were asked by a parent to help with his/her child 's problem of homelessness and drug addiction.

In gathering information about groups of clients we also mapped the pharmacies near the gathering places of our clients' groups. We were trying to find out where the greatest weekly number of disposable syringes were sold. There are pharmacies in which syringes are not sold and the staff refused to answer our questions, but we have also experienced the contrary attitude. There were clear signs that pharmacies near our clients' meeting places were more frequented than usual, and we can clearly tell the areas which are more 'infected' from those which are less infected. Our conversations with the managers of pharmacies revealed that pharmacists found mobile needle exchange schemes a good idea and were looking forward to their introduction. Several pharmacies promised to give out a flier with every syringe sold informing intravenous drug users that they should use the services of a mobile needle exchange scheme which offers them complex help.

On our exploratory walks we surveyed railway stations, underpasses and parks for thrown-away syringes. Street sweepers find one or two syringes in these places every day, but there are underpasses where they find five or six or even more. There are very few parks without thrown-away syringes and their number varies.

One of the more special aspects of our activity is the work we do in drug addict's flats. It is an important fact about homeless drug users that many of them live provisionally or permanently in the flats of their drug addict friends and that they migrate from one flat to the other, which makes their route difficult to trace. Although we have no precise numerical data, the general impression is that the number of these drug users is growing. Most of these people are opiate addicts and they are generally speaking difficult to motivate because they have a place to live in, even if it is temporary.

Most of the useful information we get in our work we get from members of the target group. By now they are no longer afraid to tell us where they spend their nights and where we can find others like them who need our help.

HOW THE SERVICE WE OFFER FITS IN WITH THE MAIN AIMS OF THE ORGANIZATION AND THEIR REALIZATION

The Baptist Charity Service is committed to helping homeless people in general and drug addicts in particular. Based on our experiences in street work and international examples, we have elaborated plans for an institutional network which in our opinion would be capable of effectively handling the problems we have identified.

Elements of this plan include

1. street social work and needle exchange services
2. heated rooms during the daytime for the homeless and a hostel for the homeless, with activities, food and a background of health care services
3. a residential center for addicts

Our street experience and especially the great number of syringes and needles we found in public places such as parks, sandpits, underpasses etc., inspired us to extend our street activity by launch-

ing a mobile needle exchange service. Our initiative was financially supported, via a successful application, by the Ministry of Child and Youth Care and Sports and the Ministry of Health, Social Affairs and the Family, so we were able to start our mobile needle exchange project in the capital at the end of last summer.

Without an appropriate institutional background, street work can only play the role of a 'fire extinguisher', so one of our main aims is to establish a facility in which we can offer shelter as part of a complex of services to homeless people in general and drug addicts in particular. On January 1, 2003 we are going to open a new establishment, a residential home for addicts in a 150 square meter house with a garden, owned by the Baptist Charity Service, which will probably be fit to receive ten persons.

The Baptist Charity Service wishes to operate a comprehensive scheme designed to counterbalance the adverse conditions of life under which homeless drug addicts suffer. Street social work and participation in the needle exchange scheme are thought of as the first step toward full entry into the system. The daytime and residential facilities we are planning and the residential home for addicts with its system of cumulative services stand a good chance of offering realistic solutions and a long-term perspective to our clients.

THE JUSTIFICATION FOR THE SCHEME, WAYS OF MEETING LOCAL NEEDS IDENTIFIED

The work begun by the Baptist Charity Service was originally motivated by the recognition that the closing of the provisional accommodation facility in Tündér utca meant the complete disappearance of residential provision for homeless drug addicts in the capital. Our decision was also influenced by our awareness of the fact that there was no other organization aiming specifically at helping homeless drug addicts in the entire area of Budapest. Last but not least we thought, indeed we knew, that addicts could give up only if there was motivation and street work seemed the only way to provide that motivation. Our aim is to provide our clients with motivation and foster that motivation until they reach the state of abstinence and even after that, i.e. during follow-up care. This is possible only if regular contact is kept up, i.e. regular outreach through street social work.

Besides still working to map the Budapest drug scene, we have been providing help to people with the following needs:

- Liaising with hospitals to get our clients into detoxication treatment, liaising with rehabilitation homes to arrange for our client's entry, attending our clients to admission interviews, searching for lost relatives with the help of the Red Cross, replacing missing IDs, social insurance cards, birth certificates, transportation to health care establishments for X-ray lung screening, to public baths, distribution of blankets and other donations, help with the disability pension procedure, transportation to places of needle exchange, bandaging wounds, help with the admission procedure to hostels, information about and help with the procedure for obtaining financial relief and aid, help with the 'new start support' procedure for persons who have grown up in state-run child care homes, help with HIV and Hepatitis screening procedure, help with dog vaccination, visits at hospitals and rehabilitation centers, provision of information about where and how to get various kinds of aid and relief.

NECESSARY INFRASTRUCTURE, EQUIPMENT AND PERSONNEL, IDEAS FOR DEVELOPMENT

Besides providing social workers, one clerk, a car, an office with computers and a conference room, the Baptist Charity Service regularly secures new donations. For some time now, our permanently employed staff have been occasionally helped by two college students and a few volunteers.

The main idea underlying our views of possible development is to build up the above-mentioned complex of institutions. Our short-term goal is to extend our mobile needle exchange service so as to tailor it to the needs of street social work and .

We are also thinking of buying bicycles so that our street workers can get around the town more efficiently, which would leave them with more time to spend on work on the spot, to cover greater areas with greater attention and needle collection and mapping typical drug scenes could also be done more efficiently.

We are also thinking of launching a research project to find out about the number of homeless drug addicts, their life situation, their needs and their habits of drug use.

FORMAL, TEMPORAL AND SUBSTANTIVE CHARACTERISTICS OF THE SERVICE

During the first few months, which were taken up by the mapping of the Budapest drug scene, we were working – as most people do – from nine to five. Later however, in order to be better able to adjust to our clients' lifestyle, we changed this system and now we are working from 1 p.m. until 9 p.m. Our working days always start with a team briefing, at which we discuss experiences we had during the previous day and distribute the tasks for the day. Our street workers make records of each working day. The quality of our work is greatly enhanced by supervision sessions, which are held every second or third week. Supervision is designed so as to emphasize the building of staff, efficiency of internal communication, outsider's control over the work we do, internal training and the building up of contact with our clients.

SUMMARY

The Number and Age of Those Provided For

We have been to a hundred or so spots in Budapest over 200 times. These included spots where we have only been once. We have made helping contact with 67 persons and talked to 150 or so people whom we asked for help in getting to know local conditions. We have talked to policemen, street sweepers, keepers of public areas*, dog-walkers, park attendants, keepers of pubic lavatories, caretakers, pharmacists and a lot of homeless persons.

Most of our clients have been men between 14 and 50 years of age.

Efficacy and Efficiency

It is very difficult to measure efficacy in street social work and helping work in general. The efficacy of what we do normally depends on the state of our clients there and then and the level of their motivation. Success can be of several kinds. If they are willing to talk to us and accept our gifts, that is already a kind of success. More serious success consists in the building up of an atmosphere of trust and our clients' willingness to share their personal problems with us. Great success and achievement

**** Keepers of public areas in Hungary are employed by local authorities to secure the proper and orderly use of public areas, places and buildings.***

is when there is a regular contact and the helping process gets under way. The fullest degree of success – a degree which is not attainable without the clients' maximal cooperation – is assisting the client in giving up, helping him or her to get prepared for hospital treatment, attending him or her to the admission interview and subsequent visits and contact-keeping.

Of our 67 clients we have helped four to get to hospital, one of whom is at present in rehabilitation treatment. We have visited our clients in hospitals and rehabilitation centers 15 times. Three of our clients went to admission interviews but did not get any further, for lack of motivation, so their problems remain unsolved. One of our clients died of an overdose on the night before he was to have gone to hospital.

We have collected 278 used syringes, needles as well as possibly infectious accessories of intravenous drug use such as spoons and filters in playgrounds, parks and out-of-the-way corners of housing estates. Most of the thrown-away syringes were found in the area of the major housing estates of the city.

CHAPTER IV

Needle Exchange Programs in Hungary[1]

INTRODUCTION

Needle exchange schemes are low threshold services which do not require that the drug user should be registered in the health care system as a patient under treatment. These services are marked off from traditional forms of treatment also by their objective: they have reducing the harm inherent in drug use as their aim rather than achieving abstinence on the client's part.

Needle exchange schemes in Hungary are of two kinds. Under one kind of arrangement, clients get as many injectors as they bring or are expected to bring back a certain percentage of the needles obtained. The other arrangement emphasizes the provision of sterile equipment without making its service conditional upon the return of used equipment. Services may further differ in terms of whether they concentrate exclusively on needle exchange or provide other services of a supplementary kind. All needle exchange schemes run in Hungary try to offer complex services which usually comprise the following:

1. sterile equipment for the prevention of HIV and hepatitis and accessories necessary for safe drug use (mop, tourniquet, ascorbic acid, filter, water container etc.).
2. condoms for the prevention of sexually transmitted infections such as venereal diseases, HIV, hepatitis;
3. ointments, and information about safe stabbing, for the prevention of venous inflammations,
4. vitamins and calcium tablets for the improvement of intravenous drug users' state of health.
5. various information leaflets, brochures etc. which provide information about harm reduction services, establishments at which treatment is available, access to these services etc.

There are altogether six needle exchange schemes operated in Hungary at the moment, two in the capital, the other four in four country towns. One of these, in Budapest, operates on a mobile basis (see Chapter III.), the others are either offered in Drug Outpatient Clinics or in other establishments independent of clinics.

Government support for the low threshold services are coordinated by the Ministry of Child and Youth Care and Sports. Government support is the only funding arrangement for these services in this country at the moment. This being so it is the political task and responsibility of the government at any time to uphold, and possibly extend, approval of harm reduction schemes in general and needle exchange schemes in particular.

MINISTRY OF CHILD AND YOUTH CARE AND SPORTS

The first written document on the harm reduction approach to handling the drug problem was the 'National Strategy for Fighting Back the Drug Problem', issued by the Ministry of Child and Youth Care and Sports in 2000. Colloquially called 'the National Drug Strategy', the document enunciates the basic conceptions of the anti-drug strategy of the then government, with a separate chapter devoted specifically to the task of institutionally grounding harm reduction practices in Hungary. This is how the concept of harm reduction is described in the very first few statements made in the doc-

1. We received great help to the collection of the materials on which this article is based from the following persons: Judit Honti (Szeged), Ferenc Köves (Pécs), Lajos Pesti (Veszprém), Margit Tarnóczky (Miskolc), and Ilona Veres (Budapest). We are greatly indebted to all of them.

ument 'The essential point of harm reduction methods is to reduce the harm caused by psychoactive substances to both the individual and society at large.'

The document also undertakes to define short-term goals, i.e. goals for 2000–2002. These include plans for developing and supporting outreach schemes (low threshold harm reduction schemes) and the building up of a network of model institutions. The central organ responsible for the implementation of the tasks set out in the National Drug Strategy is the Coordination Committee of Drug Affairs. It was to promote the activity of this establishment that the Ministry of Youth Care and Sports (since May 2002 called Ministry of Child and Youth Care and Sports) set up its state secretariat responsible for drug coordination which started its activities in 1998 under the leadership of the vice state secretary who is still in office at the present day.

One might wonder how the vice secretary responsible for drug affairs sees the situation of harm reduction services in general and needle exchange schemes in particular three years after the establishment of the office. How does he assess the work done by the state secretariat whose task has been to coordinate the funding of these schemes? In what follows I will summarize the main points of an interview which he gave to us in November 2002.

The vice state secretary thinks professionals have by no means all but most of the means for practicing harm reduction at their disposal: there is street social work, there are advisory services, needle exchange schemes, and a protocol for methadone treatment was recently drafted and legally regulated in 2002. Although these schemes and the institutional background necessary for their functioning run at a very low capacity, it is nevertheless true that their number has been growing recently.

The supporting system of the "drug ministry" rests on two pillars: tenders and scheme grants. The Ministry has been supporting low threshold services through tenders since 2000. Despite the fact that the Ministry of Child and Youth Care and Sports could divert several million HUF of its slice of the budget a year to supporting the reduction of harm caused by drug use, there are not enough civil associations engaged in harm reduction for any ministry to support. In this connection, the vice state secretary pointed out that the legal regulation of these schemes in Hungary was in good order because the State Public Health Office can already interpret the notions of a needle exchange scheme and of a methadone scheme. (The State Public Health Office is the central government organ which makes decisions about permissions for such schemes.) The Professional College of Psychiatrists issued its statement on 'Professional Guidelines for Needle Exchange' in 2000, and methadone maintenance treatment and its funding was legally regulated in the spring of 2002. The vice state secretary thinks the extent to which the profession can represent these interests depends on the professionals themselves since only they are in the position to exert pressure on decision-making bodies.

As far as needle exchange schemes are concerned, the ministry responsible for drug affairs elaborated a program called '4+1' for the realization of short-term objectives. This consists of the following elements:

1. needle exchange schemes should be accessible to intravenous drug users every day of the week
2. support for 'outreach' schemes.
3. launching mobile needle exchange schemes.
4. acquisition of needle exchange machines

+1. needle exchange in pharmacies

The Ministry decided to develop needle exchange automata and mobile needle exchange services in 2002. Two needle exchange automata have already been purchased from German manufacturers and are to be installed in the near future outside two therapeutic facilities in Budapest, as yet unidentified, after a Swiss example. The automata will be run, re-filled and maintained by the nearby therapeutic facilities. The Ministry's long-term goal is to make needle exchange automata available in many places where there are no such services. The above-mentioned two automata give, in exchange for 20 HUF (0,08 EUR), a sterile injection set, a mop, a condom and an information leaflet about safe drug use and the whereabouts of therapeutic facilities. It has been suggested that ascorbic acid should be included in the package but the State Public Health Office gave no permission. Despite criticisms voiced against needle exchange automata (the lack of personal contact, insufficient safety) the vice state secretary is of the opinion that there is a need for this kind of service, primarily in order to cater to the needs of those drug users who have no contact with therapeutic facilities for some reason or other.

The vice state secretary spoke with a sense of satisfaction about the fact that with the Ministry's assistance the first mobile needle exchange scheme was launched in September 2002 and that a civil association is going to start a similar scheme in the near future, thanks, again, to the Ministry" assistance.

It is a well-known fact that pharmacy assistants are often reluctant to serve intravenous drug users turning up in pharmacies to purchase sterile needles and syringes. This problem is going to be settled in the future as the Hungarian Chamber of Pharmacists is going to launch an education project targeted specifically at pharmacy assistants.

The Ministry is determined to support already running needle exchange schemes and is going to support new ones.

The Ministry's long-term plans also include the launching of other harm reduction schemes. The Ministry supports e.g. a suggestion made by the head of the Baptist Charity Service for the establishment of a Safe Injection Room and they are also willing to finance a civil initiative aimed at creating the possibility of examining extasy tablets possibly under conditions of anonymity.

The Ministry would also like to start in Budapest a Drug Ambulance Service specifically designed to offer emergency treatment in reported cases of overdose and a mobile screening station offering facilities for screening primarily sexually transmitted diseases (HIV/AIDS). However, to the question whether the Ministry has a crisis scenario for the contingency of a sudden burst of AIDS epidemic among intravenous drug users, the vice state secretary told us that it was a task for the Ministry of Health, Social Security and the Family and that as a result the Ministry of Child and Youth Care and Sports had no strategy for that eventuality.

DRUG PREVENTION FOUNDATION – BUDAPEST

The needle exchange scheme presently run in the basement of a building situated in the inner city was the first among needle exchange schemes in Hungary to undertake to launch such a service. The present leaders of the scheme thought already in 1990, a time when the 'underground' drug consumption of previous years gave way to an increasingly obvious awareness of the proportions of the problem, that an adequate response had to be found to meet the challenge of the drug problem in general and that of intravenous drug se in particular.

The first idea that pointed beyond the shared contemplation of possible remedies to action came

from the mobile preventive services that had been run in the West for several years then and the idea was supported by the liberal municipal authority. The 'Drug Bus', which has been running ever since, was started in 1993 with the help of the Budapest Municipality. Originally campaigning 'officially' for the prevention of drug consumption (with the associates in the bus dressed in the blue coats reminiscent of the socialist era) the bus service soon adjusted itself to the demands and tastes of the target group – schoolchildren and students – and came to be covered with the graffiti made by the target individuals themselves. This was when the bus began to fulfill the role it was designed to fulfill, namely of providing candid and useful information which lead to a genuine contact being built up with the students whom they met. The Budapest campaign which became widely known under the name 'Do not lose your head' did a lot to introduce the Drug Bus to a great many more members of the public. Over the past ten years the Drug Bus has propagated its underlying preventive philosophy to a great number of schools in and outside Budapest. The service has been funded by the capital authorities, and much of these funds has gone to the service itself rather than the associates who, as is so often the case with harm reduction schemes in Hungary, have been doing their work for very modest remunerations.

The year 1993 was an important year in the process toward the introduction of needle exchange schemes, being the year when the number of syringes thrown away by an increasing number of intravenous drug users in public places had risen so sharply that it spurred some deeply concerned and devoted associates of the Drug Prevention Foundation to action. Their determination was further confirmed by the accidental contact they hit upon on the Internet, with a Swiss dentist who helped them to a Swiss state grant, with the help of which they were finally able to start a needle exchange scheme two years later. At the beginning of the road leading to needle exchange stood the HIV/AIDS prevention project undertaken by the Prevention Foundation, an interest representation organization for the homosexuals which was still in active in 1993. Between 1993 and 1995 the Swiss government was looking specifically for a Hungarian organization for the prevention of the spread of the virus and found it in the above-mentioned civil association. After the project for the prevention of the spread of the virus was launched, negotiations about the possibility of starting a needle exchange scheme to be targeted specifically at intravenous drug users, also started in 1994. The talks with the representative of the Swiss government lead to an agreement under which the Swiss government undertook to support the project for two years on the condition that those in charge of the project would find a Hungarian supporter for later years while the project was being financed from the Swiss grant. After this in 1995 the first official needle exchange scheme in Budapest started in a basement in the inner city of Budapest.

In accordance with the protocols, the scheme has been run on an anonymous basis from the very start. The Swiss government stipulated that the associates should get back 75% of the needles distributed.

Although the needle exchange scheme received great publicity in the press, it took several months for the first drug users to 'gather up the courage' to enter the place. This delay was due to the strong antipathy toward drug consumers – especially those involved intravenous drug use –, the public image of drug users as somehow illegal, to the resulting fear, to the novelty of the service and to the lack of experiences.

In view of the fact that drug consumption in Hungary today counts as a crime and in addition the concept of harm reduction was unknown in 1993 to society including the police, for a long time, the

police did not know what exactly they were supposed to think of harm reduction. It is therefore not surprising that in the beginning the police saw itself obliged to watch the drug users turning up outside the building in which the service was offered. This lead to the unfortunate incident a few months after needle exchange was launched that several intravenous drug users were arrested during a police raid near the premises. This put the associates of the needle exchange scheme in an awkward situation because the incident understandably lead to a great loss in trust toward their service among their young clientele. The solution finally came in the form of an agreement negotiated between an attorney of the Hungarian Civil Liberties Union and the District Chief of Police and signed by the latter, in which the police undertook to abstain from any police action, indeed presence, affecting the clients of the needle exchange scheme. The agreement laid down also that the social workers taking part in the scheme (who were already engaged in active street work) would be registered by the police and be given identity certificates in order to prevent unjustified police action against them in the future. This was an important step, with a number of lessons for the future work not only of associates of the Drug Prevention Foundation but equally for harm reduction schemes to be launched later on.

In the winter of 1995 the number of services offered by the needle exchange scheme was extended . Adverse weather conditions gave associates the idea of handing out hot tea to the clients in addition to the usual exchange of needles and syringes. This soon lead to a general relaxation of the atmosphere at the exchange place, which made it possible for social workers (who had become increasingly open toward the young drug users' problems) to provide young clients with information about all sorts of problems they apparently had. At that time the exchange scheme had Outpatient Clinic for two hours three times a week

By two years from then certain changes had matured. It had taken the Foundation two years to convince the Capital Municipality of the importance of needle exchange, as a result of which the Municipality undertook, from 1995 on, to support the scheme with a million HUF a year. Running costs (rent, purchase of equipment etc.) have been covered from these funds ever since. Funds from the Swiss government stopped, as originally agreed. The Ministry of Youth Care and Sports was founded in 1998 with its secretariat responsible for the coordination of drug policies and it did not take long until it introduced its system of tenders for supporting civil associations which would undertake harm reduction.

In the same year the Drug Prevention Foundation moved to another basement in another inner city district. Thanks to support from the Ministry of Youth Care and Sports (1,5 million HUF – 6000 EUR – in 2000) the new premises were redecorated after six months and the foundation, now with a wider circle of clients, was able to adjust to the new demands of a now wider circle of clients and to continue as a social contact scheme. (They have been offering facilities for washing clothes to those in need.) The opening times of the needle exchange scheme also changed at this time to two hours a day five days a week and the range of their activities already comprised nearly all forms of assistance in practical matters. For instance, associates of the needle exchange scheme help clients with such matters as getting the social insurance card, arranging admission to a rehabilitation establishment or to hospital detoxication treatment. By this time, the scheme had become well known in the capital, there was a formal as well as an informal network of relations functioning smoothly and the circle of clients had also grown.

In 1999 the serious negative effects of tightened-up criminal legislation came to be felt in the form

of a decrease of general 'turnover' at the facility. This is shown not only by the stagnation in the number of clients presenting for all sorts of service (270 persons in 1999, 307 persons in 2000, 287 persons in 2001) but also in the number of syringes given out and brought back.

Year	Number of syringes handed in	Number of syringes handed out
1995-1996	40477	55418
1997	13876	20261
1998	25453	28173
1999	39023	45590
2000	20966	35684
2001	10515	15499
Until the end of October, 2002.	3806	9938

The Ministry of Youth Care and Sports supported the scheme with a grant of 2 million HUF (8000 EUR) and it also offered to finance 24-hour operation, which, unfortunately, the Foundation could not undertake because of insufficient number of staff. As a compromise, opening hours were set at six hours a day every day of the week. As before, this practically meant duty hours in the evening which the associates distributed among themselves. This is still the order of everyday operation at the facility.

In the year 2002 the Ministry of Child and Youth Care and Sports has supported the scheme with a grant of 7 million HUF (28 000 EUR). The scheme is now operated by ten associates, most of whom have some sort of qualifications related to the work they do (social workers, addictologists, consultants), but there are also teachers and sociology students among them. Two of them have attended a course in ear acupuncture so they can help those who wish to give up by alleviating the pain they experience as a result of withdrawal.

Since 2000 the social workers on the scheme have been handing out 300-400 needles a month to Roma intravenous drug users at the housing estate in Illatos út, 50% of which amount is usually returned. This part of the activity of needle exchange is of special importance, being targeted at the most marginalized and segregated segment of society. It is a sign of the success of the efforts of the past two years that the Roma are already turning up occasionally at the basement facility in the inner city and are showing increasing interest in both the needle exchange and the supplementary services.

Another 'achievement' of which the associates on the Drug Prevention Foundation's scheme are proud is the fact that their activity has served as a model for almost all needle exchange services which were later organized. This gives them a sense of importance in a general atmosphere which was captured by a remark made by the leader of the service: 'There are colleagues working with young drug users who say their conscience forbids them to administer harm reduction services to them.'.

The Foundation cooperates with all civil associations engaging in needle exchange, supplying most such associations with the sterile equipment needed for their operation. As a result of their efforts there are quite a few persons, formerly intravenous drug users, who have gone into detoxication therapy and rehabilitation and some of them have since married and successfully reintegrated into society.

SOUTHERN HUNGARIAN HARM REDUCTION ASSOCIATION – SZEGED

The needle exchange scheme in the town of Szeged was launched in 1992 by associates of the Dr. Farkasinszky Terézia Youth Drug Center in response to frequent reports from an entertainment establishment frequented by young people which informed associates of the great number of syringes thrown away on and around its premises.

From 1992 to 1999 the needle exchange scheme was operated as part of, and in the very building of, the Drug Center until in 1999 associates founded the Southern Hungarian Harm Reduction Association in the hope that a separate legal and organizational entity would be better able to serve the goals. The Association is housed in the same building.

The Association's original protocol allowed for a scheme which was restricted to the exchange of syringes and needles, but as years went by the scheme tried to adjust to the needs of the clientele. As secondary needle exchange was more and more emphasized, today syringes and needles are not only exchanged but are also given out. The flexible working hours of the social workers on the scheme respond to the needs of secondary needle exchange, who are prepared to work practically any day during the week so as to be able to respond flexibly to the needs of drug users. Besides the street work, needle exchange is made available at the Drug Outpatient Clinic 8 hours a day five days a week. This is primarily important for the secondary needle exchange as it often happens that a drug consumer arriving from a smaller place in the country who does not know the social workers of Szeged seeks the service offered at the Drug Center taking sometimes as many as several hundreds of needles which he then distributes among the intravenous drug users in his home town or village. Associates of the Center , knowing the law, do not expect these youths to turn up with hundreds of used syringes on them at the Center exposing themselves to the risk of a police check of identity and the embarrassment the discovery of the syringes might involve. Social workers are fully aware of the negative image of their clients in the public eye and of how embarrassing it may be for their clients to have their social status publicly revealed before police. Despite these difficulties, and thanks to their efforts to spread information about the dangers of sharing equipment, 70% of the needles handed out have been returned to them.

At present there is a 6-strong staff engaged in needle exchange in the street, some of them former intravenous drug users who have had the strength to stop. Their presence is a great boost to the efficacy of street work, the leader of the scheme thinks. In fact, the team try to involve former drug users whom they know to have many personal contacts with drug users. All associates are equipped with mobile phones, which makes it possible for intravenous drug users in need of sterile needles and syringes to contact them.

Street social workers usually take 100 sterile syringes from the Drug Outpatient Clinic for every round, an amount which usually runs out in 3-7 days. Depending on the kind and number of drug users they know, the social workers usually do the needle exchange in flats, parks and other public places. This obviously depends on the demands of the drug user they are in contact with, namely where he or she is willing to see them. The associates of the scheme have tried several times to arrange for needle exchange at places of entertainment but they have been invariably turned down by the managers.

Social workers are protected by a number of measures designed to prevent them from being infected. They are vaccinated against Hepatitis B and they are given protective gloves. Some of the

social workers protect themselves by telling clients to break off the end of used needles before handing them over, and they also tell users to do the same if they ever throw away a needle so as to prevent used needles from being used again.

A tragic incident among Roma drug users in Szeged in 1999 drew attention to the immense importance of needle exchange and the propagation of information among drug users. Roma drug users in this town of southern Hungary used to prefer amphetamines until, unexpectedly, their accustomed dealer was imprisoned. As a result, the Roma drug users, who were well acquainted with amphetamines, switched to heroin, a substance which had been totally unknown to them before. They had no information about its chemical properties, effects or the hazards involved in using it intravenously. As the members of this group continued sharing needles and as one of them was a carrier of Hepatitis B, they all died of the acute infection . Unfortunately, when the Drug Center of Szeged and the associates on the needle exchange scheme contacted them, it was too late to avert the tragedy. This shocking incident impelled then associates on the scheme to invest extra effort into virtually imposing their harm reduction services as far as possible on Roma drug users in general and Roma intravenous drug users among them in particular, a drug using population which had traditionally been difficult to approach and difficult to involve in harm reduction schemes. They undertook to conduct an intense information campaign in the street to inform those Roma who would choose intravenous drug use about the hazards of heroin use and ways of using it properly. Since the tragic incident one of the social workers has been concentrating specifically on needle exchange among the Roma.

The Szeged team of social workers have not had the time for systematic record-keeping and data processing for years, the leader of the Szeged project told us. Insufficient funds prevent them from employing a person for this task. The estimated number of needles exchanged a year is 18-50.000, but there was a year when it came near 100.000.

The efficacy of the center's work always depends on the state of the heroin market (at present one gram of heroin costs 30.000 HUF (120 EUR) on the black market while in Budapest it varies between 9000 and 15.000 HUF (36-60 EUR)) and on the presence of drug dealers in the town, which fluctuates with the efficacy of police detection.

The street social workers on the Szeged scheme estimate that their work covers 70% of Szeged and nearby towns (Hódmezővásárhely, Makó), and that secondary needle exchange has made its way to other counties. Under the secondary needle exchange program 20-30 heroin addicts receive sterile equipment in Orosháza and 15 in Hódmezővásárhely. There are about 280-300 heroin addicts in Szeged, and over 500 intravenous drug users have cooperated in the needle exchange scheme.

With clients being registered under code numbers, needle exchange is conducted under conditions of anonymity. Free HIV testing is also conducted under code numbers under a cooperation agreement with the local State Public Health Office. The Szeged scheme has not had a client with HIV, but the number of clients with Hepatitis C is rather high. Drug users are always willing to undergo screening and since screening is anonymous the dentist of the Drug Outpatient Clinic treats patients free of charge if they have a negative screening test result not older than six months.

In addition to receiving the three kinds of sterile needles and syringes drug users are provided with a number of further harm reduction equipment such as

- vitamins
- condoms
- mops

- antiseptic balm
- rubber tourniquet
- calcium
- therapy
- HIV testing
- legal aid
- social services.

The scheme was supported by the Open Society Foundation in 1996, later by the Soros Foundation, and from 2000 by the Ministry of Youth Care and Sports. They received 902.000 HUF (3608 EUR) from the Ministry in 2000, 4 million HUF (16 000 EUR) in 2001 and 3 million (12 000 EUR) in 2002. They are presently running the scheme from this last sum. They would like to extend their services in the future.

GYÖNGYHÁZ ASSOCIATION – PÉCS

Like in many Hungarian towns after the political transformation of 1989, intravenous drug use grew significantly in the town of Pécs. Street heroin did not become wide-spread, but poppy seeds and 'compote' (a home-made opiate derivative used intravenously), amphetamine and ephedrine nose drops have become popular and characteristic of intravenous drug use in this town to the present day.

Needle exchange in Pécs started eight years ago. The idea of starting a needle exchange service was first raised by a number of young people in 1994, who undertook to contact intravenous drug users at the expense of their own free time, without any institutional support. The young volunteers went to the flats of drug users they knew personally to distribute sterile equipment but they soon realized that there was a need for an institutionally organized scheme.

It was in the summer of 1996 that they started their work in the building of the Drug Outpatient Clinic of Pécs. From the beginning, they had good contacts with the Drug Prevention Foundation of Budapest and received exchange sets – consisting of a sterile needle, syringe and a mop – from them, At first they only engaged in street exchange, which practically meant exchange done in the drug users' flats, with four street workers. Through secondary needle exchange , i.e. the contacts of social workers, they were able to contact 20-25 further intravenous drug users. In this early phase one to two hundred syringes were handed out a week, but always more were collected. This amounted to a 70% coverage of the existing need.

In 1997 the organization became independent of the Drug Outpatient Clinic and moved to a new building. (It was the time when they were given permission by the local State Public Health Office to run a scheme offering a daytime facility for addicts to serve a maximum of 20 persons.) The associates of the scheme, hand in hand with young drug users, redecorated the building with their own hands. When the building was finally in good working order, they started operating on a 24-hour basis seven days a week, but as time went by opening hours were reduced as a result of a combination of a number of factors. In this period their clientele consisted of 12-17 persons, who were regularly contacted by the 6-8 social workers . Thanks to their wide circle of stable contacts they were able to exchange about 1000 needles a month, which was a significant number compared with the size of the town. Between 1997 and 2000 there was also an unofficial injecting room in the building. With 2-3 intravenous drug users a day injecting their drug in the presence of one of the social

workers in what normally served as the duty room. There was one case of overdose during these years (the young man was taken to hospital).

In Pécs, as is the case with all needle exchange schemes in the country, the extent to which the service is used depends on the mobility of the intravenous drug using population. While the high number of intravenous drug users in the capital results in full use of the services offered, the disappearance of a drug user with many contacts from a country town vitally affects the demand for needle exchange. Since methadone maintenance treatment was started at the Drug Outpatient Clinic in Pécs, the number of people using the needle exchange service has fallen sharply. In 2001, for instance, associates of the needle exchange scheme were able to reach out to heavy opiate addicts until three intravenous drug users, who had played a significant role in secondary needle exchange, died of overdose. In the same year twelve more drug users went to a rehabilitation establishment at the same time, nine of whom were intravenous users. The general tendency of decrease was made worse by the fact that in 2000 four more contact persons dropped out of the activity, likewise for reasons of rehabilitation, and the associates on the scheme were left without contacts, and their chances of getting new contact persons are rather slim. By the beginning of last year practically their entire clientele had dropped out. The number of stable clientele in 2002 has been 4-5 persons coming for needle exchange 2-3 times a week.

In addition to needle exchange, the Association also offers other services such as the opportunity of cooking a meal together with the associates once a week, access to computers and Internet, and organized excursions with drug users during the past few years, which associates informally refer to as 'wilderness therapy'. It was after one of these rowing tours that three young people stopped using drugs

The scheme is financed from two main sources. The Municipality of Pécs has an obligation to support the scheme with 1,5 million HUF (6 500 EUR) a year, while the Ministry of Child and Youth Care and Sports funds their activity after the number of persons served, which comes to 3 million HUF (12 000 EUR) a year. This adds up to an annual 4,5 million HUF (18 000 EUR) which does not suffice for paying the social workers' salaries, the leader of the scheme told us. The street social work scheme was financed by the government for the first time in its history this year, receiving 4 million HUF (16 000 EUR) for running costs. They have also received 400.000 HUF (1 600 EUR) from other sources such as the World Bank and the Bank Caritas Foundation.

ALCOHOL-DRUG AID OUTPATIENT CLINIC – VESZPRÉM

Needle exchange in the town of Veszprém started as part of a project called 'Running Wild', in the building of the local Drug Outpatient Clinic in 1997. It had become necessary to do something about the alarming increase of used needles on the beaches of nearby Lake Balaton and the sense of indignation among the population running high. There was some resistance in the way of efforts to get the service started.: the County Supervisory Head Physician despite his awareness of the facts, had tried to prevent the service from getting started. His resistance was broken down by a regrettable incident, in which an intravenous drug user had physically assaulted the pharmacist who was giving out a sterile needle to him. Getting the required permissions from the State Public Health Office also took some patience, but despite these initial difficulties harm reduction schemes have come to stay and are gaining ground. The first step was the launching of needle and syringe exchange, but in 2000 methadone maintenance treatment also got under way.

At the time they called the needle exchange service into being, the associates of the Outpatient Clinic organized a discussion forum which was designed to give the participants, all affected in their roles by the drug problem in varying ways – the leader of the Outpatient Clinic, a physician, a social worker and the police officer from the local police responsible for drug affairs – a chance to reach an expert consensus on a number of vital issues. The negotiations resulted in an agreement with the police, who had regularly turned up around the Outpatient Clinic to collect information about the patients, under which the local police now committed themselves to cooperate with associates of the scheme. The significance of this last part of the agreement can only be understood against the background of some facts from the previous history of the two institutions. Before the agreement, police officers had often turned up at or around the Outpatient Clinic to collect information about the patients. They had often asked the associates of the Clinic via fax to provide them with information about the patients, and it took associates quite a long 'educative effort' to get the police officers to present their requests in the appropriate official way. This unbridled police practice had once even lead to an incident in which the police from another county, who had been investigating some drug-related case, arrived in several microbuses at the Clinic with sirens howling, where, of course, they were not allowed to enter but their appearance succeeded in undermining the trust among the Clinic's clientele. After these bitter experiences the head of the Outpatient Clinic had a few personal discussions with the town and county chief of police to put an end to the untenable situation, which at long last lead to an arrangement which put an end to the police practice which had made things so much more difficult for the Outpatient Clinic's staff. At the same time police also put an end to raids at the local discotheque.

After overcoming these initial difficulties the needle exchange service functioned rather effectively until 1998. In this period 600 patients visited the Outpatient Clinic a month, which meant about 300 drug users, who turned up altogether 6000 times at the Outpatient Clinic a year. In the first few years of the operation of the needle exchange service 3-5.000 needles were given out, compared to which the number of used needles and syringes was more modest. Used needles and syringes, a very hazardous refuse, have been destroyed by a firm under a contract with the Outpatient Clinic.

The introduction of tighter criminal law legislation concerning drug use had an unmistakably negative effect. Actual demand for the services of the Outpatient Clinic in general and those of the needle exchange scheme in particular decreased by 8-15%, and after the establishment of the methadone substitution scheme in 2000 the number of those using the needle exchange service fell back to negligible, with 2-300 needles exchanged annually. In the same year the new situation raised the need for separating the clientele of the two different services, which could only be solved by arranging for opening hours in the morning for one, in the afternoon for the clientele of the other service. Both schemes offer personal consultations.

There are eight persons working on the harm reduction scheme at the moment, four of whom have received training in harm reduction and two of them teach the subject. For several years, the Outpatient Clinic had a most efficient collaborator in the person of a former drug user who was outstandingly effective in his street social work, but unfortunately he relapsed into using drugs in 1998. Street work since then has been languishing, despite the fact that the Outpatient Clinic has 3 former drug users on its staff, all of whom have higher education qualifications.

In addition to needle exchange and methadone maintenance, the Outpatient Clinic also engages in other harm reduction activities. These include a primary prevention scheme which has operated

mainly in schools since 1996. In 1998 associates met 21000 pupils. They also give lectures all over the country, honoring every invitation they get from wherever in the country it may come from. They are often accompanied to these preventive lectures by a former drug user who has succeeded in giving up.

Another activity carried on by the staff is education, the provision of information for intravenous drug users, which is done in lectures held every six months, tailored specifically to the needs of intravenous drug users. The use of imported heroin is not wide-spread in and around Veszprém for some reason or other. Opiate addicts in the area use 'compote', a substance made in the home from poppy seeds. Thus associates of the Outpatient Clinic staff have to inform users not only about the hazards of sharing syringes and needles but also about those involved in sharing cooking utensils. The existence of these hazards became known to the staff by the spread of hepatitis which had been happening despite the provision of sterile injection equipment. All drug users registered at the Outpatient Clinic are transferred to the State Public Health Office's screening facility where free and anonymous HIV and hepatitis screening is provided. The data thus acquired reveal that although there is no HIV carrier at present, the proportion of those infected with Hepatitis C reaches 70-80%.

DRUG OUTPATIENT CLINIC – MISKOLC

The Drug Outpatient Clinic in the town of Miskolc started its activities in 1996 as a result of a successful cooperative effort on the part of the Drug Outpatient Foundation founded by social workers and the Semmelweis Hospital. 20% of the drug users presenting for treatment at the Outpatient Clinic are heroin users (227 persons out of 1133 registered patients in 2002), a fact which made the need for some sort of harm reduction service increasingly urgent over the years. A tender invited by the Ministry ofYouth Care and Sports in 2000 gave associates of the Outpatient Clinic the idea to launch a needle exchange scheme in Miskolc. The idea seemed to be warranted by a research project conducted among their clients which was designed to find out about their clients' attitudes to harm reduction methods. Many of the interviewees clearly expressed a need for needle exchange, while others felt indifferent about it. The replies which cast a shadow of doubt on the need for needle exchange were based on two kinds of argument. One was that with sterile equipment being available in Hungarian pharmacies, there was no need for such a service, and in fact the standard practice among intravenous drug users in Miskolc was simply to go to pharmacies for supplies. The other argument was highly alarming to associates of the Outpatient Clinic but it underscored the need for education about the hazards involved in needle sharing and drug use in general: the majority of interviewees said once they had acquired their heroin dose, the particular equipment with which they would administer it was perfectly indifferent to them.

Would-be associates on the needle exchange scheme wanted to run the service in a place independent and separate from the Outpatient Clinic building, but this wish has been frustrated by insufficient funds till the present day. The needle exchange scheme is thus run in the building of the Drug Outpatient Clinic. Like with many other similar civil initiatives in the country, the launching of the scheme was facilitated by the fact that the Crime Prevention Foundation of the police was cooperating very favorably in the process of establishment. Leading police officials committed themselves to the policy of police officers on duty avoiding even the vicinity of the Outpatient Clinic building, which they have observed until the present day. The first steps were also made easier by the fact that the Outpatient Clinic had already had permission from the State Public Health Office, which saved quite

an amount of their time. With 1,2 million HUF (4 800 EUR) won at a Ministry ofYouth Care and Sports tender via the Drug Outpatient Foundation for the year in 2000 and with a 100.000 HUF (400 EUR) support from the local Municipality sufficient for the acquisition of sterile needles the scheme was called into being and started functioning without major teething troubles, discounting the fact that intravenous drug users were suspicious in the beginning and it took a few months until the first clients turned up.

Needle exchange is anonymous. Clients are registered under a code number on their first visit. After the first period of neglect, attendance, especially by patients of the Drug Outpatient Clinic and young people they knew, grew. The service is at present regularly used by 25 persons, who are willing to engage in secondary needle exchange and thus make it possible for the Outpatient Clinic to reach further consumers. Those attending are standardly sent over to the nearby Semmelweis Hospital compound for free and anonymous AIDS screening. There has not been an HIV carrier among the Outpatient Clinic's intravenous clients and the percentage of those carrying the Hepatitis infection is very low.

To prevent meetings between drug users attending abstinence-directed therapies and intravenous drug users coming to exchange needles the latter service has been open in the evening hours, from the beginning. It is open twice a week after the working hours of Outpatient Clinic staff. The scheme employs seven associates full time (social worker, mental hygienist and addictologist, consultants) whose work is assisted by four volunteers. They have not yet succeeded in involving former drug consumers in their staff. They think this will remain difficult to achieve as in their experience someone who has managed to go off drugs tends to be reluctant to resume contact with drug users whereas, on the other hand, someone who is still on drugs tends to be unreliable as an associate.

Sterile injection equipment, scarce mops and condoms are given out only at the facility. The number of syringes and needles given out far exceeds the number of used equipment brought back. These are destroyed in the nearby hospital building. The staff on the exchange scheme do not collect or process data, so they have no precise data on the turnover realized by the service facility.

In the past three years they have also undertaken street social work in the area of town most infected by intravenous drug use, the Avas housing estate. Another service, more effective perhaps even than attendance at the Drug Outpatient Clinic, was the needle exchange service which was run at a place of entertainment for half a year, with three associates of the exchange scheme making themselves available in turns to the young people who were 'living it up' there. In addition to the distribution of sterile equipment, this gave them the opportunity to expound their views on prevention in a number of informal conversations and they found that young people had great interest in this kind of information. Unfortunately, the Hungarian public conception of drug consumption as something intrinsically criminal and a general aversion to harm reduction schemes, allows a needle exchange project run at a place of entertainment a rather slim chance of surviving for any considerable time. The half-year existence of the needle exchange project in Miskolc was unique in its kind and was made possible by the truly accidental circumstance that the owner of the place of entertainment in question was doing his non-armed military service at the Outpatient Clinic. The exchange project, which had been running smoothly for half a year, came to an abrupt, though perhaps not final, end for the down-to-earth reason that the place of entertainment closed up for some time. It would be truly lamentable if this opportunity for the associates of the scheme to make contact with young people under more favorable circumstances than at the Outpatient Clinic would be lost, but

fortunately future cooperation remains possible and is likely to restart when the place of entertainment opens to its customers again,

Knowing that harm reduction schemes in Hungary are still in their teething phase with all its troubles, the oldest of them having a history of only ten years, and knowing, further that Hungarian society has a strongly disapproving attitude to drug consumption in general, which has been reinforced by the strict drug policy of the past few years, it is by no means surprising that professionals in the helping line are having a hard time winning the trust of intravenous drug users, a segment of the population which is difficult to reach anyway. It is therefore important for them to seize every opportunity to get closer to these young people. If such schemes are impeded in their running by financial difficulties, the efficacy of the work is bound to suffer. Like other needle exchange schemes in the country, the needle exchange service of Miskolc has been able to survive thanks to grants won at the tenders invited by the Ministry of Child and Youth Care and Sports. In view of the above facts and of the official attitude to promoting harm reduction efforts, it is difficult to understand why the Ministry and its body which makes the decisions about the applications, sometimes create difficulties for harm reduction services which are already running.

To take the example of the Miskolc needle exchange scheme, in their first year of operation (2000), the project was awarded a grant of 1.200 000 HUF (4 800 EUR) at the tender invited by the Ministry then, which was sufficient to cover salaries and the equipment necessary for running. In the following year the 2 million support from the Ministry allowed for significant improvements. By contrast, their application for 2002 was at first rejected, and it is probably due to the head physician's personal efforts that at a hastily invited 'additional tender' they won some support, which suffices only to cover the salaries. Interestingly, however, these additionally granted funds do not appear in the Ministry's records of grants given to low threshold service schemes. We can only hope that the Ministry officials are aware of the gravity of the harm that may be caused by the stopping of a scheme which has been running for some time and that efforts to restart one later after a period of cessation of activities are fraught with difficulties and expenses much greater in comparison than those involved in uninterrupted functioning.

Very often it is only through low threshold services that intravenous drug users can get a chance to become able to stop using drugs, and that only these services have a chance to build up a trustful relationship with drug consumes which makes it possible for helping professionals to protect them as well as society at large from the harm connected with drug use.

Despite all these difficulties the Miskolc needle exchange scheme plans to extend the choice of its services and to get the needle exchange service to nearby towns affected by intravenous drug use (Tiszaújváros, Kazincbarcika, Sárospatak). They think of the continuation of street social work and securing the opportunity for needle exchange at places of entertainment as equally important. They would like to leave the Outpatient Clinic building and move to a new building where they can arrange for better conditions for service and extend opening hours. The only problem left to be sorted out is the question of sufficient funds.

SUMMARY

It is estimated that 5-10% of all HIV infections in the world result from intravenous drug use. There are approximately 10. 000 intravenous drug users in Hungary at present, of whom only 5-10% are receiving treatment in the health care system. The proportion of those infected with Hepatitis C is

around 10-30%. We have reliable data which reveal that 60-80% of HIV carriers in successor states of the former Soviet Union (such as the Ukraine, Russia) are intravenous drug users. We have no reason to suppose that this epidemic will kindly go round the borders of Hungary, no reason to assume that we are not exposed to the same hazard. Support for low threshold services therefore is important not only for harm reduction but also for tertiary prevention.

Despite widespread disinformation, public aversion and, unfortunately, a sense of doubt on the part of some professionals, the idea of needle exchange schemes is acquiring increasing influence among the staff of establishments providing for drug patients. Against the background of a continuously increasing number of drug users in general and intravenous drug users in particular the number of needle exchange schemes is still very far from sufficient to cover the existing need.

Schemes already operated have had to fight a lot of difficulties over the past few years. One of these difficulties was the 1998 modification of the Criminal Code which tightened up the sanctions attached to the criminal act of 'abuse of drugs' and thereby narrowed down access to the previously more liberally defined alternative of therapy and had a negative impact on attendance at needle exchange facilities. In the years after the new legislation became effective, the number of intravenous drug users presenting for treatment decreased palpably (see the data of the Alcohol and Drug Aid Outpatient Clinic, Veszprém), and trust in low threshold services decreased. Afraid of the possibility of criminal proceedings, police officers were increasingly reluctant to keep contact with harm reduction schemes.

Newly started needle exchange services have often been watched by the police or have been disturbed in their functioning by their intermittent present. It has been shown that nothing except explicit agreements with the police can help surmount the difficulties caused by this 'side effect' of harm reduction.

At several points, this study has indicated the lines along which those engaged in these services think of 'extending', the aim generally being to reach out to the drug users of nearby towns and villages. Most schemes however are unable to invest into development because of insufficient funds. There are altogether six services offering sterile equipment to Hungary's 19 counties, and two of them are based in Budapest. Despite the official emphasis in the drug strategy on the importance of harm reduction, for example the Miskolc project was virtually paralyzed by insufficient funding by the Ministry of Child and Youth Care and Sports.

50% of the needle exchange services presently functioning are based in buildings of Drug Outpatient Clinics, which prevents them from keeping open at times which really suit the needs of intravenous drug users, as the clients of these services have to be constantly separated from drug users who attend the Outpatient Clinic with abstinence in mind as well as from methadone substitution clients.

Many of the short-term objectives set in the National Drug Strategy or the program of the state secretariat responsible for drug affairs of the Ministry of Child ad Youth Care and Sports have not been attained. There is no needle exchange facility in the country which is open 24 hours and half of the existing schemes are running with few opening hours. There are a few who cannot afford to offer anything other than sterile needles and syringes.

Most needle exchange schemes in the country lack the human resources that would be needed for regular collection and processing of data. Data relating to the turnover of sterile and used equipment are all based on estimates.

Despite an insecure existence depending on the Ministry's decisions under the prevalent system of annual tenders, low threshold services can claim quite a number of successes. For instance, in Szeged and Budapest the street social workers are able to reach out to consumers who are not approachable to professionals in any other way. The practice of providing information and help as part of the needle exchange service has sometimes even helped drug users to build up the determination to free themselves of drugs and paved the way for them to treatment units.

Departing from their original protocols, most needle exchange services have extended their service toward simply providing users with sterile equipment as opposed to merely exchanging. In spite of this, the collection of used equipment has not dropped below 70% anywhere. This is another palpable result of efforts to provide drug users with information, which are an integral part of the harm reduction strategy. Secondary needle exchange can be expected to reach out to several times as many clients as is possible under primary exchange.

Mobile service started in the capital with support from the Ministry of Child and Youth Care and Sports and it is hoped that the number of these projects may increase in the future. Those engaged in mobile exchange for a few months invariably report favorable experiences of having regular clients and conversations touching on important points of prevention.

In summary, it can safely be said that the justification for needle exchange schemes has by now become indisputable. As a result of the change in the government at the last elections a modification to the Criminal Code is expected to ease presently severe punishments and to reintroduce for drug users the institutional alternative of going into therapy. This is likely to allow greater room for the realization of the progressive objectives laid down in the National Drug Strategy. It is hoped that the budget will pay greater attention to the needs of harm reduction services so that there will be a chance to make up for the shortcomings caused by insufficient funding in the system in its present state, so that professionals in this helping line will be able to provide effective help under conditions of a service system which matches up to the proportions of the problem it is designed to alleviate.

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5. Ilona Veres' s data about the Budapest NEP.

Postscript

As is hopefully clear from the present volume, harm reduction is here to stay as an irrevocable and indispensable part of Hungarian drug policy, present or future. The most important kinds of service are in good working order and there is hope that as the general atmosphere becomes more favorable for drug policy, other forms of service will also take root. That the schemes are in operation and available is one question, however, and it is another question whether they are receiving the political esteem and financial support they unquestionably deserve. In order for these forms of service to be supported rather than just tolerated, it is indispensable, in HCLU's opinion, that both society and politicians, whether in the government or in the opposition, should become aware of, and accept, the need for harm reduction.

East and Central European countries are in a difficult situation, having to live with the legacy of problems generated by the Communist system, which will linger for years or even decades to come. This is an additional reason for us to try and convince our politicians that they should learn from the practice of countries which have greater experience than we have in ways of dealing with the drug problem. As if to make matters more difficult for us, it is not enough simply to look forward – to more advanced countries – rather than backward. We have the example of the greatest world power, the United States, where the harm reduction approach is often ignored, as opposed to the example of certain Western European states. The claim that harm reduction is an absolute necessity in East and Central European countries is a challenge that cannot be side–stepped by any professional with a sense of responsibility and knowledge of the real facts.

Unquestionably, then, there is a need for organized harm reduction services. Drugs are here to stay, and anyone who thinks he or she will ever be able to purge society of drugs once and for all, is clinging to an illusion. A realistic drug policy can only aim at the attainable goal of minimizing the individual and social harm caused by the consumption of illegal drugs and reducing, a s far as possible, the misery, disease and death caused not only by drugs but equally by anti-drug laws. Once this claim – that drugs have always been and will always be with us – is accepted both by ourselves and at least the greater part of our societies, our task boils down to finding the appropriate means and methods which will be adequate to serve the objective of reducing the inevitable harm. It has been several decades since some countries started applying procedures and schemes which are based on and themselves spawn scientific results and we had better borrow from them. Equally important is a concerted effort to save our drug policy from being inspired by ignorance, fear and prejudice. Drug policy is a serious matter and we must not let these influences take control over it. An unbiased view of the demands of public health, respect for human rights and scientifically proven facts – these are the motives which can serve as the driving force behind a realistic drug policy which takes account of people's interests.

Appendix I.

Senitel Examinations Conducted in Hungary[1]

	Nuber of Persons Examined	Nature of Sample	Sample Taken At	Financed by
1996-1997	325	blood and saliva	Drug outpatient surgeries, Erzsébet Hospital Toxicology Department	National AIDS Commettee
1998-1999	approx. 400	blood and saliva	Drug outpatient surgeries	National AIDS Commetee
2000-2001	350	blood and saliva	Drug outpatient surgeries, (Pécs, Budapest, Szeged) Erzsébet Hospital Toxicology Department, Persons, who have died of overdose on drugs	Ministry of Youth Care and Sports, Budapest Municipality, National Funds for the Development of Scientific Research
2002	500	blood	Erzsébet Hospital Toxicology Department Methadone Service offered at drug outpatient surgery (Nyírő Gyula Hospital) Persons, who have died of overdose on drugs	Ministry of Youth Care and Sports, National Funds for the Development of Scientific Research

1. The examinations were carried out by the supervision of Eszter Újhelyi, on the Departement of Immunology of Szt. László Hospital. The necessary samples for the examinations were provided primarily by the Department of Toxicology of the Erzsébet Hospital with the participation of Gábor Zacher.

Types of Infection Transmittable by Blood Examined

1996-1997	HIV, HCV, acute and completed HBV
1998-1999	HIV, HCV, acute and completed HBV
2000-2001	HIV, HCV, acute and completed HBV, vaccine against HBV, Syphilis (in patients overdosed)
2002	HIV, HCV, acute and completed HBV, vaccine against HBV, Syphilis (in patients overdosed)

Distribution According to Age and Sex among the Intravenous Drug Users Examined:

- 2/3 of those examined male
- Approx. 50% of those examined between 20-24 years of age
- The proportion of those below 19 years of age continuously on the increase

Frequency of HCV infection outstandingly high among those below 19 (presumably owing to practice of sharing needles)

Results:

	Infected with HIV	HCV	Acute HBV	Completed HBV	Vaccine
1996-1997	0	16%	2%		
1998-1999	0	17%	4%		
2000-2001	0	28%	1.4%	7-8%	2%
2002	3	30%	2.5%	7-8%	5%

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