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Evaluation of the implementation of the national strategy to combat drugs
A Hungarian – Dutch cooperation

Report of the external mid-term Evaluation

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1. Executive summary

1.1. Introduction

This mid-term evaluation of the implementation of the Hungarian National Strategy to Combat Drugs (hereinafter referred to as the National Drug Strategy) is based on an decision of the Hungarian Coordination Committee on Drug Affairs (CCDA)[1]. The decision calls for an evaluation of implementation of the short- and mid-term objectives of the National Drug Strategy. In fact, the National Drug Strategy itself has stipulated the need for such a mid-term evaluation.

The Ministry of Children, Youth and Sport (now the Ministry of Youth, Family, Social Affairs en Equal Opportunities, abbreviated MYFSAEO) has the responsibility to coordinate the implementation of the National Drug Strategy and the governmental programmes with the concerned ministers[2]. The ministry decided in 2003 to look for the involvement of external experts to do this evaluation. This resulted in a project 'Evaluation of the implementation of the National Strategy to Combat Drugs' financed by the MATRA Pre-accession Projects Program of the Netherlands Ministry of Foreign Affairs. The Trimbos Institute – the Netherlands Institute of Mental Health and Addiction - was selected to do this evaluation in close cooperation with the Hungarian National Institute for Drug Prevention (NDI).

The project consisted of two key elements, defined by the following project results that had to be achieved:

1. *The methodology and capacity for the evaluation of the National strategy to combat drugs is developed by carrying out a (partial) evaluation of the medium-term priorities of this strategy;*
2. *The co-ordination of policy evaluation and formulation of drugs policy is strengthened.*

Thus,, besides evaluating the implementation of the National Drug Strategy, which is the main focus of this report, the MATRA project also aimed at reflecting on how to strengthen the existing coordination structure in the field of drug policy in Hungary. Regarding the latter a separate report has been published which was presented to the CCDA in December 2005[3].

Project result 1: the evaluation of the implementation of the Drugs Strategy
Regarding the mid-term evaluation of the implementation of the National Strategy to Combat Drugs, some preliminary remarks about the scope and focus of the evaluation have to be made.

First of all, it must be emphasised that this mid-term evaluation does not concern an evaluation of the objectives of the policy as such and the question whether these are relevant and/ or correct. In fact, the mid-term evaluation tries to answer the following three key-questions:

1. **Is the National Drug Strategy a consistent policy document? This part of the evaluation refers to the consistency of the policy theory, SMART policy objectives and the relationship between objectives, actions and indicators?**
2. **Does the National Drug Strategy define the necessary priorities, instruments, and responsibilities for realisation of these objectives?**
3. **Did the implementation of the National Drug Strategy result in the achievement of the short-term and mid-term objectives?**

1.2. Structure of this evaluation report

In order to answer the above mentioned three key-questions, a number of activities have been conducted in the past two years, which are reflected in Chapters 2 to 5 of this report. In order to conduct a proper mid-term evaluation of the implementation of the National Drug Strategy, a theoretical framework has been chosen that fits in well with the National Drug Strategy: the Logical Framework Approach. This theoretical background is presented in Chapter 2. In Chapter 3, the first analytical steps in the evaluation are presented, including the preparatory steps consisting of a stakeholder identification and a preliminary analysis of relevant documents that provide information on the National Drug Strategy, information of tasks and roles of its implementing

[1] CCDA decree 9/2003
[2] 157/2002. (VII.11.) Government Decree about the remit and the competence of the Minister of Children, Youth and Sports
[3] Trautmann, F. & M. Gallà & A. van Gageldonk (2005). How to Strengthen the Coordination of Drug Policy Formulation and Evaluation in Hungary. *Trimbos Institute, Utrecht, The Netherlands*.

structures, action plans and reports, working documents and other relevant papers. In Chapter 4 the National Drug Strategy is broken down, its underlying policy theory made visible and its internal consistency analysed. In Chapter 5 insight is given into the extent to which the short- and mid-term objectives in the National Drug Strategy have been achieved, as well as how the main coordination structures at local and National level function as key agents in the implementation of the Strategy. This information results in some general conclusions in Chapther 6, followed by an extensive set of recommendations in Chapter 7.

1.3. Methodology, approach and justification of the mid-term evaluation

Evaluating policies has often been done in America and elsewhere and is documented in an abundance of publications. For drug policy in particular however, evaluation is no common practice. Still, especially in highly politicised fields – such as drug policy - evaluation is indispensable to make policy less ideological and more rational and effective. Evaluation can contribute to make drug policy 'smart', reflecting on the appropriateness of the formulated objectives, measures and results. Evaluation can help to improve the tuning of the different elements in a complex policy field. In fact, it is a prerequisite for an effective and more consistent policy. Taking all this into account, we should realise that the evaluation of the Hungarian National Drug Strategy by a third, independent and foreign party is quite unique, not only in Europe.

The approach to this mid-term evaluation immediately reflects the main difficulties it encountered. The National Drug Strategy is a very comprehensive document, containing many objectives and actions that are aimed at a wide variety of policy makers, executive agencies, service providers, local communities and end users. Given the broad scope of the National Drug Strategy, the limited time and resources available, the absence of a structured system of monitoring and data collection to measure progress in the implementation and – not the least problem – the language barrier, the evaluators had to be pragmatic and choose an evaluation method that would provide a global answer to the three questions above, but leave the in-depth analysis of the implementation of the policy to the Hungarian political and policy structures.

As a result this mid-term evaluation is not an in-depth evaluation and its main sources of data concerns document analysis and qualitative interviews with stakeholders responsible for (parts of) the implementation of the National Drug Strategy. At the local implementation level the evaluators did not asses specific written sources of information (e.g. KEF Annual Reports) from the responding Local Coordination Forums on Drug Affairs (KEFs). The evaluation data gathered at that level concerns self-reported information of representatives of the participating KEF structures. On KEF level possible bias concerning the achievements in the field of the short- and mid-term objectives cannot be ruled out completely. The outcome of the interviews at national level provided qualitative information about the overall implementation of objectives of the National Drug Strategy. However, it did not provide enough comparable and reliable detail about the (level of) achievement of each specific objective in the National Drug Strategy as many respondents primarily had knowledge about the objectives that were relevant for their own organisation.

The limitations as described above do not interfere with the possibility to draw relevant conclusions as a result of this mid-term evaluation. The methodology followed was sufficient and appropriate to answer the three main research questions as described above. The findings and conclusions regarding the functioning of the local and National coordination structures are carried by a wide range of stakeholders that are either directly or closely involved, as well as by the analysis of relevant documents. Both the achievements regarding the implementation of the National Drug Strategy as the functioning of the coordination structures have been presented to and discussed with relevant stakeholders in two separate focus groups.

1.4. Outcomes of the mid-term evaluation

During the inception phase of the project as well as throughout the evaluation process, attention was paid to the existence of key documents with relevance for the evaluation process. Due to language barriers, the identification of such documents depended largely on the stakeholders who had a role in the evaluation process as well as of the representative of the main beneficiary, the Deputy State Secretary for the Coordination of Drug Affairs. The National Drug Strategy is the key policy document and the main focus of this mid-term evaluation. Other relevant documents provided information on legal mandates, task divisions, procedures and situation analysis (e.g. Annual Reports to the EMCDDA).

1.4.1. Consistency check of the National Drug Strategy

The National Drug Strategy is a comprehensive and – in most parts – consistent policy plan. The Logical Framework structure within the Strategy has not completely been unfolded. The overall framework of project

goal, results and long-term objectives shows coherence, but the operationalisation of objectives could be more specific. Not all of the Strategies' objectives are SMART; a number of objectives are not specific enough and leave room for differences in interpretation and sometimes call for a general change in policy without specifying what exactly needs to be changed. The timeframe for the implementation of some objectives seem to be somewhat unrealistic. Some short-term objectives are in fact mid-term aims and vice versa. The relation between some of the short- and mid-term objectives is not clear. The strategy identifies indicators but these are not clearly linked to the objectives. Furthermore, many indicators are not very precisely formulated. The objectives regarding international cooperation, information, monitoring & evaluation and community level objectives might have been better projected horizontally as they all cover elements of prevention, treatment and supply reduction. One major challenge for the implementation of the National Drug Strategy is the lack of priority. The Strategy provides a series of objectives for the first 2-3 years of its implementation and for the whole duration. It is not specified what objectives need to be reached in the period 2005-2009.

The National Drug Strategy is a visionary policy document which sets out guidelines for policymakers to guide implementation. At the same time, the authors have included elements of a drug action (and implementation) plan into the Strategy, identifying objectives that are sometimes so specific that they are in fact policy actions. The National Drug Strategy has fulfilled the functions it was envisaged to achieve. It is an inclusive policy paper that sets fundamental goals and values and that formulates the main directions of drug policy in Hungary. As a Strategy, it provides assistance and guidance for executive agencies that are involved in its implementation. Within the group of main stakeholders, the Strategy reflects a broad consensus regarding aims and objectives of the policy. The policy theory, the approach chosen, is well in line with the mainstream of EU drug policy. Furthermore the Hungarian National Strategy to Combat the Drug Problem provides an all-in-one approach to the drug problem. So the Hungarian National Drug Strategy has the function that was envisaged by its authors.

Nevertheless, a Strategy can not be used as an implementation plan. The National Drug Strategy has elements of both. It should be considered to operationalise the results and long-term objectives into short- and mid-term objectives in one or more separate implementation plans, breaking down the long-term objectives and priorities into short- and mid-term objectives and specific actions, indicators and instruments, following the budgetary cycle of government.

1.4.2. External effectiveness of the National Drug Strategy

The National Drug Strategy consists of many short-, mid- and long term objectives (see Annex 6). As it was impossible to evaluate the implementation of all these objectives, a selection of 17 out of over 90 objectives was made by the evaluation team, representing the broad perspective of the Strategy.

Each of these pre-selected objectives was carefully considered and argued, also weighing the importance of this selection against the background of the requirements of balanced and comprehensive drug policies as these exist abroad. A group of Hungarian stakeholders at national policy level was asked to provide advice after which he final selection was made by the evaluators of the Trimbos Institute, which resulted in a breakdown of objectives for *Community*, *Prevention*, *and Treatment* and for *Supply Reduction (see Table 5.1)*.

1.4.2.1. Evaluation of the implementation at local coordination level – the KEF structure

The data obtained from the interviews with the KEF respondents provides a good picture regarding the overall structure of the KEFs. It also provides information on the performance of the KEFs regarding the activities that have been attributed to KEFs in the National Drug Strategy. Regarding the functioning of the KEFs, the participation of local organisations and structures in the work of KEFs seems to be reasonable. Municipalities, the police, the public health service and educational institutions participate most in the work. Treatment and prevention service providers participate to a lesser degree, but this may be due to the fact that they are not represented in every KEF and provide services at a more regional level. Perhaps for the same reason, Public Prosecutors are not very well represented in the KEF work.

Almost all of the KEFs have collected data on the local drug problem, including information on drug use, on risk groups and on police and judicial affairs. KEFs also provide reports of their annual activities. Practically all KEFs discuss the outcomes of the local data collection with the municipalities, but much less with non-official organisations and structures. Most KEFs also draw up annual work plans (local drug strategies) in which they describe their activities for the next year. It is unclear whether these activities are subsequently evaluated. Analysis shows that there is no clear relation between the collection of local data and the

achievement of objectives. KEFs have the task to develop their own local strategy plans, tailor-made to the local drug situation. Quite a number of KEFs have conducted an assessment on the local situation. It is unclear, though, to what extent these assessments have been used as input for local activities and policies. To answer that question a more in-depth analysis of the local reports and work plans is required.

KEF respondents mentioned as their most important tasks: the creation of local and/or regional contacts and co-operative networks to address drug problems, including the establishment and strengthening of the KEF structure. The fact that the KEFs exist is considered a major achievement by many. The organisation of local activities and actions in the field of prevention were mentioned second and third most important. The training of experts was also considered a task of considerable importance.

The most important barriers hindering the development of the KEFs are a lack of funding and a lack of expertise. KEF respondents indicate that app. 3/8th of the funding is provided by municipalities, while the rest of the funding is acquired through tenders made to (national) funding programs. These funding programs increasingly expect that KEFs have arranged their own local infrastructure, an assumption that has not been supported by evidence. In third place a lack of motivation and even scepticism and resistance among professionals, decision makers seems to complicate the work of the KEF, while another important barrier for success concerns the lack of a legal status.

Overall, the functioning of KEFs differs a lot and depends to a great extent on the support a KEF receives from Local Self-Governments and on the idealism and input of volunteers. In order to improve the basis and functioning of KEFs in local Communities, the Local Self-Governments should accept greater responsibility for local drug policy, including prevention and treatment, as an important element of public health policy. This, however, may require a revision of the Act on Local Self-Governments, which is not easy to realise without additional funding and support from national government.

1.4.2.2. Evaluation of the implementation at local coordination level – the Strategy objectives

The results of the KEF performance in regards to the 17 pre-selected objectives were more difficult to interpret. As indicated in 5.2, some concerns may be raised concerning the question whether all KEF respondents had adequate knowledge of the existence and contents of National Drug Strategy before they answered the questions. Furthermore, the scores in regards to the achievement of the pre-selected objectives should be read as indicative scores rather than exact outcomes.

Regarding the achievement of the pre-selected objectives from the National Drug Strategy; especially objectives in the field of prevention have been achieved or partly achieved by KEFs. Almost 64% of the 4 identified Prevention objectives had been achieved or partly achieved by mid 2004. The pre-selected objectives at Community level had been achieved or partly achieved by almost 50% of the KEFs. The objectives regarding Social Work, Treatment and Rehabilitation had been achieved or partly achieved by almost 28% of the KEFs, while objectives in the field of Supply Reduction had been achieved or partly achieved by 28% as well. About one-fifth of the KEF respondents indicated that they did not know whether Supply Reduction objectives had been achieved, which was significantly higher than for the other areas.

In the thematic field of Prevention, objectives focusing at school prevention and health promotion among young people are most popular. At Community level, achievement concerns to a large extent the establishment of prevention services and preventive actions in the community. Regarding Social Work, Treatment and Rehabilitation, KEFs reported that there is an increase in the number of drug users in treatment after an initial decrease in the first years after adoption of the Strategy. It must be noted here that the data collections need further development, both at the level of registration (which is sometimes unreliable due to the registration protocols used by treatment centres, which are sometimes biased towards drug users), as well as at national aggregation level (the National Focal Point). A limited number of KEFs reported achievement or partial achievement regarding the actions that aim at high-risk or special populations, such as drug users with mental health problems, HIV/ AIDS infected drug users, drug dependent infants, etc.

In the field of Supply Reduction, according to the KEF respondents the most successful objective concerned the reinforcement of the fight against drug trafficking and dealer networks. The question must be raised here what the exact interpretation of this objective has been and to what extent KEFs have an overview of the achievement of this objective as the fight against organised, drug-related crime is centrally coordinated at the level of the National police.

About one-third of the KEFs report that the objective to improve the security of places for entertainment and other areas where drugs are being used has been achieved or partly achieved. However, there might be some difference in interpretation as to the exact achievement. One National respondent indicated that this objective focused to safe 'conditions' for people visiting entertainment places (free available water, air conditioning, fans in the toilets, etc..) in order to avoid drug related health harms, while others interpreted this objective as an aim to increase police control in order to prevent drug dealing.

Nevertheless, it seems that the conclusion can be drawn that in Community Actions and Prevention the KEF structure plays a useful role. Whether this is the case to the same extent for objectives in the field of Social Work, Treatment & Rehabilitation and Supply Reduction, is an issue for further debate. Organisations and structures in these two particular fields are not always represented in each KEF area (treatment services, prison services, customs and finance guard, etc.).

1.4.2.3. Evaluation of the implementation at National level – the CCDA structure

The interviews and discussions with key stakeholders showed a general agreement that the existing structure of the CCDA makes sense and should be kept as such. It has proved to be useful. Therefore, the CCDA should continue to exist. However, the majority of interviewed key stakeholders also agreed that there is the need of adaptation, mainly to allow a more flexible, quick and effective response to identified needs. As we did not find fundamental contradictions between the suggestions made by the key stakeholders we have been able to identify some basic lines along which a change of policy making structure could be ameliorated.

Analysis of the working process of the CCDA in relation to the implementation of the National Drug Strategy shows that improvements need to be made to make the CCDA more effective and the implementation of the Strategy more manageable. Concrete action plans could be developed with prioritised, specific and realistic objectives, measurable (qualitative) indicators, realistic time tables and a budget. The growing sense of 'ownership' that has been mentioned by some stakeholders could be enhanced further. It is recommendable that some kind of agreement and consensus is found regarding the allocation of structural funding to those objectives in the Strategy that do not have an incidental character, but that require systemic changes and long-term investment. The implementation of the National Drug Strategy might progress better if it is seen as an effort in which each ministry and agency has its own share of the burden. Important aspects for change may include more attention for planning, decision making, transparency, mandates and tasks, prioritisation within the implementation process and a stronger system of feedback.

1.4.2.4. Evaluation of the implementation at National level – the National Drug Strategy

The CCDA has adopted Action Plans for the implementation of the Strategy in 2002 and 2004. The objectives in these action plans show great similarity with the short- and mid-term objectives in the Strategy without specifying them further. The responsibility and task divisions for implementing departments and agencies need to be described more clearly; the same goes for the indicators for success. The time table is on some points not realistic. Furthermore, the action plans do not include a description of instruments to be used for implementation (subsidy, public relation, sanctions, legislation, research, etc.).

The document analysis (e.g. National Reports to EMCDDA) and the interviews with stakeholders show that there are quite some achievements, but more overview and feedback at the coordinating level of implementation is needed. Furthermore, the evaluators have also understood that no internal evaluation of the achievements of the CCDA action plan that was adopted in 2002 has taken place before the next action plan was adopted.

Regarding the perceptions of the National Drug Strategy, there was a great deal of consensus among most respondents. Despite the fact that the structure of the Strategy is not seen as perfect and the level of ambition perhaps somewhat too high, respondents felt there was an adequate balance between the four thematic areas. They indicated that the National Drug Strategy is inclusive and provides a good point of departure for policy and reflects the Hungarian view of society, i.e. the involvement of civil society and bottom-up approaches. One point of attention, though, concerns the consistency with other parts of drug policy and especially legislation that existed or was put in place before the Strategy was adopted: the conditions for the 'diversion' scheme and the problems with the interpretation of the Criminal Law when the possession of drugs is concerned and possible conflicts with other legal imperatives. These discrepancies may lead to undesired consequences.

As to identified problems, many of the respondents indicate that the time table for the Strategy seemed adequate in the beginning, but needs revision. Many of the respondents also indicate that there is a great lack of feedback on achievements, making it difficult to monitor progress and anticipate on future developments.

Regarding the external effectiveness of the Strategy, the conclusion is mixed. One important element regarding the implementation of a policy plan like the National Drug Strategy concerns the 'span of control' or the 'influence spectrum' of the executing departments and agencies. Where a Strategy can reflect on the desirability of (long-term) societal changes, calling active participation, roles and tasks of other actors in society (civil society, the public, the media), a policy implementation plan or action plan is needed including objectives and envisaged results that can actually be influenced and achieved by the policy and its implementation structures itself. The mid-term evaluation shows that at the level of implementation of the National Drug Strategy, no clear and comprehensive *overall* implementation plans have been developed or adopted by the responsible body, the CCDA.

1.5. Conclusions

In Chapter 2, three research questions were formulated for this mid-term evaluation. Based on the evaluation, the following answers can be given.

1. Is the National Drug Strategy a consistent policy document? This part of the evaluation refers to the consistency of the policy theory, SMART policy objectives and the relationship between objectives, actions and indicators?

The National Drug Strategy is a visionary document which sets out policy directions for drug policy in Hungary by the elaboration of a wide range of objectives. At the same time, the authors have included elements of an implementation plan into the Strategy, identifying objectives that are sometimes so specific that they are in fact policy activities. It might have been better to separate these two types of documents. When looking back at the functions identified in 4.2, the Hungarian National Drug Strategy is an inclusive policy paper that sets fundamental goals and values and that formulates the main directions of drug policy in Hungary. As a Strategy, it provides guidance for executive agencies that are involved in its implementation. For stakeholders, the Strategy reflects a broad consensus regarding aims and objectives of Hungarian drug policy. The policy theory, the approach chosen, is well in line with the mainstream of EU drug policy. Not every EU Member State – including the Dutch Government - has combined its drug policies into one holistic policy document as the Hungarians have done. Thus, the authors succeeded to write a Drug Strategy that functions as an overall covering framework for various objectives and activities.

Looking at the policy designs from a policy research perspective, most are not entirely consistent, which is not suprising. Policy rationality is different from scientific rationality. Policy analysis mostly serves as a mirror of reflection for politicians in order to improve future plans and actions. As already mentioned earlier in this survey, Log Frame structures are rarely complete and consistent in every detail. So, in the Hungarian National Drug Strategy, causal links between goal, objectives and activities are not always clearly elaborated and environmental factors, risks and preconditions largely remain undefined. The caveats that have been mentioned in former chapters may stimulate further thinking on drug policy in order to elaborate general objectives into specific targets and actions. The Strategy provides a multitude of short- and mid-term objectives that can not possibly be reached in the short-term period that was available. Therefore, one of the major challenges for the further implementation of the Strategy concerns the setting of priorities. A registration system, including monitoring and evaluation activities, enables national policy to assess developments that may be crucial for the initiation of activities or measures.

2. Does the National Drug Strategy define the necessary priorities, instruments, and responsibilities for realisation of these objectives?

Implementation of the comprehensive Hungarian National Drug Strategy, or even parts of it, is complex and requires a prioritised Action Plan, a clear time table, a realistic budget, implementation instruments and a specified division of tasks and responsibilities between implementing agencies. The Action Plans of the CCDA that were adopted in 2002 and 2004 do not offer adequate guidance to do this.

Implementation of the National Drug Strategy is assumed to be a shared responsibility for all levels of public administration and civil society. For coordination and implemention at local level, the structure of local KEFs was successfully set up. By the end of 2004 over 77 KEFs had been established, many of which were

increasingly performing the tasks that have initially been attributed to them. Still opinions were mixed about the functioning and usefulness of the KEF structure and questions were raised about the funding of the KEF structure in the long run and its coverage of all four result areas of the Strategy. The overall feeling is that support and commitment from local governments (municipalities, counties) is crucial for the realisation of this all. Doubts were also raised about the sustainability of the voluntary character of the structure. Finally, a lack of prioritty setting, cooperation (also between KEFs) and protocols are mentioned as weak points of the KEF structure.

The responsibility for coordination and implementation at national level has been attributed to the Deputy State Secretariat for Drug Affairs, which is part of the Ministry of Youth, Family, Social Affairs and Equal Opportunities and the CCDA. Implementation of the Strategy is an important task of these structures. The CCDA involves many stakeholders in public administration and even from civil society in implementation activities, but one main obstacle for implementation continues to be the limited available budget. The Deputy State Secretariat for Drug Affairs has cannot sanction nor enforce the implementation of drug policy, partly because the adoption of the Strategy has not been followed by an adequate level of resources and instruments. Funding arrangements for registration, research and monitoring – the prerequisites for supporting a fact-based drug policy – is also quite limited. This evidently results in a large gap between the ambition level reflected within the National Drug Strategy and the realisation level of this Strategy until now. A clear prioritisation of funding arrangements would help to deal with the limited resources available.

Although the National Drug Strategy defines some of the necessary priorities and responsibilities for the realisation of its objectives, a clearer specification of the priorities and division of responsibilities would enhance both the possibilities for the development of an implementation and the guidance of activities.

3. Did the implementation of the National Drug Strategy result in the achievement of the short-term and mid-term objectives?

The evaluation shows that there has been substantial progress and activity taking place in many covered by the short- and mid-term objectives. The interviewed respondents at local and national level mentioned quite a few positive experiences and results. Progress has been made on a variety of objectives by a wide range of agencies, structures and organisations. Many mid-term objectives have not been achieved during the implementation period, but seem to be well underway. Nevertheless, the lack of pre-set indicators and baseline data makes it difficult to obtain a thorough overview.

The most successful area of development in the National Drug Strategy is the field of Prevention. Many initiatives have been undertaken and a good deal of the short- and mid-term objectives from the National Drug Strategy seem to have been (partly) achieved or are being worked upon. The development of a coherent system of Social Work, Treatment and Rehabilitation requires further efforts. The realisation of a broad range of treatment options, suited to the needs of different groups of drug users, is a challenge for the coming years. It is worthwhile to consider a more focused approach on high-risk groups. The recent modification of the Social Act, which mandates the establishment of Low Threshold Services is an adequate first step. Regarding rehabilitation, the cooperation between social work and the treatment sector needs to be further developed.

In the domain of Supply Reduction, the level of achievement of objectives in the Strategy seems to be reasonable. Although some supply reduction objectives in the Strategy are insufficiently specific and clear indicators for success are often absent, some National respondents reported positive results on specific supply reduction objectives. However, there appears to be friction between coordination efforts and (a lack of) inter-institutional cooperation on local level. For instance, the National Police indicated that local police gives too little priority regarding the proper registration of drug related offences (in ERÜBS), which makes a thorough analysis of the drug related crime situation difficult. At the same time, objectives that aim at e.g. increases in drug seizures are – like in other EU countries – difficult to assess, as there is limited knowledge about the size and magnitude of drug trafficking volumes and the magnitude of drug production. This makes the achievement of supply reduction objectives that aim to counter trafficking difficult to assess.

Regarding the area of Information, Monitoring and Evaluation, which is not defined as a separate area in the Strategy, more investments should be considered. Progress was made in the past few years, especially regarding the improvement of the functioning of the Hungarian Reitox National Focal Point. However, the compliance with all five key epidemiological indicators of the EMCDDA is still not yet completed. The police- and justice database ERÜBS is modernised, but still requires further development.

Regarding the coordination of drug affairs at National Level, this paper provides some initial suggestions and recommendations for reflection and perhaps improvement. When the coordination of drug affairs at Local (KEF) Level is concerned, more attention is needed for the enhancing and promoting the role of Local Self-Government in supporting, funding and making use of the KEF structure to the Municipalities, but many do not do so. The Act on Local Self-Governments leaves the responsibility for supporting the KEF structure, but many Municipalities do not act accordingly. An assessment needs to be made to what extent the KEF structure is the most suitable for the thematic areas of Social Work, Treatment & Rehabilitation and that of Supply Reduction, as many operational agencies and services in these two areas are often not coordinated on local level. Treatment facilities and social work are mostly funded by the Ministry of Health and by MYFSAEO. Penitentiaries, the Customs and Finance Guard, the Border Police and the Prosecutors Office are coordinated by the Ministries of Interior and Justice and other National Executive Agencies..

The implementation of the National Drug Strategy has resulted in the achievement of a substantial number of short- and mid-term objectives, but the rate of achievement is difficult to asses precisely due to a lack of resources and feedback in the main Coordination mechanisms. Overall, it can be concluded that the outcomes of the implementation of the National Drug Strategy are positive given the circumstances. Still results can improve considerably with setting priorities, increasing resources for implementation and improving the system of planning and coordination.

1.6. The Way Forward

One overall conclusion of this mid-term evaluation of the Hungarian National Strategy to Combat the Drug Problem is that the development of the Strategy has been a watershed with the past. There seems to be a great consensus that the Strategy is comprehensive, inclusive and reflects a widely supported direction for Hungary's approach to tackle the drug problem. Four years after its adoption, the Hungarian National Strategy to Combat the Drug Problem is still highly relevant and comprehensive when compared to the revised EU Drug Strategy 2005-2012 and the EU Action Plan 2005-2008. In general, the Strategy objectives match the broad range of the latest priorities in EU drug policy. The discrepancy in approach and philosophy between the National Drug Strategy and the Hungarian Criminal Code regarding drug use needs to be resolved as it is causing debates in society, confuses the public perception of drug policy in Hungary and may complicate the implementation of specific objectives of the National Drug Strategy.

1.6.1. Recommendations for the further implementation of the National Drug Strategy

The mid-term evaluation shows that after an initial slow start-up in 2000-2001, the implementation of the National Drug Strategy caught speed in 2002-2004 and is now at a crossroads. One leads to sustained growth and reconfirmed support, the other to gradual erosion if the appropriate actions are not being taken. Many of the first hour 'activists' have changed positions. The socio-economic situation and the drug-problem in Hungary have changed as well. Hungary has acceded to the European Union. After an active period of enthusiasm and various activities at many levels, the risk of becoming weary of the Strategy should not be underestimated. People may not see enough results (due to the lack of feedback), resources and instruments for implementation may remain insufficient, while the aspiration levels of the Strategy remain high. Such a situation may lead to frustration and gradual erosion of policy output and of the support for the implementation of the policy.

Crucial for the future is to 'rejuvenate' the implementation process by reconfirming the principles and objectives of the National Drug Strategy, by identifying, sustaining and reinforcing progress that has been made so far and by improving the level of coordination and implementation for the remaining period of 2005-2009. The conclusion of this mid-term evaluation is that the National Drug Strategy 2000-2009 still provides adequate guidance for Hungarian drug policy for the next five to eight years. Many of the objectives in the Strategy are basic requirements for a balanced and multidisciplinary drug policy. The Strategy is still relevant, but needs to be updated to take into account new trends and developments regarding the drug phenomenon, as well as possible new objectives derived from the new EU Drug Strategy 2005-2012. Key questions are how the implementation of the National Drug Strategy can be improved and/or how the Hungarian Government can organise improved knowledge base and grip on what is happening at grass-root level and at implementation level.

Based upon the findings above, a plan for further action is being shaped. With this evaluation report at hand and with the inclusion of other progress reports and – to be identified – monitoring data, the further

implementation of the National Drug Strategy could be seen as a 'project' in itself. The following steps could be undertaken:

1. A relatively small Task Force could be created, consisting of well positioned, knowledgeable policy makers, representing the main thematic policy fields covered by the Strategy.
2. For each result area in the National Drug Strategy this Task Force could make a short assessment of the current state of affairs, based upon this evaluation and based upon a fast screening of the outcomes of the Action Plan 2002 of the CCDA, identifying which of the short- and mid-term Strategy objectives have been achieved to a great deal of satisfaction and which of these objectives still need to be implemented.
3. Based upon this 'state-of-play', an implementation plan can be developed that takes the results of the first five years of the implementation of the Strategy into account.
4. For each of the four result areas (Community, Prevention, Treatment and Supply Reduction) the key objectives that have not yet been implemented should be ranked in order of importance. In order to do so it is advisable that for each of the four result areas a set of selection criteria's is developed that may help the ranking process. Criteria may include elements such as feasibility (in the remaining period), level of harm to society, priority ranking in the EU Drug Strategy, etc..
5. Subsequently, each vertical thematic 'pillar', consisting of Ministries and other implementing agencies in each of the four main thematic field could subsequently identify feasible and realistic priorities regarding the ranked key objectives, as these can probably not all be implemented.
6. These prioritised objectives should – if necessary – be reformulated and provided with clear outcome indicators (quantitative and/or qualitative).
7. The next step is to define the required instruments needed for implementation of these objectives (e.g. budget, legislation, research, subsidies, incentives, sanctions, etc..) and the identification of the actual activities that need to be undertaken.
8. It is essential that there is a clear appointment of one (coordinating) responsible Ministry for each of the prioritised objectives, so that the Deputy State Secretariat for the Coordination of Drug Affairs can develop a hands-on information and feedback system. The other tasks and roles should be defined as well and a deadline for the completion of each separate activity should be set.
9. The next step is that the CCDA, by asking advice to its expertcommittees and by involving representatives from civil society, brings together the four 'strands' of well defined and elaborated priority objectives and budgets. A distinction is made between those activities and objectives that require incidental funding and those that require structural funding. The first lost of prioritised objectives will be brought together into an implementation plan of the CCDA for the years 2006-2009. The second will be identified and brought together on a separate action list, identifying long-term investments in drug demand and drug supply reduction that need to be covered by (additions to) the respective annual budgets of the implementing Ministries, agencies and background institutions.
10. The support for the National Drug Strategy should ideally be reconfirmed by Government and Parliament by:
    - The adoption of the above mentioned multi-annual, prioritised implementation plan.
    - The adoption of an appropriate multi-annual financial arrangement that covers the implementation of the prioritised structural expenditure at the level of the implementing Ministries and the implementation of the prioritised incidental expenditure in support of the implementation of the Strategy.
    - The identification and solving of discrepancies regarding objectives and philosophies between the National Drug Strategy and other areas of Drug Policy, including those in regards to the Criminal Code.
11. The CCDA, with the advice of and in dialogue with the NGO sector and civil society, should identify mechanisms for the involvement of non-governmental structures in the decision making and implementation process regarding the implementation of the National Drug Strategy.
12. The Deputy State Secretariat for the Coordination of Drug Affairs continues to be the central actor, with an adequate and high ranked administrative positioning. It has the task to coordinate the implementation of the incidental and structural action plans by facilitating the coordination processes and by gathering and processing feedback information from the implementing ministries and agencies. It is advisable that the Deputy State Secretariat for the Coordination of Drug Affairs is granted its own budget so that it can develop a monitoring and feedback system, conduct feasibility and other relevant surveys and develop and implement a PR and media strategy with the aim to provide information and feedback about the National Drug Strategy to civil society.

Without predetermining the outcomes of the process as described above, the evaluators feel that emphasis might be placed upon the implementation of objectives in the result areas of prevention, treatment and supply reduction and on the horizontal issue of information, monitoring and evaluation. Regarding the field of Community, Cooperation the evaluators feel that it is of great importance to maintain and strengthen the KEF structure, to analyse and if necessary adjust the legal environment (at local level), solving discrepancies between the Strategy andother policies and (local) legislations, but also identifying the roles and responsibilities of Local Self-Governments regarding the drug problem.

1.6.2. Recommendations for the improvement of the national coordination structure

For a successful further implementation of the National Drug Strategy in the coming years an appropriate coordination structure is vital. In a separate report[4] options and recommendations for how to improve the coordination of drugs policy have been discussed. As stated in the introduction the MATRA project on the evaluation of the National Drug Strategy enclosed besides the actual evaluation described in this report another part aimed at reflecting on how to strengthen the existing coordination structure in the field of drug policy in Hungary.

Making the CCDA work more efficiently

It is worth considering keeping, on the one hand, the CCDA in her present inclusiveness, primarily as a platform for discussing and preparing drug policy (issues) and for information exchange and distribution among the members. On the other hand, one could think of working with a less extensive committee only involving the core stakeholders, functioning as a sort of executive committee of the CCDA to deal with 'daily matters'.

The executive committee of the CCDA could formulate tailor-made policy proposals for responses to current developments and needs. Information on developments and needs could come from the monitoring tools developed (e.g. the National Focal Point) as well as from questions put forward in the parliament, media, etc. Tasks of this executive committee of the CCDA could be – among others – the following:

- Discussing urgent, topical drug policy matters and preparing proposals for an appropriate policy response;
- Preparing the agenda of the general CCDA meetings (allowing input from other involved Ministries, from experts and the field, reflecting relevant contents in the media and public opinion);
- Monitoring if / taking care that the necessary follow-up actions of the general CCDA meetings are taken by the member organisations responsible for a certain task / field;
- Monitoring if / taking care that the approved procedures are followed, e.g. on the information flow between CCDA members and reporting.

Furthermore, for a more efficient functioning of the CCDA sub-committees as the existing expert committees focusing on different issues are of course helpful. The opinion on the existing expert committees varied substantially, from not very to quite useful / effective. Therefore it should be discussed if the existing expert committees should stay as they are or if there are better ways of organising the input of experts.

Making the CCDA a policy preparing body

The overall conclusion among stakeholders was that the CCDA is rather a policy preparing than a policy coordinating body. It helps to find consensus among its members, it prepares policy position papers, etc. It should be considered to formally endorse this role of the CCDA. As the coordination of and decisions on drug policy are political decisions they should be taken on the political level, i.e. in the parliament, by the government. The task of the CCDA can in fact not go beyond facilitating drug policy coordination by preparing policy plans (as for instance the Drugs Strategy), by creating conditions for / monitoring the realisation of politically authorized policy plans and by reporting to the Parliament and government.

By clearly identifying the place and responsibility of CCDA in the decision making process the CCDA does not get more decision making power; together with clearly defining the mandate of the CCDA (or the

[4] Trautmann, F., Gallà, M., van Gageldonk, A., (2005). *How to Strengthen the Coordination of Drug Policy Formulation and Evaluation in Hungary*, Trimbos Institute, Utrecht, The Netherlands.

executive committee), the mandate of the Ministerial Commissioner charged with the coordination of drug Commissioner and the obligations of the CCDA members one creates conditions for a more effective coordination of the policy preparation work.

Clearly dividing tasks and responsibilities within CCDA
A clear division (and assignment) of responsibilities and tasks between (to) the members of the CCDA seems to be one of the most important things to do. For an effective functioning of such an explicit division of tasks it is necessary that it is monitored and controlled if tasks are done according plan. This could be done by the (executive committee of the) CCDA.

It is according to us essential to make – as a first step – a clear distinction between the different layers of stakeholders in the field of drug policy as they have different responsibilities in the policy making process, i.e. decision makers, policy makers, experts and professionals (including volunteers).

Mixing these layers in one body results in an unclear (picture of the) mandate of this body. To avoid as much as possible misunderstandings about what the tasks and responsibilities of the CCDA are it is vital to define as precisely as possible a division of these responsibilities and tasks between the different players.

Improving the implementation planning and feedback process
As chapter 5 shows, the National Drug Strategy has to do with a lack of priority, coherence, specification and feedback regarding the planning and implementation of objectives in the National Strategy. The CCDA Action Plans are rather vague and a structural feedback mechanism is missing as well as a clear division of responsibilities and tasks (see above). The planning and implementation process needs improvement.

Improving the management infrastructure
To make the management infrastructure work better a number of smaller and bigger measures should be considered. It should be considered to have besides a protocol defining the information flow (e.g. concerning CCDA meetings: which information has to be sent out and when) a regular control if this protocol is followed by the CCDA member organisations. The coordinating ministry (MYFSAEO) should be given a clearly defined mandate for coordinating the CCDA including means to *enforce* this mandate. This would include among others a clear description of responsibilities and tasks for the members of the CCDA (defining which input they have to give in policy preparation, etc.).

The fast 'turn-over' of staff in influential positions in the field of drug policy making is a problem not easy to tackle. Measures in human resource management can help to limit the impact of the first factor. E.g. career planning and management for the involved staff, offering career opportunities, regular individual support of the involved staff by the superiors and caring / coaching management approach.

Facilitate expert input
Expert input can best be realised through the sub-committees of the CCDA, taking into account what has been suggested above concerning a clear definition of domains and tasks of the sub-committees. Again, this should clearly be described in a profile and task description of the different sub-committees in which the expert input (including expert profiles, their tasks, etc.) is stipulated.

Enhance transparency of policy implementation
The lack of information from policy makers to policy 'implementers' on the contents of the strategy, on priorities and on what has been reached till now, could be countered by developing and implementing an information policy / pr strategy defining among others:

- How to inform relevant parties about drug policy developments and the state of affairs of policy implementation.
- Whom to inform with which information (policy executors, experts, media, and general public).

Installing an information office and appointing a spokesperson of (the executive committee of) the CCDA and/or the government are options worth thinking of. An active and coherent PR strategy in the field of drug policy also helps to make reports in the media more fact-based, to counter misunderstandings and misrepresentations and to promote the idea of the balanced approach as an example of an EU mainstream and adequate drug policy.

Involvement of civil society
A PR strategy also facilitates the desired involvement of civil society. In the implementation of the Strategy this involvement is mainly instrumental (through the KEFs and – in some cases – through expert committees). For the acceptability (part of the SMART methodology) of many of the Strategy's objectives, a change in public perception of the drug problem is important. The idea that the drug problem can be managed but perhaps not solved, that negative consequences can be limited but not totally eradicated and that a balanced approach can be effective if supported by society at large are important elements in a communication strategy.

The importance of monitoring and evaluation
The data collection on drug issues (including monitoring and research data) that are available to experts, professionals and policy makers in Hungary should be further developed. It is worth considering to develop a national monitor of the drugs situation including all data sources relevant for monitoring. Overall the more 'real-time' policy information is needed to facilitate the policy making process, allowing the development of timely and appropriate policy responses to the actual situation and new developments. The CCDA needs to determine what key indicators are needed to assess the progress that is being made in implementation of the Strategy.

1.6.3. Recommendations for the improvement of the local coordination structure
The importance of a sound local coordination structure is a cornerstone of the National Drug Strategy. Some recommendations can be made regarding the sustainability of the KEF structure and its further development.

The KEFs do not have the political mandate to take policy decisions necessary for genuine coordination of drug policy on the local level. Therefore, also for the KEFs it can be concluded that they are rather policy preparing than policy coordinating bodies. Policy decisions are – in line with the constitutional order – taken on the political level, i.e. by the local / municipal government. To allow the KEFs to play their policy facilitating role efficiently it is essential to identify the place and responsibility of KEFs in the decision making process as clearly as possible. This means that there should be a formal agreement on the routing of the input and out put of KEFs, in accordance with what has been stated regarding the CCDA above. To allow the KEFs to play their role in facilitating and monitoring policy implementation effectively the member organisations should have the formal obligation to report according agreed standards and rules about the state of affairs of policy implementation in their domain and, more specifically, about what has been done with tasks and responsibilities assigned to them by KEF agreements. Finally, as with the CCDA the scope and substance of the mandate of the members of the KEFs should be clearly defined.

For the KEFs it is essential to clearly decide on who is responsible to take action, to specify which party has to do what and (till) when. A clear definition of the domains and thereby the tasks and responsibilities of the member organisations of a KEF would be helpful in this respect. For an effective functioning it is furthermore necessary that the effectuation of this plan is monitored and controlled. A problem on local level that needs special attention here lies in the fact that some agencies and services operating on local level are doing so under the control of national bodies. An issue that needs to be solved is how these agencies can be involved in coordination of local drug affairs.

Sufficient funding of the implementation of objectives at local level is a key to success. Local activities that do good to local communities also should receive – at least to some extent - local funding. This responsibility could be translated into concrete support for KEFs, both by financial and by administrative and political means.

One key finding from this mid-term evaluation was that not every KEF has insight and oversight regarding the availability, planning and development of prevention and treatment service providers that operate within their working area. One recommendation in this regards may be to support communication and cooperation between KEFs in 'service regions', i.e. all KEFs that are served by one or a number of different treatment service providers (in-patient, out-patient, etc.). KEFs in which a service provider is located could function as coordinating KEF for that service in the service region. Agreements regarding needs assessment, planning, developing of appropriate treatment options, etc. should be made together with the other KEFs using the services of these providers A strong involvement of the local Self-Governments is important.

Further investments should be considered in raising the level of knowledge and know-how at KEF level. The NDI started in 2005 a website with information on drug prevention, drug treatment and drug research (SZIP).

The role of the NDI in gathering and disseminating relevant information and expertise on drug prevention, treatment and research should be further developed and maybe broadened with information on local policy, models of local coordination, etc.

Most of the above named features are not so much a problem as long as there is sufficient commitment of the KEF members and, in particular, of the local political level. However, the point is that – based on what is said in the National Drug Strategy about the KEFs – the involvement of structures, organisations and individuals from local communities should be conducted on a voluntary basis. The implementation of the National Drug Strategy has not been formalised in legal arrangements at the level of local communities. The existing Act on Local Self-Government does provide a basis for action regarding public safety (drug demand and drug supply reduction), health and health promotion. Local authorities decide themselves to take up additional responsibilities. Though, given the limited financial resources and the relative negative public perception of the drug problem in Hungary, not every Local Self-Government attributes a high priority to the implementation of the National Drug Strategy. Therefore, the question is whether the implementation of the National Drug Strategy by local drug policy can rely so heavily on – de facto – voluntary commitment. The evaluation results have shown that this has resulted in substantial differences in the establishment and functioning of the KEFs and the active involvement of Local Self-Governments throughout the country. Therefore it is worth a discussion whether at least a minimum level of what municipalities have to do in the field of drug demand and supply reduction should be defined in a legally binding regulation.

2. Introduction and background of the evaluation

This evaluation of the Hungarian National Strategy to Combat the Drug Problem[5] (hereinafter referred to as the National Drug Strategy) is based on an agreement of the Hungarian Coordination Committee on Drug Affairs to have a mid-term evaluation of the National Drug Strategy. This agreement has also been stipulated in the strategy. The Ministry of Children, Youth and Sport (now the Ministry of Youth, Family, Social Affairs en Equal Opportunities, abbreviated MYFSAEO) has the responsibility to harmonise the implementation of the National Drug Strategy and the governmental programmes with the concerned ministers, it participates in their implementation and follows their effectiveness[6]. This Ministry decided in 2003 to seek the involvement of external experts to conduct a mid-term evaluation of the implementation of the National Drug Strategy. This resulted in a project with the title *'Evaluation of the implementation of the National Strategy to Combat Drugs'* financed by the MATRA Pre-accession Projects Program of the Netherlands Ministry of Foreign Affairs. The Trimbos Institute – the Netherlands Institute of Mental Health and Addiction - was selected to do this evaluation in close cooperation with the Hungarian National Institute for Drug Prevention (NDI).

The project consisted of two parts, defined by the following project results that had to be achieved:

1. The methodology and capacity for the evaluation of the National strategy to combat drugs is developed by carrying out a (partial) evaluation of the medium-term priorities of this strategy;
2. The co-ordination of policy evaluation and formulation of drugs policy is strengthened.

Thus, besides evaluating the strategy, the MATRA project also aimed at reflecting on how to strengthen the existing coordination structure in the field of drug policy in Hungary. The output of this part of the project is meant to assist Hungary in meeting the requirements of the EU in the field of drug policy. A separate report contains a discussion of options and recommendations for how to improve drugs policy coordination[7]. This report contains the findings and recommendations of the first part of this evaluation.

2.1. Key aspects of the National Drug Strategy

The National Drug Strategy – adopted in 2000 – has been an attempt to write a policy paper, formulating a long-term (ten years), comprehensive drug policy. It approaches the drug problem from a *multidisciplinary model*[8] and advocates a *balanced approach*[9] between supply and demand reduction, such in line with the European Union drug strategy. This drug policy should serve as a general framework for defining short, medium and long-term objectives and priorities in the field of demand and supply reduction. The National Drug Strategy is divided in four result areas, representing important drug policy fields (**in bold**):

1. 'Society should become sensitive to the efficient management of the drug issue and local communities should improve their problem-solving capabilities in countering the drug problem'. (**Community**, **cooperation**).
2. 'Creation of opportunities to enable the young to develop a productive lifestyle and to reject drugs' (**prevention**).
3. 'Helping individuals and families dealing with drugs and struggling with drug problems' (**social work, treatment, rehabilitation**).
4. 'To reduce the opportunities of access to drugs' (**supply reduction**).

One of the key objectives in the National Drug Strategy concerns the establishment of an infrastructure of so-called Local Drug Forums (KEFs). These KEFs operate as local co-ordination points in drug affairs with the participation of representatives of all bodies and organisations having tasks in the drugs field, i.e. the local government, police, schools, medical services and NGOs. According to the National Drug Strategy these KEFs have a crucial role in carrying out the National Strategy at local level.

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[5] National Strategy to Combat the Drug Problem (2000). [EN]

[6] Hungarian Government (2002). Government Decree about the remit and the competence of the Minister of Children, Youth and Sports, 157/2002. (VII.11.).

[7] Trautmann, F. & M. Gallà & A. van Gageldonk (2005). How to Strengthen the Coordination of Drug Policy Formulation and Evaluation in Hungary – report based upon the mid-term evaluation of the Hungarian National Strategy to Combat the Drug Problem, Trimbos Institute, Utrecht, The Netherlands.

[8] National Strategy to Combat the Drug Problem (2000), p. 30. [EN].

[9] National Strategy to Combat the Drug Problem (2000), p. 32. [EN].

The above mentioned Hungarian Institute of Drug Prevention (NDI) was set up in 2001 under the auspices of the Ministry of Children, Youth and Sport, and is tasked with assisting in the monitoring and controlling the implementation of the National Drug Strategy, as well as providing professional and technical services for the new system of the Co-ordination Forums on Drug Affairs (KEFs).

2.2. Research question and remarks

According to the original plan, the project should be confined to developing an instrument and the capacity and skills of the people in charge of doing the evaluation. Trained Hungarian staff should have piloted this instrument by doing a part of the evaluation supervised and supported by experts of the Trimbos Institute. This meant that only a limited part of the actual evaluation should have been done during the project period. However, after the so-called inception phase it has been agreed between the responsible parties in Hungary and the Netherlands to have the whole evaluation done under the responsibility of the Trimbos Institute to assure independence. The NDI and other interviewed stakeholders stressed that an external, independent evaluation is of importance and strongly supported the idea of a more 'evidence-based', fact-driven approach to drug policy. In addition to this evaluation and its report, a separate manual will be written on the approach used for this evaluation.

The aim of this mid-term evaluation is not to analyse whether the policy and approach towards the drug problem that has been chosen by the Hungarian Government is correct. It merely deals with a critical analysis of key aspects of the Hungarian National Drug Strategy and the way it has been implemented in the first years after its adoption.

Policy evaluation serves mainly as a mirror for all stakeholders committed to a policy, in order to support decision making on improving policies. This report tries to answer three key questions.

1. **Is the National Drug Strategy a consistent policy document? This part of the evaluation refers to the consistency of the policy theory, SMART policy objectives and the relationship between objectives, actions and indicators?**
2. **Does the National Drug Strategy define the necessary priorities, instruments, and responsibilities for realisation of these objectives?**
3. **Did the implementation of the National Drug Strategy result in the achievement of the short-term and mid-term objectives?**

Evaluating policies has often been done in America and elsewhere and is documented in an abundance of publications. For drug policy in particular however, evaluation is no common practice. Still, especially in highly politicised fields – such as drug policy - evaluation is indispensable to make policy less ideological and more rational and effective. Evaluation can contribute to make drug policy 'smart', reflecting on the appropriateness of the formulated objectives, measures and results. Evaluation can help to improve the tuning of the different elements in a complex policy field. In fact, it is a prerequisite for an effective and more consistent policy. Taking all this into account, we should realise that the evaluation of the Hungarian National Drug Strategy by a third, independent party is quite unique, not only in Europe.

2.3. Methodology, approach and justification

2.3.1. Policy implementation and evaluation

One of the key challenges in making public policy work, concerns the actual transformation of policy objectives and goals into effective policy actions and – if necessary - policy change with the aim to realize the desired effects. This is implementation. Policy implementation concerns all activities or actions that are being executed on behalf of realizing a specific policy in the public arena. It usually entails a variety of policy instruments. Policy makers can make use of several instruments to reach these effects, such as legislation and/or regulation, sanctions, taxation and/ or subsidies, incentives and benefits, research & development, public campaigns, etc.

In most democratic societies, there is a clear distinction between *civil servants* and *politicians*. Civil servants are policy experts that formulate policy solutions for problems that dominate the political agenda. Civil

servants are expected to loyally accept the outcomes of the political decision making process and take responsibility for the implementation of the public policy.

Politicians are the people who are "in power" and who make the political decisions. They assess the alternative policy solutions provided by civil servants and choose the one that fits their and ideally societies' interests, aims and values best. They also set the conditions under which a policy is to be implemented. In order to allow politicians to follow the progress made and/or problems encountered during implementation processes, feedback is required through progress reports, monitoring information and evaluation studies. When required or when politically adequate, adjustments or a reformulation of the public policy is proposed and decided upon by the political decision makers. Basically, policy making is an iterative process of formulation, implementation and reformulation, rather than continuous evolution.

Evaluation – especially when combined with monitoring – can contribute to make drug policy more fact-driven. A well-designed evaluation methodology, adopted in advance by the relevant stakeholders and actors can contribute to depoliticising evaluation outcomes. A mid-term evaluation serves to collect information in order to enable answering a number of questions: Have important parts of the targeted situation changed? Have the objectives been specific, measurable, attainable, realistic, and time-bound? And if not, in what way should they be adapted? To which degree have the results been achieved? Have the interventions and activities been appropriate to reach the results? What are strengths and weaknesses in the process of policy formulation and implementation? Has it been well-managed, have there been interfering conflicts? Have the implicit or explicit assumptions underlying the National Drug Strategy been inclusive, and were they justified?

Policy evaluation is no easy job. In general it is complex as effects of policies are not easily measured. Furthermore, those who decide upon conducting an evaluation often have high expectations regarding the outcome, while the outcome is often depending on the quality of implementation itself. In evaluation of public policy, emphasis is often placed upon aspects such as:

- *Internal consistency*, i.e. checking the internal logic of the policy, including a check of the logic of the problem, needs analysis, etc.
- *External effectiveness*, i.e. covering the results and impact of policy. Does a policy reach its initial objectives?
- *Efficiency*, comparing the inputs (resources) with the outputs (results and impact). Does a policy reaches its objectives in a cost-effective way;
- *Relevance of the objectives of the policy vis-à-vis a broader policy framework*, i.e. the EU framework (National Drug Strategy versus EU Action Plan);
- *Utility*. Do policy impacts (direct results and longer-term outcomes) correspond with the needs of target populations (local / regional policy makers, demand and supply reduction professionals who have to work within this policy framework, substance users and their environment);
- *Sustainability*. To what extent has the policy also a more lasting impact (long-term effects)?

Of course one can and usually has to limit the scope of policy evaluation. In general, the primary focus of evaluation is on effectiveness. Reducing the scope of evaluation does not mean that evaluation becomes easier. Policy generally covers a broad area of actions and drug policy is not an exception to this. The main areas or fields of drug policy, demand and supply reduction, include a wide range of objectives and results to be achieved. Evaluating the impact of drug policy on a national level has taught us that collecting the necessary relevant and valid data requires an extensive effort. An evaluation of the envisaged results of a policy is time-consuming and therefore expensive. Looking at it with a researcher's eye brings two questions in mind: "With what indicators can we measure success or failure?" and "How can we be sure that certain changes can be defined as results of the policy evaluated?" These questions cannot be answered without a certain degree of uncertainty. In general, the maximum we can get out of an evaluation are indications of policy effects but not sufficient evidence for success or failure of policies. This means, naturally, that an evaluation of a National Drug Strategy is always limited. It is impossible to measure in exact terms to what extent the desired results that are formulated in a policy plan have been reached.

Besides this there are important conditions and requirements for realising a policy evaluation. The most important ones are mentioned below.

Describing/identifying the evaluation programme *(i.e. the National Drug Strategy)*

- The needs for evaluation (background) of the National Drug Strategy
- Evaluation targets and effects. Should be specific, measurable, attainable, realistic and time bound (SMART). Most policy evaluations violate this methodological rule
- Methods and activities (also specifying external factors that may influence the effects of the strategy

Engaging stakeholders

Engaging persons involved in or affected by the strategy and primary users of the evaluation:

- to understand their perspectives
- to address important elements of the objectives, operations, and outcomes
- to increase credibility
- to increase chances that the evaluation is useful for stakeholders
- fostering input, participation and power sharing

Evaluation strategy and design for collecting evidence

- combining or comparing different data from different designs and different methods is preferable to using a single method
- nevertheless, be realistic (feasibility)

Credibility, confidence-building, justification, utility of evidence

- to be increased by feed back with stakeholders (agreement)
- serve the information needs of intended (direct and indirect) users
- using multiple procedures for data collection
- using several process and/or effect indicators

Sharing the lessons learned

- organizing feed back meetings
- organizing result meetings

2.3.2. Choosing the methods for analysis of the National Drug Strategy

As has been stated already, an important limiting factor from a scientific point of view is that 'soft' methods cannot measure effects of policy interventions. In fact these effects can only be judged, based on the amount of evidence. In order to compensate for these inherent scientific shortcomings of policy evaluation, many analysts use several methods for compiling or adding evidence from more than one source or viewpoint. Non experimental research designs are at best capable of unfolding correlations or associations between phenomena, but these designs cannot determine causal relationships. The reason for this is that historical developments or simultaneous events may have 'co-caused' the same effect. We cannot separate the specific effect of an intervention from the other ones in these designs. The limited scientific validity can be partly counteracted by collection and validation of evaluation data before, during and after the policy has been accepted. Other limiting factors that are often mentioned in the literature of policy evaluation are: psychological resistance mechanisms among participants or stakeholders in the policy process (especially – but not exclusively - of the politically more powerful ones), judicial barriers, and lack of money or funds to realize the decisions made.

Important stimulating factors for success of policy evaluations are: specification of the initial policy problem and/or target(s) before starting the evaluation; frequent contacts and tuning between researchers and all relevant stakeholders during the study; clarity about limitations and possibilities of the policy itself; clarity about limitations and possibilities of the chosen policy evaluation strategy; making a 'best fit' between the evaluation study and current policy processes and procedures.

Thinking over both limiting and stimulating factors brought us to our choices in evaluating the Hungarian National Drug Strategy. An interim strategy has been used for the evaluation of the Hungarian National Drug - because the strategy was already introduced in the period before this evaluation started. Among the available methods we chose a specific kind of desk research (i.e. document analysis, in this case *log frame* analysis), combined with stakeholder analysis, questionnaires, individual interviews and focus group interviews.

2.3.3. The method of log frame analysis

Methodological origins

The roots of log frame analysis date back to the early sixties of the former century[10]. In essence, log frame analysis is a variant of older types of analyses from psychology, applied social science, business and administrative science. These analyses have been very diversely labelled, e.g. analysis (or mapping) of: personal scripts or schemes, concepts, cognitions, theories-in-use, policy theories, policy programmes or programme theories. The common trait in these analyses is (re)construction of (often implicit) assumptions, ideas or theories, irrespective of whether these are individual, social or political in nature.

The concept 'theories' in this research tradition is understood as a logical arrangement of collections of implicit and explicit assumptions. Often these assumptions are derived from document texts. Logical relationships between these assumptions can be unfolded by argumentation analysis. By doing so, a set of interrelated assumptions (interconnected in a scheme by arrows) is reconstructed, resulting in a 'logical framework of assumptions'. When evaluators limit themselves to written texts, these logical frameworks are not necessarily consistent or complete. Often, policy documents show 'blind spots' or 'loose ends'. Some statements may in itself be unclear. Sometimes, no reasons for specific statements are mentioned or no means to certain ends or goals.

Strengths and weaknesses

Uncovering logical inconsistencies may stimulate learning processes or debates in order to improve policies or strategies. Confrontation with an unfolded policy theory has an *enlightenment* function for participants and stakeholders. It presents a clearer picture and may endorse criticisms and improvements of follow-up steps in policy making.

Possible weaknesses of this method are: 1) lack of involvement of participants or stakeholders in the process of articulation of a policy theory (difference of interests), 2) the often time consuming activity of reconstruction of policy theories, 3) not paying much attention to results of differences in power positions of participants or stakeholders.

Policy programme reconstruction (or log frame analysis) is recommended when: 1) the impact of a policy is large, 2) when there are many risks involved in a policy, and 3) when a policy is expensive.

General remarks about the method

Logical reconstruction necessitates an argumentative or logical analysis of text parts in documents[11]. Explicit and implicit assumptions are found in all written documents and consist of statements like: "It is evident that …", "The best way to tackle this problem is …", "Therefore …", etc. Such phrases assume reasoning in terms of "if … then", "the more … the less", etcetera. What is often left is the "because-part" of the reasoning. Though sometimes formulated explicitly, in many cases researches have to infer and "fill in" this part of the argument (i.e. the assumed causes). Assumptions may deal with causality in behavioural mechanisms or politic action. Means-ends relationships are variations of these assumptions.

Log frame analysis is in fact a variation of the methodology of reconstruction and evaluation of *policy theories*. It concerns reconstruction and evaluation of a selection of *means-ends relationships* (means-end trees) and a selection of factors that may influence (stimulate or hamper) the outcomes ("ends"). These relationships may also be understood as *action-target relationships*.

Policy programme reconstruction uses the multi method approach in order to uncover what is actually planned or what has been done and what is missing. Evaluation may be done either by critical appraisal of results of scientific literature (e.g. behavioural statements) but also by verifying the content of (parts of) the log frame with stakeholders' answers in questionnaires and interviews. Questionnaires and interviews may also be used for illuminating important and less important parts of the log frame or strengths and weaknesses.

Comprehensive policies result in comprehensive log frames. In most cases it is unfeasible to check and evaluate all parts of such a logical framework, thus in most cases a selection of parts of policies or a log frame

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[10] Leeuw, F.L. (2003). Reconstructing program theories: Methods available and problems to be solved. *American Journal of Evaluation*, 24 (1), pp. 5-20.

[11] Toulmin, S. (1958). *The uses of argument.* Cambridge, Cambridge University Press. Mason, I. & Mitroff, I. (1981). *Challenging strategic planning assumptions.* New York, Wiley.

is necessary. Our checks were limited to the internal consistency of (parts of) the log frame and the external effectiveness of the National Drug Strategy.

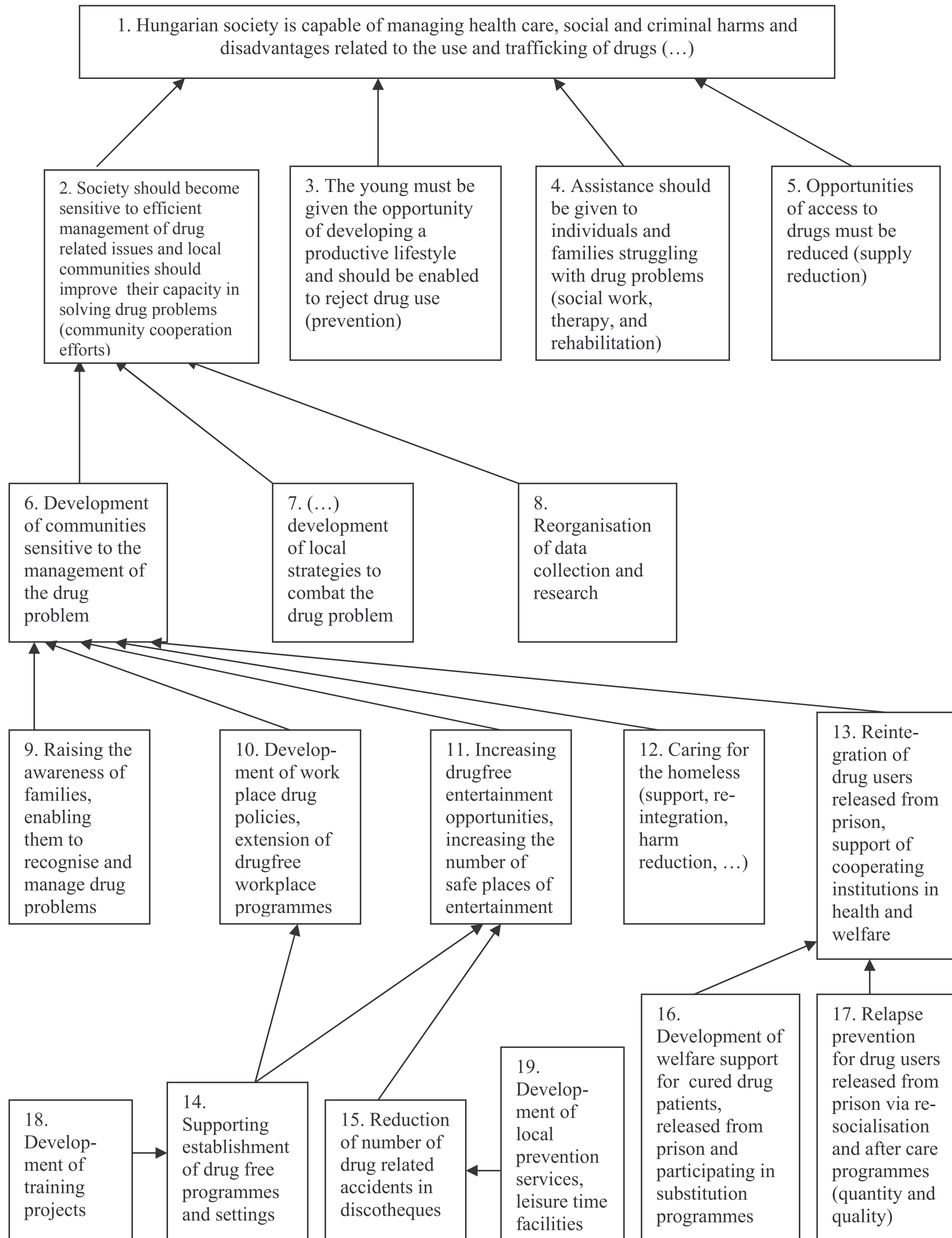
2.3.4. Determining internal consistency: an example

A check on the internal consistency of a policy theory is useful because it reveals the quality of causal thinking in the Strategy. These checks are helpful for construction of future policy documents.

In **Figure 2.1** the policy goal of the National Drug Strategy is represented and the four key objectives (2 to 5). All parts have been ordered logically and hierarchically as far as appeared to be feasible. The parts itself were derived from the text of the Strategy.

The figure is meant as *an example*, and shows *a selection* of the policy theory underlying the Hungarian National Drug Strategy. We selected the first key objective (2) together with the three underlying priority aims (6, 7 and 8). We (again) selected the first priority aim (6) with its underlying five actions (9 to 13) and the activities that have been written in the Strategy (14 to 19).

Figure 2.1: in search of consistency: an example



Short comments
Key objective 2 is a political statement and is very generally stated. What is meant by "sensitive" remains unclear? A second point is that "efficient management" includes a weighting of effects and costs, while the costs (or related expenditures) are not mentioned anywhere in the text of the Strategy.
Priority aim 6 deals with *local* communities and the word "efficient" does not appear here anymore (cf. key objective 2).
Among the **actions 9 to 13** 'schools' are missing (these are mentioned elsewhere, namely under prevention).
Actions 9 and 12 (families and the homeless) are not defined in more detail by specific activities, resulting in 'open ends' in this scheme.
Activities 14 to 19 are still phrased in terms of reduction, support and development. Instead specific actions or initiatives are expected here. In short, WHAT should be done has already been mentioned in the actions, but HOW it will be done is still missing.
General remarks: important and well known policy instruments (e.g. legal regulations or legislation, specific incentives and grants or expenditures) are missing entirely in this policy theory.

2.3.5. The log frame matrix

In our log frame analysis the different elements of the National Drug Strategy are arranged in a logical framework (see figure 1.1 for an example). In general the log frame is put down in a table or matrix that in this case has the following format:

Figure 1.1: LOGFRAME MATRIX:			
Overall Objectives of the National Drug Strategy *(longer-term aims)*	**Objectively Verifiable Indicators** *(to verify to what extent the overall objectives are fulfilled)*	**Means of Verification** *(Data sources for indicators for overall objectives)*	
Strategy Goal *(general aim of the policy)*	**Objectively Verifiable Indicators** *(to verify to what extent the policy goal is achieved)*	**Means of Verification** *(Data sources for indicators for project goal)*	**1. Assumptions and risks**
Key objectives ***(representing desired results)***	**Objectively Verifiable Indicators** *(to verify to what extent results are achieved)*	**Means of Verification** *(Data sources for indicators for project results)*	**2. Assumptions and risks**
Priority Aims ***(inferred – LTO)***	**Objectively Verifiable Indicators** *(to verify to what extent the priority aims have been realised)*	**Means of Verification** *(Data sources for indicators for project results)*	**3. Assumptions and risks**
Actions and activities ***(many – STO/ MTO)***	**Actual input** *(policy instruments necessary to implement the activities)*		**4. Assumptions and risks**
			Preconditions

The first column of this matrix is filled with data of the following characteristics or variables. The starting point (first row) is the (perceived) target problems of the policy, here translated in the overall objectives of the National Drug Strategy. The second row presents the attainable strategy goal, the desired situation that reflects the outcome of the policy itself once it has been fully implemented. The matrix proceeds with the defined or reconstructed key policy objectives. These key objectives represent the results that are to be reached with (parts of) the National Drug Strategy. In the fourth row, priority aims of each key objective are inserted presented, representing desired results of the National Drug Strategy. The appropriate activities that serve to realise these results are presented in the fourth row.

For the overall and key objectives and for the priority aims (objectively verifiable) indicators are identified. For actions and activities the actual input is identified in order to reach these objectives (the policy instruments). The indicators are meant to monitor whether the desired results have been achieved or not. In the last column, factors that are assumed to stimulate or hamper the realisation of parts of the Hungarian National Drug Strategy are described ("assumptions and risks"). In the far-right bottom cell of the Log Frame, the preconditions for implementation of the policy need to be defined.

As has been explained earlier, this type of log frame analysis aims at 1) a more thorough insight in, and 2) a tool for testing the internal logic (or consistency) of the divers (reconstructed) policy trees. But the results of

these steps can also be used for 3) evaluating a policy on its effectiveness. Are adequate indicators used? Have the envisaged results of a policy been reached? What factors have frustrated the envisaged results?

2.3.6. The scope of evaluating the Hungarian National Drug Strategy

We stated earlier that a comprehensive national strategy on a complex field like drug policy would require an extensive log frame. In the timeframe of this project this is not feasible but regarding the targets (enlightenment, debate and further improvement) a thorough log frame analysis would not be useful either. Therefore we limited ourselves to two key issues of the log frame that were checked in our analysis:

- internal consistency (clarity of concepts, completeness of means-ends relationships done with argumentation analysis)
- external effectiveness (self-reported, done with questionnaires and interviews).

Other targets that – if feasible - need attention:

- a rough analysis of costs and effects
- an assessment of the relevance of the objectives of the Hungarian National Drug Strategy for the EU framework
- an assessment of the utility of the strategy for the different stakeholders or target populations
- a rough assessment of the longer-term impact of the strategy

2.3.6.1. Checking the internal consistency of the National Drug Strategy

The internal logic of the National Drug Strategy is evaluated by checking the consistency between problems, goals, key objectives, proposed actions and activities, indicators and assumptions. We have done this by translating the National Drug Strategy into a log frame, analysing the links between its different elements and checking the results in interviews with a number of key persons. We selected as key persons individuals who play a key role in the field of Hungarian drug policy who have an overview of the policy field and have knowledge about this policy that exceeds their personal professional domain.

The interviews focused on the following main issues:

- Were the objectives defined SMART (specific, measurable, acceptable, realistic and time specific) enough to allow measuring if they have been reached?
- Were the results formulated in the National Drug Strategy realistic?
- Were the objectively verifiable indicators appropriate to measure if results have been achieved?
- Were the assumptions and risks well-defined and inclusive?

2.3.6.2. Checking the external effectiveness of the National Drug Strategy

After the consistency check, we examined if and to which extent the envisaged results of the National Drug Strategy have been realised. In our log frame translation of the National Drug Strategy we had identified over 90 short- and mid-term objectives, too many to be evaluated in our evaluation. Thus we selected 17 objectives that are assumed to be essential for the National Drug Strategy during the implementation period covered by the evaluation. This selection has been done by the Trimbos Institute in consultation with Hungarian key stakeholders.

In order to obtain insight to what extent these objectives have been achieved, we conducted interviews and subsequent focus groups with a selection of key policy makers and experts working in the field. Over 20 key policy makers, representatives from national implementing agencies (e.g. customs and the police) and other stakeholders have been interviewed personally. Representatives of 64 KEFs, being key stakeholders in the field and involved in realising the policy objectives, have been interviewed by telephone. Finally, focus groups have been organised to discuss a selection of diverging and otherwise relevant outcomes of the interviews.

2.3.7. Monitoring and evaluation

For a more extensive evaluation it would be necessary to include / build upon monitoring. Monitoring and evaluation are different activities that are complementary. Monitoring – examining over regular time intervals

the state of affairs concerning predefined indicators – delivers valuable additional data for an evaluation. Therefore, to benefit optimally of an evaluation instrument as we have used it, it should be considered to develop a combined monitoring and evaluation instrument. Monitoring delivers data on the progress made and changes in the drugs field.

Because the PHARE twinning project aiming at the development of a National Focal Point as part of the REITOX network of the European Monitoring Centre on Drugs and Drug Abuse (EMCDDA) had insufficient results, an important monitoring instrument of drug policy has not been realised at the time the evaluation started. Moreover, there were no baseline data available to compare the situation in 2004 with 2000. Therefore it appeared not feasible to include monitoring data in our evaluation. A future evaluation building on monitoring data will certainly facilitate a more need-driven policy approach. It will enable focused adaptations and additions reflecting current developments and needs.

2.4. Structure of this report

As indicated earlier in this document, the evaluation as conducted by the Trimbos Institute focused on two specific results, namely a mid-term evaluation of the implementation of the policy objectives of the National Drug Strategy and the evaluation of the coordination structure governing the implementation. In this document, the analysis of both results can be found. However, the recommendations regarding the coordination structure have been explicated in a separate report[12].

In Chapter 3 of this report, the outcomes of the stakeholder and document analysis are presented, identifying the relevant structures and organisations within the Hungarian drug policy field as well as identifying some of the key documents that were examined for this evaluation. Combined, an impression of the Hungarian drug policy field is created. In Chapter 4, the internal consistency of the National Drug Strategy is examined and described, based upon the Log Frame analysis conducted by the evaluators. In Chapter 5, the results of the evaluation of the external effectiveness of the National Drug Strategy are presented, divided into the level of implementation at local level (the perspective at the level of the Local Coordination Forums on Drug Affairs) and the level of implementation at National level (the perspective of the key stakeholders). In Chapter 6 the conclusions of this mid-term evaluation can be found. Chapter 7 provides recommendations for 'The Way Forward', reflecting on possible steps to enhance the implementation of the National Drug Strategy and the reinforcement of its implementing and coordinating structures.

[12] Trautmann, F. & M. Gallà & A. van Gageldonk (2005). "Strengthening the National Coordination of Drug Affairs in the Republic of Hungary, Trimbos Institute, Utrecht, The Netherlands.

3. Analysis of the policy system and implementation structures

3.1. Introduction

In order to obtain a better understanding of the policy system regarding the National Drug Strategy and its implementation, during the inception phase of the project as well as throughout the evaluation process, emphasis has been on identifying key stakeholders who have a good knowledge about the National Drug Strategy and its implementation and/or the domains it is aimed at. Furthermore, key documents with relevance for the evaluation process were identified and gathered. Due to language barriers, the identification of such documents depended largely on the key stakeholders who had a role in the evaluation process as well as on the representative of the two project beneficiaries, i.e. the Ministry of Youth, Family, Social Affairs and Equal Opportunities and the National Drug Prevention Institute (NDI).

3.2. Stakeholder analysis

Stakeholders are all those actors (individuals and bodies) that have a substantial ‘stake’ or interest in the (implementation of the) National Drug Strategy. Conducting a stakeholder analysis is of great importance for an evaluation, as the effectiveness of implementation of a policy is often seen differently by the different groups involved in or affected by a policy, as each of them has its own positions role and perspective.

3.2.1. Why stakeholder involvement is important

The importance of the involvement of a broad range of stakeholders in policy evaluation has not always been self-evident. In the early years of policy evaluation, but even in some cases today, evaluations are sometimes focused at the main actors in policy making and implementation and their perception of reality, i.e. the responsible policy makers and managers of core implementing bodies. This type of evaluation is often hampered by managerial bias and/or top-down blindness. The evaluators only obtain a limited view of reality. Independent evaluations ensure the involvement and active participation of other stakeholders, i.e. the target groups, clients or users of a policy.

But even if a wide range of stakeholders is involved, a proper outcome of an evaluation is not guaranteed. Many evaluation studies do not question the correctness or suitability of the policy that is being evaluated, but try to fit recommendations and conclusions within the existing policy framework even if more effective or efficient alternatives may be thinkable or available. This is partly due to the fact that many stakeholders do not think ‘out of the box’ of the system they are part of. Secondly, despite the original intentions, the results of an evaluation are rarely used to improve policies and decisions about those policies. So stakeholders that give input enthusiastically with the expectation that change may be at hand, are often disappointed with the follow up of an evaluation. Finally, stakeholders are often used just as information providers in an evaluation. They often do not participate in the further evaluation process or in the analysis of results even if their interests might be at stake[13]. A proper evaluation tries to take these elements into account or at least explicates its own limitations.

As already explained in Chapter 2, one other major deception for many stakeholders, including the implementing structures, concerns the expectation that an evaluation of a complex, multifaceted policy that is being implemented in society can result in something like an ‘objective truth’. In most cases, evaluations do not provide such clarity about the impact and effectiveness of implemented policies. As one cannot work with a randomised trial to check in concrete terms the impact / effects of a national policy, evaluations always include judgements and assumptions of the stakeholders. Policy evaluation has to simplify reality in order to make it manageable.

The latest generation evaluation scientists[14] believe that objective and value free evaluation does not exist and that evaluation is always influenced by subjective perspectives and interests of stakeholders. They identify three groups of actors that might be ‘at risk’ when the outcomes of an evaluation are concerned. They identify a) *agents* of a policy or program (policy makers, professionals, financers), b) *beneficiaries* (who (indirectly) benefit from a policy), and c) *victims* (those who feel the negative consequences of a policy).

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[13] Abma (2000), p. 393-394;
[14] Guba & Lincoln (1989). pp. 41

Other policy analysts[15] identify three perspectives in which stakeholders operate: that of the a) *centre* (the initial policymaker, in our case in the first place the National Drug Coordinator), b) the *periphery* (the field implementing officials, in our case the CCDA members, implementing ministries, implementing agencies and KEF respondents) and c) the *target group* (the private actors at whom the policy is aimed at, the drug users, drug prevention & treatment professionals, non-profit organisations and volunteer groups, etc..)..

3.2.2. Stakeholder involvement in this mid-term evaluation

This evaluation focused at stakeholders at both national and local level. Before the actual evaluation activities started, an initial round of open interviews was conducted with key-informants in the policy making and implementation process, including the responsible drug coordinator, the head of the Reitox national focal point, (senior) policy makers representing the wide spectrum of drug policy making and implementation and other experts who were not part of the policy process but that had a good understanding of the policy system, e.g. researchers. A social map of people and organisations involved in or affected by the implementation of the National Drug Strategy was drawn up. By doing so, a snapshot was obtained of relevant stakeholders with claims or interests in the implementation of the National Drug Strategy and the relative importance and influence they have in the process of implementation of the National Drug Strategy.

On the basis of this - with the advice of the National Drug Prevention Institute (NDI) and the Ministry of Youth, Family, Social Affairs and Equal Opportunities - a list of relevant stakeholders that were to be involved in the evaluation was drafted by the Trimbos Institute. This list included members of the Coordination Committee on Drug Affairs (CCDA), experts involved in the making of the National strategy to combat drugs (National Drug Strategy), experts involved in evaluating and monitoring elements of drug policy in Hungary and stakeholders that were affected by the implementation (e.g. representatives of NGO's and service providers). For the evaluation at local level, it was decided to focus on the representatives of the Local Coordination Forums on Drug Affairs. A further breakdown of local stakeholders was deemed impossible due to the timeframe and resources of this mid-term evaluation.

One difficulty in drafting a stakeholder overview concerns the fact that these may have different 'stakes' and positions, depending on the level of implementation that is being analysed. The Hungarian National Drug Prevention Institute is an actor in the periphery (background) of the Ministry of Youth, Family, Social Affairs and Equal Opportunities (at national implementation level. At the same time it is a central actor in the implementation of the strategy at local level. The Local Coordination Forum on Drug Affairs (KEF) is hence an actor in the periphery of implementation vis-à-vis the National Drug Prevention Institute, but a central actor at local level vis-à-vis the KEF Members (periphery) and the general public (target group).

This entails that policy actors can have the role of policy maker, policy implementer and sometimes even target group of the policy at the same time. Furthermore, some actors at local level (e.g. the local branches of the Public Health Service) are both target group of the National Public Health Service and of the local KEF. This 'mix' of roles of actors makes clear that interests, perceptions and perspectives of actors vary depending on the focus of the evaluation and the role each stakeholder has within the implementation process. In Table 3.1 an overview is provided of the key stakeholders that were involved in this mid-term evaluation of the National Drug Strategy.

Table 3.1 – overview of key stakeholders involved in the mid-term evaluation (Inception and Interview rounds)

Stakeholder	Responsibility	Role in the implementation process
Ministry of Youth, Family, Social Affairs and Equal Opportunities	Responsible for coordination of drug policy, health promotion, youth policy, social policy	Policy making; coordinating
Deputy State Secretariat for the Coordination of Drug Affairs	Responsible for coordination of implementation of National Drug Strategy	Policy making; coordinating
Ministry of Health, including the Public Health Directorate	Responsible for the State Public Health Service (ÁNTSZ); Responsible drug treatment and rehabilitation	Policy making

[15] Mazmanian & Sabatier (1989), p.11.

Ministry of the Interior - Deputy State Secretariat for Crime Prevention	Responsible for Crime Prevention	Policy making
Ministry of Education - Department for Public Education Development	Responsible for health promotion and drug prevention	Policy making
National Police - Organised Crime Unit	Responsible for countering drug trafficking, money laundering and organised crime	Implementing agency
Budapest Court of Justice	Responsible for the interpretation of Law and administration of sanctions	Independent body; part of National Magistrature
Budapest Public Prosecutor's Office – Children and adolescents section	Responsible for the prosecution of (juvenile) drug related offences and crimes	Implementing agency under the responsibility of the Ministry of Justice
Hungarian Customs and Finance Guard – Directorate General for Enforcement	Responsible for countering drug trafficking and money laundering	Implementing agency
Hungarian Prison Service	Responsible for the State Penitentiaries	Policy making & implementing structure; part of Ministry of Justice
National Development Office	Responsible for International (and European) cooperation programmes	Coordination of EU funds (incl. Phare Twinning)
National Drug Prevention Institute	Responsible for Drug Prevention; Responsible for the support to the Local Coordination Forums on Drug Affairs	Implementing agency (background institute) of Ministry of Youth, Family, Social Affairs and Equal Opportunities.
Blue Point NGO	Responsible for service provision in the field of drug prevention	Prevention Service provider
Nyiro Gyula Hospital	Responsible for service provision in the field of drug treatment	Treatment service provider
Hungarian Civil Liberties Union (TÁSZ)	Civil rights organisation; watchdog function	Independent NGO
Sziget Drug Services	Civil organisation	NGO in prevention
Hungarian Catholic Charity Service	Civil organisation	NGO in prevention
Budapest University of Economics	Policy research	Research & monitoring
National Institute of Criminology	Policy research	Research & monitoring

3.2.3. *Initial observations from the stakeholder analysis*

One of the initial observations that could already be made in the inception phase (early 2004) of this evaluation concerned the fact that the field of key-stakeholders involved in the original development and implementation of the National Strategy was quite compact. The initial interviews with these persons resulted in consistent suggestions about whom to include in the evaluation.

A second observation concerned the fact that personal relations and perceptions about persons seemed to have influence on the judgment of several stakeholders regarding the effectiveness of coordination and the level of success regarding the implementation of the National Drug Strategy. Stakeholders indicated that the coordination style of the Ministry of Youth, Family, Social Affairs and Equal Opportunities did not always facilitate 'ownership' among those involved in implementation to contribute fully to the implementation process, something they considered to be an important requisite. By the end of 2004 and the beginning of 2005, those stakeholders that were interviewed for a second time indicated the situation had improved. The evaluators tried to disregard sensitivities between stakeholders as much as possible and focused their work on what had actually happened.

3.3. *Document analysis*

Although it was clear that a mid-term evaluation that focused on the implementation of the National Drug Strategy would primarily concentrate on that specific policy document, it was also deemed important to analyse relevant documents and papers that were derived from the National Drug Strategy and/ or that could provide information about the extent to which the National Drug Strategy was actually being implemented. During the Inception Phase of the mid-term evaluation, a list of relevant documents was drafted that were considered relevant for the evaluation. These documents included:

- *the National Drug Strategy to Combat the Drug Problem, English translated version;*
- *the tasks of the Deputy State Secretary for the Coordination of Drug Affairs;*
- *the Governmental Decree about the remit and the competence of the Minister of Children, Youth and Sports (157/2002 – VII.1.1);*
- *the Government Decision on the tasks of the Government concerning the implementation of short and mid-term objectives of the National Drug Strategy (1036/2002 – IV.12);*
- *the Government Decision on the Establishment of the Coordination Committee on Drug Affairs (1039/1998 – III.31.);*
- *Lists of chairs and expert committees of the CCDA.*

During the course of the mid-term evaluation, other documents were added to the review list, including:

- *the Hungarian National Reports to the European Monitoring Centre for Drugs and Drug Addiction for 2002, 2003 and 2004;*
- *the reports of the Mini Dublin Group for Hungary 2000 and 2001 and the Thematic Reports for those two years;*
- *the National Crime Prevention Strategy, adopted by the Hungarian Parliament in 2003;*
- *the work schedules of the Coordination Committee on Drug Affairs for the years 2002, 2003, 2004 and 2005.*
- *Act LXV of 1990 on Local Self-Governments (extract), (Lezárva; 2005. marcius 31; Hátaly: 2004.V.I);*
- *the Government Decree on the implementation of Government tasks related to attaining the objectives of the National Strategy to Combat the Drug Problem (1129/2004 – 24 November).*

These documents provided ample insight into the relevant stakeholders involved in the implementation of the National Drug Strategy, its implementing mechanisms and structures and the conditions for implementation. The list is not exhaustive but includes the most important documents and therefore provided an adequate basis for the mid-term evaluation in combination with the interviews and other data collections.

3.3.1. *The National Drug Strategy to Combat the Drug Problem*

The National Drug Strategy is the key document of the Hungarian drug policy and the main focus of this mid-term evaluation. Other relevant documents provided information on legal mandates, division of tasks, procedures and monitoring information. The National Drug Strategy is a comprehensive document that combines an assessment of the drug problem in Hungary with an analysis of existing drug policies, after which a choice was made for a multidisciplinary and balanced approach (*see Box 1*), which matched well with the EU Drug Strategy 2000-2004 and the EU Action Plan on Drugs 2000-2004. The National Drug Strategy recognised that Hungary faced a drug problem that was – among others – characterised by an increasing use of illicit drugs, an increase in drug related harms and a growth in drug related crime, while the response systems of the country (prevention, treatment, supply reduction) were not well enough developed and at times ill-equipped[16].

General objectives of the strategy

By establishing the National Drug Strategy, the Hungarian Government identified a number of overall policy objectives aimed at the gradual reduction of drug consumption in Hungary. These objectives are[17]:

- To call a halt to the growth and, if possible, reduce the number of drug users and addicts;
- To call a halt to the negative trends in drug consumption;
- To increase the number and ratio of those receiving treatment and those being cured;

[16] National Strategy to Combat the Drug Problem (2000), Ch. 3 [EN].
[17] National Strategy to Combat the Drug Problem (2000), p. 5. [EN].

- To comprehensively develop prevention and the dissemination of information;
- To reduce the harm caused by drug consumption to the individual and society;
- To curb drug-related crime, and;
- To expand international co-operation.

In order to reach these overall objectives, the National Drug Strategy identifies a general strategy goal, which reads as follows[18]: *"(...) the society is capable of managing health care, social and criminal harms and disadvantages related to the use and trafficking of drugs".*

The operationalisation of this strategy goal has been broken down into a number of short-, medium- and long term objectives. The long-term objectives reflect the totality of the actions required for the implementation and are to be achieved by 2009. These objectives reflect four main areas: Community support; Prevention; Treatment, Social Work and Rehabilitation; and Supply Reduction. The medium-term objectives specify the tasks to undertake within the (fiscal) years 2000-2002. The short-term objectives list the tasks that needed to be directly undertaken and that are needed to implement the medium term objectives.

Box 1 – Model and approach for the National Drug Strategy

Multidisciplinary model: this is a sociological approach, building on the preceding models and using the appropriate empirical data. It examines the place of the phenomenon from the viewpoint of society's values and norms on the one hand, and the role of individuals, families and communities in socialisation, on the other hand. It uses the achievements of modern criminology and psychiatry as well as other sciences (e.g. pharmacology, genetics, social statistics, and public health). It calculates with the manifold nature of the problem and the manifold nature of the professions called to manage it. This approach takes into account the fact that social action itself, aimed at influencing drug consumption contributes to a transformation of the phenomenon, making it more or, to the contrary, less manageable".

An approach building on a balance between demand and supply reduction: this is the approach which the international community (UN, EU) regards as advantageous, hence this is what it recommends in its documents, recognising that as long as there is demand, there will also be supply. In itself, therefore, supply side intervention is indispensable but not sufficient. In addition to the instruments of the criminal justice system, there is also a need for appropriate prevention, health and social care for drug users struggling with problems. The phenomenon of drug consumption cannot be segregated from social problems— among others, the issues of inequality, poverty, unemployment, social exclusion and marginalisation. An increase in the role of demand reduction can be observed in international documents (in addition to the regulations concerning the supply side, which had earlier been preferred); moreover, certain recommendations set the objective of reducing the individual and social harm caused by drug use. Such an objective could not be envisaged in a "purely" prohibitionist model. There are differences among individual countries in the assessment of the gravity of the drug issue (or in relation to their quantity), in the penal evaluation of consumption (one-timer, ad hoc, recurrent user, consumer and addict) as well as with respect to the extensiveness of the use of the alternative to the penal procedure. There can also be differences with respect to the evaluation of harm reducing methods. There seems to be agreement, however, that only a policy of intervention based on a balance of demand and supply reduction, the combined and co-ordinated use of prevention, therapy and the practice of the criminal justice system together with a more differentiated evaluation of drug users can be successful.

Although not clearly attached to any specific objectives, the National Drug Strategy also includes a series of indicators for success and instruments. These indicators do not reflect quantitative achievement levels (because of a lack of data collection systems) and could be attributed to a number of objectives.

Finally, the National Drug Strategy also identifies a number of general instruments required to manage the drug problem and to reach the objectives, including:

- The elaboration of scientifically well-founded outcomes *(research and development)*;
- A uniform and comprehensive management of prevention, therapy, risk reducing instruments and supply reduction through the instruments of criminal law *(legislation and coordination)*;
- Allocating the necessary funding;

[18] National Strategy to Combat the Drug Problem (2000), pp. 33. [EN]

- Raising social awareness with respect to the drug problem and its management *(awareness raising & advocacy)*;
- Active participation on the part of citizens and their organisations *(involvement of civil society).*

3.3.2. Implementation at National level: structures, mandates and regulations

In order to facilitate a proper implementation of the National Drug Strategy, the Hungarian Government established a coordination structure at national level. Until 1998, the coordination of drug policy the responsibility of an Interdepartmental Committee on Drugs (ICD) that was established in 1991. The ICD was finally dissolved because of its incapacity to draft a national strategy to counter drugs and was replaced – in 1998 – by the Coordination Committee on Drug Affairs (CCDA). From 1998 to 2001, the CCDA was situated within the Ministry of Health and Social Affairs. From 2001 onwards, the tasks regarding the coordination of drug affairs was moved to the newly established Ministry of Youth, Family, Social Affairs and Equal Opportunities.

3.3.2.1. Tasks of the Ministry of Youth, Family, Social Affairs and Equal Opportunities

The tasks of the Minister of Children, Youth and Sports regarding the coordination of drug affairs have been stipulated in a government decree[19] from 2002. The tasks are:

- Harmonize the implementation of the National Strategy to Combat the Drug Problem and the governmental programmes with the concerned ministers, participate in their execution and follow their effectiveness;
- In co-operation with the concerned ministers , the Minister of CYS prepares - in order to inform the Government and the international organizations – the reports on the drug consumption, performs his duties concerning data-supply, such according to his sectoral tasks;
- The Minister is the chairman of the Co-ordination Committee on Drug Affairs;
- The Minister co-operates in the harmonization of the nation-wide programmes that popularize the healthy lifestyle and prevent drug consumption;
- The Minister co-operates - relying upon the relating governmental decisions – in the implementation of the tasks concerning the provision of the drug users and drug addicts;
- The Minister co-operates with civil organizations, institutions, Churches and denominations and in the higher education centres – in co-operation with the Minister of Education – he incites and countenances the training and research to gain expertise in the field of prevention, this in order to support the information and the prevention to combat drug consumption.

The main responsibility for the coordination of the implementation of the National Drug Strategy lies with the Ministry of Youth, Family, Social Affairs and Equal Opportunities and its background institute, the National Drug Prevention Institute (NDI).

3.3.2.2. The Coordination Committee on Drug Affairs (CCDA)

Several other line ministries are involved in policy formulation in the area of drug policy. These ministries co-operate in the framework of a Co-ordination Committee on Drug Affairs (CCDA), which is chaired by the Minister of Children, Youth and Sports. The Minister of Health, Social and Family Affairs (MH) is the vice-chair of the Committee. The first mentioned ministry is responsible for the secretariat of the Co-ordination Committee (*see figure 3.1*).

The tasks of the Co-ordination Committee on Drug Affairs have been adopted in a special Governmental Decree[20]. Its tasks are to examine the implementation of the Drugs Strategy, to co-ordinate the operation of individual departments and public institutions and to assist in the approximation of sectoral approaches. The official tasks of the CCDA are the following:

- To co-ordinate the operation of central administrative organisations involved in drug affairs;
- To monitor the implementation of the National Strategy to Combat the Drug Problem after its formulation and acceptance;

[19] 157/2002. (VII.11.). Government Decree about the remit and the competence of the Minister of Children, Youth and Sports
[20] 1039/1998. (III.31.) Government Decree on the Tasks of the Coordination Committee on Drug Affairs

- To draft proposals regarding the allocation and use of the resources available for anti-drug efforts;
- To initiate the passing of laws directly concerning any of the areas of the drug issue and to offer opinions on draft proposals for laws and other Government measures;
- To co-ordinate the tasks that are connected to legal harmonisation and other tasks flowing from EU accession in regards to drug affairs,
- To inform the Government on an annual basis on the drug situation in Hungary, on the state of implementation of the National Drug Strategy and on the work of the Committee;
- To represent the government vis-à-vis the drug-related bodies of international organisations while respecting the mandates of the different portfolios;
- To initiate prevention and information programmes and campaigns necessary in order to curb drug use.

The CCDA is expected to meet at least four times a year. In practice, the Committee does not meet more often than that. The CCDA Membership has also been established by the decree and includes *full-mandated representatives* of the following ministries and national organisations: the Ministry of the Interior; the Ministry of Health, Social and Family Affairs; the Ministry of Labour and Employment; the Ministry of Agriculture and Regional Development; the Ministry of Economics and Transport; the Ministry of Child, Youth and Sports Affairs; the Ministry of Defence; the Ministry of Justice; the Ministry of Foreign Affairs; the Prime Minister's Office; the Ministry of Education; the Ministry of Finance; the State Public Health Service (Ántsz); the National Police Headquarters; the National Headquarters of Customs and Finance Guard; and the State Penitentiary Service.

The Supreme Court, the Supreme Prosecution Office and the National Crime Prevention Council were invited to participate in the work of the Committee with the right of consultation. Finally, the President of the CCDA is entitled to commission experts to fulfil certain specialist tasks.

After the changes in the governmental structure after the general elections in 2002, the Coordination Committee on Drug Affairs reviewed its statute and submitted a proposal for amendment (Government Decree No. 1035/2003. (IV.24)) on November 21, 2002. As a consequence new representatives were delegated to the Coordination Committee and the National Committee for Crime Prevention became a member organisation with consultation rights[21].

3.3.2.3. Expert committees of the CCDA

The CCDA has a number of subcommittees. The Decree establishing the CCDA[22] mentioned the establishment of one specific subcommittee, the sub-committee that had the task to monitor the activity of the Hungarian Reitox National Focal Point, which is part of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The responsible Ministries for this Expert Committee are the Ministry of Health and the Ministry of Youth, Family, Social Affairs and Equal Opportunities. Members of this Expert Committee are the Deputy State Secretary for the Coordination of Drug Affairs and the delegated representatives of the Ministry of Youth, Family, Social Affairs and Equal Opportunities, the Ministry of Health, Social Affairs and the Family, the Ministry of Justice, the Ministry of Home Affairs, Ministry of Finance, the National Police Headquarters and the State Public Health Service. Apart from these formal representatives, the Expert Committee may also invite individual experts to participate in its work.

The tasks which were defined for this subcommittee were to:

a) regularly revise and evaluate the activity of the Centre as it concerns the tasks of the Committee
b) inform the Committee and the head of the Centre about the results of its work in a Report;
c) based on the contents of the Report make proposals to the head of the Centre in the interest of optimal operation;
d) request the head of the Centre to give feedback on the execution of the proposals. If the proposal was inadequately fulfilled, the discrepancy has to be justified by the Centre.

In order to fulfil tasks described under points *a)* to *d):*

- it regularly addresses the head of the Centre for information and may put questions to the Centre regarding its activity at any time;
- may look into documents generated during its activity at any time;

[21] National Report to the EMCDDA (2004), pp. 11
[22] 1039/1998. (III.31.) Government Decree on the Tasks of the Coordination Committee on Drug Affairs

- may request information about the data available;
- must receive the draft Reports of the Focal Point for evaluation in due time in order to formulate its point of view.

The CCDA has the task to inform the Government about its experiences of the activity of the Focal Point through its President and Co-President. Detailed regulations on the operation of the CCDA and the Secretariat are contained in the procedural code accepted by the CCDA.
To date, the CCDA structure includes eight other expert committees (see Table 3.2). One specific aim of the subcommittees, mentioned by a number of respondents in this evaluation, is to have civil society represented in the work of the Drug Coordination structure. In 2005, some changes may be implemented regarding the number of expert committees (a possible merger of the committee on epidemiology and the committee on the Hungarian National Focal Point) and the Membership of these committees (greater involvement of civil society).

- **Expert Committee on Epidemiology**
  Responsible: Ministry of Youth, Family, Social Affairs and Equal Opportunities
- **Expert Committee on Legal Affairs**
  Responsible Ministry: Ministry of Justice
- **Expert Committee on Health**
  Responsible: Ministry of Health
- **Expert Committee on Social Affairs**
  Responsible: Ministry of Youth, Family, Social Affairs and Equal Opportunities
- **Expert Committee on Security Affairs**
  Responsible: Ministry of the Interior
- **Expert Committee on Prevention**
  Responsible: Ministry of Youth, Family, Social Affairs and Equal Opportunities
- **Expert Committee on Forensic Science**
  Responsible: Ministry of Interior, Ministry of Youth, Family, Social Affairs and Equal Opportunities
- **Expert Committee on Local Authorities**
  Responsible: Ministry of Interior, Ministry of Youth, Family, Social Affairs and Equal Opportunities

These additional eight Expert Committees have been established neither through any Governmental Decree nor in the rules of procedure of the Coordination Committee on Drug Affairs. Their role vis-à-vis the CCDA and stakeholders in the drug policy field is unclear as they do not have a clear mandate, no clear budget and no clear role in the policy development and implementation process.

3.3.2.4. Tasks of the Deputy State Secretary for the Coordination of Drug Affairs

Within the Ministry of Youth, Family, Social Affairs and Equal Opportunities, the day-to-day coordination of drug affairs was situated in a coordination body under the supervision of a Deputy State Secretary for the Coordination of Drug Affairs. The Deputy State Secretary has the task to:

- Co-ordinate the projects and tasks concerning the combat against drug consumption and the drug co-ordination.
- Perform the duties of the Secretary of the Government's Co-ordination Committee on Drug Affairs.
- Perform the duties of the Secretary of the Minister's Advisory Council on Drug Affairs.
- Co-operate in the inter-ministerial tasks concerning the combat against drug consumption and other substances causing harm; in case of necessity the Deputy State Secretary initiates the frame of a law or the amendment of a law.
- Participate in the implementation of the different tasks concerning health promotion among the youth and the prevention of drug consumption.
- Present suggestions in terms of ministerial and governmental tasks concerning the combat against drug consumption, rehabilitation and reintegration of drug addicts, low-trash and harm reduction provisions and according to the decisions participates in the implementation of the tasks.

- Within the frame of inter-ministerial co operations the Deputy State Secretary co-operate in the implementation of tasks concerning supply reduction and crime prevention to combat drug consumption.
- In co-operation with the Head of the International Directorate of the Hungarian Government organize the tasks of the professional line in the field of international relations and the relationship with the EU.
- In co-operation with the Head of the International Directorate of the Hungarian Government supervise and direct the settlement of the Phare programmes concerning drug co-ordination.
- Present suggestions in terms of state budgetary resources, manners and amounts of subventions; co-operates in the evolving and the controlling of the frames and conditions of the money allocation.
- Maintain relations and participates in the co-operation with civil organizations, Churches and denominations, professional organizations, scientific workshops and institutions.
- Exercise professional control over the drug co-ordination tasks of the Mobilitás and the work of the National Drug Prevention Institute.

As of June 2005, the function of the Deputy State Secretary has been replaced by that of the Ministerial Commissioner charged with the Coordination of Drug Affairs. In order to fulfil its tasks, the Deputy State Secretariat for the Coordination of Drug Affairs is supported by a number of background institutes, among which the National Institute for Drug Prevention.

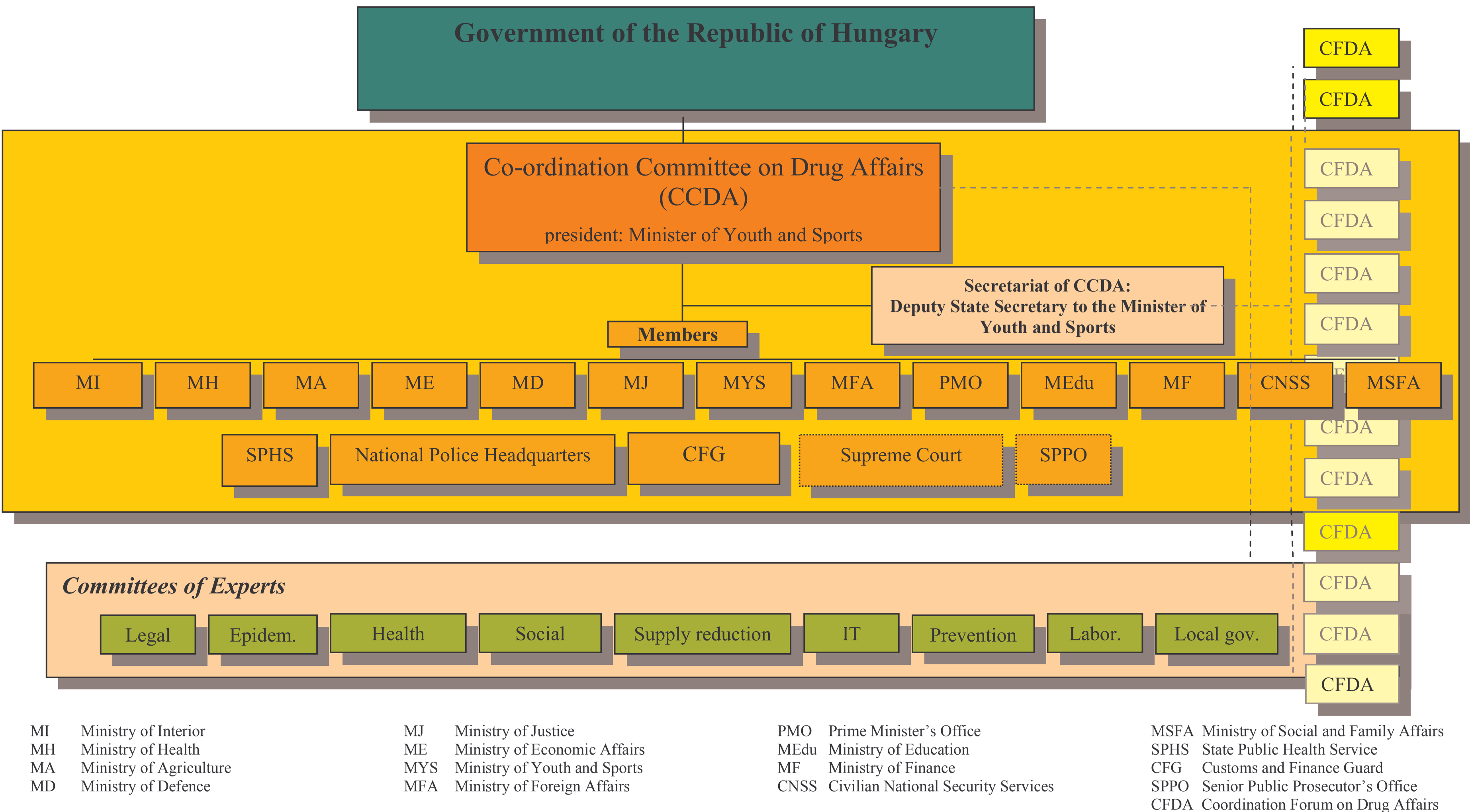
The Ministry of Youth, Family, Social Affairs and Equal Opportunities is covering the operational costs for the Deputy State Secretariat for the Coordination of Drug Affairs, but this coordination unit has no budget of its own, nor does the Coordination Committee on Drug Affairs have a budget for its own activities. Annually, the Hungarian Government and Parliament allocates a limited budget for the implementation of the National Drug Strategy. The CCDA decides on the allocation of this funding.

3.3.2.5. Tasks of the National Drug Prevention Institute

The NDI was set up in 2001 under the auspices of the Ministry of Children, Youth and Sport, and is tasked with assisting in the monitoring and controlling of the implementation of the National Drug Strategy (with an emphasis on the objectives regarding drug prevention), as well as providing professional and technical services for the local Co-ordination Forums on Drug Affairs (KEFs). These KEFs operate as local co-ordination points in drug affairs with the participation of representatives of the local government, police, schools, medical services and NGOs.

The National Drug Prevention Institute was responsible for the development of a national network of Local Coordination Forums on Drug Affairs (KEFs). The NDI actively promotes the establishment of KEFs in cities with more than 20.000 inhabitants. It supports the KEFs with information on know-how and best practice, with trainings, a national helpdesk and projects database (SZIP). The NDI functions as knowledge centre for research, monitoring and evaluation regarding drug prevention in Hungary.

Figure 3.1 Organigram of the Coordination Committee on Drug Affairs



MI	Ministry of Interior	MJ	Ministry of Justice	PMO	Prime Minister's Office	MSFA	Ministry of Social and Family Affairs
MH	Ministry of Health	ME	Ministry of Economic Affairs	MEdu	Ministry of Education	SPHS	State Public Health Service
MA	Ministry of Agriculture	MYS	Ministry of Youth and Sports	MF	Ministry of Finance	CFG	Customs and Finance Guard
MD	Ministry of Defence	MFA	Ministry of Foreign Affairs	CNSS	Civilian National Security Services	SPPO	Senior Public Prosecutor's Office
						CFDA	Coordination Forum on Drug Affairs

3.3.3. Implementation at local level –Local Coordination Forums on Drug Affairs

One specific characteristic of the National Drug Strategy is the strong focus on the implementation of the strategy within local communities, representing a 'bottom-up' approach. As the National Drug Strategy reads *"One of the most important depositories of the National Strategy is the local community. Rallying forces at the local level and co-ordinated action could have a decisive impact on the management of the problem…"*[23].

In order to implement the National Drug Strategy at local level, one of its key objectives concerns the establishment of Local Co-ordination Forums on Drug Affairs (KEF), which – according to the Strategy – are *"(…) called to co-ordinate local measures and initiatives and to create a forum for the institutional functioning in the territory of the local community in parallel with the national objectives. This Forum is an important part of the chain, which guarantees the translation of strategic ideas into reality (…)"*[24].

The Strategy considers the local Co-ordination Forums on Drug Affairs as key factors in the implementation of the National Drug Strategy. It stipulates that: *"The local public, municipal, voluntary and church organisations will have themselves represented in these committees: the agents of the world of prevention and therapy as well as the local offices of the State Public Health Service (ÁNTSZs), which combine them at an organisational level, the organisations of community development, the child welfare services as well as the justice system, the penitentiaries, the police and the specialised agencies in the Municipalities"*[25].

The Strategy also defines some of the key tasks of the Local Coordination Forums, including:

- collecting information related to the local drug problem;
- monitoring changes in the local drug problem;
- identifying and determining of the most important risk groups;
- defining targets of communal prevention and possibilities of therapy;
- keeping record of the capacities of prevention, community development and therapy;
- ensuring availability of information concerning local services to members of the local community;
- drawing up an annual plan on local tasks in line with the objectives of the National Strategy;
- drawing up an annual report on the work done at the end of the year;
- disseminating the report to the members of the local community;
- forwarding the annual report to the Co-ordination Committee on Drug Affairs (CCDA), to enable it to draw up the annual country report.

The National Drug Prevention Institute (NDI) is the driving force behind the promotion and support of the establishment of the Local Coordination Forums on Drug Affairs. Since its establishment, the NDI has contacted a large number of Municipalities, counties and regions in Hungary, resulting in the establishment of 77 KEFs by the end of 2004. In general, a KEF is established when a municipality has approximately 20.000 inhabitants or when it has a regional function. As indicated above, the KEF structure is based upon voluntary participation of local community organisations and structures that have an interest or concern with one or more aspects of drug policy. This model has been adapted from the UK model of Drug Action Teams. The KEFs have a limited budget, an unpaid KEF coordinator and no other KEF staff. In 2002 the National Drug Prevention Institute published a KEF manual[26], containing guidelines and information on how to establish and maintain a Local Coordination Forum on Drug Affairs.

The responsibility and the implementation of drug demand reduction policies as laid down in the National Drug Strategy has not been formalised in any legal format, obliging Municipalities, Counties and Regions to carry specific responsibility. The National Drug Strategy does state the need for Government to give all the support it can to municipalities so that they can implement their activities as effectively as possible[27].

The National Drug Strategy had a visionary approach that the involvement of structures, organisations and individuals from local communities should be conducted on a voluntary basis. However, as the evaluation

[23] National Strategy to Combat the Drug Problem (2002), p. 38 [EN].
[24] Ibid. p.38.
[25] Ibid. p.40.
[26] The KEF manual was developed in the Phare Twinning Project between the NDI and the Trimbos Institute (HU/02/IB/JH/01).
[27] Ibid p. 39.

results in the next chapters will show, this has resulted in a somewhat diverse picture when the establishment and functioning of the Local Coordination Forums on Drug Affairs is concerned, as well as regarding the active involvement of Local Self-Governments.

The lack of formal legislation supporting the National Drug Strategy does not mean that local self-government does not carry responsibility at all. The Act LXV (1990) on Local Self-Governments clearly stipulates that "*Local authorities shall be responsible for providing the following services to the local public: local development, local planning (…) providing for local fire protection and public safety; (…) provision of kindergartens, primary education, health and social services as well as other responsibilities concerning children and youth; (…) promotion of the community conditions of a healthy way of life*"[28].

Furthermore, the Act stipulates that: "(…) *the local authorities shall determine – in accord with what is required by the local population and with the financial strength of the community – the responsibilities they will undertake and the extent and manner in which they will be provided*"[29].

Finally, the Act stipulates that: "*Within the range of their responsibilities, local authorities shall support the activities of groups organised by local residents and shall cooperate with these groups. In its organisational and operational regulations, the council shall determine the local group or groups whose councillors shall be admitted to the meetings of the council and its committees"*[30].

So despite the fact that the implementation of the National Drug Strategy nor the implementation of drug demand reduction has been formalised in legal arrangements at the level of local communities, the existing Act on Local Self-Government does provide a basis for action regarding public safety (drug demand and drug supply reduction), health and health promotion. Local authorities can decide themselves to take up additional responsibilities. Somewhat understandably, though, given the limited financial resources and the relative unpopular public perception of the drug problem in Hungary, not every Local Self-Government attributes a high priority to the implementation of the National Drug Strategy. Nevertheless, as the outcome of this mid-term evaluation as presented in Chapter 5 shows, the involvement of Local Self-Government (in particular Municipal support) is an important factor for success for the Coordination of Drug Affairs at Local level.

Apart from the Local Coordination Forums on Drug Affairs, there are similar structures for e.g. Crime Prevention and Environmental hygiene issues, as well as local branches of National Executive agencies.

3.3.4. Monitoring and evaluation

Monitoring and evaluation are important instruments for policy making. With the accession to the European Union in May 2004, Hungary became a full member of the Reitox Network of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). It has been participating as an observer since 2001. As described under §3.3.2.3, the CCDA has an important role to facilitate the work of the Reitox National Focal Point. The establishment of this NFP has been somewhat troublesome. The decision whether to place the Focal Point within the Governmental structure or within an independent NGO, has taken a lot of time. Currently, the Focal Point has been situated in the National Centre for Epidemiology Joszef Béla. In 2002, 2003 and 2004 it has published National Reports on the Drug Situation in Hungary. The national reports in general provide a comprehensive overview on the state of affairs regarding drug policy and make use of standardised reporting tables and indicators so that overall trends in and between EU countries can be made visible. The data that is being used for the National Reports is collected from a number of other epidemiological research institutes in Hungary.

To date, Hungary has successfully implemented 3 out of 5 EMCDDA key indicators (problem drug use, prevalence, drug related crime). A fourth key-indicator (the Treatment Demand Indicator) is being implemented at this moment, but still not completely in line with the EMCDDA guidelines. The fifth key-indicator (Drug Related Deaths and Mortality) has not been implemented so far.

[28] Parliament of the Republic of Hungary (1990). Act LXV of 1990 on Local Self-Governments, Section 8, sub 1. Lezárva: 2005. március 31; Hátaly: 2004.V.1.
[29] Ibid. Section 8, sub 2.
[30] Ibid. Section 8, sub 1.

In general, data collections in Hungary have shown improvement when methodology and reliability is concerned, but more input needs to be given in this area. In 2004, the National Focal Point planned to make a gap-analysis of data sources that are not available and flaws in existing data sources.

Annually, the CCDA sends an Annual Report on the State of Drug Affairs in Hungary to the Parliament, which is largely based upon the National Report for the EMCDDA. The National Focal Point does not play a specific role in the implementation of the National Drug Strategy other than those tasks allocated to it by the Strategy itself. As a result, the information and data provided by the National Focal Point is not tailored to inform policy makers and implementing structures about progress made in the field of drug policy.

4. Evaluation of the internal consistency of the National Drug Strategy

4.1. Introduction

This mid-term evaluation focuses at the extent to which the National Drug Strategy is internally consistent and externally effective. It is important to keep in mind that policy papers do not change societies, people do. Even the best designed policy is just as effective as the weakest link in the process of implementation. Furthermore, policy papers tend to aspire to 'catch' reality on paper, something which is next to impossible as reality (and the behaviour of people) is unpredictable.

A good policy plan can improve the chances for successful implementation. Consistent policies that are realistic regarding aspired aims and objectives, sensitive to their environment and flexible towards changes over time may actually be successful. As described in Chapter 2, the analysis of internal policy consistency focuses on the different aims and objectives within one policy being complementary, consistent and leading to an added value in achieving the primary policy goals when combined with each other. A consistent policy reduces the chance that unexpected and/or unwanted consequences appear because it anticipates on future developments and impact.

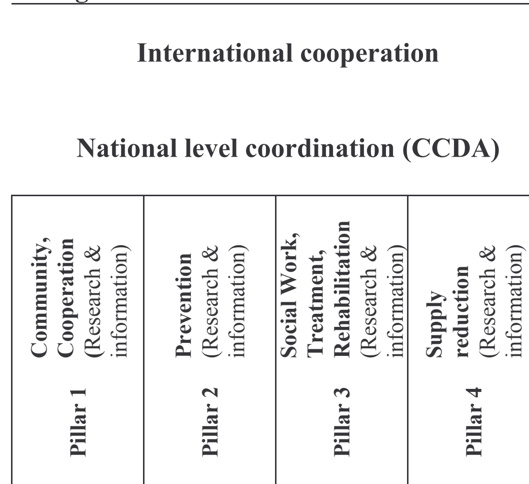
4.2. Structure of the National Drug Strategy

The internal consistency of the National Drug Strategy has been assessed by 1) a thorough analysis and breakdown of the policy text itself (the Strategy), 2) a reconstruction of the policy theory underpinning the National Drug Strategy by reconstructing the Logical Framework and by drafting policy 'trees' that reflect the means-end relationships, 3) an assessment of the question to what extent the policy and its objectives are consistent, SMART and the extent to which they reflect a policy theory

The National Drug Strategy was adopted in December 2000 and reflects a blueprint for Hungarian Drug Policy. Figure 4.1 presents a schematic breakdown of the Structure of the policy. It is built upon 4 pillars that represent the main result areas (community & cooperation; prevention; social work, treatment, rehabilitation; and supply reduction). Local coordination of drug policy has been primarily allocated in the first pillar (the establishment of the KEF structure). National coordination and international cooperation are horizontal themes, while research & information (& training) are mentioned in all four pillars, but not coherently connected between the pillars.

In order to analyse the internal consistency of the National Drug Strategy, each chapter of the document has been analysed. The content of the Strategy is as follows:

Figure 4.1 – Schematic breakdown NDS



Chapter 1 - Introduction, problem identification and key objectives

In the introduction the case for the need for a National Drug Strategy is made, shortly reflecting on the four main result areas (Community, Prevention, Treatment and Supply Reduction). In this introduction, a justification is given why the National Drug Strategy is focusing on illicit substances and not – also – on licit substances such as alcohol and tobacco by pointing out the international (inter connective) dimension of the illicit drug problem and the international treaties Hungary has signed up to.

Chapter 2 - Argumentation for developing a National Drug Strategy

In this chapter the justification of the need for a National Drug Strategy is explicated. It points out that problematic drug use and the criminal activity that accompanies it had been dramatically growing since the early 1990s, resulting in an increase in drug use in the general population, an increase in drug related harms and an increase in drug related crime. The authors recognise the need for a multi-sectoral approach in order to be effective. In this chapter too, the longer-term objectives of the Strategy are formulated and the main coordination structure that is responsible for the coordination of the implementation of the National Drug Strategy is identified.

Chapter 3 - Analysis of the Drug Problem
This chapter provides context against which the National Drug Strategy was developed. It identifies and describes the growing problems with problematic drug use and drug related crime, while recognising that the Hungarian drug demand reduction and drug supply reduction systems were underdeveloped and in many cases not able to cope with the problems and challenges they were faced with. The chapter also describes the state-of-affairs in treatment, prevention as well as the legal environment regarding drugs and drug policy.

Chapter 4 - History and development of the NDS
This chapter reflects on the antecedents or history of the National Drug Strategy. A short reflection is given on the work of the predecessor of the Coordination Committee on Drug Affairs, the Interdepartmental Committee on Drugs, which was replaced by the CCDA in 1998 and that had been incapable of developing a National approach to the drug problem for a number of years. The chapter also presents the main functions of the National Drug Strategy. These functions were:

- the determination of fundamental goals and values;
- the formulation of the main directions of drug policy;
- providing assistance and guidance for executive agencies when implementing the Strategy;
- the development of a social consensus on the aims and objectives of the Strategy;
- serving the attainment of the requirements Hungary had to face regarding the EU Acquis Communautaire in the field of drugs in relation to the accession process.

Finally, this 4th Chapter briefly justifies the choices made by the Hungarian government regarding the perception of the drug problem, trying to explain the phenomenon and the choice of an approach towards it. The Hungarian Government has chosen to base its drug policy on a multi-disciplinary approach, recognising that the drug problem is multi-dimensional and requires a multi-faceted approach. Furthermore, the Hungarian Government – partly based upon its own experiences in the past – has chosen to follow a balanced approach to the drug problem, which entails that demand and supply reduction measures reinforce and complement each other in order to obtain greater effectiveness.

Chapter 5 - Objectives, principles and approach
In this chapter the National Drug Strategy's goal and its main objectives or results are being presented, reflecting the approach and interpretation of the drug problem as described in Chapter 4. Furthermore, the key principles of the National Drug Strategy are being introduced:

- a *fact-based* and *scientific approach*;
- *partnership* and *joint action* between a wide range of actors in society at both local and national level;
- the importance of a *comprehensive approach* which requires a multidimensional, balanced and well-segmented approach;
- *accountability*. The Strategy claims that it includes indicators of success for all objectives. It also stipulates that the National Drug Strategy will be reviewed at regular intervals;
- *long-term planning*, calling for a gradual development rather than short-term successes.

Subsequently, the instruments of the National Drug Strategy are being presented. These instruments are not really policy instruments but rather conditions for success and characteristics of the policy. They include:

- a *wide participation of civil society and public services*; the *need for cooperation* with *experts* involved in different aspects of the drug problem and its consequences;
- the National Drug Strategy sets *important development tasks* for public and voluntary organisations in drug demand and drug supply reduction;
- the need for the development of a *broad social consensus* in terms of the management of the drug problem, including activation of (civil) society in support of the implementation of the National Drug Strategy;
- the *effective functioning and coordination* of the Coordination Committee on Drug Affairs.

This 5th Chapter also presents the time line for the implementation of the objectives of the National Drug Strategy. It is stipulated that:

- *Long-term objectives* represent the totality of actions required to implement the National Drug Strategy. These need to be achieved by **2009**;
- *Mid-term objectives* need to be achieved in the fiscal years **2000-2002**;
- *Short-term objectives* need to be achieved directly (**2000-2001**) and also include actions needed to implement mid-term objectives.

This chapter also identifies the task division regarding the implementation of the National Drug Strategy, attributing to the CCDA the task of controlling the implementation of the Strategy, coordinating the cooperation between individual departments and public institutions and the approximation of sectoral approaches. The CCDA has to report to the Government on an annual basis regarding the developments in the Hungarian drug situation and the implementation of the Strategy. The Local Coordination Forums on Drug Affairs are considered to have an important task for the implementation of the Strategy at local level.

Finally, in this chapter it is also written that the CCDA is to assess on an annual basis the progress of implementation of the Strategy and that it will carry out screening and efficiency examination of the Strategy and the institutions implementing it every three years, after which a report is drawn up for the Government and Parliament.

Chapter 6 - Breakdown of results and objectives
The next chapter contains the 'substance matter' of the National Drug Strategy: the policy objectives. It identifies four main result areas, which are described underneath. The chapter identifies main stakeholders and actors in the process of implementing and achieving the formulated results.

1. **Community, cooperation** – *making society sensitive to the effective management of the drug issue and making local communities improve their problem solving capabilities in countering the drug problem.* In order to reach this objective, a number of long-term, mid-term and short-term objectives have been formulated that – when implemented appropriately – should make it possible to achieve this result. Some of the main (long-term) objectives that have been formulated here concern the establishment of Local Coordination Forums on Drug Affairs, the raising of awareness of families, the increase of prevention efforts in all settings at local level, the reintegration of drug-users released from prison, the development of local drug strategies and the need for better use of data collection and research at local level.
2. **Prevention** – *creation of opportunities to enable the young to develop a productive lifestyle and to reject drugs.* Some of the main (long-term) objectives identified here concern the need to halt the spreading of drug use, preventing that the use of drugs becomes culturally acceptable behaviour for young people, to promote the health and drug free lifestyle and the development of a school health strategy.
3. **Social Work, Treatment, Rehabilitation** – *helping individuals and families having come into contact with drugs and struggling with drug problems*. This result focuses at the establishment of improvement of a full spectrum of drug treatment in Hungary and includes (long-term) objectives such as: to halt and reverse the increase in the number of problematic drug users, reduction of social and health harms associated with drug use, improvement in the availability, receptivity and effectiveness of health and social care in the treatment of drug problems and the development of social care for addicts.
4. **Supply Reduction** – *to reduce the possibility of access to drugs*. This result aims at all actions regarding law enforcement to reduce drug trafficking, availability of drugs and drug related crime. The main (long-term) objectives focus on reducing access to illicit drugs and other substance abuse, the reduction of cross-border trafficking of illicit drugs and precursor control, the reduction of the production of illicit drugs and greater control of the production of licit substances, the reduction of domestic illicit drug production, the reduction of the number of places were drugs are supplied and the drafting of a uniform and interdisciplinary anti-drug law.

For each Strategy result a number of indicators and means for verification (instruments for monitoring) of success have also been provided, be it that these have not been directly linked to any of the specific objectives. Apart from the long-term objectives, for each result mid- and short-term objectives have been formulated. Overall, more than 90 short- and mid-term objectives are included in the National Drug Strategy.

Chapter 7 - International cooperation
In this chapter the importance of international cooperation with EU and UN structures in achieving the goals of the National Drug Strategy is highlighted. The Strategy reconfirms Hungary's determination to meet its international obligations, to meet the criteria for EU accession, to work together on a sub-regional basis with UNDCP and to stimulate bilateral cooperation between national agencies and their international counterparts. Furthermore, the importance of the collaboration with the Pompidou group and the need for participation in scientific cooperation is stressed.

Chapter 8 - Monitoring achievement
This final chapter of the National Drug Strategy concerns the aspect of monitoring progress in the implementation of the short- and medium-term objectives. It is not very clear to what extent the monitoring instruments (very similar to indicators) are different than those already presented for each Strategy result.

4.3. Reconstructing the policy

4.3.1. The policy theory behind the National Drug Strategy
After having mapped the structure of the National Drug Strategy, the task of reconstructing the policy behind it focused on the analysing of the policy structure, the coherence and consistency between the different policy objectives and the means-end constructions (what actions and means need to be undertaken to achieve an objective. The mid-term evaluation did not have the objective to evaluate the policy theory itself.

A policy theory is the theory that underpins the overall aims and objectives of a policy plan or programme and that provides answer to the question why the authors think that the policy will lead to the achievement of its goal and the longer term objectives. In other words, the policy theory explains the reasons, assumptions and principles of the policymaker to choose this specific policy and the way he plans to implement them.

As could be seen from the chapter overview in § 4.2, the authors of the National Drug Strategy have paid attention to the assessment of the drug problem in Hungary, analysed models of drug policy in other European countries (United Kingdom, the Netherlands, US, Germany, etc.) and have assessed and analysed the different scientific explanatory theories for the drug phenomenon (e.g. drug use as an 'infectious disease', etc.) and intervention models (prohibitionist, legalising approach, etc.). The policy approach that has been chosen as a basis for the National Drug Strategy reflects this thinking and despite the fact that there is limited evidence that any of the available approaches and models actually provide an overall solution for the drug problem, there is adequate proof that a balanced approach as chosen by the Hungarian Government can actually help to attain the main goal of the Strategy: "(..) *A society that is capable of managing health care, social and criminal harms and disadvantages related to the use and trafficking of drugs"*[31].

Without giving a normative judgment or value statement about the policy theory of the National Drug Strategy itself, it can be concluded that the Hungarian Government has presented solid arguments for its choice of a comprehensive approach which is in the mainstream of EU drug policy.

4.3.2. Breakdown of the structure of the National Drug Strategy
The next step was to break down the policy structure of the National Drug Strategy. This was not an easy task. The National Drug Strategy is based on the principles of the Logical Framework Approach (LFA). The LFA is a policy design method which is often used in Development Aid programmes, where accountability and management control is and important requirement given the often complex environment such programmes are implemented in.

The LFA in formulating policy is a useful tool to present the main objectives, interrelations and measurements for success of a policy programme in a clear format. A Log Frame can contribute to a shared understanding, especially important when several (governmental) stakeholders and structures are involved in the development of a policy plan. It reflects stages/ levels in policy plans and the hierarchies between them. It provides tools (indicators) to assess policy achievement and provides an 'all in one' graphical lay out of sometimes complex policies. But the development of a Logical Framework requires thorough attention and thinking.

[31] National Strategy to Combat the Drug Problem (2000), pp. 33

The National Drug Strategy presents a *goal*, *results* (the outcomes of the policy), long-, medium- and short-term *objectives* (the outputs of policy), *indicators* and *instruments*. Based on the policy text an attempt was made by the evaluators to capture the causal relations between objectives into a 'policy tree' that makes the logic behind the policy visible. Such 'policy trees' reflect the different results, long-, mid- and short-term objectives and their perceived causal relationships. In Figure 4.3 the breakdown for result area I *('Community, Cooperation')* is presented. In Annex 2 a breakdown of the means-end relations is given for each of the four result areas (community, prevention, treatment and supply reduction). The relationship between the goal of the National Drug Strategy and its results are clear. For the long-term and the mid- and short-term objectives the most likely relationships have been indicated, as the Strategy does not present a clear causal theory in that regard other than that these objectives have been grouped around each result.

The assumption behind the causal relationship regarding result I is such that the aim of the result, *"Society should become sensitive to the efficient management of the drug issues, and local communities should improve their problem solving capabilities in countering the drug problem (community, co-operation)"*, will be attained by three main long-term objectives. These objectives are: 1) the development of functional communities that are sensitive to the drug problem (*empowering civil society*), 2) the need for the development of local drug strategies due to the differences in characteristics, resources and opportunities between local communities (*local tailor-made approaches*) and 3) a reorganisation of data collections and research (*improving the knowledge base for policy*). In short, the envisaged result is that with targeted and well-designed capacity and institution building activities at local level society will become stronger so that it can deal with the drug problem.

This policy result and its long-term objectives have subsequently been broken down in a number of sub-objectives for the short- and mid-term, each of which are expected to contribute to the long-term objectives and – indirectly – to the envisaged result and the strategy goal. As indicated earlier in this chapter, the short- and mid-term objectives should have been implemented by the end of 2002. The 'policy trees' in figure 4.3 and in Annex 2 show that there are a considerable number of short- and mid-term objectives in the National Drug Strategy. The 'policy trees' reflect a certain hierarchy between objectives, which are partly based on the time span they needed to be achieved in, but are also grouped from specific to more general or comprehensive aims (several short-term objectives may lead to the achievement of one mid-term objective).

Due to the formulation and sometimes overlap between objectives, other links may be drawn between objectives, but for the purpose of illustrating the structure of the policy behind the National Drug Strategy, the reconstruction in Annex 2 is adequate.

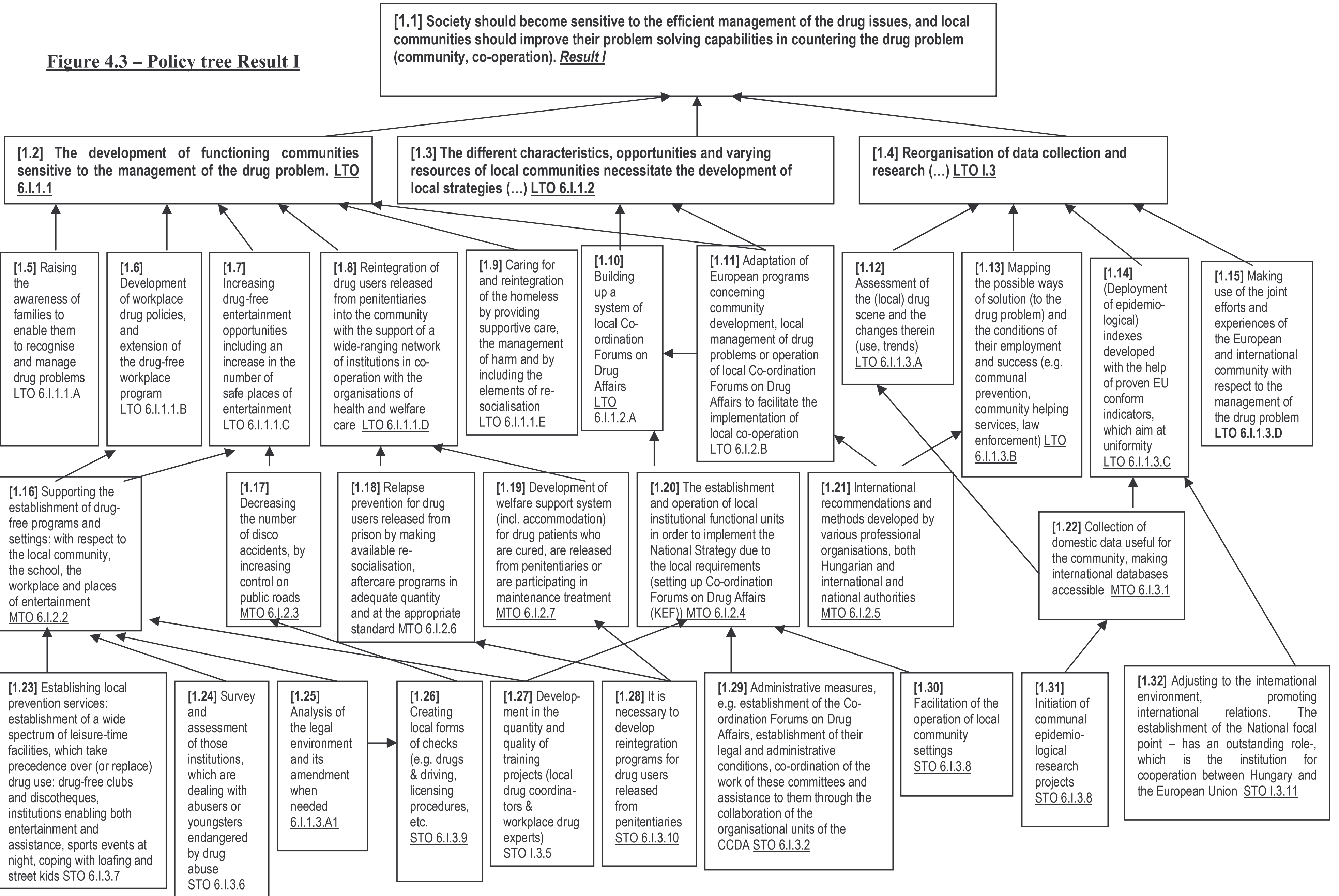
The National Drug Strategy and especially Chapter 6, that includes the objectives for the policy, is describing the ideas of the authors for the future and desirable results of drug policy. It is not always clear (due to the wording used) whether a phrase was a comment or description of a desirable situation in the future or a concrete objective. The policy tree does not reflect those elements of the Strategy that deal with principles, conditions, instruments, indicators and means of verification. Ideally a policy tree includes policy activities. In the National Drug Strategy one might argue that some short- and mid-term objectives should rather be seen as policy activities (e.*g. short-term objective 1.25: Analysis of the legal environment and its amendment when needed*). Objectives may be interrelated with more than one other objective, as they may serve several aims.

During the evaluation process, several respondents have indicated that the structure of the National Drug Strategy might have been constructed differently, as the vertical pillar of the result 'Community, Cooperation' is showing overlap with – among others - the pillar of the Result 'Prevention' and because objectives in this first result could easily be part of other result areas. A good deal of the Community, Cooperation objectives concern the facilitation and enabling of drug coordination at local level. Local coordination is a prerequisite and tool for many objectives. Furthermore, objectives regarding information & research are part of all Strategy results. At the same time they are conditions for measuring progress and therefore also a tool and a prerequisite for the achievement of many objectives. It might have been more logical to tilt the Result Community, Cooperation and make it a horizontal measure in the strategy (similar to international cooperation and national coordination) and to include a horizontal measure covering all objectives in the field of (policy) information & research (*see Figure 4.2*).

Figure 4.2 – alternative schematic NDS

<table>
<tr><td colspan="3">International cooperation</td></tr>
<tr><td colspan="3">Horizontal measure:
National level coordination (CCDA)</td></tr>
<tr><td>Prevention</td><td>Social Work, Treatment, Rehabilitation</td><td>Supply reduction</td></tr>
<tr><td colspan="3">Horizontal measure
(Local) Community, cooperation (KEF)</td></tr>
<tr><td colspan="3">Horizontal measure:
(Policy) information & research</td></tr>
</table>

Figure 4.3 – Policy tree Result I



4.4. *Internal consistency of the National Drug Strategy*

The analysis of the National Drug Strategy showed that it is a visionary policy plan that aims to provide a solid and multidisciplinary basis for Hungarian drug policy for a longer period of time. It presents a clear argumentation for the policy choices that have been made (a multidisciplinary and balanced approach).

The National Drug Strategy has been developed in the format of a Logical Framework, which is a frequently used for the formulation of policy plans and programmes and which can offer a certain level of overview and structure to complex policies. The EU Drug Strategy 2005-2012 has also been developed in a Logical Framework format. A proper Logical Framework structure makes clear distinctions between objectives and results, between activities and indicators by which the achievements of those activities can be measured. The Logical Framework in the National Drug Strategy has not been fully developed.

By analysing the policy plan and by visualising the policy design by making use of policy trees, the National Drug Strategy has been reconstructed and translated into a Logical Framework. In Table 4.1 an example of the Log Frame extracted from the National Drug Strategy can be found for result 1 ('Community, cooperation'). A Logical Framework has a vertical and a horizontal dimension. The 'vertical dimension' in the Logical Framework concerns the causal relationships between the different levels of objectives and actions. The 'horizontal dimension' in the Logical Framework includes objectively verifiable indicators for objectives, means of verification of those indicators and assumptions & risks. The horizontal logic identifies the measurements of success and the external influences that may have an impact on the policy. The objectively verifiable indicators provide insight into the question whether the objectives of a policy are being achieved. The identification of assumptions, risks and essential preconditions in a policy plan is very important as they have an influence on the implementation of a programme and can usually not be influenced by the policy itself. They have an impact on the actual feasibility of a policy and the extent to which it can be implemented. We have not included a complete Log Frame for the whole Strategy.

4.4.1. *Limitations of the Logical Framework Approach*

A Logical Framework can help to clarify objectives, aims and desirable outcomes. But it has some limitations as well. One major problem is that the exercise of producing a strategy in the format of a Logical Framework is very energy consuming and might become an aim in itself. In such a situation there is a risk that the Log Frame is 'jammed' and/ or that people feel they have reached a major achievement when the Log Frame is completed, but do not use it afterwards anymore.

Gasper (2000)[32] has identified a number of flaws and problems regarding the use of a Logical Framework for the formulation of policy and cautions for an improper use and/or rigidness in its application. The National Drug Strategy seems to be hampered by some of these. Typical problems with a Log Frame include:

- Not every element of a policy plan can be fitted into a Logical Framework. The Log Frame can become somewhat 'unnatural' if it has to fit all details;
- A Log Frame can become a top-down instrument if the active involvement of stakeholders the design-phase is not properly safeguarded. A broad involvement of all relevant stakeholders needs to be maintained throughout the implementation process;
- The horizontal dimension of a Log Frame is sometimes marginalised or poorly developed. The 'push' to make each objective in a Log Frame as SMART as possible lead to 'indicator frenzy'. In those cases indicators are added because there needs to be a measure or target, even if the indicator is not relevant or when the achievement may have been the result of other factors. It is often more useful to select a limited number of key indicators for success, including qualitative indicators;
- The assumptions & risks column in a Log Frame is often marginalised. Assumptions such as 'the policy will be successful when it is properly implemented' are not to be taken seriously. Assumptions reflect the ability of the policy maker to identify external factors that may be of influence to the policy and that may be influenced by the policy as well (e.g. unintended effects) or external factors that cannot be influenced by the policy itself but that may have an impact (e.g. trend towards individualism instead of community sense, new trends in drug use, etc.);
- The Logical Framework is a static model. Once the policy has been 'carved in stone', the tendency exists not to look at it anymore or to forget that changes might need to be made. A proper policy

[32] Gasper, Des (2000). "*Logical Frameworks": Problems and Potentials*. Unpublished Paper. Institute of Social Studies. The Hague, The Netherlands.

plan, especially if it involves several branches of government and a longer period of time, needs to be flexible enough to allow for changes to be made. As indicated earlier, no policy can capture reality. A policy that claims to do so is pretentious;
- A Logical Framework that brings together several branches of government is not only a document with guiding principles, but also a basic document for collaboration and learning (trial-and-error). Not every objective needs to be achieved (in the way foreseen) as long as there is progress in solving problems and adjusting policies and activities.

4.4.2. Precision and priority

The Logical Framework in the National Drug Strategy seems to be hampered by some of the concerns indicated above. It is a comprehensive document, but it sometimes lacks sharpness. On the one hand it is a very detailed policy plan; on the other hand the details do not make it any clearer because policy elements have not been linked to each other.

The overall goal of the National Drug Strategy is rather generally formulated. The four key results (Community, Prevention, Treatment and Supply Reduction) give more in-depth sense of what elements should constitute the achievement of the Strategy goal, but they are not formulated as clear results as to what exactly has been reached through the implementation of this policy by 2009.

For example, Strategy result I reads: "*Society should become sensitive to the efficient management of the drug issues, and local communities should improve their problem solving capabilities in countering the drug problem (community, co-operation)".* This result is quite unspecific because it is unclear how society should be sensitised, which drug issues need to be addressed, whether all local communities should improve their capabilities and whether these capabilities should actually result in any improvement. A more specific, SMART formulation of result 1 could read as follows: *"A majority of local communities have developed and implemented local drug strategies, including approaches and activities that have proven to be sensitive to local needs and that have successfully contributed to the management of the most serious negative consequences of the drug problem."*

For the four Strategy results no objectively verifiable indicators have been formulated nor any assumptions. If the Log Frame exercise would have been completed, these indicators should have been formulated. If we stick to the example of the revised text of result 1, the following indicators could be formulated:
- 50% + 1 of the total number of XX local communities have developed a local drug strategy;
- Successful local drug strategies identify the most serious negative consequences of the drug problem that exists within the respective local communities, based upon a local needs assessment;
- These most negative consequences have shown a declining trend since the local drug strategy has been implemented.

Possible assumptions & risks for this revised result may include:
- the local communities have the capacity and instruments to develop and implement a local drug strategy;
- there is an identifiable drug problem within the local community;
- the local needs assessments are translated correctly into a local drug strategy.

Many objectives in the Strategy are not formulated with adequate precision and clarity. Indicators for success have not been clearly attributed to the respective long-, mid- and short-term objectives. Indicators are not always precisely formulated. The means to verify the changes in indicators (*the information sources that are used to monitor progress and assess achievement*) have not been specified for each objective. The consistency within the policy plan (the causal relations between the overall policy objectives, the policy goal, the main policy results, the policy activities and indicators for success and their interrelationships) is hampered, especially on the level of mid-term and short-term objectives. Little or no attention is paid to assumptions, risks and conditions that might have an influence on the extent to which the National Drug Strategy can be implemented. The overall framework of the National Drug Strategy is relatively comprehensive and the long-term objectives are coherent but the operationalisation of the long-term objectives (their break-down in short- and mid term objectives or rather activities) could be more consistent.

Table 4.1: Example Logical Framework National Drug Strategy

Overall Objectives of the National Drug Strategy *(longer-term aims) Ref: chapter 2*	**Objectively Verifiable Indicators**	**Means of Verification**	
1. Call a halt to the growth and, if possible, reduce the number of drug users and addicts 2. Increase the number and ratio of those receiving treatment and those being cured 3. Comprehensively develop prevention and the dissemination of information 4. Reduce the harm caused by drug consumption to the individual and society 5. Curb drug-related crime 6. Expand international co-operation 7. Call a halt to the negative trends in drug consumption	Not specified	Not specified	
Strategy Goal *(general aim of the policy)*	**Objectively Verifiable Indicators**	**Means of Verification**	**1. Assumptions and risks to longer-term objectives** (NDS, Ch. 5)
(…)The society is capable of managing health care, social and criminal harms and disadvantages related to the use and trafficking of drugs (…).	Not specified	Not specified	○ wide participation of society &voluntary organisations ○ important development tasks need to be carried out ○ broad consensus regarding the direction of the NDS is needed ○ CCDA needs to function and coordinate effectively
Key objectives *(representing desired* results*)*	**Objectively Verifiable Indicators**	**Means of Verification**	**2. Assumptions/ Risks to policy goal**
[I] Society should become sensitive to the efficient management of the drug issues, and local communities should improve their problem solving capabilities in countering the drug problem (community, co-operation).	Not specified	Not specified	Not specified
Long term objectives (LTO) related to result 1	**Objectively Verifiable Indicators**	**Means of Verification**	**3. Assumptions/ Risks to result I**
[1.2] The development of functioning communities sensitive to the management of the drug problem. [1.3] The different characteristics, opportunities and varying resources of local communities necessitate the development of local strategies (…) [1.4] Reorganisation of data collection and research (…) [1.5] Raising the awareness of families to enable them to recognise and manage drug problems [1.6] Development of workplace drug policies, and extension of the drug-free workplace program [1.7] Increasing drug-free entertainment opportunities including an increase in the number of safe places of entertainment [1.8] Reintegration of drug users released from penitentiaries into the community with the support of a wide-ranging network of institutions in co-operation with the organisations of health and welfare care [1.9] Caring for and reintegration of the homeless by providing supportive care, the management of harm and by including the elements of re-socialisation. [1.10] Building up a system of local Co-ordination Forums on Drug Affairs [1.11] Adaptation of European programs concerning community development, local management of drug problems or operation of local Co-ordination Forums on Drug Affairs to facilitate the implementation of local co-operation [1.12] Assessment of the (local) drug scene and the changes therein (use, trends) [1.13] Mapping the possible ways of solution (to the drug problem) and the conditions of their employment and success (e.g. communal prevention, community helping services, law enforcement [1.14] (Deployment of epidemiological) indexes developed with the help of proven EU conform indicators, which aim at uniformity [1.15] Making use of the joint efforts and experiences of the European and international community with respect to the management of the drug problem	○ are there local drug strategies and are they operational ○ are there prevention programs in exposed workplaces ○ has the number of varied leisure-time programs increased ○ a positive trend in statistical figures ○ municipal programs, resolutions reflecting local drug policy ○ reports of the local (city, county, regional) Co-ordination Forums on Drug Affairs ○ drug related databases ○ how many people participate in information flow: • experts receive more	○ written reports and statistics (local) (reports of the city, county, regional Co-ordination Forums on Drug Affairs) submitted to the Co-ordination Committee on Drug Affairs ○ local and nation-wide epidemiological research projects, special epidemiological research projects carried out among those at the highest risk ○ analysis of those making use of the institutions	Not specified

	information • lay people receive more information • press and media analysis • research projects and the use made of them		
Mid-term objectives (MTO) and activities	**Objectively Verifiable Indicators**	**Means of Verification**	**4. Assumptions/ Risks to LTO**
[1.5] Raising the awareness of families to enable them to recognise and manage drug problems [1.6] Development of workplace drug policies, and extension of the drug-free workplace program [1.7] Increasing drug-free entertainment opportunities including an increase in the number of safe places of entertainment [1.8] Reintegration of drug users released from penitentiaries into the community with the support of a wide-ranging network of institutions in co-operation with the organisations of health and welfare care [1.9] Caring for and reintegration of the homeless by providing supportive care, the management of harm and by including the elements of re-socialisation. [1.10] Building up a system of local Co-ordination Forums on Drug Affairs [1.11] Adaptation of European programs concerning community development, local management of drug problems or operation of local Co-ordination Forums on Drug Affairs to facilitate the implementation of local co-operation [1.12] Assessment of the (local) drug scene and the changes therein (use, trends) [1.13] Mapping the possible ways of solution (to the drug problem) and the conditions of their employment and success (e.g. communal prevention, community helping services, law enforcement) [1.14] (Deployment of epidemiological) indexes developed with the help of proven EU conform indicators, which aim at uniformity [1.15] Making use of the joint efforts and experiences of the European and international community with respect to the management of the drug problem	○ are there databases (on health care, prevention, communal services and police databases) accessible to experts and the public ○ are there local (city, county, regional) Co-ordination Forums on Drug Affairs ○ the licensing procedure for music and dance places of entertainment evolves as envisaged, the prescribed requirements are guaranteed on site	○ written reports and statistics	Not specified
Short-term objectives (STO) and activities	**Objectively Verifiable Indicators**	**Means of Verification**	
[1.23] Establishing local prevention services: establishment of a wide spectrum of leisure-time facilities, which take precedence over (or replace) drug use: drug-free clubs and discotheques, institutions enabling both entertainment and assistance, sports events at night, coping with loafing and street kids [1.24] Survey and assessment of those institutions, which are dealing with abusers or youngsters endangered by drug abuse [1.25] Analysis of the legal environment and its amendment when needed [1.26] Creating local forms of checks (e.g. drugs & driving, licensing procedures, etc. [1.27] Development in the quantity and quality of training projects (local drug coordinators & workplace drug experts) [1.28] It is necessary to develop reintegration programs for drug users released from penitentiaries [1.29] Administrative measures, e.g. establishment of the Co-ordination Forums on Drug Affairs, establishment of their legal and administrative conditions, co-ordination of the work of these committees and assistance to them through the collaboration of the organisational units of the CCDA [1.30] Facilitation of the operation of local community settings [1.31] Initiation of communal epidemiological research projects [1.32] Adjusting to the international environment, promoting international relations. The establishment of the National focal point – has an outstanding role-, which is the institution for cooperation between Hungary and the European Union	○ amount of allocated funds ○ quality assurance, collection of protocols, international protocols, development of those that are not available by the appropriate professional organisations ○ process assessment indicators	○ prorated use of funds available for the task ○ enactment of laws and measures	Not specified
			Preconditions
Key objectives *(representing desired* results*)*	**Objectively Verifiable Indicators**	**Means of Verification**	**2. Assumption/ Risks to policy goal**
II. The young must be given the opportunity of developing a productive lifestyle and must be enabled to reject drugs (prevention).	Not specified	Not specified	Not specified

Long term objectives (LTO) related to result 2	**Objectively Verifiable Indicators**	**Means of Verification**	**3. Assumptions & Risks to result 2**
[2.2] Halting the spreading of drug use in the following areas by reducing the growth rate in the number of drug users, by reducing experimental drug use and by increasing the age of first use [2.3] Preventing drug use to become a culturally accepted behaviour of young people by raising awareness, i.e. about social prevalence knowledge (…) [2.4] Promoting the healthy, drug-free lifestyle [2.5] Developing a school health strategy	○ epidemiological indicators ○ attitude, lifestyle indicators	○ epidemiological survey ○ research into attitudes and lifestyles	Not specified
Mid- term objectives (MTO) and activities	**Objectively Verifiable Indicators**	**Means of Verification**	**4. Assumptions/ Risks to LTO**
[2.6] Prevention should be professionally and adequately represented in the local Co-ordination Forums on Drug	○ change in attitudes and knowledge at school and in the groups of the young at risk ○ teachers being trained in prevention and health promotion ○ school drug strategies in place ○ increase in the number of school drug co-ordinators ○ participation of experts in prevention in the local (city, county, regional) Co-ordination Forums on Drug Affairs ○ written reports on local inter-institutional co-operation ○ number of marginalised young (dropouts, jobless, at risk)	○ attitude and knowledge surveys ○ monitoring teaching activity, assessment of prevention and health promotion under school quality assurance ○ written reports on the operation and experiences of the local (city, county, regional) Co-ordination Forums on Drug Affairs (to be submitted to the Co-ordination Committee on Drug Affairs to prepare the annual country report) ○ sociological and health surveys on the situation of the Hungarian young	Not specified
[2.6] Creating such youth, education and social policy which is sensitive to the problems of the young They improve the social, educational and labour market position, of the young, helping those groups being driven towards marginalisation			Not specified
[2.7- etc.			Not specified
			Preconditions
Key objectives *(representing desired* results*)*	**Objectively Verifiable Indicators**	**Means of Verification**	**2. Assumptions/ Risks to policy goal**
III. (….) etc…			

Furthermore, one important condition for the extent to which a policy can be implemented concerns its 'span of control' or the 'influence spectrum' of the departments executing it. A Strategy can reflect on the desirability of (long-term) societal changes and the roles and tasks of other actors in society (civil society, the public, the media). But when it comes to setting policy objectives a Strategy should primarily include objectives and envisaged results that can actually be influenced and achieved by the policy itself.

The National Drug Strategy shows a certain lack of prioritisation in the short-, medium- and long-term objectives that have been formulated for the four key-result areas. The time frame (short-medium-long) seems to suggest priority, but given the fact that there are over 90 short- and mid-term objectives, varying from very concrete actions (e.g. *establishment of a National Focal Point*) to the changing or development of health care systems (e.g. *develop a continuum of care*) makes it very difficult to compare achievement and to plan resources as the differences in scope and required resources for implementation vary considerably between objectives.

Key stakeholders that were involved in the drafting of the National Drug Strategy explained the lack of priority through the high ambitions and through the fact that there was not really a possibility to prioritise, as every objective was very much needed. Furthermore, some objectives were added and/ or amended during the political decision making process. Despite this explanation, it might have been better to prioritise the objectives (including the long-term objectives) – within the 10 year timeframe – from being most urgent to urgent to desirable, to identify more specifically what objectives need to be achieved first as a pre-condition for other objectives and – very importantly – match the prioritised objectives to the actual instruments and capacity for implementation that is made available.

The National Drug Strategy is not really a SMART Strategy (*with Specific, Measurable, Acceptable, Realistic and Time bound objectives*). A considerable number of objectives are not specific enough, leave room for differences in interpretation and call for a general change in policy without specifying how this change should be realised. Furthermore, the timeframe of implementation of some objectives has proven to be not realistic. Some short-term objectives could also be mid-term objectives and vice versa and the causal relation between them is not always clear.

Table 4.2 reflects – by means of example - a part of the monitoring instruments and/ or indicators that have been presented in Chapter 8 of the National Drug Strategy. It includes examples of mixing up the different 'Boxes' in a Logical Framework, for example by not clearly differentiating between indicators (*increasing numbers of participants and treatments*) and means of verification (*written reports*). The tables link the objective levels (short-, mid-, long-term) per Strategy result to instruments. These instruments, however, are variations of indicators and means of verification. And these are of mixed quality and specificity. For example: what objective has been reached if '*a reduction in the time period from first drug use to treatment*' has been achieved? Is this an indicator for *improved outreach of treatment services to drug users* or an indicator for the *success of the diversion scheme*? Is it an indicator for *effective treatment of an addiction in problematic drug users* or is it an indicator that *drug users – independent of the question whether they actually need treatment – are referred effectively to treatment services*.

Table 4.2 – Monitoring instruments and indicators for the National Drug Strategy

Objective	**Result 1** **Community, cooperation**	**Result 2** **Prevention**	**Result 3** **Social Work, Treatment, Rehabilitation**	**Result 4** **Supply Reduction**
Mid-term objectives	• are there databases (health care, prevention, com-munity services, police databases) available both to experts and the public • Are there local (city, county, regional) Co-ordination Forums on Drug Affairs • the process of licensing music and dance places of entertainment evolves as envisaged, prescribed requirements are guaranteed on site	• change in attitudes and knowledge at school and among groups of high-risk young people • training of teachers in prevention and health promotion • school drug strategies in place • increase in nr. of school-drug coordinators • participation of prevention experts in local (city, country, regional) KEFs • written reports on local inter-institutional cooperation	• increase nr of participants in treatment • helping, reintegrating attitude on the part of society vis-à-vis drug users • reduction in the time period from first drug use to treatment • effectiveness of treatment • written reports and strategies of the KEFs • number of accredited treatment places and programs • number of those receiving education • scientific publications	• increase in the quantity seized (Customs and Finance Guard and Police seizures) • reduction in the growth of drug-related crime (acquisition crime, trafficking, violent crime) • registration of legal drugs and precursors, their control, quality of reporting • increase in the illegal money and assets seized

4.4.3. *Assumptions and risks*

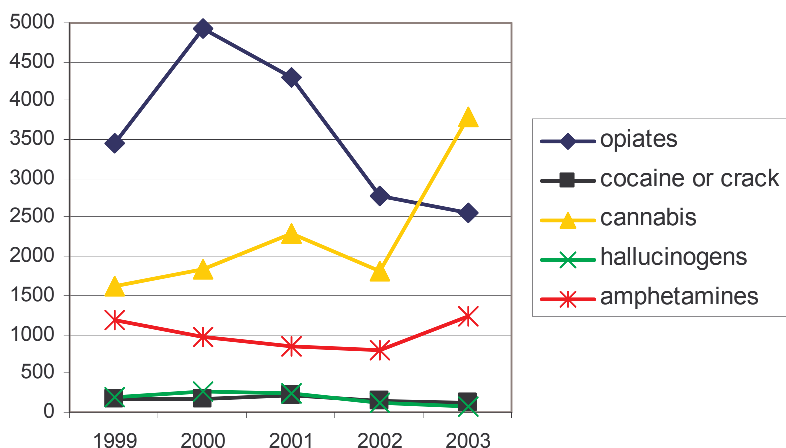
The Logical Framework of the National Drug Strategy contains very few assumptions and risks that may have an influence on the implementation of the Strategy. The Strategy did analyse the *ex-ante* situation before it was adopted, but one might say that perceptions about future developments after adoption – for as far as it was not intended and described as part of the policy plan itself - have been left out of the Strategy. However, the National Drug Strategy has great expectations of Hungarian Society. Chapter 5 presents the instruments of the National Strategy. When analysed carefully, one could say that they are assumptions and/ or conditions that are required for successful implementation of the overall Strategy goal (see table 4.1). The aim to have a wide participation of civil society and voluntary organisation is covered by several objectives in the Strategy. At the same time it is a condition for success, as the KEFs are based on voluntary involvement of local stakeholders. Apart from the instruments or assumptions/ conditions presented in Chapter 5 of the Strategy, no assumptions or risks have been formulated.

How important it is to formulate assumptions about factors that may have an influence on the implementation of the Strategy can be illustrated by the following examples of external developments and factors:

Example: interaction with other policies that might have an impact on the National Drug Strategy

This example concerns the Hungarian diversion scheme (alternative to imprisonment) that was introduced in 2003 but that was not one of the objectives in National Drug Strategy. The philosophy behind the diversion scheme is in line with the vision reflected by the National Drug Strategy. However, the implementation of the scheme might have unintended or unexpected effects. The diversion scheme became operational in 2002 and includes – among others - the referral of first-time and experimental Cannabis users to treatment services, when they are caught by the Police. Drug treatment services received (new) funding to provide such treatment. The 2002 data show a decline in the number of Cannabis users in drug treatment, while in 2003 there was a sharp increase[33]. At the same time, between 2000 and 2003 the number of opiate addicts in treatment almost dropped with 50% (see figure 4.4).

Figure 4.4 Number of clients in treatment using illicit drugs, 1999-2003



Source: OSAP/ 2004 National Report to the EMCDDA

Respondents in this evaluation indicated that there was a build-up of diversion cases in 2002 that could be processed in 2003 only, which might explain the number of Cannabis users in treatment to decline in 2002 and increase in 2003. There was already a decline in opiate users in treatment after the year 2000. This could be the result of effective treatment for opiate addicts and a reduction of new cases from 2000 onwards.

[33] 2004 National Report to the EMCDDA. p. 38-40.

But data about treatment demand in Hungary is incomplete and information about the effectiveness of treatment is not available. The decline in treatment for opiate drug users and the sharp increase in treatment for Cannabis users might be and unintended effect of the diversion scheme might. Treatment centres may have shifted their priority to getting more Cannabis users into treatment and recuce the number of opiate addicts. Such an unintended effect makes realisation of the objectives in the National Drug Strategy that aim at improving access and coverage for those who suffer most from drug use, more difficult unless treatment capacity is expanded. On the other hand, occasional Cannabis users receive a different (outpatient) treatment from opiate addicts, often from different service providers. Perhaps larger numbers of people, including those with mental disorders, may experiment with Cannabis. The exact explanation about cause and effect as described above can not be supported by facts as there is a lack of information and monitoring data that could explain this phenomenon. As a safeguard, the authors of the National Drug Strategy could have identified the condition (and by doing so identifying the risk) that drug policies not covered by the Strategy are screened to see what possible effects on the objectives of the National Drug Strategy may be.

Other examples

The example above concerns one example of possible unwanted or unexpected effects of policies, which might go by unnoticed if assumptions – and based on that – conditions are not formulated. Other examples of assumptions of possible developments that are essential for programme compliance are:

- *Result community, cooperation*: KEFs can be set up and there is a willingness and support at local level to support these structures; the local level share the problem assessment of the National Drug Strategy regarding the drug problem;
- *Result prevention*: prevention programmes are available and can be disseminated to prevention services and local communities; the school system is receptive and supportive to prevention efforts;
- *Result treatment*: there is national coverage of treatment programmes and/or that these can be created in the period encompassed by the Strategy;
- *Result supply reduction*: law enforcement and judicial community supports the balanced approach, a unification of penal code can be carried through in support of the new vision adopted in the drug policy;
- *Whole Strategy*:
  - assumption that a multi-sectoral policy which requires an active involvement of several branches of government can actually be implemented, despite the existing bureaucratic culture in Hungarian public service;
  - the respective Ministries and Departments will take up and maintain their responsibility for relevant sections of the National Drug Strategy;
  - the required funding is made available for the implementation of the National Drug Strategy (estimates at least 17 Billion Forint by the end of 2009);
  - Hungarian Society is supportive of the new approach in drug policy.

Undesired effect/risk: municipalities feel less responsible for the drug problem as this responsibility is attributed to the KEF structure.

The formulation of these assumptions and conditions is important for coordination and implementation. By analysing the extent to which assumptions have been correct, the feasibility of implementation and the need for adjustment of objectives and expectations can be identified more easily.

4.5. Conclusions

The National Drug Strategy is a comprehensive and – in most parts – consistent policy plan. The Logical Framework structure within the Strategy has not completely been unfolded. The overall framework of project goal, results and long-term objectives shows coherence, but the operationalisation of objectives could be more specific. Not all of the Strategies' objectives are SMART; a number of objectives which are not specific enough and leave room for differences in interpretation and sometimes call for a general change in policy without specifying what exactly needs to be changed. The timeframe for the implementation of some objectives seem to be somewhat unrealistic. Some of the short-term objectives are in fact mid-term aims and vice versa. The relation between some short- and a mid-term objectives is not clear. The strategy identifies indicators but these are not clearly linked to the objectives. Furthermore, many indicators are not very precisely formulated. The objectives regarding international cooperation, information, monitoring &

evaluation, and community level objectives might have been better projected horizontally as they all cover elements of prevention, treatment and supply reduction. One major challenge for the implementation of the National Drug Strategy is the lack of priority. The Strategy provides a series of objectives for the first 2-3 years of its implementation and for the whole duration. It is not specified what objectives need to be reached in the period 2005-2009.

The National Drug Strategy is a visionary policy document which sets out guidelines for policymakers to guide implementation. At the same time, the authors have included elements of a drug action (and implementation) plan into the Strategy, identifying objectives that are sometimes so specific that they are in fact policy actions. When looking back at the functions identified in §4.2, the Hungarian National Drug Strategy is an inclusive policy paper that sets fundamental goals and values and that formulates the main directions of drug policy in Hungary. As a Strategy, it provides assistance and guidance for executive agencies that are involved in its implementation. Within the group of main stakeholders, the Strategy reflects a broad consensus regarding aims and objectives of the policy. The policy theory, the approach chosen, is well in line with the mainstream of EU drug policy. Furthermore the Hungarian National Strategy to Combat the Drug Problem provides an all-in-one approach to the drug problem. So the Hungarian National Drug Strategy has the function that was envisaged by its authors.

But a Strategy can not be used as an action and/ or implementation plan. It should be considered to operationalise the results and long-term objectives into short- and mid-term objectives in one or more separate implementation plans, breaking down the long-term objectives and priorities into short- and mid-term objectives and specific actions, indicators and instruments, following the budgetary cycle of government.

The National Drug Strategy is a policy plan. The Logical Framework structure within it is a planning tool. Both the policy document and the policy structure are not an aim in themselves. They facilitate and might increase the chances for successful implementation. The level to which the Strategy is successful depends to a large extent to the activities and compliance of all stakeholders that are involved in implementing it. The analysis presented in Chapter 5 will focus on that part of the evaluation.

5. Evaluation of the external effectiveness of the National Drug Strategy

5.1. Introduction

As indicated in Chapter 2, the mid-term evaluation also includes an assessment of the external effectiveness of the National Drug Strategy. This part of the evaluation focuses at the question whether the short- and mid-term objectives of the National Drug Strategy have actually been implemented and with what result. The National Drug Strategy is a policy document with over 90 identified short- and mid-term objectives. The available resources and time did not allow evaluating the achievement in the implementation of all those objectives. It was decided that the evaluation would focus on a limited number of cross-cutting objectives that are in line with main themes in drug demand and drug supply reduction and that represent the broad scope of the National Drug Strategy at the same time.

5.2. Approach, methodology and justification

5.2.1. Focus of the evaluation

As a result of the decision to evaluate the implementation of only a limited number of objectives from the National Drug Strategy, a selection of 17 out of over 90 objectives was made by the evaluation team, representing the broad perspective of the Strategy.

Each pre-selected objective has been carefully considered and argued. The evaluators have also weighed the importance of the pre-selected objectives against the background of the requirements of balanced and comprehensive drug policies as these exist abroad. It was the expectation of the advisors and evaluators that the vast majority of these objectives were also relevant for the activities at the level of the KEFs. The same 17 objectives have been used for the interviews with the National respondents.

Before a final selection was made, a group of Hungarian stakeholders at national policy level was asked to provide advice on what objectives they felt were most important and most relevant. The final selection was made by the evaluators of the Trimbos Institute, which resulted in a breakdown of objectives for *Community (1-3)*, *Prevention* (4-8), *and Treatment* (9-12) and for *Supply Reduction (13-17; see Table 5.1)*.

Table 5.1 – Breakdown of 17 pre-selected short- and mid-term objectives from the National Drug Strategy

nr.	**Pre-selected objective** (NDS reference)	nr.	**Pre-selected objective** (NDS reference)
1.	Raising the awareness of families to enable them to recognise and manage drug problems. (I.1.1.A)	**10.**	Increase in the number of drug users participating in a helping relationship (from the first contact phase to treatment and re-socialisation). (III.2.2)
2.	Analysis of the legal environment and its amendment when needed. (I.3.3)	**11.**	Programs for high-risk or special populations need to be set up, e.g. long-term care for those struggling with other psychiatric problems (dual diagnosis, co-morbidity), medical care for HIV+ and AIDS patients, hepatitis carrying drug users, creation and expansion of special programmes for pregnant women and drug-dependent infants. (III.3.14)
3.	Establishment of local prevention services: establishment of a wide spectrum of leisure-time facilities, which take precedence over (or replace) drug use: drug-free clubs and discotheques, institutions enabling both entertainment and assistance, sports events at night, coping with loafing and street kids. (1.3.7)	**12.**	Training courses on addiction problems (treatment and rehabilitation) should be developed and put in place for psychiatrists, addictologists, child psychiatrists; clinical and prevention psychologists, addictological consultants and assistants, graduate nurses, and other relevant professionals. (III.3.2.5)
4.	A youth, education and social policy is required, sensitive to the problems of the young and aimed at improving their social, educational and labour market position, helping those marginalised young people. (II.2.12)	**13.**	The security of places of entertainment and other areas infected by drugs should be improved. (IV.2.10)
5.	Operational health promotion programs including drug prevention in all the settings where the young grow up (family, public education, higher education, supplementary educational systems, leisure-time and other communal activities, sports, church life). (II.2.1)	**14.**	Combating drug trafficking and dealers' networks should be reinforced. (IV.2.6)
6.	Long-term school prevention and health promotion should be focused on skills development. Drug prevention needs to be integrated into subjects related to health promotion and life management (focusing on skills development). (II.2.4/ II.2.7)	**15.**	It is necessary to reinforce the protection of Hungary's borders against incoming and transit drugs. A reduction in internal drug production and manufacturing and more intensive control of legal manufacturing should be achieved. (IV.2.1)

7.	A school drug co-ordinator (teacher, school psychologist, youth nurse, health educator) should be named who, owing to his/her sensitivity and qualifications in the field is assigned this task against remuneration for his/her activities. (II.2.6)	**16.**	The number of violent and anti-property criminal acts related to drugs should show a declining tendency. (IV.2.8)
8.	Drug prevention and health promotion training courses should be developed addressing in particular the problems of adolescence and youth. (II.3.10)	**17.**	Drug-related training should be improved and made general for the internal (local or national) organisations so that the staff is prepared for solving problems arising in the course of their practical work. The conditions for the EU-compliant operation of policing agencies will have to be established. (IV.2.14)
9.	By using various instruments of social policy (e.g. protected accommodation and jobs, day-care, reintegration programs, etc.) the number of criminal acts committed by drug users will have to be reduced. (III.2.6)		

5.2.2. Evaluation at local level

Given the fact that the National Drug Strategy has attributed such an important role in its implementation to local structures, it has been decided to conduct a mid-term evaluation of the establishment and the functioning of the KEFs. Because over 70 KEFs had been established already by mid 2004, the conclusion was drawn that it was impossible to arrange face to face interviews with representatives of each of the KEFs at local level. At the same time it was considered desirable that a broad range of KEFs was involved in the evaluation. As a result, the decision was made to organise a semi-structured interview by telephone with respondents (KEF coordinators/ secretaries) of all the formally established KEFs except for the KEFs in Budapest – Buda side, which had only been established shortly before the beginning of the evaluation.

Because of the assumption that many of the KEF respondents would not be able to participate properly in an interview conducted in English, the staff of the Trimbos Institute concluded they could not perform the KEF evaluation themselves. A team of local interviewers, some of them employees of the NDI, were selected and trained by Trimbos Institute staff on how to conduct a semi-structured telephone interview. In order to improve cooperation from and reduce bias at the side of the KEF respondents and at the side of the interviewers, the latter were not allowed to interview KEF respondents they were contact person for in their daily work.

For the telephone-interviews, the evaluators drafted a semi-structured questionnaire containing over 30 questions (*see Table 1, Annex 4*) on the establishment and functioning of the KEFs. These questions focused on the establishment of the KEFs, the participation of the local community in the daily work, the tasks regarding assessment and response to local needs, the dissemination of information and the relevance, importance, success and failure of the local KEF structure.

In addition to the questions about the functioning of the KEFs, a second series of questions was formulated focusing at the implementation of the short- and mid-term objectives in the National Drug Strategy at local level. This second series of questions contained 9 standardised questions for each of the 17 pre-selected short- and mid-term objectives that were to be evaluated (*see Table 2, Annex 4*).

Two weeks before the beginning of the telephone interviews, the KEF respondents received the questionnaire and the list of 17 pre-selected short- and mid-term objectives by mail, after which they were contacted by NDI staff to schedule an appointment for the actual interview. For the registration of the response of the KEF interviewees, the Trimbos Institute developed a bilingual computer-based data-entry application which allowed the Hungarian interviewers to process the response electronically. The local interviewers received training in how to use the computer application and how to ensure maximum reliability in the data collection.

The interviews were conducted in September and October 2004. In total 65 KEFs were contacted, 64 of which completed the interview. A full list of participating KEFs has been included in Annex 3. Each telephone interview lasted app. 2 hours. The data of the interviews was transferred to the Trimbos Institute at the end of the interview cycle. The data was subsequently processed and analysed by the Trimbos Institute staff. The analysis resulted in a number of further questions about the interpretation of some of the findings as well as explanatory questions.

In February 2005 a *focus group* was organised with 9 representatives from KEFs, covering the main regions in the country. During the focus group initial outcomes of the interviews and the questions about the

interpretation of some of the findings were presented and discussed. Furthermore, in the interviews that were conducted at national implementation level from December 2004 to February 2005, the interviewed stakeholders were asked to give their opinion about the functioning of the KEF structure. In § 5.3 the report of the analyses at local level is presented.

5.2.3. Evaluation at National level

The mid-term evaluation of the implementation at national level had to be structured differently. The evaluators were not only interested in the achievement of a number of objectives from the National Drug Strategy at national level and the functioning of the KEF structure, but also in the question which of the national respondents could indicate for which objectives their department or agency was responsible in terms of implementation.

The difficulty with this part of the evaluation was that over 20 ministries, agencies and structures at national level have some kind of responsibility in the implementation of the National Drug Strategy (see also stakeholder analysis in Chapter 3). Some of these actors have shared responsibilities for specific objectives. Like on local level it was not possible to conduct a detailed evaluation of the achievement on the broad range of objectives, given the available resources and time. The evaluators decided to arrange qualitative interviews with a selection of key stakeholders. These stakeholders were identified on the basis of the information obtained during the first round of interviews conducted in the beginning of 2004, as well as on the assessment of key actors identified in the National Drug Strategy itself, the members of the CCDA and upon advice of some of the Hungarian project partners. Twenty-two key stakeholders were interviewed, representing key departments, agencies, professional organisations and civil structures that are involved in the implementation of the National Drug Strategy.

These national respondents were confronted with six areas of questions, including:

a) their perception of the National Drug Strategy as a policy document;
b) their opinion about the functioning of the Local Coordination Forums on Drug Affairs (the KEFs);
c) their opinion about the functioning of the Coordination Committee on Drug Affairs;
d) their judgment regarding the level of achievement of those of the 17 pre-selected objectives their organisation was either responsible for or involved in, and;
e) their judgment regarding other short- and mid-term objectives in the Strategy their organisation was either responsible for or involved in;
f) their selection of the most and least successful objectives of the National Drug Strategy and its strongest and weakest points.

The interviews were conducted from December 2004 to February 2005. Staff of the Trimbos Institute conducted the interviews in all cases but one. About 1/3rd of the interviews were conducted in English, while the other interviews were conducted with consecutive interpretation. Each interview lasted app. 1.5-2 hours. The outcomes of the interviews were analysed by the Trimbos Institute staff. In February 2005 a focus group was organised in which six representatives of national stakeholders participated. The focus group was organised with the aim to provide feedback about the initial findings of the mid-term evaluation so far to obtain further insights in some of the central findings from the interviews and to clarify issues that were unclear.

5.2.4. Limitations and potential bias

It is important to repeat that this mid-term evaluation is not an in-depth evaluation and that its main sources of data concerns document analysis and qualitative interviews with stakeholders responsible for (parts of) the implementation of the National Drug Strategy. At the local implementation level the evaluators did not asses specific written sources of information from the responding KEFs. The evaluation data gathered at that level concerns self-reported information of representatives of the participating KEF structures. When combined, this information made it possible to draw conclusions and formulate recommendations.

Regarding the achievements in the field of the 17 pre-selected short- and mid-term objectives on KEF level, possible bias due to the length of the questionnaire, a possible lack of specific knowledge among the KEF respondents regarding the objectives of the National Drug Strategy and a possible bias that may be attributed to socially desirable answering cannot be ruled out completely. Furthermore, it must be noted that the telephone interviews have primarily been aimed at the coordinators and not at the participating member organisations and

structures in the local KEFs, who might have a different perspective. The KEF coordinators are presumed to have a good overview of the activities at local level, though.

The outcome of the interviews at national level provided qualitative information about the overall implementation of objectives of the National Drug Strategy. However, it did not provide enough comparable and reliable detail about the (level of) achievement of specific objectives as many respondents primarily had knowledge about the objectives that were relevant for their own organisation.

The limitations as described above do not interfere with the possibility to draw relevant conclusions as a result of this mid-term evaluation. The methodology followed was sufficient and appropriate to answer the three main research questions as described in Chapter 2. Despite the fact that the level to which short- and mid-term objectives have been achieved can not be determined by nor supported with hard data, the views and perceptions of the more than 90 stakeholders involved in this evaluation present a congruent and complementary picture. For a more detailed evaluation of the implementation of specific objectives, the focus of the evaluation would have to be to be narrowed with a methodology that includes both quantitative and qualitative analyses.

5.3. Evaluation of the implementation of the National Drug Strategy at local level

5.3.1. Evaluating the establishment and functioning of the KEF structure at local level

Several objectives in the National Drug Strategy refer to the establishment and tasks of the KEFs. The establishment of these KEFs is one of the visible implemented objectives of the Strategy. The KEF respondents that were interviewed were asked in what year since 2000 their structure was established. Six of the 64 KEFs were established in 2001, against 36 in 2002, 17 in 2003 and 5 in 2004. Table 5.2 shows that the peripheral areas of the country were among the pioneers in establishing a Local Coordination Forum.

Table 5.2 – Year of establishment of KEFs per region

Region	2001	2002	2003	2004	Total
I. Közep-Dunántúl (Middle-Transdanubia)	1	4	3	1	***9***
II. Nyugat- Dunántúl (Western-Transdanubia)	1	6	1	-	***8***
III. Közep –Magyarország (Middle-Hungary)	-	4	3	-	***7***
IV. Budapest – Pest Side	-	0	1	3	***4***
V. Dél-Alföld (South-Plain)	1	9	2	-	***12***
VI. Észak-Alföld (North-Plain)	1	1	5	1	***8***
VII. Észak - Magyarország (Northern-Hungary)	-	8	-	-	***8***
VIII. Dél-Dunántúl (Southern-Transdanubia)	2	4	2	-	***8***
Total	***6***	***36***	***17***	***5***	***64***

The KEF respondents were asked a series of questions in which they had to indicate the level of involvement of local stakeholders, organisations and structures. These questions aimed to provide an insight into the question whether the KEFs are really Local Coordination Forums on Drug Affairs, platforms that represent a broad group of local stakeholders in the drug issue. The National Drug Strategy explicates that KEFs should carry out their coordination tasks properly and contribute to the improvement of the problem solving skills of Local Communities in handling the drug problem. Active participation of relevant structures and organisations is considered to be a prerequisite for success.

5.3.1.1 Representation and participation of local community structures in KEF activities

In the questionnaire a difference was made between the official representation of local organizations and structures and the question whether these structures actively participate in the work of the KEFs (see table 5.3). Four organisations and structures appear to be represented for more than 90% in the interviewed KEFs: the municipality, the police, child welfare services and educational institutions. Organisations that are often represented (80<>90%) are: local branches of the State Public Health Service (ÁNTSZ), family support centres and civil organizations (53).

Organisations and structures that are represented less frequently (35%<>65%) are (among others): addiction treatment services, churches, social institutions, the media, drug prevention services, and organisations dealing

with diversion. The Army, the Customs and Finance Guard (VPOP) and public prosecutors were involved in very few cases (<10%). Finally, some organisations were named only once or twice.

The outcome that drug treatment services are not represented in all KEFs so much might have to do with the fact that not every KEF that was interviewed actually has a treatment service in its local (or regional) community. This assumption was confirmed during the focus group meeting in February 2005. KEF respondents mentioned in incidental cases other represented organizations, including organizations representing the Roma minority, cultural organizations such as theaters, student associations and neighborhood watch programmes, the Blue Cross, the City Court, probation services and the Lions Clubs.

Table 5.3 – Representation and frequency of participation KEF Members

Organisation/ Structure	Represented In KEF		*And* participating in meetings	
Municipalities	64	*98%*	62	*97%*
Police	63	*97%*	55	*87%*
Educational institutions	62	*95%*	58	*94%*
Child welfare services	59	*91%*	56	*95%*
Municipal health service (ÁNTSZ)	57	*88%*	51	*89%*
Family support centres	55	*85%*	52	*95%*
Civil organizations	53	*82%*	50	*94%*
Institutes dealing with therapy	41	*63%*	34	*83%*
Churches	37	*57%*	26	*70%*
Social institutions	37	*57%*	35	*95%*
Media	31	*48%*	24	*77%*
Prevention service providers	25	*38%*	23	*92%*
Organization dealing with diversion	24	*37%*	21	*88%*
Customs and Finance Guard (VPOP)	5	*8%*	3	*60%*
Public prosecutor office	4	*6%*	2	*50%*
Army	4	*6%*	2	*50%*

The question if the organizations represented (member) in the KEFs are actually participating frequently in the KEF meetings and/or activities had four categories for answering: '*every time*', '*often*', '*rarely*' and '*never*'. When we look at the total scores for the first two answers ('*every time*' or '*often*'), the participation rate of most organisations was high (range 70<>97%). Participation of the three organisations with low representative rates (i.e. customs, public prosecutor office and the army) was low (only two to three times mentioned). Regarding the army, the customs and finance guard, the reason might be that these structures only have local sections but are coordinated at the national level. The last two answer categories ('*rarely*' or '*never*' participated) had low scores (range 3<>27% and 0<>7% respectively). The highest scores for these two 'negative' answer categories were found for churches (11), media (7) and therapy institutes (7).

In general it can be concluded that participation of relevant local community organisations and structures in the KEF work is up to standard. However, the evaluation does not provide details on the quality of cooperation and input of local structures.

5.3.1.2 Collecting information and monitoring the local drug problem

One of the key tasks attributed to the KEFs concerns the conducting of a local assessment (e.g. by means of a Rapid Assessment) into the local aspects of the drug problem and to identify local needs.

Since 2002, 58 (91%) of the participating KEFs have *collected* data on regional or local drug problems, while some of the KEFs have done so more than once. In 2002 all of the 42 existing KEFs had collected data. In 2003 a total of 32 out of the 59 KEFs that existed at that moment did so, while by September 2004 a total of 20 of the 64 existing KEFs had conducted the data collection.

42 (78%) of the 58 KEFs that reported to have conducted a data collection since 2002, had gathered information on the level of drug use in the community (prevalence). A total of 39 of these 42 KEFs reported also to have collected information on the most important risk groups in the community, while 30 of them reported to have collected data on police and court related drug issues. A total of 20 of the 42 KEFs reported to

have collected other relevant information on the local, regional or county drug problem. Of the 58 KEFs that reported to have collected information 16 did not specify the type of data they collected.

In 49 of the 58 cases the KEF also drafted a report on the local, county or regional drug problem. In total 46 of these 49 KEFs that made a report distributed it to the municipality. Surprisingly, the report was distributed to half or less than half of all the other represented and participating organizations in the KEF. ÁNTSZ, the family support centres, children welfare services, the police, educational institutions and civil organizations were among the structures that received a report in app. 50% of the cases. Institutes dealing with treatment received the report in 20 of the 58 KEFs that collected data. Organisations dealing with diversion, prevention service providers, the customs and finance guard, army and public prosecutor's office received the report in 10 or less cases.

A *discussion* about this report was arranged in a large majority of cases with the municipality (90%), but less frequent with educational institutions (63%), child welfare services (61%), the police (59%), family support services (55%), social institutions (53%) and ÁNTSZ (51%). Again, in 20 cases the report was discussed with treatment institutes (41%).

5.3.1.3 Keeping record of the capacities of prevention, community development and therapy

Information on local or regional prevention activities was *collected* by 49 out of 64 KEFs (77%), while 14 KEFs indicated they had not collected such information and one KEF did not answer the question. Two KEFs indicated that such data had been collected in their municipality between 1999 and 2000. In 2002 a total of 27 of the existing 42 KEFs (64%) had collected this type of information. In 2003 and 2004 information was collected by 35 respectively 23 KEFs. In total 32 of the 49 KEFs (65%) that collected information have sent the report to the National Drug Prevention Institute (NDI) in the period of 2002-2004.

If information on prevention activities was collected, local or regional stakeholders were *informed* about these activities, with the municipality scores highest (84%), followed by ÁNTSZ (57%), civil organizations (49%), the police (48%), child welfare services (47%), family support centres (44%) and churches (41%). Treatment services (39%) and prevention service providers (19%) were informed less frequently. Frequencies of *discussions* about this information show the same pattern, with the municipal officials as the most frequent initiators (82%), followed by educational institutes (69%), child welfare services (67%), the police (65%) and family support centres (61%). Churches, the media and organizations dealing with diversion were among those least involved in discussions. Absolute numbers ranged from 1 to 40 participating parties in discussions.

Somewhat more than half of the KEF respondents said that discussions with stakeholders resulted in judgments about the quality and quantity of existing prevention facilities. Over 27 (55%) of the 49 KEFs that collected information on prevention reported that overall stakeholders were satisfied about the *quality* of these activities and somewhat less about the *quantity* of services (49%). Approximately 9 (18%) of the respondents indicated that the stakeholders that participated in the discussions about prevention services were not satisfied with the quality of services, while 12 (25%) of the stakeholders had this opinion about the quantity of services. Almost 28 of all 64 KEFs did not answer this question (44%).

5.3.1.4 Treatment activities

Compared to prevention, information on treatment was *collected* far less frequently by organisations, namely by 21 out of 64 KEFs (33%). In total 39 out of 64 (61%) KEFs indicated not to have collected information on this issue while four respondents did not answer the question. One KEF collected information on treatment services already in 1997. In 2002 the 12 KEFs collected information on treatment activities, against 17 in 2003 and 6 in 2004. Approximately 15 of 21 KEFs that collected information in the period 2002-2004 actually sent a report to the NDI.

When information on the treatment of drug problems was collected, local or regional stakeholders were *informed* about existing treatment activities. Again, municipal officials were informed most frequently (19 of 21/ 90%), followed by ÁNTSZ (86%), educational institutes (81%), child welfare services (76%), family support centres (71%) and the police. The media scored low on distribution of treatment information (29%).

Discussions about this information took place less frequently, ranging from 24% for the media up to the highest score for municipal officials (71%). Compared with the same question on prevention facilities, even

fewer KEF respondents answered the question on stakeholders opinions about the quality and quantity of existing treatment activities (14 and 15 respectively), i.e. somewhat more than two-thirds of the number of KEF respondents that reported to have collected information on treatment activities. Of these respondents, 10 (48%) indicated that stakeholders were satisfied about the *quality* of these activities, while 4 of the 14 respondents said quality was considered insufficient by the stakeholders. Regarding the quantity of treatment activities, 7 of 15 respondents reported that stakeholders had indicated that it was sufficient, while 8 had reported the opposite.

One explanation for this relatively low response rates regarding treatment activities may be found in the fact that not all KEF municipalities or counties have a treatment centre in their area. We excluded from this part of the analysis three stakeholders with low representation scores (see below: public prosecutor, customs and army) unless explicitly mentioned.

5.3.1.5 Annual work plans

One of the tasks identified in the National Drug Strategy for the work of the KEFs on Drug Affairs concerns the drafting of an annual work plan. The respondents were asked to indicate whether their KEF had developed a work plan and whether KEF Members had played an active role in its development. They were also asked if KEF Members were informed about the contents of the work plan and its planning and whether it was discussed with these stakeholders. Most of the KEFs had developed a work plan in the years 2002-2004. In 2002 nearly all existing KEFs had developed such a plan, while in 2003 57 out of 59 KEFs fulfilled this task. In 2004, 53 out of 64 KEFs had developed a work plan. In all, by the end of 2004, 61 out of 64 existing KEFs had developed a work plan at least once.

As table 5.4 shows, the participation of KEF members in the development of the KEF work plan was considerable, especially from the side of the municipality, educational institutions, family support centres, and the police and child welfare services. The KEFs also provided information to their members. Again, the municipalities were informed in most cases. The police, educational institutions, family support centres (67%) and child welfare services (62%) were also well informed. Interestingly, KEFs also seem to inform the media (46%) about their work in a great number of cases. Discussions about the work plan when it was adopted have taken place in a large number of cases. The KEFs discussed the work plans with the municipalities in 90% of the cases. Police and educational institutions were good runner-ups, while family support centres and child welfare services were somewhat less involved in discussions. Here too, the relatively high score of the media (31%) is interesting.

Table 5.4 Involvement of KEF Members in KEF work plan

Organization/institute	Participated In drafting		Informed By KEF		Discussed With KEF	
Municipalities	53	*87%*	57	*93%*	55	*90%*
Educational institutions	44	*72%*	45	*74%*	44	*72%*
Family support centres	41	*67%*	41	*67%*	37	*61%*
Police	40	*66%*	46	*75%*	44	*72%*
Child welfare services	37	*61%*	39	*64%*	37	*61%*
ÁNTSZ	36	*59%*	38	*62%*	34	*56%*
Civil organizations	31	*51%*	37	*61%*	32	*52%*
Institutes dealing with therapy	22	*36%*	28	*46%*	22	*36%*
Social institutions	22	*36%*	29	*48%*	26	*43%*
Churches	17	*28%*	24	*39%*	20	*33%*
Prevention service providers	15	*26%*	18	*30%*	17	*28%*
Media	14	*23%*	28	*46%*	19	*31%*
Organization dealing with diversion	12	*20%*	19	*31%*	12	*20%*
Public prosecutor office	4	*7%*	8	*13%*	5	*8%*
VPOP	0	*0%*	4	*7%*	2	*3%*
Army	0	*0%*	4	*7%*	1	2%

5.3.1.6 Annual report on activities

Some 90% of the KEF respondents said that their KEFs published an annual report(s) of the work done since 2001, such in line with the National Drug Strategy. Five KEFs published a report in 2001 already. Practically all of the KEFs that existed in 2002 made an annual report of their activities. Most of the KEFs did so in 2003 (92%) as well. Of the 58 KEFs that have published an annual report since 2001, 43 have done so in two subsequent years. By the end of 2004, only 6 KEFs had not published an annual report on their activities. An increasing number of KEFs forwards the annual report to the NDI. Practically all KEFs have done so with the report of 2002, while 92% of KEFs have sent the report over 2003 to the NDI.

The KEF respondents were also asked to what extent the local or regional stakeholders were participating actively in contributing to this report, whether the KEF has *informed* the local or regional stakeholders about the outcomes of this report, and whether the local or regional stakeholders were involved in *discussions* on this report (see table 5.5).

Table 5.5 – Involvement of KEF Members in KEF annual report

Organization/institute	Participated in writing		Informed by KEF		Discussed with KEF	
Municipality	46	*79%*	53	*91%*	53	*91%*
Police	30	*52%*	42	*72%*	42	*72%*
Educational institutes	30	*52%*	43	*74%*	37	*64%*
Family Support Centre	29	*50%*	39	*67%*	34	*59%*
Children Welfare Service	26	*45%*	37	*64%*	36	*62%*
ÁNTSZ	24	*41%*	38	*66%*	37	*64%*
Civil organizations	24	*41%*	34	*59%*	30	*52%*
Institutes dealing with therapy	18	*31%*	23	*40%*	23	*40%*
Social institutions	15	*26%*	28	*48%*	22	*38%*
Church(es)	14	*24%*	22	*38%*	21	*36%*
Prevention Service Provider	13	*22%*	19	*33%*	19	*33%*
Organizations dealing with diversion	12	*21%*	16	*28%*	14	*24%*
Media	10	*17%*	28	*48%*	19	*33%*
Public prosecutor office	2	*3%*	8	*14%*	7	*12%*
VPOP	1	*2%*	4	*7%*	5	*9%*
Army	1	*2%*	3	*5%*	3	*5%*

The *active participation* in writing this report was highest among municipal officials (79%). Percentages for other organisations were ranging at lower level compared with former questions (from 52% and lower). In a vast majority (91%) of the KEFs that published an annual report, the municipality was not only informed about its content but also engaged in a discussion on it. The police was also informed about the report and engaged in a discussion about the contents in 72% of the cases. Educational institutions, the local branches of the state public health service, the child welfare services and family support centres were among the most involved organizations.

5.3.1.7 Important tasks, successes and barriers

The KEF respondents were also asked to mention the five *most important tasks* of KEFs, the five *most successful tasks* of KEFs and the five *most important barriers* that stand in the way of realisation of the KEF tasks[34]. Regarding the five most important KEF tasks, 172 valid answers were counted. For the question in which respondents could list the five most successful tasks, 158 valid answers were counted. Finally, the question in which the respondents could list the five most important barriers resulted in 160 valid answers. The results should be read as a rough guide, an impression of most and less frequently mentioned tasks and

[34] The number of missing answers was not reported adequately in the evaluation process and remains unknown. Several answers to this open question were not valid, i.e. not to the point or difficult to understand, thus difficult to categorise. This analysis draws on the numbers of valid answers.

barriers. Basic assumption is that the frequency of mentioning a task or barrier to an open question is an indication for its (on average) perceived importance.

Many of all given answers were mentioned only once or a few times, resulting in a large differentiation of answers. We present the most frequently mentioned ones. For a more detailed overview we refer to tables 3, 4 and 5 in Annex 4.

Important KEF tasks

The most frequently mentioned tasks of the KEF are the creation of local or regional contacts or co-operative networks for combating drug problems (26 of 172, 15%) and being a basis for information sharing (13%). Less frequently mentioned were: building a local or regional co-ordinating structure (10%), creating a local or regional drug strategy (9%), continuing and strengthening KEFs, e.g. by selective prevention (8%), creating a knowledge basis for action (6%; e.g. by conducting survey studies), and training of local experts or KEF members (6% *see Table 5.6*).

Table 5.6 - Important KEF tasks - Frequently mentioned

(Creating a sufficient basis for) co-operation on a local level, keeping in contact, co-operation of key persons on local/regional level (who are involved in mapping and solving drug problems); mapping local relations; getting key persons involved; increase co-operation with the media	15%
Giving information about the local drug situation; prevention programmes; treatment; Giving information to the local communities, to the people; Making a website; making databases; Influencing public opinion; Informing prevention workers; Informing other KEFs; Informing parents and students	13%
Developing or co-ordinating work, actions, institutes; building an effective co-ordination structure; community actions; get in contact with local institutes	10%
Creating a local drug strategy, a city strategy, making a map with local drug issues, making a county strategy, informing decision makers about it; specifying work plan or targets	9%
Continuing and/or strengthening KEF; drug prevention activities; making programmes for high-risk groups; creating a drug prevention centre	8%
Conducting a survey study to create local/regional information on drug use; Creating drug related knowledge about local situation	6%
Training experts; securing competence; training KEF-members	6%

Successful tasks

The task which was mentioned most frequently as successful task (33 of 158; 21%) concerned preventive activities at school and for families. Another frequently mentioned answer (13%) is a bit tautological and non-specific (the mere existence of KEFs is perceived as a success). Local activities (summer programme, exhibition, games, conferences, etc.) were named third (12%), while local surveys supporting preventive actions (11%) were mentioned in the fourth place. Local co-operation (9%) and training of experts or members (8%) were mentioned fifth and sixth most frequent (*see Table 5.7*).

Table 5.7 - Successful KEF tasks – Frequently mention

Developing or starting school-based drug prevention, a (anti) drug strategy in schools or locally, establishing drug prevention programmes; Family-based prevention; information for parents; Drug prevention from kindergarten to adulthood	21%
The mere existence of a KEF; that it is working; that the city know about the KEF; KEF conferences	13%
Organising local actions (summer programme, exhibition, inhabitants forum, games, conferences; drug prevention programmes for students)	12%
Local survey; school survey; creating a local picture; drug use among students; making a drug map; informing the community permanently	11%
Co-operation with the younger ones; co-operation with local organisations; having a continuous dialogue locally; co-operation within or between KEFs; between school drug-coordinators; with the municipality	9%
Expert training, peer training; training of drug workers	8%

Important barriers

Two barriers to success were mentioned more than 30 times: lack of money for KEFs (32 of 160, 20%) and lack of expert KEF workers (22%). Third came a perceived lack of motivation or even scepticism and resistance among professionals, decision makers or stakeholders (13%). Somewhat less frequently mentioned barriers are: the lack of legal status (8%); communication problems among KEF members or between experts, e.g. due to professional chauvinism (8%). Whether communication problems, lack of money and a lack of motivation are interdependent, remains hypothetical (*see Table 5.8*).

Table 5.8 - Most important barriers/ limiting factors – frequently mentioned

Lack of experts, of fulltime workers, of human resources; co-ordination work is voluntary and this shapes the working attitudes; KEF members can only work for a short time (also have their own work); no permanent place;	22%
Municipality does not fund KEF (anymore); lack of funding possibilities; lack of money (resources); inadequate funding arrangements; Grant Scheme is unclear about money arrangements;	20%
Lack of motivation; passivity; lack of decision making; envy; scepticism (of professionals or institutes); changing local culture and situations is difficult. Lack of local motivation or perceived interest in the drug problem; resistance on local level; ignoring drug problem by stakeholders	13%
Lack of institutionalisation; of legal status (not clear); of legal regulation (cannot make decisions); lack of legal autonomy, of identification	8%
Communication problems between experts; inadequate local communication (e.g. between organisations of addiction care and KEFs or to the local world); professional chauvinism; working with psychiatrists is difficult;	8%

5.3.2. Evaluating the implementation of the National Drug Strategy at local level

As explained in § 5.2.2 the interviewed KEF respondents were also asked to indicate to what extent each of the 17 pre-selected objectives had been achieved by their KEF, on what written sources they base their judgment on and what they think were the greatest barriers to success and the most important priorities to improve the situation. Finally, the respondents were also asked what they thought to be the most successful and least successful (short- and mid-term) objectives in the National Drug Strategy and what they thought to be its two strongest and two weakest points.

5.3.2.1 Objective achieved / not achieved

Table 5.9 reflects the extent to which KEF respondents have indicated that the pre-selected objectives in all four thematic fields (Community, Prevention, Treatment and Supply Reduction) have been achieved, partly achieved or not achieved, are still being implemented and/or where the results are unknown. The outcome shows clearly that objectives in the thematic field of Prevention are the ones which have been achieved for the most part, all with scores of over 50%. The second thematic field with for the most part achieved or partly achieved objectives is that of the Community, followed by the thematic field of Social Work, Treatment and Rehabilitation and Supply Reduction.

Table 5.9 – Overview achievement per thematic -area

Thematic field	(Partly) achieved		Not achieved		Working on it		Don't know		TOTAL		Missing
	Xav	%	Xav	%	Xav	%	Xav	%	Xav	%	n
Community	29	*46%*	13	*20%*	14	*22%*	5	*9%*	62	*97%*	*2*
Prevention	40	*63%*	8	*13%*	13	*20%*	2	*3%*	63	*99%*	*1*
Treatment	18	*28%*	14	*22%*	11	*17%*	7	*11%*	50	*78%*	*14*
Supply reduction	18	*28%*	13	*20%*	11	*18%*	14	*22%*	56	*88%*	*8*

Over one-fifth of the respondents indicated that they did not know whether the supply reduction objectives had been achieved, which is much more than the 'don't know' answer for the other objectives. At the same time, over one-fifth of the respondents did not answer whether objectives in the field of Social Work, Treatment and Rehabilitation had been achieved. On average one-fifth of the respondents indicate that objectives have not been reached for the thematic fields of Community, Treatment and Supply Reduction.

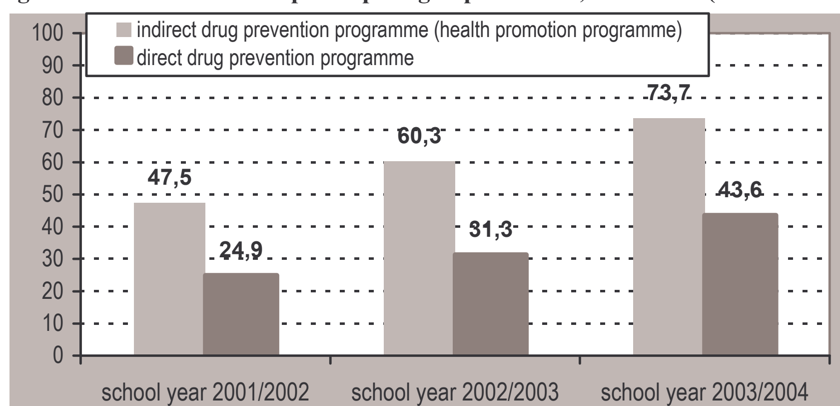
Table 5.10 presents the breakdown of respondents' answers regarding the achievement of each of the 17 pre-selected objectives. The pre-selected objective that has been (partly) achieved for the most part (according to 77% of respondents) concerns the *implementation of health promotion programmes in settings where young people grow up* (objective 5).

Table 5.10 – Breakdown per pre-selected objective

Thematic Field	Pre-selected objective 1-17	(Partly) achieved n	(Partly) achieved %	Not achieved n	Not achieved %	Working on it n	Working on it %	Don't know n	Don't know %	TOTAL n	TOTAL %	Missing n
Community	**1**	32	***50%***	8	***12%***	24	***38%***	0	***0%***	64	*100%*	0
	2	15	***23%***	19	***30%***	7	***11%***	17	***27%***	58	*91%*	6
	3	41	***64%***	11	***17%***	11	***17%***	1	***2%***	64	*100%*	0
Prevention	**4**	33	***52%***	5	***8%***	22	***34%***	1	***2%***	61	*96%*	3
	5	49	***77%***	15	***23%***	0	***0%***	0	***0%***	64	*100%*	0
	6	40	***63%***	4	***6%***	16	***25%***	3	***5%***	63	*98%*	1
	7	42	***66%***	10	***16%***	12	***19%***	0	***0%***	64	*101%*	0
	8	38	***60%***	6	***9%***	15	***23%***	4	***6%***	63	*98%*	1
Treatment	**9**	17	***27%***	19	***30%***	14	***22%***	6	***9%***	56	*88%*	8
	10	30	***47%***	9	***14%***	11	***17%***	5	***8%***	55	*86%*	9
	11	7	***11%***	16	***25%***	8	***13%***	14	***22%***	45	*71%*	19
	12	18	***28%***	11	***17%***	11	***17%***	2	***3%***	42	*65%*	22
Supply Reduction	**13**	18	***28%***	33	***52%***	8	***12%***	3	***5%***	62	*97%*	2
	14	26	***41%***	5	***8%***	15	***23%***	13	***20%***	59	*92%*	5
	15	16	***25%***	5	***8%***	11	***17%***	12	***19%***	44	*69%*	20
	16	14	***22%***	15	***23%***	9	***14%***	23	***36%***	61	*95%*	3
	17	14	***22%***	6	***9%***	14	***22%***	18	***28%***	52	*81%*	12
Total		**450**	***41%***	**197**	***18%***	**208**	***19%***	**122**	***11%***	**977**	***89%***	**111**

This conclusion seems to be supported by the Hungarian National Report to the EMCDDA 2004[35], which reports a strong growth of health promotion programmes in schools (*see figure 5.1*). However, the National Report also indicates that there are no data available on the spread of out-of-school prevention activities targeting (school-aged) youth and the size of the covered population, with the same depth and reliability compared to the data on school-based prevention activities.

Figure 5.1 - Rate of schools participating in prevention, 2001-2003 (% of schools)



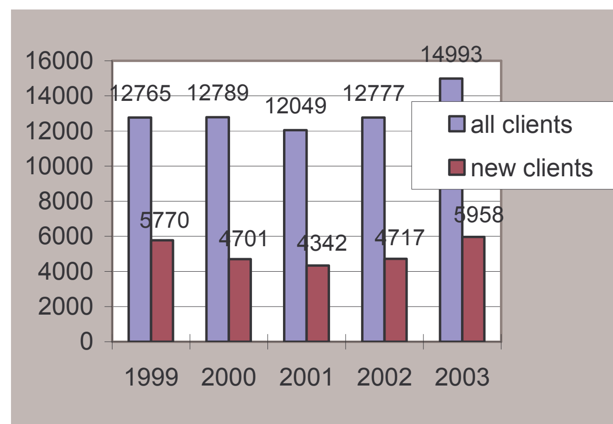
Source: Paksi et al. (2004) in: Hungarian National Report to the EMCDDA 2004.

The next for the most part achieved objectives include *the appointment of a school-drug coordinator* (obj. 7), the *establishment of local prevention services and activities* (obj. 3) and the *development of school-based drug prevention programmes that are integrated in a life-skills oriented and broader health promotion programme* (obj. 6). Also these conclusions seem to be supported by the National Report 2004. The objective in the field of Social Work, Treatment and Rehabilitation that is for the most part achieved concerns the objective aiming at *an increase of the number of drug users participating in a helping relationship (first contact – treatment – rehabilitation)* (obj. 10). The National Report to the EMCDDA 2004[36] does report an increase of drug users in treatment by 2003, after a slight decrease in the years 2000-2001 (*see Figure 5.2*).

[35] Hungarian National Report to the EMCDDA (2004), p. 30;

[36] Hungarian National Report to the EMCDDA (2004), p. 36;

Figure 5.2 - Number of drug users entering treatment in Hungary, 1999-2003



Source: OSAP, in: Hungarian National Report to the EMCDDA

According to the KEF respondents, the for the most part achieved objective in the field of Supply Reduction concerns the objective that aims for a *reinforcement of the combat against drug traffickers and dealers networks* (obj. 14; *see Table 5.11*). This outcome seems to be supported by the statistics reported in the National Report to the EMCDDA 2004[37], in which the amount of drugs seized in the markets has increased considerably, be it that the number of seizures has not increased with the same pace. Provided the statistics are reliable, this may entail that the police and customs became more successful in targeting drug dealing networks that operate larger quantities of Marijuana, Heroin, Amphetamines and Ecstasy.

Table 5.11 - Number of seizures and quantity of seized drugs

	2002		2003	
	Number of seizures	Seized quantity	Number of seizures	Seized quantity
Marijuana (kg)	1965	103.44	2015	206.8
Heroin (kg)	97	159.65	90	256.33
Cocaine (kg)	57	54.9	95	23.47
Amphetamines (kg)	256	3.51	373	12.11
Ecstasy(tablet)	304	24854	362	135634
LSD (doses)	17	623	17	345.5

Source: Criminal Professional and Researcher Institute; in National Report 2004 to the EMCDDA

The objective in the field of Supply reduction that is reported to have been achieved by less than half of the KEFs concerns the improvement of the *security of places of entertainment* (obj. 13). The objective that aims *to reduce drug related criminal acts by means of social (integrated) policies* (obj. 9) was least achieved in the field of Social Work, Treatment and Rehabilitation. In the thematic field of the Community, the least achieved objective was that which focused on the *analysis and adjustment of the legal environment in support of the local drug policy* (obj. 2). One third of all respondents did not answer the question whether training courses for professionals in drug addiction have been developed and implemented (obj. 14), while a similar number of respondents did not answer the question whether the objective to reinforce the protection of Hungary's Borders against incoming and transit drugs had been achieved (obj. 15). The fact that so many KEF respondents did not answer these questions might be explained by the fact that many KEFs have no Customs and Finance Guard (VPOP) in their structure (not in the last place because the VPOP is nationally organised and operating in regions with external borders) and training curricula for professionals in addiction are usually not developed at the level of the KEFs.

5.3.2.2 Written sources and indicators

The respondents were also asked to support their judgment regarding the level of achievement of the 17 preselected objectives by indicating what written sources of evidence they would typically use to base their

[37] Hungarian National Report to the EMCDDA (2004), p. 73.

judgment on. Furthermore, they were asked to agree with a number of pre-defined indicators that may be used as performance indicators for the level of achievement of an objective. The KEF respondents overall agreed with the indicators for success which had been formulated by the evaluators, some of which were mentioned in the National Drug Strategy, although not connected to specific objectives. Regarding the question on written sources, there was quite some similarity between the answers of the KEF respondents about which written source of verification they would use to justify their perception regarding the level of success in achieving the pre-selected objectives. These sources include (progress) reports from the institutions that are member of the KEF, but also local decrees, strategies and statistical reports. The annual reports of the KEF themselves were also mentioned quite frequently, as well as reports from educational institutions.

5.3.2.3 Barriers to successful implementation

Table 5.12 reflects the average number of respondents per thematic area that mentioned a specific barrier for implementation of the 17 pre-selected short- and mid-term objectives. The KEF respondents indicated that the predominant barriers were a *lack of funding* and a *lack of human resources*. These two barriers were mentioned across the board for all four thematic fields, with the highest score for Prevention. The third most frequently mentioned barrier concerned the *lack of priority in local policy*, especially when Community objectives were concerned. But this lack of priority was also frequently mentioned for Prevention objectives and Social Work, Treatment and Rehabilitation. This barrier was considered less relevant for Supply Reduction. The fourth most frequently mentioned barrier concerns the *ignoring of problems by stakeholders*. The barrier 'unspecified aim' (unclear objectives) is mentioned relatively often in the Prevention field compared to the other fields. Overall it must be said that the KEF respondents identified quite a lot more barriers in the thematic field of prevention (37%) compared to Supply Reduction (23%, mainly thanks to the objective on safe places of entertainment), Community (20%) and Treatment (20%).

Table 5.12 – Breakdown of *average* number of respondents that mentioned barrier to implementation

	Unspecified aim	Lack of funding	Lack of human resources	Lack of knowledge	Lack of databases	Ignoring problem by stakeholders	No inter-institutional protocols	No priority in local policy	No priority in national policy
Community	7	23	19	9	5	14	7	14	5
Prevention	10	29	23	11	5	11	9	13	5
Social Work, Treatment, Rehabilitation	2	22	16	6	3	8	6	11	6
Supply Reduction	4	19	17	7	5	7	5	7	3
Total per barrier	**22**	**93**	**75**	**32**	**17**	**40**	**27**	**45**	**19**

5.3.2.4 Change factors

As Table 5.13 shows, the increasing funding and human resources are ranked as the two most important requirements for change to improve the implementation of the 17 pre-selected short- and mid-term objectives. This is not surprising given the most frequently mention barriers. Accordingly, the raising of priority in local policy is mentioned third most important in especially objectives in the Community, Treatment and Prevention thematic fields. This concerns especially the Community objectives regarding the analysis of the legal environment (2) and the development of prevention services and activities (3). Convincing stakeholders is mentioned as an important requirement for the objective aimed at improving the security in places of entertainment (14).

Again it must be said that the KEF respondents identified more change factors in the thematic field of Community and Prevention compared to Supply Reduction and Treatment. One reason for this overrepresentation may be that Community and Prevention are the more 'natural' and popular thematic fields at KEF level, which was also concluded in the previous paragraph.

Table 5.13 – Breakdown of *average* number of respondents that mention most important change factor

	Specify aim	Raise funding	Raise human resources	Improve knowledge and know how	Improve databases and research	Convince stakeholders	Improve inter-institutional protocols	Raise priority in local policy	Raise priority in national policy
Community	5	22	16	8	2	13	5	14	4
Prevention	3	29	22	8	4	10	6	10	2
Social Work, Treatment, Rehabilitation	2	21	14	7	2	5	3	9	5
Supply Reduction	3	18	16	6	3	7	3	8	1
Total per change factor	**13**	**91**	**68**	**29**	**10**	**34**	**17**	**42**	**12**

5.3.2.5 Objectives reached by 2010

The KEF respondents were asked to indicate – for each of the 17 pre-selected short- and mid-term objectives – whether they expected that these would be achieved at the end of the implementation period of the National Drug Strategy (*see Table 5.14*). This is a speculative question, but is expected to tell something regarding the level of expectation and motivation. The confidence regarding the Prevention objectives is quite big as almost two-thirds of respondents expect these to be achieved by 2010. The expectation is much lower for both Community and Treatment (38-40%), while the expectation about the achievement of the Supply Reduction objectives is one-third of the number of respondents. A percentage of respondents expect that Supply Reduction objectives will not be achieved while the last third does not know what the result will be. On third of all respondents did not answer this question for Treatment and Supply Reduction.

Table 5.14 – Percentage of respondents that indicate objectives in thematic field to be achieved by 2010

Thematic field	***Achieved 2010 Avg.%***	***Not achieved 2010 Avg. %***	***Don't know Avg. %***	***Nr. respondents (n of 64)***
Community	*40,2*	*29.3*	*30,5*	*57*
Prevention	*64,8*	*16,6*	*18,6*	*62*
Treatment	*38,6*	*32,2*	*29,2*	*42*
Supply reduction	*34,2*	*33,8*	*32,0*	*42*

5.3.2.6 Most successful objectives/ activities of the National Drug Strategy at local level

The respondents were asked – at the end of the questionnaire – which objectives of the National Drug Strategy they found most successful. Most respondents answered this question from their own perspective and did not refer directly to an objective in the Strategy but to general activities and results. Six of 64 KEFs did not answer the question. Approximately 235 objectives were mentioned, many of which overlapped into a limited number of overall themes (*see Table 5.15*).

Table 5.15 – Breakdown of most successful objectives National Drug Strategy as identified by KEF respondents

Prevention activities (in the community/ for youth)	24%
School prevention programmes	13%
Establishment & Functioning of KEFs	9%
Public awareness/ PR activities & impact	9%
Improved supply reduction operations	7%
More training options/ seminars for professionals	7%
Coordination, communication & strategy development	6%
Data collection & monitoring	6%
Treatment options & service development	5%
Diversion scheme (alternative to prison)	1%
Balanced approach to the drug problem	1%
Other (e.g. more funding/ cooperation with NDI)	11%

Almost 37% of these mentioned objectives concern general health promotion/ drug prevention (24%) and prevention in schools (14%). The establishment and functioning of the KEFs themselves was considered a successful objective by app. 9% of the respondents. Another important objective (which is not as such formulated in the National Drug Strategy) concerned the possibility of raising awareness about drugs in the local community and to conduct Public Relations activities to present the local activities. The improvement of supply reduction measures (policing, border control, etc.) was mentioned as often as the possibility to organise local seminars and conferences. The main tasks of the KEF (coordination, communication, strategy development) were mentioned as frequently as the objective regarding the collection of data on the local drug situation. Improved attention for treatment was mentioned by app. 5% of respondents. The diversion scheme – *which was not part of the objectives of the National Drug Strategy* – was mentioned by 1% of respondents.

5.3.3. Focus Group

In the beginning of 2005 a focus group was organised during which initial outcomes of the KEF evaluation and some additional questions were discussed. In general, the participants in the focus group could identify themselves with the main outcomes of the telephone interviews. However, they did provide some additional insights and information.

5.3.3.1 Functioning of the Local Coordination Forums

The participants agreed that the establishment of the KEF structure had been successful. However, a majority of them pointed out that the involvement of the municipality is crucial for the activities and level of impact of the KEF. A better legal position or legal mandate for the KEF structure at local level was supported strongly, with the understanding that – for reasons of flexibility – the KEF should not become part of the bureaucracy itself.

The participants also indicated that increased and stable (municipal) funding is a prerequisite for success. Regarding the current structure of the KEF and its human resource management, the participants warned that a structure that leans too much on volunteers, while not receiving adequate resources and support will not be sustainable for a long time. Some participants indicated they did not just put in their own time as KEF coordinator, but even their own money (travelling, small materials). This is considered not to be sustainable in the long run and raised question on how important the role of the KEF structure is according to the national and local political level.

One key conclusion shared by the participants which is also relevant for the national coordination of drug policy, concerns the need for commitment and partnership between the different actors and stakeholders within the KEF. Without commitment and active participation, the KEF structure, as a legally non-existent, non-bureaucratic structure with very limited resources can not coordinate any local drug policy nor enforce it.

5.3.3.2 Prevention

The participants supported the conclusion that prevention activities, especially aimed at young people, are among the most prevalent and successful activities of the KEFs and that there is a good cooperation with – among others – educational institutions.

The participants also indicated that the collection of local data on the drug problem and also on risk groups as well as policy & justice information is important for the development of appropriate local work plans, adapted to the needs of the community. They also indicated that a good feedback of the result of such information, i.e. by organising local conferences, is important.

The participants also indicated some problems in this area. Unless the municipality is involved in the collection of the data (i.e. by giving an assignment to the KEF to collect the data) the danger of red tape and/or abuse of the collected data are very real. This is especially the case when the data collected is not available for some of the local organisations or structures and/or when the origin of data is retrievable. The latter is especially problematic in case where school data is collected and this data can be traced back to one specific school which then runs the risk of stigmatisation and negative media attention. The participants indicate that data should always be aggregated on the highest level due to the sensitivity of the drug problem. The consequence may be that schools (or students) are no longer willing to participate in surveys.

In the case that data that have been collected by the KEFs is different than e.g. data collected by the police, the support of the municipality is of importance. The participants provided examples in which the data collected by the KEF (e.g. by means of a Rapid Assessment) demonstrated a higher and increasing level of drug use in the municipality, while police data showed the opposite. The police disregarded the KEF data as being unreliable, instead of entering into a discussion how the difference could be explained. Given the fact that some of the respondents in this mid-term evaluation have indicated some flaws in the Criminal Statistics of Police and Prosecution database (ERÜBS) (delayed registration, incomplete registration of drug-related offences), such a discussion would be justified.

5.3.3.3 Social Work, Treatment and Rehabilitation

The participants to the focus group were not surprised by the low numbers of response to the questions about the availability, quantity and quality of treatment services. They indicated that not in all KEF municipalities a treatment services provider exists. Local KEFs without such a service do not necessarily communicate with service providers that are based within another KEFs territory, even if such providers offer treatment services in other KEF areas as well.

The participants also pointed out some specific problems they see as being important for the match between demand for treatment and the services provided, but also in regards to the reliability of data. For example, participants indicated that there is a problem with the registration and diagnosis of problematic drug use and/or dependence. One reason lies in the fact that there is a lack of screening protocols and definition for problematic drug use (e.g. compared to the internationally accepted standards DSM-IV and ICD-10). Furthermore, in case of comorbidity between addiction and other mental health problems, the psychiatric medical staff prioritises the other mental health problem in their diagnosis (e.g. depression, schizophrenia, anxiety disorders) over the addiction problem, even if the latter is the more serious condition. The reason for this selective screening is – according to some focus group respondents – due to the medical financing and the insurance system that provides higher financing for mental health treatment than for drug treatment. It is clear that such a selective screening also has repercussions for the national registration of treatment demand.

5.3.3.4 Supply Reduction

Regarding the field of supply reduction, the participants did not have many comments. They indicated that the police are participating in the KEFs, but that the KEF is not participating very much in the work of the police. Other analysis in this evaluation has also shown that key actors in the field of supply reduction are often differently organized and/or nationally coordinated (prisons, customs & finance guard, border police, the army), which makes the KEF coordination role more difficult to implement.

5.3.4. KEF functioning seen from the National perspective

The respondents that were interviewed at the national implementation level were also asked for their perception regarding the functioning of the Local Coordination Forums on Drug Affairs. Not all national respondents could answer the questions completely, but the exercise did provide some interesting additional information.

5.3.4.1 Establishment and functioning of the KEF structure

Overall, a majority of the respondents indicated that they thought the objective (establishing a KEF) had (partly) been successfully realized in a large number of municipalities and regions. At the same time, there was some skepticism regarding the actual functioning of the KEFs and the level of sustainability of the structure in the long run. A limited number of respondents raised the question whether it is useful and necessary to have a separate structure for drug affairs only and if it is not better and more suitable to integrate the KEF tasks within the local branches of the State Public Health Service (ÁNTSZ). The actual coordination tasks regarding local drug policy should best be placed under the responsibility of the Local Self-Governments.

The evaluators had developed a list of indicators that may be used to assess the existence and functioning of the KEF structures, related to the tasks as laid out in the National Drug Strategy (see Table 5.16). Most respondents agreed with the set of pre-formulated indicators for success, although some did not find themselves knowledgeable to answer the question while others felt the indicators had not all been reached in practice.

Table 5.16 – National respondents' comments regarding indicators for success

Pre-formulated indicators	Respondents' additions and comments
1. Representation of local organisations and structures 2. Level of actual participation of these stakeholders 3. Number of developed local drug strategies 4. Number of local assessments of the drug problem organized by KEF 5. Number of local assessments of the local drug problem organized by prevention providers 6. Number of local assessments of the local drug problem organized by treatment providers 7. Number of local annual work plans published by the KEF 8. Number of local evaluations of performed activities within the KEF structure	**Indicators** • One key indicator is the involvement of the Local Self-Government/ municipality as well as the level of available resources and funding to carry out the work. • More qualitative indicators should be defined, e.g. satisfaction indicators, process indicators, quality indicators instead of only quantitative ones. • The level of cooperation and communication with other KEFs should be an indicator. **Comments** • The Public Education Law prescribes that all Hungarian schools must develop a school health strategy within 1.5 years. KEFs that are serious should have incorporated this compulsory action in their local drug strategy. • The availability of a local work plan is now a condition for funding of KEFs.

5.3.4.2 Limiting factors and barriers for success

The respondents at national level were also asked about what they thought were the most important limiting or restricting factors that complicate the work of the Local Coordination Forums on Drug Affairs. The comments corresponded to some extent with that of the KEF respondents. Lack of funding, human resources and lack of knowledge were mentioned often. A lack of legal mandate or status as well as the dependence on the work of volunteers was mentioned prominently as well.

The KEF structure is supposed to be voluntary, but in general municipalities do not say no to its establishment. The basis for establishing a KEF is not an analysis whether there is a local drug problem which requires a response, but the assumption that there is always a local drug problem and that therefore a KEF is needed to deal with it. Even if the KEF is managed by local volunteers, its establishment is often initiated top-down.

Respondents did say that a greater involvement of the municipality in the work of the KEF, including financing, is not easy to reach. Although the document analysis in Chapter 4 already indicated that Local Self-Governments have the option to be pro-active regarding the support for the KEF structure and in assuming a greater responsibility in local drug policy, the resource situation of many of these local communities is very limited, which restricts their possibilities. This does pose a risk for the KEF structure: if the national funding is decreased due to policy changes and the financing of KEF activities is not made an obligatory task for Local Self-Government, the consequences may be detrimental for the KEF structure.

One respondent confirmed that the prison sector is centralized and managed by the Ministry of Justice. As a result, one-third of the prison facilities are involved in the work of their local KEFs. But as the prison services have to comply with a broader set of policies than local drug policy as such. Prison services do have contacts with local and regional drug treatment and care services, but not with the KEFs so much. One other complicating factor concerns the fact that sentenced prisoners are not detained in the region where they come from, but as far away as possible. So, continued care for addicts before and during imprisonment and after release is difficult to organize at KEF level.

The change factors mentioned by the national respondents focus on the need for increasing the level of resources (funding, know how) for KEFs. Strong support from the NDI is also needed, especially when the dissemination of knowledge, know-how, guidelines and protocols are concerned. A better specification of local aims and objectives (SMART objectives) will contribute to a more measurable outcome. Support of the Local Self-Government is essential for success and the enforcement of local drug policy coordination (raising local priority).

5.3.5. Conclusions

The data obtained from the interviews with the KEF respondents provides a good picture regarding the overall structure of the KEFs. It also provides information on the performance of the KEFs regarding the activities that have been attributed to KEFs in the National Drug Strategy. The information gathered from the focus group and the evaluation at national implementation level seems to support the outcomes of the telephone interviews with KEF correspondents.

Regarding the functioning of the KEFs, the participation of local organisations and structures in the work of KEFs seems to be reasonable. Municipalities, the police, the public health service and educational institutions participate most in the work. Treatment and prevention service providers participate to a lesser degree, but this may be due to the fact that they are not represented in every KEF and provide services at a more regional level. Perhaps for the same reason, Public Prosecutors are not very well represented in the KEF work.

Almost all of the KEFs have collected data on the local drug problem, including information on drug use, on risk groups and on police and judicial affairs. KEFs also provide reports of their annual activities. Practically all KEFs discuss the outcomes of the local data collection with the municipalities, but much less with non-official organisations and structures. Most KEFs also draw up annual work plans (local drug strategies) in which they describe their activities for the next year. It is unclear whether these activities are subsequently evaluated. Analysis shows that there is no clear relation between the collection of local data and the achievement of objectives.

KEFs have the task to develop their own local strategy plans, tailor-made to the local drug situation. Quite a number of KEFs have conducted an assessment on the local situation. It is unclear, though, to what extent these assessments have been used as input for local activities and policies. To answer that question a more in-depth analysis of the local reports and work plans is required.

KEF respondents mentioned as their most important tasks: the creation of local and/or regional contacts and co-operative networks to address drug problems, including the establishment and strengthening of the KEF structure. The fact that the KEFs exist is considered a major achievement by many. The organisation of local activities and actions in the field of prevention were mentioned second and third most important. The training of experts was also considered a task of considerable importance.

The most important barriers hindering the development of the KEFs are a lack of funding and a lack of expertise. KEF respondents indicate that app. $3/8^{th}$ of the funding is provided by municipalities, while the rest of the funding is acquired through tenders made to (national) funding programs. These funding programs increasingly expect that KEFs have arranged their own local infrastructure, an assumption that has not been supported by evidence.

In third place a lack of motivation and even scepticism and resistance among professionals, decision makers seems to complicate the work of the KEF, while another important barrier for success concerns the lack of a legal status. Overall, the functioning of KEFs differs a lot and depends to a great extent on the support a KEF receives from Local Self-Governments and on the idealism and input of volunteers. In the future the role of the voluntary KEF may be taken over by a more formalised structure (for broader health promotion issues), but at the moment it does function as a ‘boost structure’ for agenda setting and supporting local cooperation regarding drug affairs. But there is good reason for concern: there is a limit to what can be expected from voluntary structures like the Local Coordination Forums on Drug Affairs.

There is a real danger that the ‘first hour’ activists, idealists and energetic volunteers give up if bureaucratic processes become too complex, funding is harder to get and progress is more difficult to achieve. The question whether the Local Coordination Forums on Drug Affairs are actually capable of coordinating local drug affairs without an official mandates and clear responsibilities is an issue for serious debate. The facilitation of KEFs by structures like the NDI regarding information, communication, skills trainings and know-how regarding drug issues is an essential condition for success.

In order to improve the basis and functioning of KEFs in local Communities, the Local Self-Governments should accept greater responsibility for local drug policy, including prevention and treatment, as an important

element of public health policy. This, however, may require a revision of the Act on Local Self-Governments, which is not easy to realise without additional funding and support from national government.

The results of the KEF performance in regards to the 17 pre-selected objectives are more difficult to interpret. As indicated in § 5.2 already, some concerns may be raised concerning the question whether all KEF respondents had adequate knowledge of the existence and contents of National Drug Strategy before they answered the questions. Furthermore, the scores in regards to the achievement of the pre-selected objectives should be read as indicative scores rather than exact outcomes.

Regarding the achievement of the pre-selected objectives from the National Drug Strategy; especially objectives in the field of prevention have been achieved or partly achieved by KEFs. Almost 64% of the 4 preselected Prevention objectives had been achieved or partly achieved by mid 2004. The objectives at Community level had been achieved or partly achieved by almost 50% of the KEFs. The objectives regarding Social Work, Treatment and Rehabilitation had been achieved or partly achieved by almost 28% of the KEFs, while objectives in the field of Supply Reduction had been achieved or partly achieved by 28% as well. About one-fifth of the KEF respondents indicated that they did not know whether Supply Reduction objectives had been achieved, which was significantly higher than for the other areas.

In the thematic field of Prevention, objectives focusing at school prevention and health promotion among young people are most popular. At Community level, achievement concerns to a large extent the establishment of prevention services and preventive actions in the community. Regarding Social Work, Treatment and Rehabilitation, KEFs reported that there is an increase in the number of drug users in treatment after an initial decrease in the first years after adoption of the Strategy. It must be noted here that the data collections need further development, both at the level of registration (which is sometimes unreliable due to the registration protocols used by treatment centres, which are sometimes biased towards drug users), as well as at national aggregation level (the National Focal Point). A limited number of KEFs reported achievement or partial achievement regarding the actions that aim at high-risk or special populations, such as drug users with mental health problems, HIV/ AIDS infected drug users, drug dependent infants, etc.

In the field of Supply Reduction, according to the KEF respondents the most successful objective concerned the reinforcement of the fight against drug trafficking and dealer networks. The question must be raised here what the exact interpretation of this objective has been and to what extent KEFs have an overview of the achievement of this objective as the fight against organised, drug-related crime is centrally coordinated at the level of the National police.

About one-third of the KEFs report that the objective to improve the security of places for entertainment and other areas where drugs are being used has been achieved or partly achieved. However, there might be some difference in interpretation as to the exact achievement. One National respondent indicated that this objective focused to safe 'conditions' for people visiting entertainment places (free available water, air conditioning, fans in the toilets, etc..) in order to avoid drug related health harms, while others interpreted this objective as an aim to increase police control in order to prevent drug dealing.

Nevertheless, it seems that the conclusion can be drawn that in Community Actions and Prevention the KEF structure plays a useful role. Whether this is the case to the same extent for objectives in the field of Social Work, Treatment & Rehabilitation and Supply Reduction, is an issue for further debate. Organisations and structures in these two particular fields are not always represented in each KEF area (treatment services, prison services, customs and finance guard, etc.).

It must be noted that the 17 pre-selected objectives concerned to a very large extent short- and mid-term objectives that should have been fully achieved by this moment in time already. In that regard, the timetable for implementation of the objectives in National Drug Strategy has shown to be unrealistic.

5.4. Evaluation of the implementation of the National Drug Strategy at national level

5.4.1. Evaluation of the work of the Coordination Committee on Drug Affairs (CCDA)

5.4.1.1 Analysis of the CCDA working structure

As identified in Chapter 3, the CCDA is the main coordinating body for the implementation of the National Drug Strategy. The Deputy State Secretariat for the Coordination of Drug Affairs is the facilitating structure for the CCDA.

Mid 2002, almost one-and-a-half year after the adoption of the National Drug Strategy, the first Action Plan 2002-2003[38] for the implementation of the Strategy was adopted by the Government. The Action Plan identified the priority issues for the Hungarian government regarding the implementation of the Strategy for the years 2002 and 2003. The CCDA was made responsible for its implementation. Table 5.17 presents the main elements of this first Action Plan, specifying the priorities and the division of responsibility between the implementing departments and the available deadlines for implementation. In order to match these objectives with the objectives in the National Drug Strategy and for the purpose of this mid-term evaluation, the references to the corresponding short-, mid- and long-term objectives in the Strategy have been added (see Annex 6 for a complete list of objectives). No other detailed plans or documentation were found at the level of the CCDA regarding the implementation of the Strategy. In 2004, a new Action Plan has been developed, which has a slight overlap with some of the objectives in the 2002 Action Plan.

In Chapter 4 the case had been made that the National Drug Strategy functioned quite well as a visionary document, offering guidance and directions for Hungarian drug policy. However, the conclusion was also drawn that the Strategy was of course not an action or implementation plan. In a Strategy objectives are more generally formulated. Moreover the Drug Strategy included a great number of objectives for the short-, medium- and long-term without clearly linking objectively verifiable indicators for each objective and without describing the conditional framework for implementation: the means, resources and analysis of the assumptions and potential risks.

It must be concluded that the Action Plan 2002 did not provide this guidance either. The objectives covered by the Action Plan are in many cases a clustering of short- and mid-term objectives from the Strategy, which makes it difficult to identify specific activities. This is one of the reasons why the Action Plan was not taken as the basis for this mid-term evaluation of the National Drug Strategy as each of the priority objectives in the Action Plan combines several short- and mid-term objectives in the National Drug Strategy, which makes it more difficult to operationalise an evaluation. The Action Plan 2002 indicates which Ministry is responsible for each of the objectives and which other Ministries are also involved in its implementation. What this means in practice is unclear as no guidelines are offered as to what this responsibility entails and to what extent these responsible Ministries adopt the coordination of the further implementation of these objective towards the other involved departments. It is also not specified to what extent the responsible ministry is responsible for gathering feedback information and what type of information is required to assess the progress made.

This lack of a clear description of tasks, roles and responsibilities in the CCDA makes it difficult to evaluate whether the Action Plan 2002 has been carried out or not. In fact, the study of the work schedules of the CCDA in recent years shows that no evaluation or assessment has been on the agenda of its meetings between 2002 and 2005. The work schedules include reports from several Ministeries and implementing agencies on activities undertaken, but these do not seem to be linked to the action plan but appear as rather individual items on the agenda. For the exchange of information on work carried out, this may suffice, but not as an analysis of implementation of the Action Plan.The development of the Action Plan 2004 seems to have been conducted without structured feedback from the first cycle of implementation of Action Plan 2002. Without that information, the participating stakeholders within the CCDA can not assess whether priorities have been achieved, nor can they determine whether there were any specific problems encountered during the implementation phase that may also have an effect on future implementation activities.

This does not mean that the Action Plan has not resulted in any results and outcomes. The outcomes of the interviews with the National respondents in the next paragraphs clearly show that a number of objectives have

[38] 1036/2002 – IV.12

been taken up for implementation, some of them more successful than others. Despite the lack of a detailed Action Plan, the implementation of the National Drug Strategy has been taken up by relevant Ministries and executive agencies. Budget has been allocated to activities by the MYFSAEO and implementation has taken off. But the exact extent to which implementation has taken place and the question whether the responsible Ministries and executive agencies have accepted their responsibility and implemented those parts of the Strategy they were responsible for, cannot be determined based upon the information available at the level of the CCDA. This entails that the Deputy State Secretariat for Drug Affairs also has a limited overview of what incidental and structural activities take place.

5.4.1.2 Perceptions about the Coordination Committee on Drug Affairs

The functioning of the CCDA was discussed with a wide audience of stakeholders, including the two Deputy State Secretaries and Ministerial Commissioner for the Coordination on Drug Affairs that were in function in 2004 and 2005. The issue was brought up during the inception phase interviews in the beginning of 2004, while in July 2004, a special CCDA meeting was organised during which some initial observations were presented and discussed. The functioning of the CCDA was a specific item in the interviews conducted with the national stakeholders, as well as during the focus group meeting for national respondents in February 2005.

During the inception phase in the beginning of 2004, a mixed picture about the functioning and effectiveness of the CCDA was obtained. Some respondents indicated that they felt that the CCDA was not always taken seriously by its own members. Respondents refer to a lack of feedback and monitoring activities. Respondents from Supply Reduction indicated they had felt that in the beginning the participation of their part of the drug field was underrepresented in the CCDA. Several respondents mentioned a lack of involvement of civil society within the coordination process. One problem that was also raised several times concerned the continuous change of civil servants involved in the CCDA and its expert committees.

In the special CCDA meeting in July 2004, there was a general impression that the CCDA was functioning well. However, most representatives in that meeting were not the ‘higher level’ civil servants. Points for improvement were – among others – a better allocation of money, better feedback between the CCDA and the implementing departments, a better communication and coordination within specific ‘pillars’ among CCDA Members (e.g. better collaboration between Customs & Border Guard and Ministry of Finance, between the Crime Prevention department and the National Police, etc..). Regarding the work of the expert committees some concern was raised about the unclear mandates, the lack of communication and feedback to and from the CCDA.

The interviews that were conducted with the national respondents at the end of 2004 and the beginning of 2005 completed the picture. By that time, several respondents indicated that the functioning of the CCDA was improving, including the work of the subcommittees. The CCDA was considered representative for the major players in the drug field and despite the fact that it has no formal competence, it does have informal influence. Respondents indicated that the CCDA was gradually developing into a more transparent and interactive coordination body, with more room for debate and an increase in the number of decisions taken. Respondents also reported that in the last year the style of coordination of the coordinating department had changed from a more directive style towards a style in which there is a greater sense of ‘shared ownership’ among its members, a greater sense of teamwork. One example of this increased sense of ownership concerned the fact that in the first 2-3 years the CCDA Annual Report was written to a great extent by external experts, while today the development of this report is a shared task of all participating departments. At the same time, it was also noted by some respondents that they felt that the pace of implementation of the Strategy through the CCDA had slowed down somewhat, although no clear examples could be given.

Table 5.17 - Action Plan 2002-2003 Coordination Committee on Drug Affairs	**Corres-ponding action in Strategy**	**Responsible Minister involved according to action plan & others involved**	**Deadline**
1. The Government considers it important to possess complete and real figures indicating the extent, changes and genuine components of the drugs scene in this country. In order to attain this, a) it invites the Ministers concerned to organise research projects and collect data regarding the types and amount of drugs consumed by the various age groups. Surveys organised in public education, including tertiary education, have to be regularly revised and repeated in order to keep track of changes. The preparation and execution of the surveys must involve the staff of the national Health, Hygiene and Sanitation Service (Állami Népegészségügyi és Tisztiorvosi Szolgálat) and the national Drug Prevention Institute (Mobilitás Nemzeti Drogmegelőzési Intézet).	II.3.1	Children, Youth and Sports (co-ordination), Interior, Health, Justice, Defence, Social Affairs and the Family, Education	30/06/2003; *in public and tertiary education first deadline*: 31/12/2003; *thereafter:* 31 December *every year*
b) invites the Minister of Education to commission a survey on the types and prevalence of prevention and health promotion programmes applied in educational institutions. In connection with this task the Minister of Education should review the international experiences on the realisation of prevention programmes and utilise those in formulating the Hungarian school health promotion programmes by adapting them to the local conditions.	II.3.1 II.3.6	Education, Children, Youth and Sports	31/08/2002
2. The Government considers it outstandingly important that young people should possess sufficient knowledge on the harmful effects of drug use through an adequate number of high quality health promotion and drug prevention programmes. a) we invited the Ministers concerned to elaborate comprehensive drug prevention and health promotion programmes for each branch to be realised outside the bounds of educational institutions and to provide for the practical execution of these. These programmes have to cover the widest possible range of young people and other groups at risk, such as: • those involved in public and tertiary education; • people who dropped out of school; • unemployed young people, • other people endangered for psycho-social reasons, • pregnant mothers and drug dependent newborn babies; • drug users at risk of HIV and hepatitis; • sufferers of other psychiatric problems; • young people on compulsory army service; • inmates at juvenile delinquents' prisons.	II.2.1 II.2.5 II.2.12	Children, Youth and Sports, Interior, Health, Economics, Defense, Justice, National Cultural Heritage, Education, Social & Family Affairs	*For task planning in proportion to allocated budget:* 31/08/2002; *For executing task:* 30/06/2002
3. The Government agrees that professionals engaged in handling the drugs problem must receive wide ranging further training and specialist training. In order to provide this, the portfolios concerned must support the fulfilment of training objectives by allocating adequate funds. The forms and organisational framework for the training systems must be defined. These must mainly concern the training of persons involved in the problems of adolescents and young people: • professionals in social care and child protection; • priests/pastors (in prisons), and church workers; • school drugs co-ordinators; • peer helpers, peer trainers; • health education professionals of the army, • training probation officers and police staff.	I.2.6 I.3.5 II.3.10 IV.3.4	Interior, Defense, Justice, Education, Social & Family Affairs, Children, Youth & Sports	*For reviewing training systems:* 31/08/2002; *Offering trainings, on the first occasions:* 30/09/2003; *thereafter continuous*
4. The Government considers it particularly important to make disco's and other places of music and entertainment safer from the point of view of drug use as these represent higher risk than other places. Therefore the Government invites the Ministers concerned to review the currently valid legal regulations for permitting the operation of discos and other places of music and entertainment, and to put into place a regular check-up on already functioning units. In view of the results of the review of permission regulations the Ministries are invited to execute any necessary changes	I.2.3 I.3.3 I.3.7 I.3.9	Economics, Interior	*Review*: 31/08/2002; *Modifying regulations:*

in the legal regulations.	IV.2.10		31/10/2002
5. In order to manage the drugs problem more effectively and inform the age group at risk as precisely as possible, the Government considers it necessary to publish information (prevention) publications, training manuals and teaching aids in a large number of copies and step up the number of media events on the subject. Therefore the Government invites the Ministries concerned to work out the possibilities and framework of conditions for publishing and subsidising the publication of informative publications and supporting relevant media events on a national level, i.e. for the area of the entire country.	I.1.1.A II.2.11	Children, Youth and Sports, Education, Social Affairs and the Family, Defence, Health, Finance	*For working out a system of conditions for support in proportion to budgetary planning:* 31/08/2002; *for executing the task:*31/12/2002
6. The Government agrees that it is necessary to raise general acceptance with regard to the treatment, health and social support of drug users. In order to enable the more efficient and effective operation of the so-called caring spectrum it is necessary to work out the legal and financial framework for the co-operation between the various health and social services.	III.1.4 III.2.1 III.2.11 III.3.17	Health, Social Affairs and the Family, Finance	*For working out framework of financing to the extent required for budgetary planning:* 31/08/2002; *Executing the task:* 31/12/2002
7. The Government considers it important to attain improved health care and more effective treatment of drugs users. In order to achieve this, the drugs necessary for detoxification and therapy must become registered and, after the necessary cost efficiency calculations, be subsidised by the social insurance system.	III.3.17	Health, Finance	31/12/2002
8. The Government agrees that it is necessary to use the application of social policy in order to reduce the drug use of drug addicts, particularly those at risk from a social point of view, and to contribute to reducing the number of crimes committed by such persons mainly with the aim of supporting their drug habit. In order to attain this it is necessary to create financial and legal conditions for establishing sheltered homes, sheltered jobs and implementing re-integration programmes designed for specific target groups.	I.3.10 III.2.4 III.2.6 III.2.7 III.2.11 III.3.9 IV.2.8	Social Affairs and the Family, Justice, Finance	Elaborating programmes: 31/08/02; implementing support for development: 31/12/03
9. The Government agrees that in order to reduce drug-use among homeless people and to treat health damage among homeless people it is necessary to offer special care within the institutional network in the service of the homeless. Therefore it invites the Minister of Social Affairs and the Family to have a survey produced regarding the characteristics and prevalence of drug use among the homeless and to provide for increasing the number of places offered specially to drug users within rehabilitation institutions for the homeless by 150 in 10 institutions and prepare a programme for increasing the number of places available at temporary shelters for the homeless by 200 places in 20 institutions and implementing rehabilitation programmes in 30 institutions.	I.1.1.E III.2.7	Social Affairs and the Family	Producing survey: 31/12/02; Support for development: 30/06/04
10. In order for non-governmental, local authority and state-run social and health institutions to follow a unified professional protocol and to found their operations on a broad professional consensus, the Government considers it necessary that the above mentioned institutions and organisations should strive, while following their professional requirements, to elaborate, operate and continually improve their internal quality control systems.	I.3.5 II.2.10 III.2.9 III.3.22 III.3.23 III.3.26	Health, Social Affairs and the Family	31/12/02
11. The Government considers it of special importance that the professionals involved in the care and treatment of drug users should receive a broad range of opportunities for basic training. In relation to this the Ministers concerned should elaborate a system of conditions whereby the curriculum for the undergraduate training of doctors, psychologists, chemists, social workers, nurses, qualified nurses, district nurses, police staff, and probation officers should include special modules to present the nature of drug problems and the alternative practices in their treatment. It is	I.3.5 II.2.24 II.3.10 III.2.14	Education, Health, Justice, Interior, Social Affairs and the Family	Budgetary planning: 31/08/02; Task: 31/12/02

necessary to provide the institutional framework for, and practically secure the possibility of, transfer between these various forms of training.	III.3.25 III.3.26 IV.2.14 IV.3.4 IV.3.8		
12. The Government considers it a priority task to increase the capacity of institutions of treatment and care operated by the state, by local authorities, the non-governmental sphere and church organisation as required. In the process of this the following forms of care need to be developed further: *a)* it is necessary to increase the number of outreach programmes which are active in identifying, contacting drug users, sustaining the caring relationship and motivating them for therapy;	III.2.2 III.2.3A-F III.3.1- III.3.13 III.3.14	Health, Social Affairs and the Family, Defence	31/12/03
b) considerable improvement is called for in drug reduction methods (e.g. telephone services, counselling points visited by a high number of needle using drug users, needle exchange programmes.	III.1.2 III.2.5 III.2.8 III.3.1 III.3.2	Health, Social Affairs and the Family, Defence	31/12/03
c) it is necessary to establish at least one substitution therapy centre per region with an accompanying hospital detoxification and addictology unit, and to create child addictology units as required. In connection with this it is important to formulate drug outpatient clinics for patients with a drug problem and to step up the development of existing outpatient addictology units.	III.3.2A III.3.4 III.3.6 III.3.14	Health	30/06/03
d) The portfolios concerned should elaborate a programme for creating and operating a national network of consultation points which provide assistance to drug users and their family members in matters of a social or legal nature, in problems to do with employment, in matters concerning prevention and information. In this process special attention must be paid to the possibility of developing further the possibilities inherent in already existing (mental hygiene and counselling) institutions.	III.1.3 III.2.3B III.3.10	Children, Youth and Sports, Social Affairs and the Family	31/08/02
e) It is necessary to double the number of placed offered at so-called institutions of long term therapy and rehabilitation, altogether to 500 places, covering the total area of the country. In connection with this it is important to increase the range of services available to one time drug users within the health and social institutional service aiming at their re-socialisation and to support the emergence of self-help groups created by these persons themselves with the help of the NGOs.	III.2.3A III.2.3B III.3.8	Health, Social Affairs and the Family	Elaborating programme: 31/08/02; Effecting developments: 30/06/03
f) Special attention must be paid to the treatment of drug users infected with HIV and hepatitis virus and of drug users with other psychiatric problems (double diagnosis, co-morbidity). It is necessary to create special and varied types of institutional care for them (in-patient, out-patient, after-care, community psychiatric care and rehabilitation). It is also important to create special programmes for pregnant women and drug dependent new-born babies.	III.1.2 III.2.5 III.2.8 III.3.6 III.3.7 III.3.14	Health, Social Affairs and the Family	Develop programme: 31/08/02; Extending support for developments: 30/06/03
13. The Government considers it a special priority to enforce the regulations of Act XLVII of 1997 on the handling and protection of health data and related personal data, of Act LXIII of 1992 on the protection of personal data and the publicity of data of public interest, and Act CLIV of 1997 on the health service and to attune these regulations with the norms of the European Union with respect to the drug users who enter the institutional system of treatment and care. In order to attain the above objectives it is necessary to create the institution of a data protection official even at institutions employing a data management staff of less than 20 and to defined the operational conditions and sphere of authority of the data protection official in the form of a legal regulation. In connection with this it is necessary to modify the data collection methodology as required in order to remain in tune with the expectation of the European Union.	III.3.18 III.3.19	Health, Interior, Defence, Justice, Children, Youth and Sports	31/03/03
14. The Government considers it important that prisoners struggling with a drug problem should receive adequate care and, after their release, after-care, adequate re-socialisation and care. In order to attain this objective the Government invites the Minister of Justice to take the measures necessary to implement the legal regulations to assure that penal institutions should formulate a special detoxification and a therapy unit. In connection with this it is necessary to elaborate adequate treatment regimes and re-socialisation and re-integration programmes in penal institutions in order to aid the prisoners' re-integration into society and make the use of these programmes standard practice. It is also necessary to extend	I.1.1.D I.2.6 I.2.7 IV.3.4	Justice, Interior, Health Social Affairs and the Family	Elaborating programmes: 31/08/02; Executing programmes:

adequate professional treatment, care and participation in special programmes for those held in custody in other, non-penal institutions (penal institutions of the army, police custody, juvenile delinquents' institutions, drug users serving a term of probation under the care of a probation officer). The Government also consider it important that upon their release, prisoners successfully cured or under substitution treatment should receive support with acquiring adequate housing, as part of a special social care programme.	IV.3.11		30/06/03
15. The Government gives special priority for border guard and customs organisations to be able to show the utmost effectiveness in preventing the illegal influx of drugs, their precursors and the materials required for their production in Hungary and their transit through this country. *a)* In order to attain this objective, the Government considers it necessary to increase the number of relevant experts in 2003 and at the same time to offer them an adequate level and amount of training and regular further training. At the same time it is necessary to create the financial conditions for acquiring the necessary specialist technical equipment (test sets, improved laboratory background), for renewing the stock of necessary equipment and instruments and for acquiring, training and keeping an increased number of drug search dogs.	IV.2.2 IV.2.14 IV.3.8	Interior, Justice, Finance	31/12/03
b) The Government considers it a special priority to reach an agreement with the relevant professional organisations for a legal control for monitoring the trade and circulation of chemicals required for the manufacture of drugs and psychotropic substances and, within this, to monitor the trade and circulation of new chemicals defined in the so-called ECOSOC rulings and included in the narrowed monitoring list.	IV.2.1 IV.2.11 IV.3.16	Economics, Interior, Finance	31/08/02
16. In order to eradicate the illegal drugs market and to reduce the change of laundering money from drug trade and thus gradually lowering the number of violent crimes and crimes against property and drug related crimes, the Government invites the relevant Ministers *a)* in order to increase the efficiency of the anti-crime work of the police, and within that their efforts to curb the illegal trade and circulation of drugs, they should elaborate a specific plan of action to manage the problem. They should also take every step to effect the necessary organisational changes, accompanied by an increase in staff, such as improved training of specialists, improving, broadening and updating the technical and objective conditions of the authorities (particularly diagnostic identification background).	IV.2.1 IV.2.3 IV.2.13 IV.3.8 IV.3.12	Interior	Elaborating programmes: 31/08/02; Executing programmes: 30/06/03
b) Within the training system of the police and similar authorities the tertiary training should incorporate a unified set of information about drug related crime and the latest international information.	IV.3.12 IV.3.13	Interior, Education	31/08/02
17. The Government considers it important that the activity of forensic medical experts should become unified on a national level in terms of the drug problem. Thus the Government invites the relevant Ministers to provide a unified set of professional criteria for diagnosing drug dependency.	IV.3.10	Health, Interior, Justice	31/12/02
18. The Government considers it necessary in the area of drug use screening to decentralise forensic medical laboratories and install quality control regarding their activity and to improve and maintain the technical standards of these laboratories in harmony with the EU expectations.		Interior, Justice, Health, Defense, Social & Family Affairs	Review: 31/08/02; Executing task: 30/06/03
19. The Government invites the relevant Ministers, that in harmony with the Parliamentary Ruling No 96/2000 (December 11th) on the National Strategic Programme launched in order to curb the drugs problem, they should formulate a communication strategy which also takes advantage of the opportunities offered by the media and which expresses the Government's priorities regarding drug prevention and represents a powerful response to the spreading of drug use. Besides systematically disseminating basic information on the question, this communication strategy should draw attention to the problems entailed by drug use, to positive life style models and value choices, to the availability of the treatment and care service and the consequences of the legal regulation.		Children, Youth and Sports Relevant Ministers	31/08/02
20. The Government invites the Minister of Sports and Youth, that in harmony with the regulations of Parliamentary Ruling No 96/2000 (December 11th) on the National Strategic Programme launched in order to curb the drugs problem, he should contribute to the fulfilment of the relevant tasks by acting as co-ordinator.		Children, Youth and Sports	Continuous
21. Recognising the uncommon importance of the tasks listed in the ruling, the Government invites the relevant Ministers, that in the course of preparing the Act on the Budget for the Year 2003 they should include planning for the sources necessary to fulfil the tasks listed in the Ruling, in harmony with the priorities of budgetary guidelines and with other expectations.			
22. The present ruling becomes valid on the 5th day after its publication and at the same time Government Decree No 2161/2000 (11th July) on accepting the National Strategic Programme and on the consequent legislative tasks and necessary implementation measures ceases to be valid.			

Other respondents indicated that the CCDA was still to eager to please the political level (Government, Parliament) and too little focused on the actual implementation of the Strategy. One explanation for the lack of feedback – so they suggested – might be due to that political profile, in which there is little room for mistakes as this would reflect on the implementing organisations and not on the unrealistic expectations that exist about the implementation of the Strategy. Another problem that was also mentioned several times concerned the lack of coherence and adjustment of the implementation of the National Drug Strategy and the other areas of drug policy and the legislative environment surrounding it.

Despite some of the problems, it was also mentioned several times that the CCDA was one of the most integrative and active functioning interdepartmental coordination structures in Hungary.

There were more strong points mentioned. The CCDA is seen by all interviewed stakeholders as an indispensable and – at least in some respects – well-working structure in drug policy coordination. The following strong points have been mentioned and shared by a majority of the interviewed stakeholders:

- The CCDA is inclusive: all important ministries and stakeholders are represented, which contributes to effectiveness and facilitates information exchange between and information provision to all relevant stakeholders;
- The CCDA is multidisciplinary: it allows attention for all important aspects of drug policy, which facilitates an integrative drug policy approach, including all relevant aspects demand and supply reduction;
- The cooperation between the bodies represented in the CCDA is overall good.

Respondents were also asked how essential they thought the CCDA was for the implementation of the National Drug Strategy. Overall, most respondents answered that they felt the CCDA was important. But the already identified flaws were repeated: the transparency needs to be improved and better feedback needs to be provided based on more extensive and more reliable data. The following weak points were mentioned by a majority of the respondents as key issues were improvement needs to be made in the next few years.

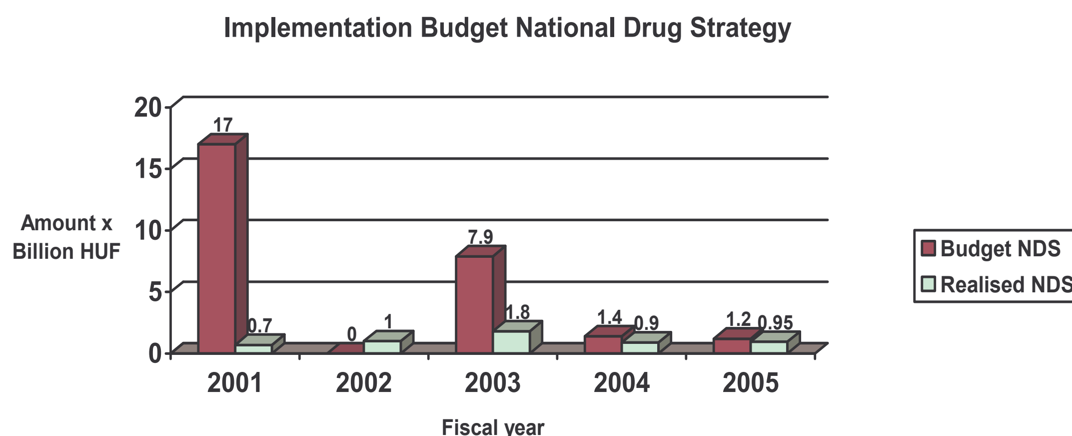
- The CCDA is too big, there are too many bodies represented in it to allow efficient decision making. Because of this it is a too 'heavy' structure, not flexible enough for efficient policy making when developments require a timely response.
- The CCDA has no real decision-making power necessary for genuine coordination of drug policy despite the fact that the National Drug Strategy stipulates that the "high political level for the operation of the Coordination Committee on Drug Affairs (Minister for Youth and Sports Affairs, co-president: Minister of Health, secretary: Under-secretary to the Minister for Youth and Sports Affairs in charge of drug related coordination) (is) enabling it thereby to directly enforce its decisions". This weak point has been worded by different stakeholders in different ways. It has been stated that agreements in CCDA meetings do not necessarily have any consequences on policy making. It also has been mentioned that the CCDA has an unclear mandate to take decisions. There were critical remarks that when decisions were expected to be made on issues that are disputed by or against the interest of a participating organisation, these organisations tend to send low ranking officials so that possible decisions lack meaningful political significance. This last point can be taken as an indication that players also – for whatever reason – do not always take their responsibilities / fulfil their obligations. Overall it has been concluded that the CCDA is rather a policy preparing than a policy coordinating body. It creates conditions for policy decisions.
- There is no clear division of tasks / responsibilities between the participating organisations. The result of this is – among others – that agreements don't lead to action. This is especially true if an agreement requires action from different members. Under this aspect it also can be subsumed that the tasks of the subcommittees are not clearly defined. They lack a clear mandate and clear communication lines with the CCDA.
- There were different critics on the CCDA's management infrastructure:
  - It has been stated that the flow of information and feedback between CCDA and member organisations does not worker properly. The information flow was characterised as inadequate and irregular.
  - Another remark was that the coordinating ministry (MYFSAEO) – which has the main responsibility for the coordination of the implementation of the National Drug Strategy – does

not really have the instruments to 'enforce' its coordinating role. The discussion about this coordination issue has been summarised by Trimbos Institute staff as follows: 'Everybody is calling for a better, more effective coordination, but nobody wants to be coordinated.'
    - The CCDA meetings are not working appropriately. The agenda of CCDA meetings is too full. The meetings are too short to cover all points on the agenda. There are too many information issues on the agenda. Discussions in the CCDA are rarely going in-depth or are at least not going deep enough.
    - The fast 'turn-over' of staff in influential positions. In recent years there have been regular changes of key staff which has a negative impact on continuity and consistency of policy. Valuable expertise is lost and a lot of time is needed to have new staff prepared to do their job properly.
- There is a lack of expert input for taking well-founded decisions.
- Furthermore, some interviewees referred to a lack of transparency of the policy making and implementing process. One key issue mentioned here was a lack of information from policy makers to policy 'implementers' on the contents of the Strategy, on priorities and on what has been reached till now. A gap between national and regional/local level has been mentioned as one of the reasons for this.
- The lack of a sufficient budget for the implementation of the National Drug Strategy was mentioned by all respondents. The limited financial possibilities not only complicate the implementation of the Strategy, but also complicate the participation in the CCDA.

5.4.1.3 Lack of funding

As one of the main barriers for reaching more success, many respondents indicate that the funding for the Strategy and the implementation of its many objectives is inadequate. The budget that has been available for the implementation of the Strategy and which is allocated to activities by the Ministry of Youth, Family, Social Affairs and Equal Opportunities has been seriously cut since 2003, after an initial increase from 2001 to 2003. Only a limited part of the implementation budget is allocated through the CCDA in order to support different Strategy related developments. In general, Ministries and national agencies should cover their drug related expenses in their own budget. At the time of adoption, the Deputy State Secretariat for the Coordination of Drug Affairs had estimated that the full implementation of the National Drug Strategy between the years 2000-2009 would require a budget of app. 17 Billion HUF (app. 7 million Euro) or an average of 1, 7 Billion HUF per year with an increased spending in the first five years. This estimated budget was required to build and increase capacity in demand and supply reduction, to improve quality, set up monitoring and evaluation system, develop innovative approaches, etc. It was not meant to cover structural prevention, treatment and law enforcement programmes and services (e.g. low threshold services, ongoing school-based drug prevention programmes, extended narcotic drug investigation services, etc.). Figure 5.3 shows that the funding that was provided by the government for the years 2001 – 2004[39] has not been sufficient to fulfil all expectations.

Figure 5.3 – Overview of requested vs. allocated budget for the implementation of the Strategy



Source: Ministry of Youth, Family, Social Affairs & Equal Opportunities

[39] Note: the requested budget for 2002 is not available.

For areas such as prevention and the establishment and running of the KEF structure, additional funding is available. The drug coordination unit at the MYFSAEO receives an operation budget for its own functioning only, but has no budget for fact-finding missions, feasibility surveys, preparatory inventories or research activities or for communication and public awareness raising activities regarding the aims and objectives of the Strategy. Many respondents have indicated that more human resources, know-how and training are needed in order to improve results.

A clear link between the Action Plan 2002 and the annual budget available for the implementation of the Strategy seems to be missing. Funding has been allocated to several innovative activities and objectives, e.g. training for staff in the Customs and Finance Guard, prevention programmes in schools and the KEF structure.

One important question in the financing of the objectives of the National Drug Strategy that has been mentioned by several stakeholders concern the question whether the responsible Ministries and executive agencies feel it is their responsibility to allocate funding within their own annual budgets for structural activities and programmes that need to be implemented on the basis of the National Drug Strategy. The Deputy State Secretariat for the Coordination of Drug Affairs has limited overview of what Ministries spend on drug related issues from their own budget. According to some stakeholders it is not always clear either what the money that is made specifically available for the implementation of the National Drug Strategy (and allocated by the MYFSAEO) is actually spent on. Feedback on achieved results and spending of the implementation money is often not available, which raises doubts on the level of implementation of specific objectives in the Strategy. Finally, the Strategy did not include predefined assumptions and response strategies for the situation in which sufficient means and instruments would not be made available for its implementation. The Action Plans 2002 and 2004, do not foresee in an alternative Strategy if a smaller budget is realised than what was asked for.

5.4.1.4 Conclusions

Analysis of the working process of the CCDA in relation to the implementation of the National Drug Strategy shows that improvements need to be made to make the CCDA more effective and the implementation of the Strategy more manageable. Concrete action plans could be developed with prioritised, specific and realistic objectives, measurable (qualitative) indicators, realistic time tables and a budget. The growing sense of 'ownership' that has been mentioned by some stakeholders could be enhanced further. It is recommendable that some kind of agreement and consensus is found regarding the allocation of structural funding to those objectives in the Strategy that do not have an incidental character, but that require systemic changes and long-term investment. The implementation of the National Drug Strategy might progress better if it is seen as an effort in which each ministry and agency has its own share of the burden. Important aspects for change may include more attention for planning, decision making, transparency, mandates and tasks, prioritisation within the implementation process and a stronger system of feedback.

The interviews and discussions with key stakeholders showed a general agreement that the existing structure of the CCDA makes sense and should be kept as such. It has proved to be useful. Therefore, the CCDA should continue to exist. However, the majority of interviewed key stakeholders also agreed that there is the need of adaptation, mainly to allow a more flexible, quick and effective response to identified needs. As we did not find fundamental contradictions between the suggestions made by the key stakeholders we have been able to identify some basic lines along which a change of policy making structure could be ameliorated.

In Chapter 7 a number of recommendations are made to improve the functioning of the Coordination Committee on Drug Affairs.

5.4.2. Evaluation of the implementation of the National Drug Strategy at National level

5.4.2.1 Introduction

At national level over 22 key stakeholders were interviewed about their perceptions and experiences in relation to the National Drug Strategy, representing key departments, agencies, professional organisations and civil structures that are involved in drug policy. These national respondents were asked about their perception of the National Drug Strategy itself and to indicate the most and least successful activities in the National Drug Strategy and its strong and weak points. They were also asked for their judgment regarding the level of

achievement of those of the 17 pre-selected objectives their organisation was either responsible for or involved in.

5.4.2.2 Perceptions about the premises, design and timeframe of the National Drug Strategy

Overall, the opinions about the principles that underpin the National Drug Strategy reflect an important consensus among most stakeholders at national level. This was also reflected in the fact that the Strategy received wide (bipartisan) support in Parliament when it was adopted. Some comments have been made on the structure, design, implementation and great level of detail, but regarding the cornerstones of the Strategy there is great support for the inclusiveness of the Strategy, both regarding its contents and the involvement of stakeholders. The fact that there is broad political support for the Strategy is also seen as an important asset, which provides the Strategy with a high level of political legitimation. The mere development of a comprehensive Strategy, including the involvement of many stakeholders and the fact that it forms a basis for fundamental legal reforms as well can be considered as a major achievement.

Respondents also mention that the prominent role of prevention, treatment and community cooperation (demand reduction) in the Strategy was very much needed. Respondents from the Supply Reduction field indicated that they supported the National Drug Strategy, but that more attention needs to be paid to their working field in future revisions. Many respondents mentioned that the Strategy is well in line with the objectives of the EU Drug Strategy 2005-2012 and consider it important that it reflects a health perspective rather than law enforcement alone. Several interviewed stakeholders pointed out that it was very important that the Strategy has chosen a psychosocial model of drug use and prioritises a public health approach, rather than a mere criminal justice approach.

The only real discussion regarding the premises of the National Drug Strategy is found within the working field of the public prosecution, where greater emphasis on rejection of drug use is preferred (especially among the young) and the continued appliance of repression towards all types of drug use is preferred. This view seems to match with that of the Hungarian Constitutional Court, which at the end of 2004 decided to reject a more flexible approach that had been adopted within the revised diversion scheme (alternative sentencing) regarding personal drug use.

For some key-stakeholders, these dissonances reflect one of the fundamental issues that still have not been resolved, namely the discrepancy between the National Drug Strategies' approach to the drug problem and its interaction with the Hungarian Criminal Code. Where the National Drug Strategy aims to reduce the negative consequences of drug use on health, social life and society as a whole by means of a pragmatic, balanced approach in which repressive measures of the State do not magnify these negative consequences.

The Hungarian Criminal Code has not yet been fully harmonised with the Drug Strategy[40]. There is a lack of clarity about the legal perspectives of drug use, which (for personal use) is still a punishable offence (prison sentence or diversion). Young people who share a cannabis cigarette can be prosecuted as drug dealer. Drug users who are arrested by the police for carrying a small amount of cannabis can be prosecuted for possession of a large amount if the user confesses that s/he has been using for some time already. The Criminal Code does not require that there is material evidence available. The Criminal Code regarding the possession of drug use is explained differently by different Courts, Magistrates and Prosecutors. However, several interviewed stakeholders indicated that there is a growing demand among politicians, policy makers and civil society to adjust the Criminal Code to bring it in line with the philosophy of the National Drug Strategy.

Design of the National Strategy

A number of interviewed policymakers indicated that they felt that the Strategy was somewhat 'overstretched'. They felt that aims and tools are not separated correctly. As a document with guiding principles it is very useful. Other respondents felt that the Strategy has a good chance to be successful. And even if only a part of it has been implemented by 2009, this would already be a major achievement.

The design and framework of the Strategy received some more criticism. A number of respondents said that they felt that the breakdown in key areas was traditional and that the result dealing with Community, Cooperation should have been a horizontal theme (see Chapter 4). Most of the Community objectives are about

[40] National Report to the EMCDDA (2004). p.8-11.

prevention and coordination of local policies and practices. Respondents also said that the treatment section, which requires big systemic changes in health and social care, is not developed enough.

Several respondents made critical remarks about the level of detail of the Strategy, which sometimes makes it difficult to have an overview so that the broader picture becomes blurred. For people working in the drug field, it might be a good idea to make a more simplified, well-structured summary covering the main objectives for their areas of work. One important comment concerns the lack of flexibility in the Strategy. As it has set many objectives for a period of ten years, there is hardly any attention or resource available to deal with new emerging trends, such as an increase in Cocaine use among the youth. The Strategy takes several Governmental cycles to complete, which encourages a long-term approach towards dealing with the drug problem. However, there should be room for flexibility and possibilities to update the Strategy.

One important problem mentioned by a number of respondents concerns the factual situation regarding the drug problem by the time of its developments. The Strategy is based upon the data of the police (ERÜBS), a database that is seen as not very reliable in the starting years of the Strategy. ERÜBS registers drug related crimes, but is not completely up-to-date (real-time), not completely reliable (not all drug related crime is registered) and not all cases are actually charged and prosecuted, some are postponed. The databases of the Courts register the number of cases at the court and the number of sentences. There might be a time gap of 1.5 years between the two. Furthermore, the Strategy stated that treatment data had been collected from a national treatment service provider's network, while such a network had not been established at that time.

Time frame for implementation

Regarding the time frame for the implementation of the Strategy, many of the respondents indicated that the time table for the Strategy seemed adequate in the beginning, but needs revision. Some respondents mentioned that the adoption of the Strategy was affected by a lot of political pressure and had to be finished very fast. As a result, the time table is too optimistic. Some of the short-term aims were been planned in a too short time frame. It is unclear when the long-term aims have to be achieved. The total duration for the implementation of ten years (2000-2009) was deemed necessary to achieve meaningful results on this complex issue. After five years the first meaningful results are expected to be achieved. After ten years the level of sustainability can be assessed. It is also important that the National Drug Strategy overarches the normal Governmental election cycles, so that it is the responsibility of several successive Governments.

In some areas the changes envisaged by the National Drug Strategy go very slow, while they are important as a framework for its implementation. For example, only in March 2005 the Criminal Code was changed regarding the prohibition of drug use. This was one of the objectives mentioned in the Strategy in 2000 already.

5.4.2.3 Perceptions about the successes, strengths and weaknesses of the National Drug Strategy

The respondents interviewed at national level were also asked about their opinion what objectives in the National Drug Strategy have been most successfully implemented and had impact. A majority of respondents agreed that the activities in the field of drug prevention and health promotion have been among the most visible and widely implemented objectives of the National Drug Strategy. This concerns not only the increase in the number of programmes but also the range of their implementation. The most successful prevention objectives – according to a large number of the interviewees – are those that aim at school based drug prevention.

The second group of objectives in the Strategy which have been mentioned most frequently as successful are those that deal with the establishment and functioning of the KEFs and the national coordination structure of the CCDA. The progress made in raising the treatment capacity and the further development of the treatment spectrum for drug users (incl. harm reduction and rehabilitation) was mentioned several times as well. Another frequently mentioned success concerns the Diversion scheme. This was mentioned by several respondents, while the scheme itself was not an objective within the National Drug Strategy.

The fact that the National Drug Strategy exists has led to a greater awareness of and sensibilisation about the drug problem in society, as some respondents claimed. The fact that a balanced, not merely repressive approach was put in place also supported that development. Finally, the fact that the Reitox National Focal Point had finally been established as well as that in several areas research has been made possible, was also considered an asset.

When the respondents were asked about their opinion regarding the least successfully implemented objectives, some issues were clearly rater highest. The objectives focusing on prevention at the work place was considered to be a failure, not in the least because there is a lack of successful intervention models. The development of 'addictology' (addiction expertise) has not taken off, while there is a lack of (funding for) adequate training opportunities for professionals in addiction care and prevention.

The objectives regarding harm reduction for intravenous drug users (HIV/ AIDS/ Hep. prevention) and for other at-risk groups have not been implemented successfully. Little has been done in the field of social care and rehabilitation. Despite increases in capacity of treatment, the continuum of care for drug users has not yet been established. In the field of Supply Reduction, according to some of the respondents (also from the supply side) the least successfully implemented objectives concern the fight against drug traffickers networks and the reduction of violent robbery related to drug use. Again, one difficulty here is that the registration of these criminal acts is not coherent and may differ per region. The lack of involvement of NGO's in the prison system was also considered a flaw, as well as the lack of services for drug users in prison.

One issue mentioned by many respondent concerns the very negative and sometimes scandal-driven approach of the national media towards the drug problem. The government has not followed a coherent media strategy, explaining the premises of the National Drug Strategy, the philosophy behind it and its coherence with the EU mainstream drug policies. National media attention regarding the drug issue is often hyped.

The strong points of the Strategy (comprehensiveness, inclusiveness, wide scope, modern approach, community approach) have been mentioned several times before. To some extent, the Strategy opened the 'eyes' of Hungarian society so that it would recognise that drug use is a problem and that it requires ongoing attention. Major weak points in the Strategy have been identified earlier in this report, but the respondents added some additional issues. As indicated before, the allocation of the budget for implementation of the Strategy is not always transparent in the sense that it is sometimes unclear what the money was spent on. The national respondents added that due to the lack of prioritisation and the need for consensus within the CCDA, the limited available funding is not always allocated to those activities that need it the most but to those activities that did not receive anything yet. Furthermore, some respondents claim that the funding is also allocated towards 'easy to reach' objectives. E.g. prevention is more visible, easier to implement and more acceptable than a costly harm reduction intervention like methadone distribution. Another weak point which has been signalled earlier concerns the lack of feedback, of policy relevant information and monitoring data.

5.4.2.4 Evaluation outcomes at national level

As described in 2.3.6.2 and 5.2.3 the mid-term evaluation also included a series of qualitative interviews with key-stakeholders at national level. The broad scope of the National Drug Strategy and the limited resources to conduct this mid-term evaluation did not allow for a technical evaluation of the extent to which the wide range of objectives in the Drug had been achieved, including analysis of datasets and other supporting documents.

Over 20 respondents were interviewed, representing a variety of involved ministries, non-governmental organisations and research institutions. Apart from the topics that have been described in the paragraphs above, these stakeholders were also asked about their judgment regarding the extent to which the short- and mid-term objectives of the National Drug Strategy had been achieved by the end of 2004. For this purpose and for reasons of comparability, we asked the national respondents to reflect on the 17 pre-selected objectives. The respondents were also allowed to reflect on other short- and mid-term objectives which their ministry or organisation was responsible for and/ or involved in. This was done to reduce the possible bias that the evaluators had pre-selected exactly those objectives that had not been taken up for implementation by the national stakeholders.

Table 5.18 contains an extract from the table in Annex 5, which contains an overview of the judgment of the respondents regarding the achievement of the implementation of short- and mid-term objectives in the National Drug Strategy. The columns in the table represent – from left to right – the organisation represented by the respondent, the responsible ministry (ies) for the implementation of the specific objective, the reference number of the objective vis-à-vis the National Drug Strategy (see Annex 6 for the complete list), the corresponding number of this specific objective with the CCDA Action Plan 2002 (see table 5.17) and the text of the objective. The next column indicates whether the respondent felt that the objective had been achieved by

the end of 2004 and the evidence/ documents/ indicators upon which that judgment was based on. For each objective barriers to implementation and the changes required for future implementation have been presented. The last two columns present the estimate of the respondents regarding the extent to which the objective was achieved and the expectation of each respondent if the objective would be achieved by 2009.

Outcomes of the evaluation at national level

Overall, many of the 17 pre-selected objectives were covered by the interviews. Most of these objectives were reflected upon by more than one respondent, so that perspectives were obtained from different implementing and/or involved stakeholders. The information thus provided by the respondents brought new perspectives into the evaluation. Overall it can be said that – like on KEF level – the short- and mid-term objectives in the field of Community & Cooperation (Result 1) and Prevention (Result 2) are overall considered to be (partly) achieved. For the field of Social Work, Treatment and Rehabilitation (Result 3), the opinions were less conclusive. Regarding the field of Supply Reduction the level of achievement as judged by the national respondents is less positive as well as the opinions are less conclusive.

One interesting phenomenon that became visible through the evaluation at National level, concerns the fact that respondents sometimes point to identical sources of information for their judgment, but seem to arrive at different conclusions. This phenomenon may be a reflection of the fact that objectives are sometimes broadly formulated and cover several activities (e.g. harm reduction and social work and prevention policy), parts of which may have been (partly) achieved while others are not achieved. Depending on the predominant perspective of the respondent, this can lead to different conclusion about achievement of aims. Despite these differences, there is also quite a lot of consensus about the achievement of objectives, despite the fact that respondents were interviewed individually over a period of three months.

Regarding barriers that hamper the implementation of objectives, there is similarity too with the KEF level. The most mentioned barriers are 'lack of funding', 'lack of human resources' and 'lack of know how'. But at national level, the diversity of barriers is broader. Problems like a lack of priority at local and/ or national level is mentioned often as well as the lack of databases and research. The absence of inter-institutional protocols reflect problems in the coordination of implementation. In many cases this barrier concerns objectives that are multi-dimensional and the require involvement of several ministries and agencies, both horizontal (between implementing departments at national level) and vertical (between coordination structures at national and local level). The lack of prioritisation and of clarity (unspecific aim) is also mentioned several times. For supply reduction, the lack of reliable and relevant data (ERUBS) is mentioned by several respondents.

The judgment of the implementing ministries compared to that of NGO's and researchers are congruent in quite a few cases. The organisations outside public administration often emphasize or strengthen the tendency of the answers provided by the civil servants. In the field of Social Work, Treatment and Rehabiliation, there seems to be less consensus between the respondents from Public Administration and the non-profit sector.

A final interesting point concerns the expectation of the respondents in regard to the question whether they think that a specific objective will be achieved by the end of the implementation period of the current National Drug Strategy in 2009. The expectation that objectives will be achieved by that time is not too convincing. Many respondents were sceptical and indicated that this depends on the level of resources and the quality of coordination and cooperation. As we indicate in Chapter 7, this apparent lack of confidence forms one of the greatest risks to the further implementation of the National Drug Strategy, as the respondents that were interviewed are often also the key stakeholders that have to make implementation happen.

Table 5.18 – Extract on National respondents reflections on achievement of short- and mid-term objectives of the National Drug Strategy

Respondent	Responsi-bility	Objec-tive	CCDA Action Plan 2002	Objective National Drug Strategy	Achieved	Sources	Barriers	Change	achie-ved %	Achieved 2009
MYFSAEO COORD	MYFSAEO & others	I.1.1.A	Nr. 5	Raising the awareness of families to enable them to recognise and manage drug problems.	Working on it	Telephone line; leaflets	Lack of funding & human resources (HR), know how (capacity)	Raise funding; Raise HR; Improve know how	10	Don't know
INTERIOR	INTERIOR & others				Partly	Annual reports at regional & national level; conferences; more voluntary groups active; more family based interventions; more funding;	Unspecified aim (what type of programs needed), Lack of funding & HR	Raise funding; Raise HR; Convince stakeholders	50	Realised up to 70%
EDUCATION	EDUCATION & others				Partly	Grant scheme exists; there is support for schools to involve parents; unclear whether aim is really achieved; not more voluntary groups active	Lack of funding & HR; ignoring of problem by stakeholders; no inter-institutional protocols; no local priority	Raise funding; Raise HR ; Raise local priority	60	Realised up to 90%
NGO DRUG FIELD1	Others				Partly	Educational materials available; more voluntary groups; more family based programs; more funds available	Unspecified aim; lack of funding; lack of know how; no inter-institutional protocol; no local priority	Specify aim; raise funding; improve know how; improve inter-institutional protocol; raise local priority	40	Not realised
MYFSAEO COORD	INTERIOR & others	I.3.3	Nr. 4	Analysis of the legal environment and making the necessary amendments.	Partly	Analysis is underway	Lack of funding No local priority	Raise funding; Raise local policy priority	40	Don't Know
COURT	INTERIOR				Partly	Thousands of opinions of the Court/ codification letters; plans on legal issues; more local (by-)laws, more professionals in enforcing them; more local political support; BUT: current Legal Act too complicated and not homogeneously interpreted, causing different sentences for the same offences!!	Courts do not agree with the lawmakers!!	Unify the Legal Acts (Criminal Code) and assure homogenous interpretation; train judges	N.A.	N.A.
CIVIL NGO	INTERIOR & others				Partly	Positive change due to Strategy; more liberal legal environment; Constitutional Court reduced diversion options; sign to establish renewed legal background	Lack of databases & research (ERUBS; e.g. no difference between dealer & user); no national priority; bad quality of Criminal Law; differences in sentences; lack of data protection (privacy)	Improve database & research; raise national priority; legal reform (simplification of Criminal Law)	60	Not Realised
RESEARCH2	Others				Partly	Research NIC on effectiveness of diversion law; new developed strategies of police, border guard, prison service; not more professionals available; not more local support for legislation changes	Unspecified aim; lack of know how; no local priority	Specify aim; improve know how; raise priority	70	Realised

With the results of the local KEF evaluation and the national stakeholder evaluation at hand, it is tempting and interesting to combine these outcomes in order to reach some overall conclusions. However, the answers obtained from respondents at local and at national level can not be combined just like that nor regarded as equal responses. The respondents at local KEF level have provided their opionion about the achievement of the objectives in the National Drug Strategy based on their local experiences. Many objectives in the National Drug Strategy have a local and national dimension, which may show differences when the level of implementation is concerned. For example, usually local implementation follows the national level which also creates the conditions for implementation of an objective. Nevertheless, in Table 5.19 we have matched the score of each of the 17 pre-selected objectives at KEF level[41] (*see Table 5.10*) with the general conclusion for these objectives provided by the National respondents. The overall judgment of the national respondents was obtained by roughly looking at the predominant answers given per objective. Where there was a big discrepancy between respondents, the judgment was considered to be inconclusive.

Table 5.19 – Comparison level of achievement National – KEF level

Thematic Field	Pre-selected objective 1-17	Part Action Plan CCDA	Judgment KEF	Judgment National respondent
Community	**1**	*5*	*Partly achieved*	*Partly achieved*
	2	*4*	*Not achieved*	*Partly achieved*
	3		*Partly achieved*	*N.A.*
Prevention	**4**	*2*	*Partly achieved*	*Partly achieved*
	5	*2*	*Achieved*	*Partly achieved*
	6	*1B*	*Partly achieved*	*Not achieved*
	7		*Partly achieved*	*Partly achieved*
	8	*3*	*Partly achieved*	*Partly achieved*
Treatment	**9**	*8*	*Working on it*	*Partly achieved*
	10	*12A-F*	*Working on it*	*Inconclusive*
	11	*12F*	*Not achieved*	*Partly achieved*
	12	*11*	*Working on it*	*Partly achieved*
Supply Reduction	**13**	-	*Working on it*	*Not achieved*
	14	-	*Working on it*	*Partly achieved*
	15	*15B / 16*	*Working on it*	*Working on it*
	16	-	*Not achieved*	*Not achieved*
	17	*15A*	*Not achieved*	*Inconclusive*

Even if a direct comparison is tricky, the result of this exercise is interesting, as it appears that there are no big differences between the local and national respondent level regarding their judgment on the level of achievement of the 17 pre-selected objectives. Where the KEF respondents indicated that app. 41% of these 17 objectives had been (partly) achieved, the national respondents seemed to be somewhat more positive as they gave a score of 52% regarding the level of (partial) achievement[42].

By linking the pre-selected 17 objectives to the actions defined in the CCDA Action Plan, a very general conclusion regarding the level of implementation of the matching actions can be obtained, with the understanding that most identified actions in the CCDA Action Plan comprise of several objectives of the National Drug Strategy, so that no overall conclusions can be drawn.

Conclusions

Regarding the implementation of the 17 pre-selected objectives from the viewpoint of the national respondents, the conclusions regarding the level of achievement is mixed. Prevention and Community objectives (including the establishment of the KEF structure) are considered most successful. In the field of Supply Reduction much emphasis is placed upon investments in people, equipment and communication. In the field of Social Work, Treatment and Rehabilitation, successes are less clear as there seem to be differences in interpretation. The interviews show that national respondents, both policy makers as representatives from the non-profit sector and

[41] The statements for the KEF level are based upon the scores in Table 5.10. The scores from that table have been transformed into answers that reflect the '*predominant*' opinions at KEF level. A score of 0-25% is interpreted as '*objective not achieved*'. A score of 25-50% is interpreted as '*still working on this objective*'. A score of 50-75% is interpreted as '*objective partly achieved*'. Finally a score of 75-100% is interpreted as '*objective achieved*'. Missing answers or a predominant score on 'don't know' are not considered in this table.

[42] Only the scores that were available have been taken into account.

scientists, lack uniform and reliable datasets and evaluation reports that are conclusive. Furthermore, as indicated earlier, the broad scope of many objectives and the lack of indicators for success makes interpretation of achievement difficult.

Nevertheless, the overall conclusion can be drawn that a small majority of short- and mid-term objectives that have been evaluated in this mid-term evaluation have been (partly) achieved, which can be considered as an important success for Hungarian Drug Policy. In order to sustain and – if possible - increase the level of achievement, improvements need to be made.

5.4.3. Focus group

As indicated in § 5.2.3, the findings of the interviews at national stakeholder level were presented to and discussed with a group of eight representatives from national stakeholder departments and organisations, representing the main thematic areas and audiences involved in the implementation of the Strategy. The focus group had the purpose of reflection on the interview outcomes and to analyse and discuss outcomes.

In general, the participants of the focus group confirmed the broad support for the National Drug Strategy, both regarding its importance as a guiding document for the development of a balanced approach in drug policy, but also regarding its broad scope and inclusiveness of the most important topics. The participants shared the opinion that the Strategy promotes cooperation between policy making departments and stimulates an integrative approach between the different sectors in drug demand and drug supply reduction.

There were some concerns too, which mostly supported the findings from the mid-term evaluation. Participants mentioned the lack of clear and realistic deadlines for the achievements of the objectives in the Strategy. Furthermore, it was noted that the CCDA action plan for the implementation of the Strategy came too late. It was only adopted in 2002, while the Strategy had been approved by Parliament by the end of 2000 already. Participants also noted that a clear division of tasks and responsibilities is lacking. Too many departments are responsible for the implementation of objectives. Due to their nature and due to a lack of specification of these objectives, there are differences in interpretation of contents and who is responsible for which field or task.

One additional problem that was mentioned, concerns the rigidness and relative slow procedures in the CCDA. There is a problem with the quality of feedback from grass-root implementation level to the level of the CCDA and vice-versa. A lot of relevant information is lost that could be of importance. Furthermore, not every executive agency at grass-root level is aware of its role and position in the implementation of the Strategy. As a result the bigger picture is missing. One additional important problem mentioned was the lack of consistency between different instruments in the Strategy. The legal and financial instruments are not in line with each other. Furthermore, participants stated that there is inconsistency between several aims of the Strategy. There is a lack of cooperation and feedback between the areas of crime-prevention and supply reduction. And when the prison system is concerned, the legal environment prohibits the fulfilment of the Strategy objective of harm reduction for drug users inside the prison system: harm reduction in prisons would be considered as illegal support for drug abuse. This also has an impact on the feasibility of reintegrating detained drug users in society after release from prison.

There was consensus among the focus group participants that the objectives of the Strategy are still very relevant, but they – and the context in which they have to be implemented – need refreshment, updating. Some participants suggested annual updates based upon feedback on the implementation process, which might be a possibility for some short- and mid-term objectives.

The lack of structural funding for the implementation of the Strategy was mentioned by several participants. Ministries and executive agencies could not or do not want to shift budgets from other tasks to the implementation of the Strategy or – even more rigid – move funding to the CCDA and have the coordination committee decide on the allocation. The implementation of the National Drug Strategy has received an inadequate amount of governmental funding, which has contributed to the fact that practically no governmental agency has manage to fulfil all its Strategy tasks. For non-governmental organisations and executive agencies that are at distance from the CCDA, it is unclear what the implementation money is spent on.

One other important concern, which was mentioned earlier, concerns the lack of coherence between the Hungarian drug policy, reflected within the National Drug Strategy, and the legal environment reflected in the Criminal Law. No choice has been made regarding the (de-)criminalisation of drug use, which leads to confusion among the general public and frustration among those professionals providing services to drug users. The National Drug Strategy reflects the mainstream balanced approach of drug policies in other countries, but the Criminal Law is still tending towards repression.

The final remarks of the participants of to the focus group concerned the functioning of the CCDA. It was recognised that despite the formal participation of the Ministers of MYFSAEO and Health, the CCDA is a light-weight structure with little implementing powers and a lack of funding. The communication between the different levels of coordination need to be improved and the role and functioning of the subcommittees need to be clarified and improved.

5.4.4. Conclusions

The CCDA has adopted Action Plans for the implementation of the Strategy in 2002 and 2004. The objectives in these action plans show great similarity with the short- and mid-term objectives in the Strategy without specifying them further. The responsibility and task divisions for implementing departments and agencies need to be described more clearly; the same goes for the indicators for success. The time table is on some points not realistic. Furthermore, the action plans do not include a description of instruments to be used for implementation (subsidy, public relation, sanctions, legislation, research, etc.).

The document analysis (e.g. National Reports to EMCDDA) and the interviews with stakeholders show that there are quite some achievements, but more overview overview and feedback at the coordinating level of implementation is needed. Furthermore, the evaluators have also understood that no internal evaluation of the achievements of the CCDA action plan that was adopted in 2002 has taken place before the next action plan was adopted.

Regarding the perceptions about the National Drug Strategy there was a great deal of consensus among most respondents. Despite the fact that the structure of the Strategy is not seen as perfect and the level of ambition perhaps somewhat too high, respondents felt there was an adequate balance between the four thematic areas. They indicated that the National Drug Strategy is inclusive and provides a good point of departure for policy and reflects the Hungarian view of society, i.e. the involvement of civil society and bottom-up approaches. One point of attention, though, concerns the consistency with other parts of drug policy and especially legislation that existed or was put in place before the Strategy was adopted: the conditions for the ‘diversion’ scheme and the problems with the interpretation of the Criminal Law when the possession of drugs is concerned and possible conflicts with other legal imperatives. These discrepancies may lead to undesired consequences.

As to identified problems, many of the respondents indicate that the time table for the Strategy seemed adequate in the beginning, but needs revision. Many of the respondents also indicate that there is a great lack of feedback on achievements, making it difficult to monitor progress and anticipate on future developments.

Regarding the external effectiveness of the Strategy, the conclusion is mixed. One important element regarding the implementation of a policy plan like the National Drug Strategy concerns the ‘span of control’ or the ‘influence spectrum‘ of the executing departments and agencies. Where a Strategy can reflect on the desirability of (long-term) societal changes, calling active participation, roles and tasks of other actors in society (civil society, the public, the media), a policy implementation plan or action plan is needed including objectives and envisaged results that can actually be influenced and achieved by the policy and its implementation structures itself. The mid-term evaluation shows that at the level of implementation of the National Drug Strategy, no clear and comprehensive *overall* implementation plans have been developed or adopted by the responsible body, the CCDA.

6. Overall conclusions and recommendations

One overall conclusion of this mid-term evaluation of the Hungarian National Strategy to Combat the Drug Problem is that the development of the Strategy has been a watershed with the past. There seems to be a great consensus that the Strategy is comprehensive, inclusive and reflects a widely supported direction for Hungary's approach to tackle the drug problem. A large majority of interviewed respondents at national level agreed that the Strategy was much needed, that its scope, its multidisciplinary character and its balanced approach to the drug problem is a success, despite operational difficulties. The evaluators had expected a paradigm conflict between the demand and supply reduction professionals. However, with the exception of one or two respondents, there seems to be full support for the philosophy and approach of the Strategy. Furthermore, the Hungarian Drug policy seems to benefit from its depoliticised status, which can add considerably to the progress that can be made.

Four years after its adoption, the Hungarian National Strategy to Combat the Drug Problem is still highly relevant and comprehensive when compared to the revised EU Drug Strategy 2005-2012 and the EU Action Plan 2005-2008. In general, the Strategy objectives match the broad range of the latest priorities in EU drug policy. Some additional efforts might be required to enhance international exchange and collaboration between Hungary and other EU Member States. One major discrepancy has not been resolved so far: the discrepancy in approach and philosophy between the National Drug Strategy and the Hungarian Criminal Code regarding drug use. This discrepancy is causing debates in society, confuses the public perception of drug policy in Hungary and may complicate the implementation of specific objectives of the National Drug Strategy (e.g. harm reduction for drug users in prison, preventing social exclusion of drug users, etc.).

In Chapter 2, three research questions were formulated for this mid-term evaluation. Based on the evaluation, the following answers can be given.

1. Is the National Drug Strategy a consistent policy document? This part of the evaluation refers to the consistency of the policy theory, SMART policy objectives and the relationship between objectives, actions and indicators?

The National Drug Strategy is a visionary document which sets out policy directions for drug policy in Hungary by the elaboration of a wide range of objectives. At the same time, the authors have included elements of an implementation plan into the Strategy, identifying objectives that are sometimes so specific that they are in fact policy activities. It might have been better to separate these two types of documents. When looking back at the functions identified in 4.2, the Hungarian National Drug Strategy is an inclusive policy paper that sets fundamental goals and values and that formulates the main directions of drug policy in Hungary. As a Strategy, it provides guidance for executive agencies that are involved in its implementation. For stakeholders, the Strategy reflects a broad consensus regarding aims and objectives of Hungarian drug policy. The policy theory, the approach chosen, is well in line with the mainstream of EU drug policy. The Hungarian National Strategy to Combat the Drug Problem is providing a comprehensive approach to the drug problem. Not every EU Member State – including the Dutch Government - has combined its drug policies into one holistic policy document as the Hungarians have done. Thus, the authors succeeded to write a Drug Strategy that functions as an overall covering framework for various objectives and activities.

Looking at the policy designs from a policy research perspective, most are not entirely consistent, which is not suprising. Policy rationality is different from scientific rationality. Policy analysis mostly serves as a mirror of reflection for politicians in order to improve future plans and actions. As already mentioned earlier in this survey, Log Frame structures are rarely complete and consistent in every detail. So, in the Hungarian National Drug Strategy, causal links between goal, objectives and activities are not always clearly elaborated and environmental factors, risks and preconditions largely remain undefined. The caveats that have been mentioned in former chapters may stimulate further thinking on drug policy in order to elaborate general objectives into specific targets and actions. The Strategy provides a multitude of short- and mid-term objectives that can not possibly be reached in the short-term period that was available. Therefore, one of the major challenges for the further implementation of the Strategy concerns the setting of priorities. A registration system, including monitoring and evaluation activities, enables national policy to assess developments that may be crucial for the initiation of activities or measures.

The National Drug Strategy is an important policy plan that offers guidance and direction for Hungarian drug policy. It identifies the main flaws and shortcomings in the drug demand and drug supply reduction fields. It is based upon a plausible, mainstream policy theory of a balanced and science-based approach to the drug problem. The National Drug Strategy fulfils its promise as the cornerstone of Hungarian Drug Policy. From a public administration perspective, the National Drug Strategy is not fully consistent and requires further development in the remaining implementation period, primarily regarding the prioritisation of objectives, the improvement of the causal theory and interactions between these objectives, the measurability of results and the assessment of risks and assumptions.

2. Does the National Drug Strategy define the necessary priorities, instruments, and responsibilities for realisation of these objectives?

Implementation of the comprehensive Hungarian National Drug Strategy, or even parts of it, is complex and requires a prioritised Action Plan, a clear time table, a realistic budget, implementation instruments and a specified division of tasks and responsibilities between implementing agencies. The Action Plans of the CCDA that were adopted in 2002 and 2004 do not offer adequate guidance to do this.

Implementation of the National Drug Strategy is assumed to be a shared responsibility for all levels of public administration and civil society. For coordination and implemention at local level, the structure of local KEFs was successfully set up. By the end of 2004 over 77 KEFs had been established, many of which were increasingly performing the tasks that have initially been attributed to them. Still opinions were mixed about the functioning and usefulness of the KEF structure and questions were raised about the funding of the KEF structure in the long run and its coverage of all four result areas of the Strategy. The overall feeling is that support and commitment from local governments (municipalities, counties) is crucial for the realisation of this all. Doubts were also raised about the sustainability of the voluntary character of the structure. Finally, a lack of prioritty setting, cooperation (also between KEFs) and protocols are mentioned as weak points of the KEF structure.

The responsibility for coordination and implementation at national level has been attributed to the Deputy State Secretariat for Drug Affairs, which is part of the Ministry of Youth, Family, Social Affairs and Equal Opportunities and the CCDA. Implementation of the Strategy is an important task of these structures. The CCDA involves many stakeholders in public administration and even from civil society in implementation activities, but one main obstacle for implementation continues to be the limited available budget. The Deputy State Secretariat for Drug Affairs has cannot sanction nor enforce the implementation of drug policy, partly because the adoption of the Strategy has not been followed by an adequate level of resources and instruments. Funding arrangements for registration, research and monitoring – the prerequisites for supporting a fact-based drug policy – is also quite limited. This evidently results in a large gap between the ambition level reflected within the National Drug Strategy and the realisation level of this Strategy until now. A clear prioritisation of funding arrangements would help to deal with the limited resources available.

Although the National Drug Strategy defines some of the necessary priorities and responsibilities for the realisation of its objectives, a clearer specification of the priorities and division of responsibilities would enhance both the possibilities for the development of an implementation and the guidance of activities.

3. Did the implementation of the National Drug Strategy result in the achievement of the short-term and mid-term objectives?

The evaluation shows that there has been substantial progress and activity taking place in many covered by the short- and mid-term objectives. The interviewed respondents at local and national level mentioned quite a few positive experiences and results. Progress has been made on a variety of objectives by a wide range of agencies, structures and organisations. Many mid-term objectives have not been achieved during the implementation period, but seem to be well underway. However, the lack of pre-set indicators and baseline data makes it difficult to obtain a thorough overview.

The most successful area of development in the National Drug Strategy is the field of Prevention. Many initiatives have been undertaken and a good deal of the short- and mid-term objectives from the National Drug Strategy seem to have been (partly) achieved or are being worked upon. The development of a coherent system of Social Work, Treatment and Rehabilitation requires further efforts. The realisation of a broad range of treatment options, suited to the needs of different groups of drug users, is a challenge for the coming years. It is

worthwhile to consider a more focused approach on high-risk groups. The recent modification of the Social Act, which mandates the establishment of Low Threshold Services is an adequate first step. Regarding rehabilitation, the cooperation between social work and the treatment sector needs to be further developed.

In the domain of Supply Reduction, the level of achievement of objectives in the Strategy seems to be reasonable. Although some supply reduction objectives in the Strategy are insufficiently specific and clear indicators for success are often absent, some National respondents reported positive results on specific supply reduction objectives. However, there appears to be friction between coordination efforts and (a lack of) inter-institutional cooperation on local level. For instance, the National Police indicated that local police gives too little priority regarding the proper registration of drug related offences (in ERÜBS), which makes a thorough analysis of the drug related crime situation difficult. At the same time, objectives that aim at e.g. increases in drug seizures are – like in other EU countries – difficult to assess, as there is limited knowledge about the size and magnitude of drug trafficking volumes and the magnitude of drug production. This makes the achievement of supply reduction objectives that aim to counter trafficking difficult to assess.

Regarding the area of Information, Monitoring and Evaluation, which is not defined as a separate are in the Strategy, more investments should be considered. Progress was made in the past few years, especially regarding the improvement of the functioning of the Hungarian Reitox National Focal Point. However, the compliance with all five key epidemiological indicators of the EMCDDA is still not yet completed. The police- and justice database ERÜBS is modernised, but still requires further development.

Regarding the coordination of drug affairs at National Level, this paper provides some initial suggestions and recommendations for reflection and perhaps improvement. When the coordination of drug affairs at Local (KEF) Level is concerned, more attention is needed for the enhancing and promoting the role of Local Self-Government in supporting, funding and making use of the KEF structure to the Municipalities, but many these do not do so. The Act on Local Self-Governments leaves the responsibility for supporting the KEF structure, but many Municipalities do not do so. An assessment needs to be made to what extent the KEF structure is the most suitable for the thematic areas of Social Work, Treatment & Rehabilitation and that of Supply Reduction, as many operational agencies and services in these two areas are often not coordinated on local level. Treatment facilities and social work are mostly funded by the Ministry of Health and by MYFSAEO. Penitentiaries, the Customs and Finance Guard, the Border Police and the Prosecutors Office are coordinated by the Ministries of Interior and Justice and other National Executive Agencies..

The implementation of the National Drug Strategy has resulted in the achievement of a substantial number of short- and mid-term objectives, but the rate of achievement is difficult to asses precisely due to a lack of resources and feedback in the main Coordination mechanisms. Overall, it can be concluded that the outcomes of the implementation of the National Drug Strategy are positive given the circumstances. Still results can improve considerably with setting priorities, increasing resources for implementation and improving the system of planning and coordination.

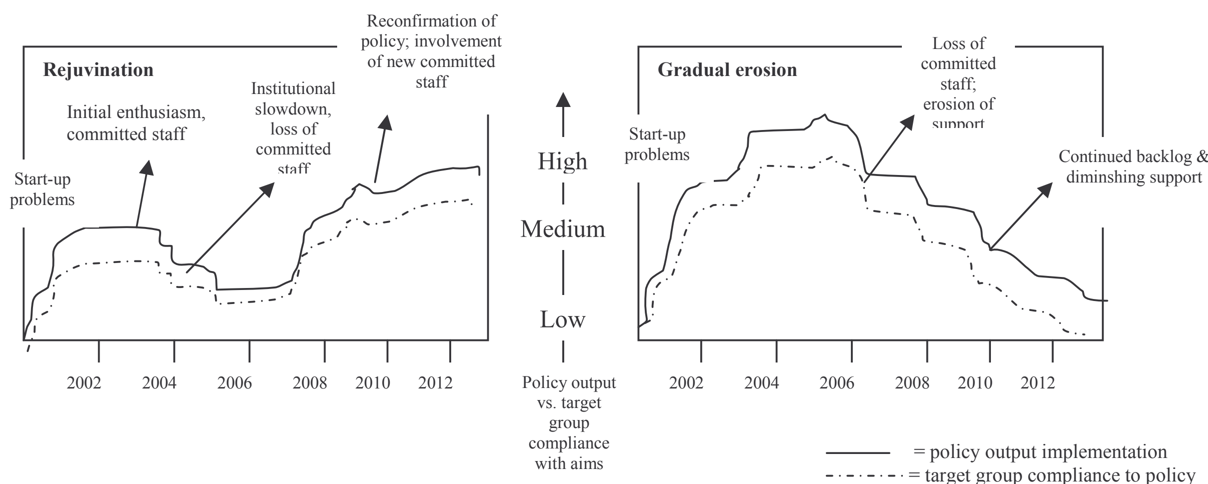
7. The Way Forward – recommendations

7.1. Recommendations regarding the future implementation of the Strategy

The mid-term evaluation shows that progress has been made and that the consensus about and support for the National Drug Strategy is still considerable. Further implementation of the National Drug Strategy will will largely depend on commitment and support of relevant stakeholders to the implementation process.

Mazmanian and Sabatier (1989, p. 276-282) have identified a number of development scenarios that are characteristic for most policy implementation processes. Target groups of a policy follow or 'comply' with the implemented objectives with some delay. This reflects the development of the implementation of the Hungarian National Drug Strategy. The analysis shows that after an initial slow start-up in 2000-2001, the implementation caught speed in 2002-2004 and is now at a crossroads. One leads to sustained growth and reconfirmed support, the other to gradual erosion if the appropriate actions are not being taken. Many of the first hour 'activists' have changed positions. The socio-economic situation and the drug-problem in Hungary have changed as well. Hungary has acceded to the European Union. After an active period of enthusiasm and various activities at many levels, the risk of becoming weary of the Strategy should not be underestimated. People may not see enough results (due to the lack of feedback), resources and instruments for implementation may remain insufficient, while the aspiration levels of the Strategy remain high. Such a situation may lead to frustration and gradual erosion of policy output and of the support for the implementation of the policy (*see figure 7.1*).

<u>Figure 7.1 – two development scenario's for the National Drug Strategy</u>



Crucial for the future is to 'rejuvenate' the implementation process by reconfirming the principles and objectives of the National Drug Strategy, by identifying, sustaining and reinforcing progress that has been made so far and by improving the level of coordination and implementation for the remaining period of 2005-2009. The conclusion of this mid-term evaluation is that the National Drug Strategy 2000-2009 still provides adequate guidance for Hungarian drug policy for the next five to eight years. Many of the objectives in the Strategy are basic requirements for a balanced and multidisciplinary drug policy. The Strategy is still relevant, but needs to be updated to take into account new trends and developments regarding the drug phenomenon, as well as possible new objectives derived from the new EU Drug Strategy 2005-2012. Key questions are how the implementation of the National Drug Strategy can be improved and/or how the Hungarian Government can organise improved knowledge base and grip on what is happening at grass-root level and at implementation level.

Mazmanian and Sabatier (1989, p.283-285) also provide a 'checklist' of key questions for increasing chances for successful implementation of a policy. Each question covers one or more ingredients for successful implementation. Underneath, these questions have been adapted to the situation regarding the Hungarian National Drug Strategy. This leads to some recommendations for further implementation of the National Drug Strategy.

Key questions for effective implementation	Assessment through the mid-term evaluation	Recommendations for further implementation
Is there a general Strategy document available and are the key objectives precise and clearly ranked in importance? Has the relative priority of these (new) key objectives been ranked within the totality of the implementing and/ or executive agency?	The objectives in the National Drug Strategy are not always precise, but give direction. They are not ranked in importance. The implementation of the Strategy is the main task of the Deputy State Secretariat for the Coordination of Drug Affairs. The implementation does not seem to be a priority for most other agencies and ministries.	For the remaining period a new assessment of priorities (including the priorities in action plans 2002 and 2004) should be made. Implementing ministries and agencies should clearly make a realistic and feasible implementation plan and indicate the level of support each priority will get within its own organisation. Regular feedback intervals should be agreed upon. The position of the Depute State Secretariat should be safeguarded in the new, much larger MYFSAEO.
Are the principal factors that affect the Strategy objectives understood (assumptions) and does the policy give the implementing officials sufficient jurisdiction and/or implementation power to – at least potentially - attain the desired goals?	This is difficult to say. Jurisdiction should be guaranteed through CCDA, but MYFSAEO has no implementing power. The KEF structure is on voluntary basis only and implemented top-down. Many different actors are involved.	The assumptions, risks and required conditions for implementation need to be clearly formulated. Furthermore, it should be considered to make an assessment on what instruments each implementing agency requires to implement priority objectives and whether compliance can be enforced by means of law-based guidelines.
Is the Strategy accompanied by sufficient financial resources to the implementing institutions to enable them to conduct the necessary technical analyses, to apply the general objectives to many specific cases, and to monitor target group compliance?	The Deputy State Secretariat for the Coordination of Drug Affairs only has a limited operational budget. The CCDA only has an implementation budget (meant for innovation and not for regular tasks) that has been gradually diminishing. It is unclear what implementing ministries spend on objectives identified in the Strategy. No budget for feasibility studies is available.	A new prioritisation of objectives should be accompanied by a realistic budget estimate. A separation should to be made between structural and incidental funding requirements, the first being the responsibility of the implementing ministry, the second requiring a decision of the CCDA. If the budget is reduced, the number of actions and priorities that are being implemented should be reduced accordingly, keeping the planning realistic and making the lack of funding visible to both the Government and the Parliament.
Does the Strategy and its implementation structure minimise the possibilities for a vetoing or blocking of the implementation of specific objectives within and among implementing institutions and does it provide sufficient sanctions and inducements to enable supportive officials to overcome resistance among their colleagues and among target groups?	The Strategy calls for many actions. There is a lack of feedback, so in practice it is sometimes difficult to determine which policy priority is being implemented and to which degree it is being implemented.	A clear division of tasks and roles is required (also with regard to expert committees). Clear deadlines are needed as well as an agreement protocol for the CCDA. Implementing agencies should be required to report back to the CCDA what has been done with the implementation of an objective, what irregularities appeared and/ or what changes were made and why.
Are the decision-making rules contained in the Strategy consistent with its objectives? For example, do they place the burden of proof on target groups? Do they give as much authority as possible within implementing organisations to those officials most likely to support statutory objectives?	This is a mixed picture. The guidelines for the KEF structure are quite well described and in line with the Strategy. The guidelines for ministries and other national agencies, though, are missing for a great deal.	The implementation of the National Drug Strategy is an issue of 'shared responsibility' and 'shared ownership'. The latter still needs further development and **political reconfirmation**! The Coordinating level should request and improve feedback regarding policy relevant information. Decision making should best take place at the lowest level possible (in order to create support), based upon clear guidelines and objectives. It is useful to find 'agents for change'; those civil servants who feel a strong involvement with the Strategy and that are willing to support its implementation.
Does the Strategy assign the responsibility for implementation to institutions or agencies which strongly support its objectives and that are likely to grant the program high priority? Specifically, can (should) a new agency to administer the program be created or else can the program be assigned to a prestigious existing agency which supports the objectives and is looking for a new	The policy foresees in the establishment of the KEF structure and an important role for the involvement of the CCDA. In 2002, the coordination was attributed to a newly established Ministry of Children, Youth and Sports. The daily coordination of the policy implementation was placed in the hands of the Deputy State Secretariat	The priority and visibility of the drug policy coordination was high within the MCYS by having the National Drug Coordinator in the position of Deputy State Secretary. Within the much larger MYFSAEO it is less prominent already as the drug coordinator has been given the position of Ministerial Commissioner. In addition, further discussions are taking place about 'lowering' the level of the coordination unit from Deputy State Secretariat to policy

mission?	on Drug Affairs). As a supporting agency, the National Drug Prevention Institute was set up, which has a key role in the implementation of the Strategy.	department. This might erode the position of the Coordination Unit vis-à-vis the other ministries and might not be instrumental for the implementation of the Strategy.
Does the policy maximise the opportunities for supporters outside the implementing agencies to participate actively in the implementation process? Specifically, does it provide standing for supporters to intervene actively in agency proceedings and to appeal against agency decisions to the courts? Does the policy provide for evaluation studies by prestigious independent organisations to monitor the extent to which agency decisions and the impacts of those decisions are consistent with policy objectives?	Outsiders (supporters and critics) can have a role within the Expert committees of the CCDA and at the level of the local coordination forums. There is limited evaluation taking place. The policy does not foresee in legal options for objections against decisions of implementing agencies. Normal rules of the Hungarian civil code apply.	It might be worth considering to appoint a liaison function within the Coordination ministry, where objections and complaints can be submitted when stakeholders in the drug field feel that decisions of implementing agencies are not in line with the overall aims of the drug policy.
What is the probability that changes in socioeconomic conditions or in technology during the foreseeable future are likely to undermine political support for policy objectives?	One key problem for the implementation of the Strategy are the limited financial resources. In the future this problem may even be more pressing as the available budget might be reduced under influence of the EU budget regulations regarding Hungary's participation in the Euro.	The implementation plans need to be matched to the available financial resources. It is strongly advised that a multi-annual budget - for the remaining implementation period - is allocated to the implementation of the Strategy. Implementing ministries have to clearly allocate funds to structural tasks or indicate they can not implement (some of) these tasks, which contributes to the transparency of the choices to be made by the political decision makers and the coordination body.
What can be done to counter the short attention span the mass media and the general public give to the issue? In particular, is it possible to convince some of the more important media to hire specialist reporters to cover the general issue addressed by the policy?	The media attention for the implementation of the Strategy objectives is positive at local level, but quite absent or negative at national level.	A targeted information strategy about the premises and contents of the Drug policy taking into account envisaged perception problems (position of drug users and drug workers) as well as a fact based information resource and contact point for the media is strongly recommended. Solving the discrepancy between the Strategy and the Criminal Code may help to reduce 'scandal' reporting.
What steps can be taken to activate latent supportive constituencies and to assure that supportive groups have the necessary staff and other resources to monitor and to participate actively in the implementation process?	The situation regarding this item is unknown.	The Strategy foresees in support to NGO's and civil society. A more active role and clearly defined position and procedure should be developed for civil society to participate in expert committees and to provide feedback and advice on choices regarding priorities and their implementation.
What can be done to assure that legislative and executive sovereigns who support the policy will actively monitor and intervene in the implementation process? In particular, is anyone available to serve as a fixer and does she or he has the staff and other resources to do so effectively? Moreover, what can be done to assure that subsequent legislation in policy areas relevant to the policy does not undermine the policy objectives and that attempts to revise the police do not weaken it?	There is still considerable support among politicians for the Strategy. However, it seems to be no real priority for many politicians, possibly because of the low profile of the Strategy. This is reflected in the limited resources that are made available. And the example of the revision of the Criminal Code, needed to bring this part of drug policy in line with the balanced approach of the Strategy, is an idea supported by different politicians but it remains an unsolved issue.	It is of great importance that the CCDA and the Drug Coordinator receive good feedback and policy relevant information of the progress made in the implementation of the Strategy. Without feedback, results and outcomes are somewhat invisible and claims for additional funding can not be supported by data and arguments. The monitoring and evaluation of the implementation is a top priority. Furthermore, by providing the Parliament with clear and detailed action plans, claims for resources are easier to explain.
Can anything be done to appoint implementing officials who are not only committed to the achievement of the policy but who also have above-average managerial and political skills?	This has been a sensitive issue in the past 2-3 years. Enlightened and skilled officials who were involved in the development of the Strategy have left. The new Ministerial Commissioner matches the required profile quite well.	The position of the implementing officials requires attention in Hungary. It is important to maintain a strong, high-ranked position of the Drug Coordinator. It is also important to provide skilled and knowledgeable officials with the necessary tools to set out a multi-annual implementation strategy, so that continuity can be safeguarded.

Based upon the findings above, a plan for further action is being shaped. With this evaluation report at hand and with the inclusion of other progress reports and – to be identified – monitoring data, the further implementation of the National Drug Strategy could be seen as a 'project' in itself. The following steps could be undertaken:

1. To begin with, a relatively small Task Force could be created, consisting of well positioned, knowledgeable policy makers, representing the main thematic policy fields covered by the National Drug Strategy.
2. For each result area in the National Drug Strategy this Task Force could make a short assessment of the current state of affairs, based upon this evaluation and based upon a fast screening of the outcomes of the Action Plan 2002 of the CCDA, identifying which of the short- and mid-term Strategy objectives have been achieved to a great deal of satisfaction and which of these objectives still need to be implemented.
3. Based upon this 'state-of-play', an implementation plan can be developed that takes the results of the first five years of the implementation of the Strategy into account.
4. For each of the four result areas (Community, Prevention, Treatment and Supply Reduction) the key objectives that have not yet been implemented should be ranked in order of importance. In order to do so it is advisable that for each of the four result areas a set of selection criteria's is developed that may help the ranking process. Criteria may include elements such as feasibility (in the remaining period), level of harm to society, priority ranking in the EU Drug Strategy, etc..
5. Subsequently, each vertical thematic 'pillar', consisting of Ministries and other implementing agencies in each of the four main thematic field could subsequently identify feasible and realistic priorities regarding the ranked key objectives, as these can probably not all be implemented.
6. These prioritised objectives should – if necessary – be reformulated and provided with clear outcome indicators (quantitative and/or qualitative).
7. The next step is to define the required instruments needed for implementation of these objectives (e.g. budget, legislation, research, subsidies, incentives, sanctions, etc..) and the identification of the actual activities that need to be undertaken.
8. It is essential that there is a clear appointment of one (coordinating) responsible Ministry for each of the prioritised objectives, so that the Deputy State Secretariat for the Coordination of Drug Affairs can develop a hands-on information and feedback system. The other tasks and roles should be defined as well and a deadline for the completion of each separate activity should be set.
9. The next step is that the CCDA, by asking advice to its expertcommittees and by involving representatives from civil society, brings together the four 'strands' of well defined and elaborated priority objectives and budgets. A distinction is made between those activities and objectives that require incidental funding and those that require structural funding. The first lost of prioritised objectives will be brought together into an implementation plan of the CCDA for the years 2006-2009. The second will be identified and brought together on a separate action list, identifying long-term investments in drug demand and drug supply reduction that need to be covered by (additions to) the respective annual budgets of the implementing Ministries, agencies and background institutions.
10. The support for the National Drug Strategy should ideally be reconfirmed by Government and Parliament by:
    - The adoption of the above mentioned multi-annual, prioritised implementation plan.
    - The adoption of an appropriate multi-annual financial arrangement that covers the implementation of the prioritised structural expenditure at the level of the implementing Ministries and the implementation of the prioritised incidental expenditure in support of the implementation of the Strategy.
    - The identification and solving of discrepancies regarding objectives and philosophies between the National Drug Strategy and other areas of Drug Policy, including those in regards to the Criminal Code.
11. The CCDA, with the advice of and in dialogue with the NGO sector and civil society, should identify mechanisms for the involvement of non-governmental structures in the decision making and implementation process regarding the implementation of the National Drug Strategy.
12. The Deputy State Secretariat for the Coordination of Drug Affairs continues to be the central actor, with an adequate and high ranked administrative positioning. It has the task to coordinate the

implementation of the incidental and structural action plans by facilitating the coordination processes and by gathering and processing feedback information from the implementing ministries and agencies. It is advisable that the Deputy State Secretariat for the Coordination of Drug Affairs is granted its own budget so that it can develop a monitoring and feedback system, conduct feasibility and other relevant surveys and develop and implement a PR and media strategy with the aim to provide information and feedback about the National Drug Strategy to civil society.

Finally, without predetermining the outcomes of the process as described above, the evaluators feel that emphasis might be placed upon the implementation of objectives in the result areas of prevention, treatment and supply reduction and on the horizontal issue of information, monitoring and evaluation. Regarding the field of Community, Cooperation the evaluators feel that it is of great importance to maintain and strengthen the KEF structure, to analyse and if necessary adjust the legal environment (at local level), solving discrepancies between the Strategy andother policies and (local) legislations, but also identifying the roles and responsibilities of Local Self-Governments regarding the drug problem.

7.2. Recommendations regarding the coordination structures to facilitate further implementation

For a successful further implementation of the National Drug Strategy in the coming years an appropriate coordination structure is vital. In a separate report[43] options and recommendations for how to improve the coordination of drugs policy have been discussed. As stated in the introduction the MATRA project on the evaluation of the National Drug Strategy enclosed besides the actual evaluation described in this report another part aimed at reflecting on how to strengthen the existing coordination structure in the field of drug policy in Hungary.

Key stakeholders generally agreed that the existing structure of the CCDA makes sense and should be kept as such. The CCDA is appreciated because of its inclusiveness (all important stakeholders are represented), multidisciplinary composition and the overall good cooperation between the bodies represented in the CCDA. However, the majority of interviewed key stakeholders also agreed that there is a clear need for adaptation, mainly to allow a more flexible, quick and effective response to identified needs. There are at least a number of options that can be considered to make the decision-making process more effective. In the following we will shortly summarise the points particularly relevant for the implementation of the National Drug Strategy.

7.2.1. Making the CCDA work more efficiently

Though the CCDA is appreciated because of its inclusiveness it is at the same time seen as a quite 'heavy' structure involving the Prime Minister's Office, 12 Ministries and some other national institutions as the National Police Headquarters and the Supreme Court. It is criticised as not flexible enough for efficient policy making when developments require a timely response. Therefore it is worth considering keeping, on the one hand, the CCDA in her present inclusiveness, primarily as a platform for discussing and preparing drug policy (issues) and for information exchange and distribution among the members. On the other hand, one could think of working with a less extensive committee only involving the core stakeholders, functioning as a sort of executive committee of the CCDA to deal with ‘daily matters’. This organisational structure could contribute to an effective coordination of drug affairs In the Hungarian situation MYFSAEO, Ministry of Health (MH), Ministry of Interior (MI) and the Prime Minister’s Office (PMO) could be the core stakeholders to be included in this executive committee. This more limited composition is expected to facilitate quick responses where needed and to contribute to a more flexible approach to drug policy.

The National Strategy in Hungary could work as general framework for drug policy, defining overall objectives and priorities. In this framework the executive committee of the CCDA could formulate tailor-made policy proposals for responses to current developments and needs. Information on developments and needs could come from the monitoring tools developed (e.g. the National Focal Point) as well as from questions put forward in the parliament, media, etc. Tasks of this executive committee of the CCDA could be – among others – the following:

[43] Trautmann, F., Gallà, M., van Gageldonk, A. (2005). *How to Strengthen the Coordination of Drug Policy Formulation and Evaluation in Hungary*. Trimbos Institute, Utrecht, The Netherlands.

- Discussing urgent, topical drug policy matters and preparing proposals for an appropriate policy response;
- Preparing the agenda of the general CCDA meetings (allowing input from other involved Ministries, from experts and the field, reflecting relevant contents in the media and public opinion);
- Monitoring if / taking care that the necessary follow-up actions of the general CCDA meetings are taken by the member organisations responsible for a certain task / field;
- Monitoring if / taking care that the approved procedures are followed, e.g. on the information flow between CCDA members and reporting.

Furthermore, for a more efficient functioning of the CCDA sub-committees as the existing expert committees focusing on different issues are of course helpful. The opinion on the existing expert committees varied substantially, from not very to quite useful / effective. Therefore it should be discussed if the existing expert committees should stay as they are or if there are better ways of organising the input of experts.

7.2.2. Making the CCDA a policy preparing body

According to the majority of the key stakeholders the CCDA has no real decision-making power necessary for genuine coordination of drug policy, for "directly enforcing its decisions" as stipulated in the National Drug Strategy. The overall conclusion was that the CCDA is rather a policy preparing than a policy coordinating body. It helps to find consensus among its members, it prepares policy position papers, etc. It should be considered to formally endorse this role of the CCDA. As the coordination of and decisions on drug policy are political decisions they should be taken on the political level, i.e. in the parliament, by the government. The task of the CCDA can in fact not go beyond facilitating drug policy coordination by preparing policy plans (as for instance the Drugs Strategy), by creating conditions for / monitoring the realisation of politically authorized policy plans and by reporting to the Parliament and government.

To take away and avoid the misunderstandings about the function of the CCDA and to allow it to play its policy facilitating role efficiently it is essential to identify the place and responsibility of CCDA in the decision making process as clearly as possible. Regarding its place and responsibility in the policy making process – among others – the following matters need thorough consideration:

- Where does the input in the CCDA come from? There should be a formal routing of input, e.g. for the agenda of the meetings of both the CCDA as a whole and the executive committee but also for other tasks of the CCDA (or the executive committee), as e.g. the preparation of policy papers, the monitoring and evaluation of the realisation of policy plans as the National Drug Strategy and the reporting to Parliament and government.
- Where does the output go to? A clear routing of CCDA output, a procedure where certain has to go to is important for a transparent (controllable) and efficient policy making process.
- What is the status of the output of the CCDA (or the executive committee)? Again a clear procedure how output of the CCDA has to be followed-up/dealt with is important.
- To allow the CCDA to play its role in facilitating, monitoring and controlling policy implementation effectively the member organisations should have the formal obligation to report according agreed standards and rules about the state of affairs of policy implementation in their domain and, more specifically, about what has been done with tasks and responsibilities assigned to them by CCDA agreements.
- The scope and substance of the mandate of the members of the CCDA should be clearly defined, both in general terms (a definition of the mandate for all members to speak in the name of the organisation they represent) and in specific per member organisation taking into account the specifics of the organisation.

By clearly identifying the place and responsibility of CCDA in the decision making process the CCDA of course does not get more decision making power. However, together with clearly defining the mandate of the CCDA (or the executive committee) and the Ministerial Commissioner charged with the coordination of drug Commissioner and the obligations of the CCDA members one creates conditions for a more effective coordination of the policy preparation work. But creating conditions is just one thing. To benefit from these conditions it is necessary that all players use their mandate and fulfil their obligations.

7.2.3. Clearly dividing tasks and responsibilities within CCDA

A clear division (and assignment) of responsibilities and tasks between (to) the members of the CCDA seems to be one of the most important things to do. To ensure that agreements of the CCDA lead to action it is essential to clearly make a decision on who is responsible to take action – this is especially true for agreements that require action from different member organisations – to specify which party has to do what and (till) when. For an effective functioning of such an explicit division of tasks it is furthermore necessary that it is monitored and controlled if tasks are done according plan. This should be done by the (executive committee of the) CCDA.

Having said this it is according to us essential to make – as a first step – a clear distinction between the different layers of stakeholders in the field of drug policy as they have different responsibilities in the policy making process, i.e.

- Decision makers, i.e. politicians in the parliament and government who actually decide on the policy (plans);
- Policy makers, i.e. mainly civil servants in the different Ministries whose task it is to prepare policy plans, create conditions for implementation (budget planning, etc.) and monitor the implementation;
- Experts (researchers, key specialists in demand and supply reduction) who advice and support policy makers and politicians;
- Professionals (including volunteers) involved in implementing the policy (staff of drug prevention, care and treatment services, police and justice staff, etc.).

It is our impression that mixing these layers in one body results in an unclear (picture of the) mandate of this body. The composition of the CCDA can be taken as an example for this. The CCDA at present is including stakeholders from all four layers, decision makers, policy makers, advisers and policy executers. This results in confusion and misunderstandings about its actual tasks and responsibilities. For a better functioning it should be considered to have the different layers more clearly divided as they have different responsibilities in the policy making process. One option would be to have the CCDA only composed of policy makers (civil servants) from the involved ministries and organisations, preferably the ones who are responsible for the coordination of drug affairs in the organisation they stand for. Experts and policy executors could be represented in the sub- or expert committees. Members of the sub- or expert committees would be appointed by the Parliamentary committee responsible for drug affairs based on a short list presented by the (executive committee of the) CCDA, based on input / proposals from the expert community and the policy executors community (KEF conference, etc.).

To avoid as much as possible misunderstandings about what the tasks and responsibilities of the CCDA are it is vital to define as precisely as possible a division of these responsibilities and tasks between the different players. This could include – among others – the following:

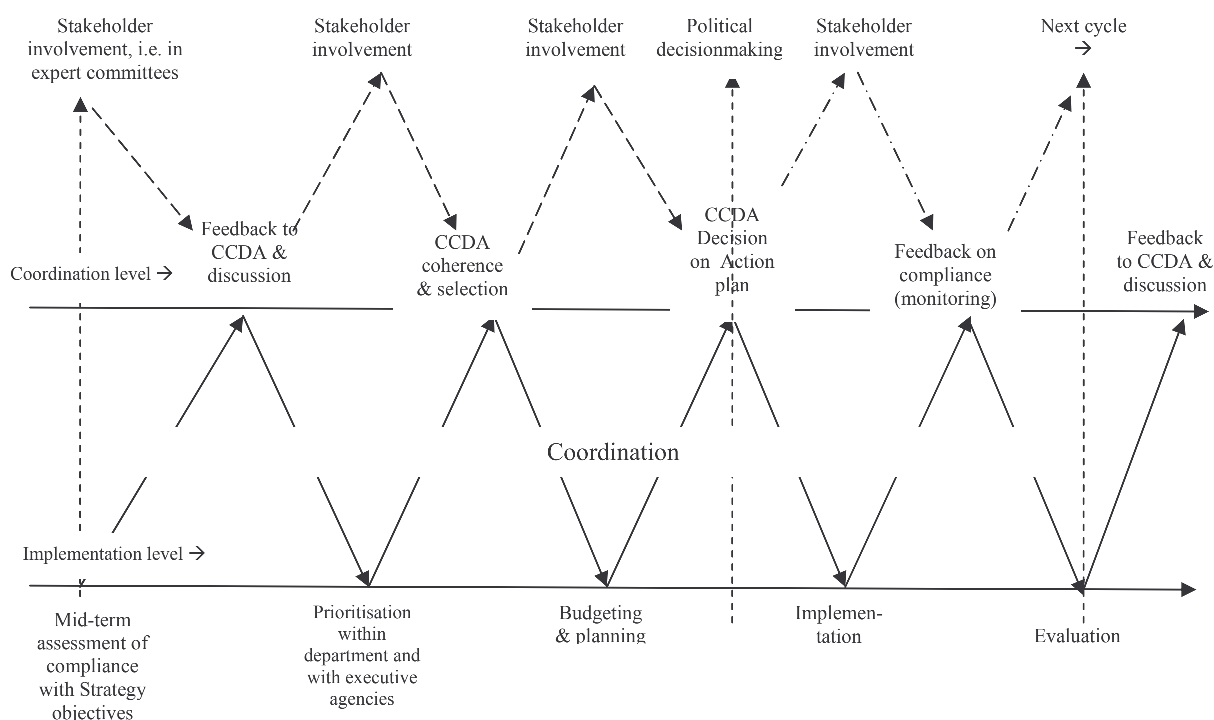
- The Ministerial Commissioner charged with the coordination of drug affairs is the chair of the (executive committee of the) CCDA, having the formal responsibility to represent the CCDA before the Parliament and government. He/she also has the final mandate to monitor if / take care that the necessary actions / steps are taken by the CCDA member organisations responsible for a certain task / field, etc.
- The domains and thereby the tasks and responsibilities of the member organisations in the CCDA are clearly defined and divided.
- The domains of the structural sub-committees are clearly defined and divided. The tasks and responsibilities of all (structural and ad-hoc) sub-committees are clearly defined. The latter should include – among others – specifications:
  - in which cases sub-committees (experts and professionals working in the field) have to be consulted;
  - on the rights of sub-committees to give uninvited opinion or advice;
  - on the procedures how the input of the sub-committees has to be routed and dealt with.

7.2.4. *Improving the implementation planning and feedback process*

As chapter 5 has shown, one major problem regarding the implementation of the National Drug Strategy has to do with a lack of priority, coherence, specification and feedback regarding the planning and implementation of objectives in the National Strategy. The CCDA Action Plans are rather vague and a structural feedback mechanism is missing as well as a clear division of responsibilities and tasks (see above). The planning and implementation process needs improvement.

In Figure 7.2 a schematic example of a feedback and planning process is given, which reflects the continuous process of interaction between the coordination level of the CCDA and the level of implementing governmental departments, background organisations and agencies. It is crucial that based on the objectives in the National Drug Strategy an annual or multi-annual implementation plan is developed. This should be done as an ongoing process, where the coordination level receives on a regular basis feedback on the current state of affairs of the implementation, where (lack of) progress, difficulties encountered and/or changes in context and needs can be discussed and – in the end - a proposal for prioritisation can be formulated. In order to obtain the support of the implementing organisations, these prioritised tasks need to be discussed and integrated into the general work programme of the implementing organisation and its vertical 'pillar' (including all agencies involved in its working field). Possible changes or amendments can then be fed back to the CCDA. In CCDA meetings priorities can be matched so that a coherent package of priorities can be selected. The next step is that the implementing organisations plan and budget the priorities relevant for their policy field, breaking them down into structural and incidental investments, the latter of which may be covered by the implementation budget allocated by the CCDA.

Figure 7.2 – Example of the implementation planning and feedback process



The next step is crucial for the implementation process. After the decision making within the CCDA, the political decision makers need to decide on the choices made and ensure that the action plan is also implemented at the level of their own ministries. The subsequent steps concern the implementation itself, the monitoring of progress and the assessment of the outcomes of the policy. Stakeholder involvement and expert input can be realised best through the sub-committees. Again, this should be clearly described in a profile and task description of the different sub-committees in which the expert input (including expert profiles, their tasks, etc.) is stipulated.

7.2.5. Improving the management infrastructure

To make the management infrastructure work better a number of smaller and bigger measures should be considered. For instance, to make the flow of information and feedback between CCDA and member organisations work more properly it should be considered to have besides a protocol defining the information flow (e.g. concerning CCDA meetings: which information has to be sent out and when) a regular control if this protocol is followed by the CCDA member organisations.

It should be considered to give to the coordinating ministry (MYFSAEO) a clearly defined mandate for coordinating the CCDA and the means to enforce this mandate. This would include among others a clear description of responsibilities and tasks for the members of the CCDA (defining which input they have to give in policy preparation, etc.).

The critics that the CCDA meetings are not working appropriately (too full agenda, too short meetings to cover all points on the agenda, too many information issues on the agenda, discussions rarely in-depth) could be tackled through working with a realistic agenda allowing enough time for relevant issues to be discussed and assuring that input from experts and professionals working in the field is taken into account. Well-defined procedures for preparing the agenda (calling for input from the CCDA members, calling for the opinion of sub-committee, etc.) are a useful instrument here.

The problem of fast 'turn-over' of staff in influential positions in the field of drug policy making (having a negative impact on continuity and consistency of policy and resulting in a loss of valuable expertise) is a problem not easy to tackle. Two factors are playing a role in it. One is the personal level, people take the decision to leave their position and take another job, mostly because of career opportunities and/or dissatisfaction with the job they have. The other factor is a result of the general political culture to change people in certain positions in case the government is changing or in case of internal changes in a government. About the second there is not so much to do. Measures in human resource management can help to limit the impact of the first factor. E.g. career planning and management for the involved staff, offering career opportunities, regular individual support of the involved staff by the superiors and caring / coaching management approach.

7.2.6. Facilitate expert input

Expert input can best be realised through the sub-committees of the CCDA, taking into account what has been suggested above concerning a clear definition of domains and tasks of the sub-committees. Again, this should clearly be described in a profile and task description of the different sub-committees in which the expert input (including expert profiles, their tasks, etc.) is stipulated. Important area's for structural expert input are:

- Serving monitoring, evaluation and research data on policy and its implementation (including evaluation of programs and activities in the field of demand and supply reduction) and recommendations based on these data.
- Advice or fact sheets on urgent problems.
- Serving information on policy development and implementation on the local level, based on the data delivered by the KEFs ensuring the influence of the local level on national (drug) policy making.
- Including information on the local situation in the CCDA discussions also facilitates input from local stakeholders in national policy making. Giving the local stakeholders (local politicians, policy makers and staff of local services and organisations) the possibility to serve input in and have influence on the national policy making is a vital condition for an effective policy implementation. Being involved / heard creates commitment. The KEF structure is represented at national coordination level by the NDI. It might be worthwhile to sort out if this representation can shared with official representations of Local Self-Governments. It might also be worth considering having one or two representatives from the municipal policy makers included in the CCDA structure.

7.2.7. Enhance transparency of policy implementation

To tackle one key issue here, i.e. a lack of information from policy makers to policy 'implementers' on the contents of the strategy, on priorities and on what has been reached till now, it should be considered to develop and implement an information policy / pr strategy defining among others

- How to inform relevant parties about drug policy developments and the state of affairs of policy implementation. Options are a newsletter (covering recent relevant issues concerning the drugs problem, the work done and planned by the CCDA, by Ministries and other agencies), conferences as the KEF conferences, seminars, etc.
- Whom to inform with which information (policy executors, experts, media, and general public).

Installing an information office and appointing a spokesperson of (the executive committee of) the CCDA and/or the government are options worth thinking of. An active and coherent PR strategy in the field of drug policy also helps to make reports in the media more fact-based, to counter misunderstandings and misrepresentations and to promote the idea of the balanced approach as an example of an EU mainstream and adequate drug policy.

7.2.8. Involvement of civil society

A PR strategy also facilitates the desired involvement of civil society. In the implementation of the Strategy this involvement is mainly instrumental (through the KEFs and – in some cases – through expert committees). For the acceptability (part of the SMART methodology) of many of the Strategy's objectives, a change in public perception of the drug problem is important. The idea that the drug problem can be managed but perhaps not solved, that negative consequences can be limited but not totally eradicated and that a balanced approach can be effective if supported by society at large are important elements in a communication strategy.

7.2.9. The importance of monitoring and evaluation

The data collection on drug issues (including monitoring and research data) that are available to experts, professionals and policy makers in Hungary should be further developed. It is worth considering to develop a national monitor of the drugs situation including all data sources relevant for monitoring, among which the National Focal Point but also the ERÜBS database, in which police and justice data are being registered. For the latter it is important to tackle the problems caused by the time lag between arrest entries and convictions, as this stands in the way of a real time overview. Overall the more 'real-time' policy information is needed to facilitate the policy making process, allowing the development of timely and appropriate policy responses to the actual situation and new developments. The CCDA needs to determine what key indicators are needed to assess the progress that is being made in implementation of the Strategy.

7.3. Some observations on local drug policy coordination

Successful implementation of a national drug policy plan as the National Drug Strategy requires besides effective policy coordination on the national level adequate policy coordination on the local / regional level. The importance of a sound local coordination structure is a cornerstone of the National Drug Strategy as can be taken from the fact that the establishment of an infrastructure of KEFs is a key objective in the Strategy. It also is one of the most successfully implemented objectives. However, some recommendations can be made regarding the sustainability of the KEF structure and its further development.

The KEFs – as the CCDA – have not the political mandate to take policy decisions necessary for genuine coordination of drug policy on the local level. Therefore, also for the KEFs it can be concluded that they are rather policy preparing than policy coordinating bodies. Policy decisions are – in line with the constitutional order – taken on the political level, i.e. by the local / municipal government. Overall, the remedy for this issue is the same as mentioned above for the national level. To allow the KEFs to play their policy facilitating role efficiently it is essential to identify the place and responsibility of KEFs in the decision making process as clearly as possible. This means that there should be a formal agreement on the routing of the input and out put of KEFs, in accordance with what has been stated regarding the CCDA above. Here, too, a clear procedure is important how output of a KEF has to be followed-up/dealt with by the political level. To allow the KEFs to play their role in facilitating and monitoring policy implementation effectively the member organisations should have the formal obligation to report according agreed standards and rules about the state of affairs of policy implementation in their domain and, more specifically, about what has been done with tasks and responsibilities assigned to them by KEF agreements. Finally, as with the CCDA the scope and substance of the mandate of the members of the KEFs should be clearly defined.

For the KEFs – again, as for the CCDA – a clear division of tasks / responsibilities between the participating organisations is vital to make sure that agreements lead to action. It is essential to clearly decide on who is

responsible to take action, to specify which party has to do what and (till) when. A clear definition of the domains and thereby the tasks and responsibilities of the member organisations of a KEF would be helpful in this respect. For an effective functioning it is furthermore necessary that the effectuation of this plan is monitored and controlled. This could be done by the KEF coordinator who clearly would need some secretariat support to this task properly. A problem on local level that needs special attention here lies in the fact that some agencies and services operating on local level are doing so under the control of national bodies. An issue that needs to be solved is how these agencies can be involved in coordination of local drug affairs.

As on national level, sufficient funding of the implementation of objectives at local level is a key to success. It is suggested at national policy making level that the KEFs – like the CCDA – should not have a budget of their own but raise funds and resources from their members. This is possible to the extent that these resources are available and that the local members see the KEF work as a priority. For nationally organised structures such as ÁNTSZ it might help to have this priority confirmed at national level. At the same time, local activities that do good to local communities should also receive local funding, at least to some extent. The evaluators think it is of crucial importance that Local Self-Governments accept a share of the responsibility for drug policy as part of a broader public health perspective. This responsibility could be translated into concrete support for KEFs, both by financial and by administrative and political means. The latter is especially important to provide the KEF with the political backing when the assessment of the local drug problem is at stake, especially when the results differ from the assessment of governmental agencies such as the police and other service providers. In regard to this issue, it might also be worthwhile to try to improve and harmonise methods and monitoring tools. Methodological support could be provided by the NDI and the National Focal Point.

One key finding from this mid-term evaluation was that not every KEF has insight and oversight regarding the availability, planning and development of prevention and treatment service providers that operate within their working area. One recommendation in this regards may be to support communication and cooperation between KEFs in ‘service regions’, i.e. all KEFs that are served by one or a number of different treatment service providers (in-patient, out-patient, etc.). KEFs in which a service provider is located could function as coordinating KEF for that service in the service region. Agreements regarding needs assessment, planning, developing of appropriate treatment options, etc. should be made together with the other KEFs using the services of these providers A strong involvement of the local Self-Governments is important.

Further investments should be considered in raising the level of knowledge and know-how at KEF level. The NDI started in 2005 a website with information on drug prevention, drug treatment and drug research (SZIP). The role of the NDI in gathering and disseminating relevant information and expertise on drug prevention, treatment and research should be further developed and maybe broadened with information on local policy, models of local coordination, etc.

Most of the above named features are not so much a problem as long as there is sufficient commitment of the KEF members and, in particular, of the local political level. However, the point is that – based on what is said in the National Drug Strategy about the KEFs – the involvement of structures, organisations and individuals from local communities should be conducted on a voluntary basis. The implementation of the National Drug Strategy has not been formalised in legal arrangements at the level of local communities. However, the existing Act on Local Self-Government does provide a basis for action regarding public safety (drug demand and drug supply reduction), health and health promotion. Local authorities can decide themselves to take up additional responsibilities. Though, given the limited financial resources and the relative negative public perception of the drug problem in Hungary, not every Local Self-Government attributes a high priority to the implementation of the National; Drug Strategy. Therefore, the question is whether the implementation of the National Drug Strategy by local drug policy can rely so heavily on – de facto – voluntary commitment. The evaluation results have shown that this has resulted in substantial differences in the establishment and functioning of the KEFs and the active involvement of Local Self-Governments throughout the country. Therefore its is worth a discussion whether at least a minimum level of what municipalities have to do in the field of drug demand and supply reduction should be defined in a legally binding regulation.

Annex 1 Literature

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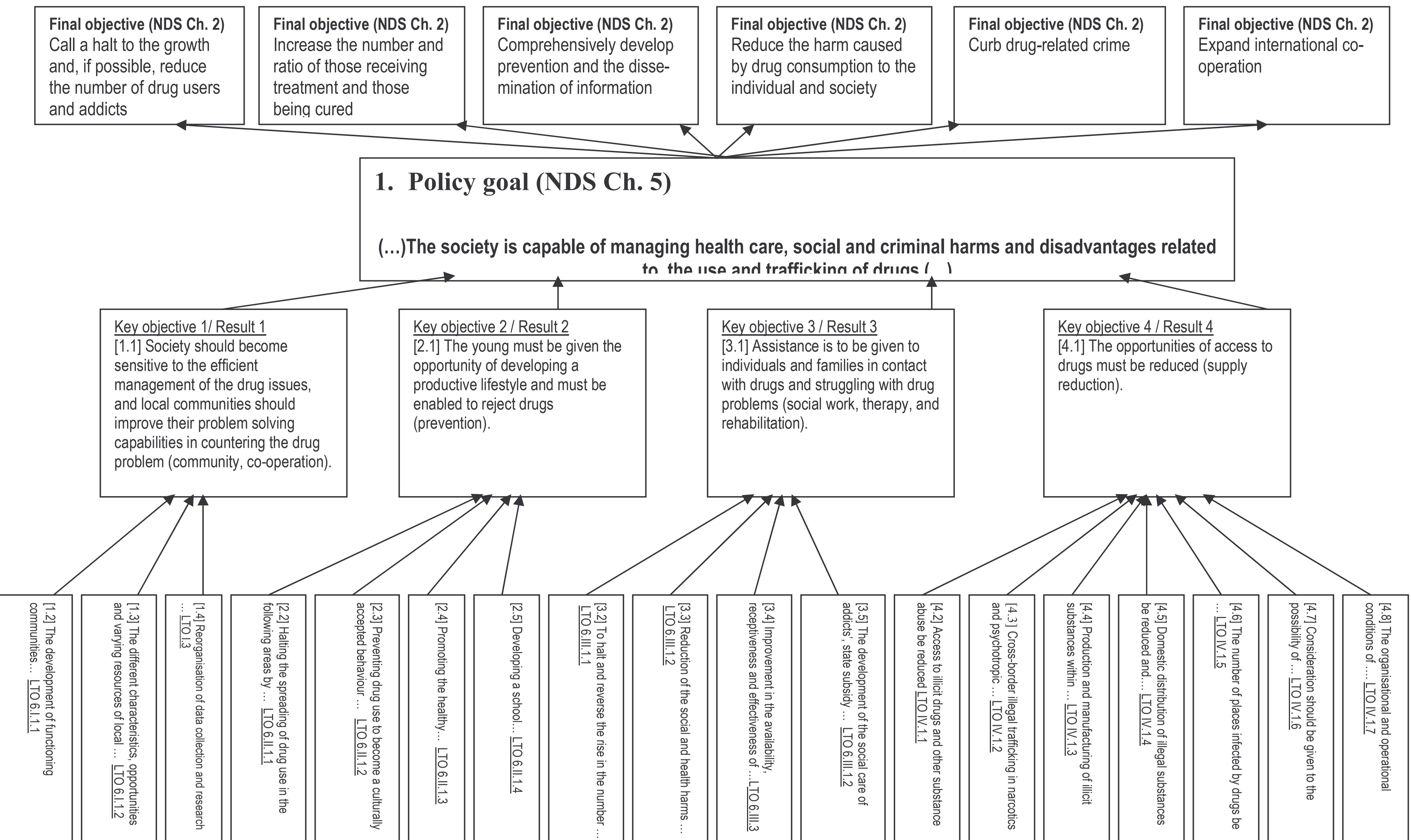
Annex 2 Policy trees National Drug Strategy



Final objective (NDS Ch. 2)
Call a halt to the growth and, if possible, reduce the number of drug users and addicts
Final objective (NDS Ch. 2)
Increase the number and ratio of those receiving treatment and those being cured
Final objective (NDS Ch. 2)
Comprehensively develop prevention and the disse-mination of information
Final objective (NDS Ch. 2)
Reduce the harm caused by drug consumption to the individual and society
Final objective (NDS Ch. 2)
Curb drug-related crime
Final objective (NDS Ch. 2)
Expand international co-operation
1. Policy goal (NDS Ch. 5)
(…)The society is capable of managing health care, social and criminal harms and disadvantages related
Key objective 1/ Result 1
[1.1] Society should become sensitive to the efficient management of the drug issues, and local communities should improve their problem solving capabilities in countering the drug problem (community, co-operation).
Key objective 2 / Result 2
[2.1] The young must be given the opportunity of developing a productive lifestyle and must be enabled to reject drugs (prevention).
Key objective 3 / Result 3
[3.1] Assistance is to be given to individuals and families in contact with drugs and struggling with drug problems (social work, therapy, and rehabilitation).
Key objective 4 / Result 4
[4.1] The opportunities of access to drugs must be reduced (supply reduction).
[1.2] The development of functioning communities… LTO 6.I.1.1
[1.3] The different characteristics, opportunities and varying resources of local … LTO 6.I.1.2
[1.4] Reorganisation of data collection and research … LTO I.3
[2.2] Halting the spreading of drug use in the following areas by … LTO 6.II.1.1
[2.3] Preventing drug use to become a culturally accepted behaviour … LTO 6.II.1.2
[2.4] Promoting the healthy… LTO 6.II.1.3
[2.5] Developing a school… LTO 6.II.1.4
[3.2] To halt and reverse the rise in the number … LTO 6.III.1.1
[3.3] Reduction of the social and health harms … LTO 6.III.1.2
[3.4] Improvement in the availability, receptiveness and effectiveness of …LTO 6.III.3
[3.5] The development of the social care of addicts', state subsidy … LTO 6.III.1.2
[4.2] Access to illicit drugs and other substance abuse be reduced LTO IV.1.1
[4.3] Cross-border illegal trafficking in narcotics and psychotropic … LTO IV.1.2
[4.4] Production and manufacturing of illicit substances within … LTO IV.1.3
[4.5] Domestic distribution of illegal substances be reduced and…. LTO IV.1.4
[4.6] The number of places infected by drugs be … LTO IV.1.5
[4.7] Consideration should be given to the possibility of … LTO IV.1.6
[4.8] The organisational and operational conditions of …. LTO IV.1.7

[1.1] Society should become sensitive to the efficient management of the drug issues, and local communities should improve their problem solving capabilities in countering the drug problem (community, co-operation). *Result I*

[1.2] The development of functioning communities sensitive to the management of the drug problem. LTO 6.I.1.1

[1.3] The different characteristics, opportunities and varying resources of local communities necessitate the development of local strategies (…) LTO 6.I.1.2

[1.4] Reorganisation of data collection and research (…) LTO I.3

[1.5] Raising the awareness of families to enable them to recognise and manage drug problems LTO 6.I.1.1.A

[1.6] Development of workplace drug policies, and extension of the drug-free workplace program LTO 6.I.1.1.B

[1.7] Increasing drug-free entertainment opportunities including an increase in the number of safe places of entertainment LTO 6.I.1.1.C

[1.8] Reintegration of drug users released from penitentiaries into the community with the support of a wide-ranging network of institutions in co-operation with the organisations of health and welfare care LTO 6.I.1.1.D

[1.9] Caring for and reintegration of the homeless by providing supportive care, the management of harm and by including the elements of resocialisation LTO 6.I.1.1.E

[1.10] Building up a system of local Co-ordination Forums on Drug Affairs LTO 6.I.1.2.A

[1.11] Adaptation of European programs concerning community development, local management of drug problems or operation of local Co-ordination Forums on Drug Affairs to facilitate the implementation of local co-operation LTO 6.I.2.B

[1.12] Assessment of the (local) drug scene and the changes therein (use, trends) LTO 6.I.1.3.A

[1.13] Mapping the possible ways of solution (to the drug problem) and the conditions of their employment and success (e.g. communal prevention, community helping services, law enforcement) LTO 6.I.1.3.B

[1.14] (Deployment of epidemiologic al) indexes developed with the help of proven EU conform indicators, which aim at uniformity LTO 6.I.1.3.C

[1.15] Making use of the joint efforts and experiences of the European and international community with respect to the management of the drug problem LTO 6.I.1.3.D

[1.16] Supporting the establishment of drug-free programs and settings: with respect to the local community, the school, the workplace and places of entertainment MTO 6.I.2.2

[1.17] Decreasing the number of disco accidents, by increasing control on public roads MTO 6.I.2.3

[1.18] Relapse prevention for drug users released from prison by making available re-socialisation, aftercare programs in adequate quantity and at the appropriate standard MTO 6.I.2.6

[1.19] Development of welfare support system (incl. accommodation) for drug patients who are cured, are released from penitentiaries or are participating in maintenance treatment MTO 6.I.2.7

[1.20] The establishment and operation of local institutional functional units in order to implement the National Strategy due to the local requirements (setting up Co-ordination Forums on Drug Affairs (KEF)) MTO 6.I.2.4

[1.21] International recommendations and methods developed by various professional organisations, both Hungarian and international and national authorities MTO 6.I.2.5

[1.22] Collection of domestic data useful for the community, making international databases accessible MTO 6.I.3.1

[1.23] Establishing local prevention services: establishment of a wide spectrum of leisure-time facilities, which take precedence over (or replace) drug use: drug-free clubs and discotheques, institutions enabling both entertainment and assistance, sports events at night, coping with loafing and street kids STO 6.I.3.7

[1.24] Survey and assessment of those institutions, which are dealing with abusers or youngsters endangered by drug abuse STO 6.I.3.6

[1.25] Analysis of the legal environment and its amendment when needed 6.I.1.3.A1

[1.26] Creating local forms of checks (e.g. drugs & driving, licensing procedures, etc. STO 6.I.3.9

[1.27] Development in the quantity and quality of training projects (local drug coordinators & workplace drug experts) STO I.3.5

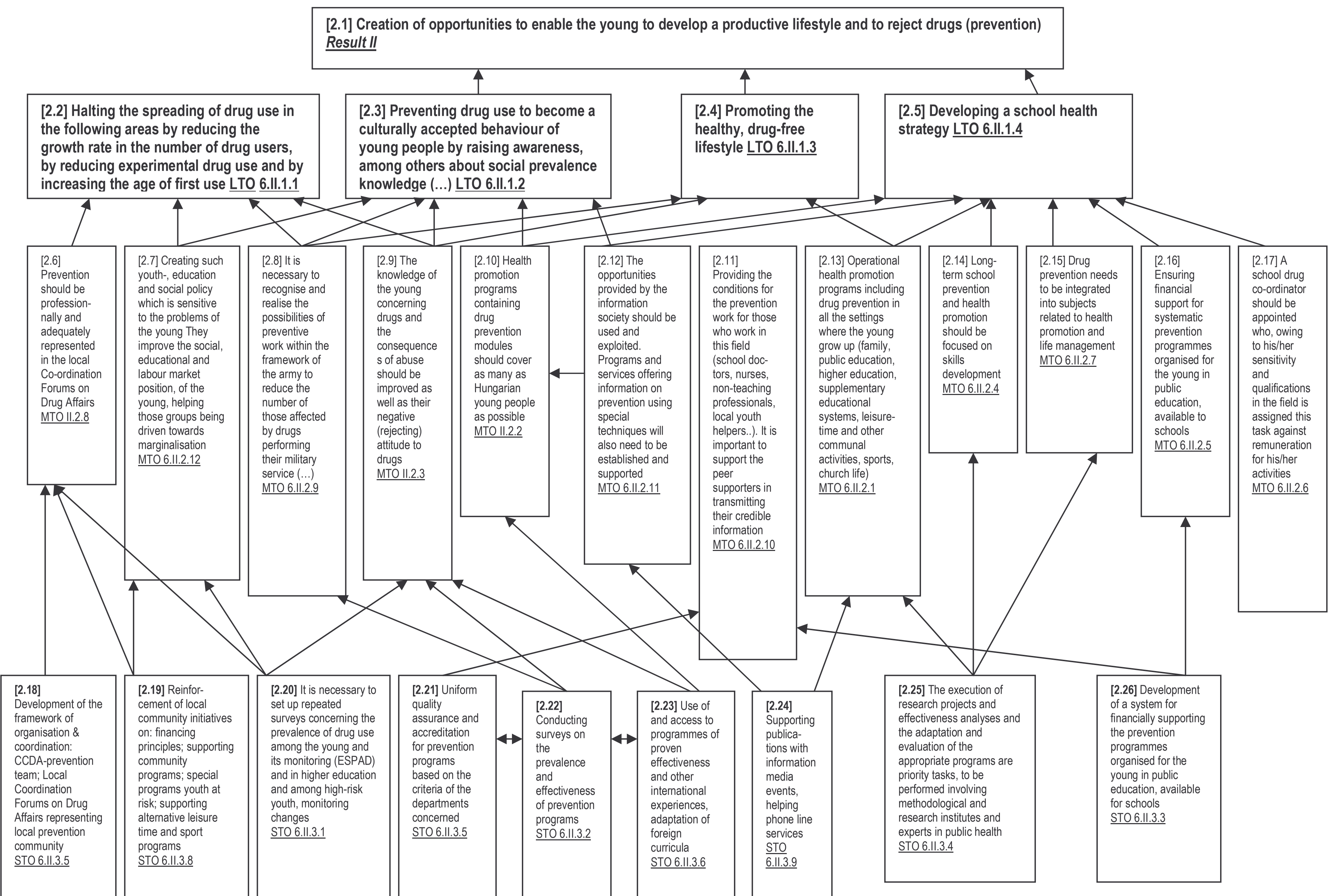
[1.28] It is necessary to develop reintegration programs for drug users released from penitentiaries STO 6.I.3.10

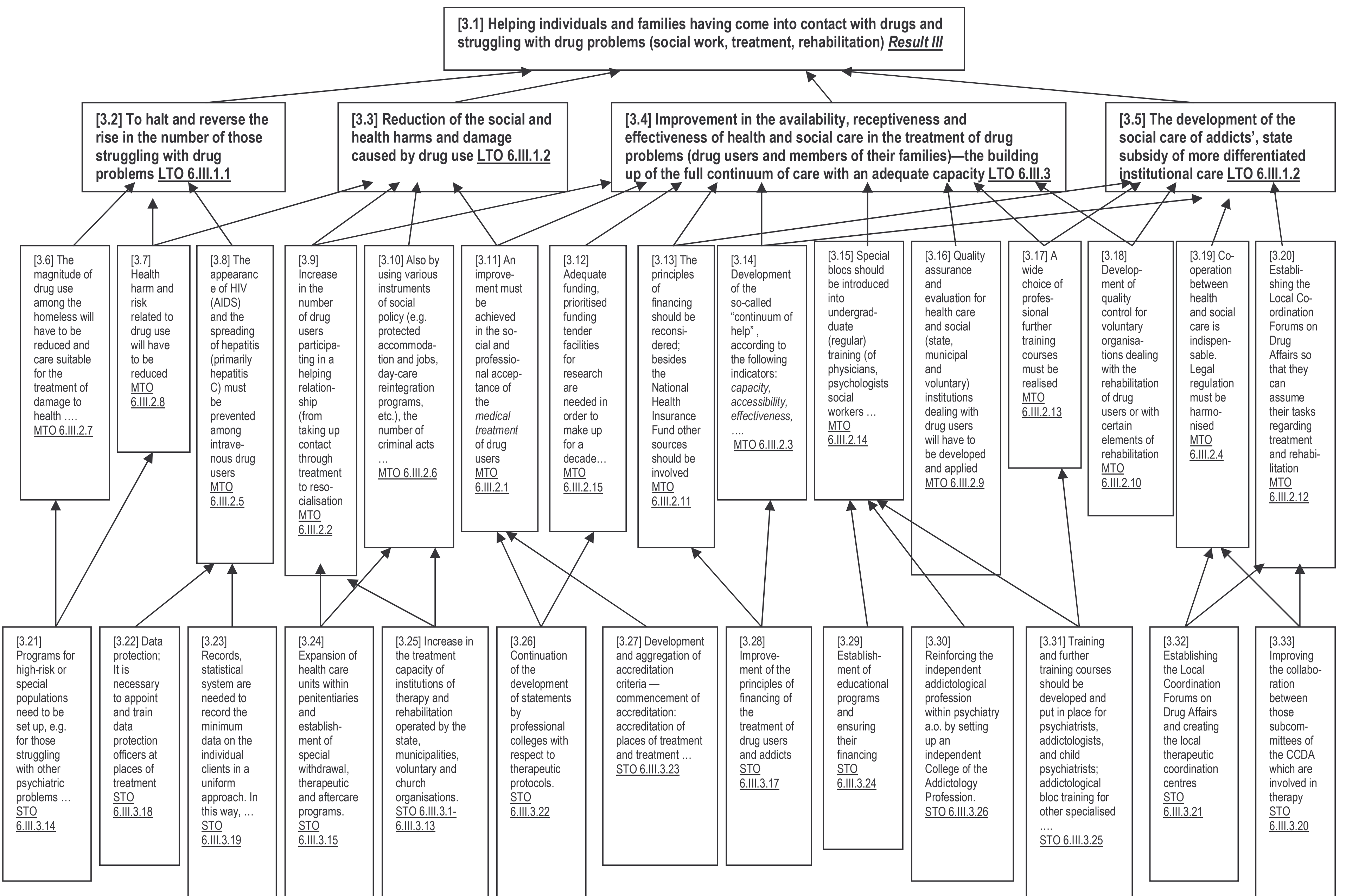
[1.29] Administrative measures, e.g. establishment of the Co-ordination Forums on Drug Affairs, establishment of their legal and administrative conditions, co-ordination of the work of these committees and assistance to them through the collaboration of the organisational units of the CCDA STO 6.I.3.2

[1.30] Facilitation of the operation of local community settings STO 6.I.3.8

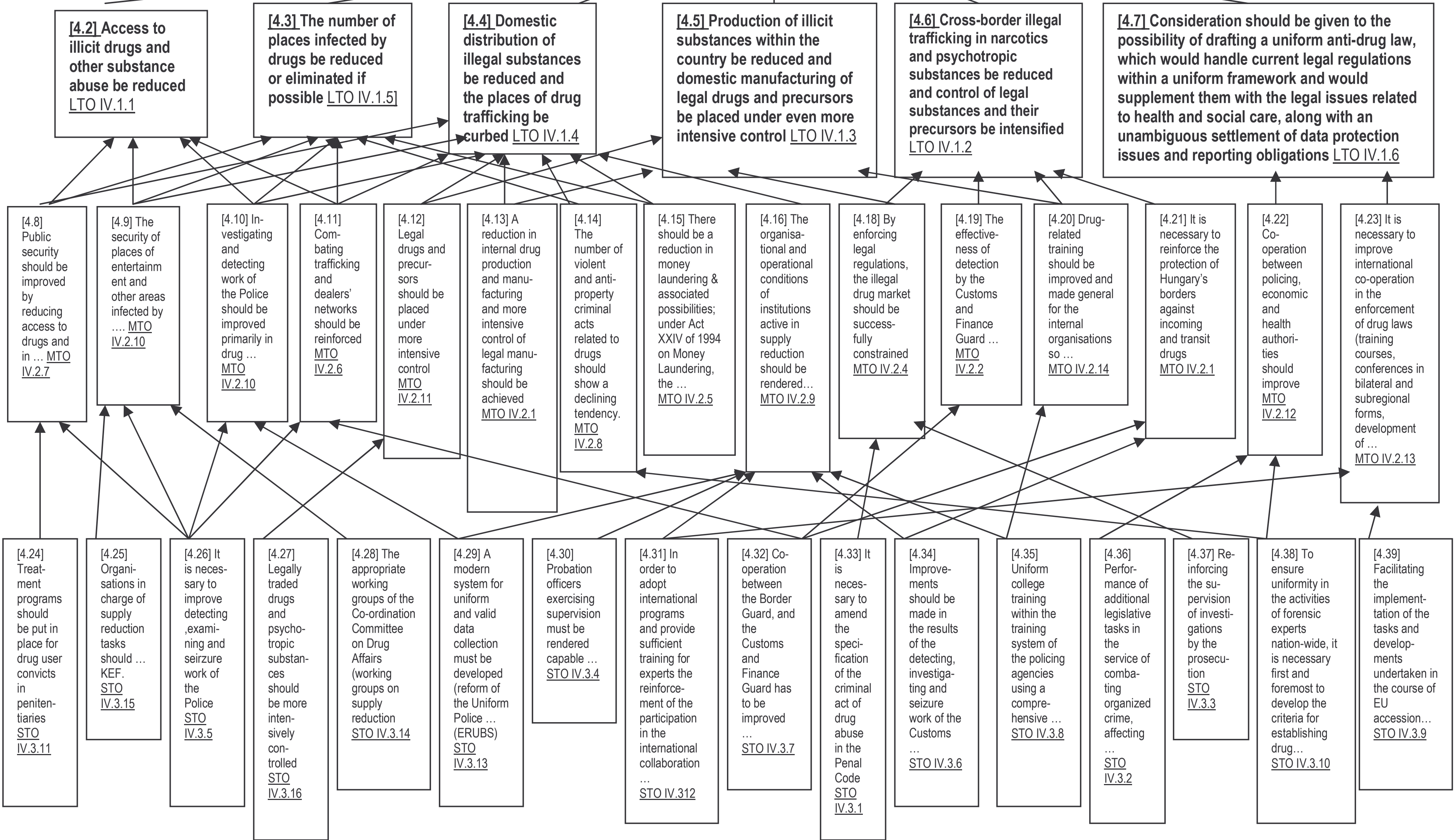
[1.31] Initiation of communal epidemio-logical research projects STO 6.I.3.8

[1.32] Adjusting to the international environment, promoting international relations. The establishment of the National focal point – has an outstanding role-, which is the institution for cooperation between Hungary and the European Union STO I.3.11


[2.1] Creation of opportunities to enable the young to develop a productive lifestyle and to reject drugs (prevention) Result II
[2.2] Halting the spreading of drug use in the following areas by reducing the growth rate in the number of drug users, by reducing experimental drug use and by increasing the age of first use LTO 6.II.1.1
[2.3] Preventing drug use to become a culturally accepted behaviour of young people by raising awareness, among others about social prevalence knowledge (…) LTO 6.II.1.2
[2.4] Promoting the healthy, drug-free lifestyle LTO 6.II.1.3
[2.5] Developing a school health strategy LTO 6.II.1.4
[2.6] Prevention should be profession-nally and adequately represented in the local Co-ordination Forums on Drug Affairs MTO II.2.8
[2.7] Creating such youth-, education and social policy which is sensitive to the problems of the young They improve the social, educational and labour market position, of the young, helping those groups being driven towards marginalisation MTO 6.II.2.12
[2.8] It is necessary to recognise and realise the possibilities of preventive work within the framework of the army to reduce the number of those affected by drugs performing their military service (…) MTO 6.II.2.9
[2.9] The knowledge of the young concerning drugs and the consequence s of abuse should be improved as well as their negative (rejecting) attitude to drugs MTO II.2.3
[2.10] Health promotion programs containing drug prevention modules should cover as many as Hungarian young people as possible MTO II.2.2
[2.12] The opportunities provided by the information society should be used and exploited. Programs and services offering information on prevention using special techniques will also need to be established and supported MTO 6.II.2.11
[2.11] Providing the conditions for the prevention work for those who work in this field (school doc-tors, nurses, non-teaching professionals, local youth helpers..). It is important to support the peer supporters in transmitting their credible information MTO 6.II.2.10
[2.13] Operational health promotion programs including drug prevention in all the settings where the young grow up (family, public education, higher education, supplementary educational systems, leisure-time and other communal activities, sports, church life) MTO 6.II.2.1
[2.14] Long-term school prevention and health promotion should be focused on skills development MTO 6.II.2.4
[2.15] Drug prevention needs to be integrated into subjects related to health promotion and life management MTO 6.II.2.7
[2.16] Ensuring financial support for systematic prevention programmes organised for the young in public education, available to schools MTO 6.II.2.5
[2.17] A school drug co-ordinator should be appointed who, owing to his/her sensitivity and qualifications in the field is assigned this task against remuneration for his/her activities MTO 6.II.2.6
[2.18] Development of the framework of organisation & coordination: CCDA-prevention team; Local Coordination Forums on Drug Affairs representing local prevention community STO 6.II.3.5
[2.19] Reinfor-cement of local community initiatives on: financing principles; supporting community programs; special programs youth at risk; supporting alternative leisure time and sport programs STO 6.II.3.8
[2.20] It is necessary to set up repeated surveys concerning the prevalence of drug use among the young and its monitoring (ESPAD) and in higher education and among high-risk youth, monitoring changes STO 6.II.3.1
[2.21] Uniform quality assurance and accreditation for prevention programs based on the criteria of the departments concerned STO 6.II.3.5
[2.22] Conducting surveys on the prevalence and effectiveness of prevention programs STO 6.II.3.2
[2.23] Use of and access to programmes of proven effectiveness and other international experiences, adaptation of foreign curricula STO 6.II.3.6
[2.24] Supporting publica-tions with information media events, helping phone line services STO 6.II.3.9
[2.25] The execution of research projects and effectiveness analyses and the adaptation and evaluation of the appropriate programs are priority tasks, to be performed involving methodological and research institutes and experts in public health STO 6.II.3.4
[2.26] Development of a system for financially supporting the prevention programmes organised for the young in public education, available for schools STO 6.II.3.3



[3.1] Helping individuals and families having come into contact with drugs and struggling with drug problems (social work, treatment, rehabilitation) Result III
[3.2] To halt and reverse the rise in the number of those struggling with drug problems LTO 6.III.1.1
[3.3] Reduction of the social and health harms and damage caused by drug use LTO 6.III.1.2
[3.4] Improvement in the availability, receptiveness and effectiveness of health and social care in the treatment of drug problems (drug users and members of their families)—the building up of the full continuum of care with an adequate capacity LTO 6.III.3
[3.5] The development of the social care of addicts', state subsidy of more differentiated institutional care LTO 6.III.1.2
[3.6] The magnitude of drug use among the homeless will have to be reduced and care suitable for the treatment of damage to health …. MTO 6.III.2.7
[3.7] Health harm and risk related to drug use will have to be reduced MTO 6.III.2.8
[3.8] The appearanc e of HIV (AIDS) and the spreading of hepatitis (primarily hepatitis C) must be prevented among intrave-nous drug users MTO 6.III.2.5
[3.9] Increase in the number of drug users participa-ting in a helping relation-ship (from taking up contact through treatment to reso-cialisation MTO 6.III.2.2
[3.10] Also by using various instruments of social policy (e.g. protected accommoda-tion and jobs, day-care reintegration programs, etc.), the number of criminal acts … MTO 6.III.2.6
[3.11] An improve-ment must be achieved in the so-cial and professio-nal accep-tance of the medical treatment of drug users MTO 6.III.2.1
[3.12] Adequate funding, prioritised funding tender facilities for research are needed in order to make up for a decade… MTO 6.III.2.15
[3.13] The principles of financing should be reconsi-dered; besides the National Health Insurance Fund other sources should be involved MTO 6.III.2.11
[3.14] Development of the so-called "continuum of help", according to the following indicators: capacity, accessibility, effectiveness, …. MTO 6.III.2.3
[3.15] Special blocs should be introduced into undergrad-duate (regular) training (of physicians, psychologists social workers … MTO 6.III.2.14
[3.16] Quality assurance and evaluation for health care and social (state, municipal and voluntary) institutions dealing with drug users will have to be developed and applied MTO 6.III.2.9
[3.17] A wide choice of profes-sional further training courses must be realised MTO 6.III.2.13
[3.18] Develop-ment of quality control for voluntary organisa-tions dealing with the rehabilitation of drug users or with certain elements of rehabilitation MTO 6.III.2.10
[3.19] Co-operation between health and social care is indispen-sable. Legal regulation must be harmo-nised MTO 6.III.2.4
[3.20] Establi-shing the Local Co-ordination Forums on Drug Affairs so that they can assume their tasks regarding treatment and rehabi-litation MTO 6.III.2.12
[3.21] Programs for high-risk or special populations need to be set up, e.g. for those struggling with other psychiatric problems … STO 6.III.3.14
[3.22] Data protection; It is necessary to appoint and train data protection officers at places of treatment STO 6.III.3.18
[3.23] Records, statistical system are needed to record the minimum data on the individual clients in a uniform approach. In this way, … STO 6.III.3.19
[3.24] Expansion of health care units within penitentiaries and establish-ment of special withdrawal, therapeutic and aftercare programs. STO 6.III.3.15
[3.25] Increase in the treatment capacity of institutions of therapy and rehabilitation operated by the state, municipalities, voluntary and church organisations. STO 6.III.3.1-6.III.3.13
[3.26] Continuation of the development of statements by professional colleges with respect to therapeutic protocols. STO 6.III.3.22
[3.27] Development and aggregation of accreditation criteria — commencement of accreditation: accreditation of places of treatment and treatment … STO 6.III.3.23
[3.28] Improve-ment of the principles of financing of the treatment of drug users and addicts STO 6.III.3.17
[3.29] Establish-ment of educational programs and ensuring their financing STO 6.III.3.24
[3.30] Reinforcing the independent addictological profession within psychiatry a.o. by setting up an independent College of the Addictology Profession. STO 6.III.3.26
[3.31] Training and further training courses should be developed and put in place for psychiatrists, addictologists, and child psychiatrists; addictological bloc training for other specialised …. STO 6.III.3.25
[3.32] Establishing the Local Coordination Forums on Drug Affairs and creating the local therapeutic coordination centres STO 6.III.3.21
[3.33] Improving the collabo-ration between those subcom-mittees of the CCDA which are involved in therapy STO 6.III.3.20


[4.1] To reduce the opportunities of access to drugs (supply reduction) Result IV
[4.2] Access to illicit drugs and other substance abuse be reduced LTO IV.1.1
[4.3] The number of places infected by drugs be reduced or eliminated if possible LTO IV.1.5]
[4.4] Domestic distribution of illegal substances be reduced and the places of drug trafficking be curbed LTO IV.1.4
[4.5] Production of illicit substances within the country be reduced and domestic manufacturing of legal drugs and precursors be placed under even more intensive control LTO IV.1.3
[4.6] Cross-border illegal trafficking in narcotics and psychotropic substances be reduced and control of legal substances and their precursors be intensified LTO IV.1.2
[4.7] Consideration should be given to the possibility of drafting a uniform anti-drug law, which would handle current legal regulations within a uniform framework and would supplement them with the legal issues related to health and social care, along with an unambiguous settlement of data protection issues and reporting obligations LTO IV.1.6
[4.8] Public security should be improved by reducing access to drugs and in … MTO IV.2.7
[4.9] The security of places of entertainm ent and other areas infected by …. MTO IV.2.10
[4.10] In-vestigating and detecting work of the Police should be improved primarily in drug … MTO IV.2.10
[4.11] Com-bating trafficking and dealers' networks should be reinforced MTO IV.2.6
[4.12] Legal drugs and precur-sors should be placed under more intensive control MTO IV.2.11
[4.13] A reduction in internal drug production and manu-facturing and more intensive control of legal manu-facturing should be achieved MTO IV.2.1
[4.14] The number of violent and anti-property criminal acts related to drugs should show a declining tendency. MTO IV.2.8
[4.15] There should be a reduction in money laundering & associated possibilities; under Act XXIV of 1994 on Money Laundering, the … MTO IV.2.5
[4.16] The organisa-tional and operational conditions of institutions active in supply reduction should be rendered… MTO IV.2.9
[4.18] By enforcing legal regulations, the illegal drug market should be success-fully constrained MTO IV.2.4
[4.19] The effective-ness of detection by the Customs and Finance Guard … MTO IV.2.2
[4.20] Drug-related training should be improved and made general for the internal organisations so … MTO IV.2.14
[4.21] It is necessary to reinforce the protection of Hungary's borders against incoming and transit drugs MTO IV.2.1
[4.22] Co-operation between policing, economic and health authori-ties should improve MTO IV.2.12
[4.23] It is necessary to improve international co-operation in the enforcement of drug laws (training courses, conferences in bilateral and subregional forms, development of … MTO IV.2.13
[4.24] Treat-ment programs should be put in place for drug user convicts in peniten-tiaries STO IV.3.11
[4.25] Organi-sations in charge of supply reduction tasks should … KEF. STO IV.3.15
[4.26] It is neces-sary to improve detecting ,exami-ning and seirzure work of the Police STO IV.3.5
[4.27] Legally traded drugs and psycho-tropic substan-ces should be more inten-sively con-trolled STO IV.3.16
[4.28] The appropriate working groups of the Co-ordination Committee on Drug Affairs (working groups on supply reduction STO IV.3.14
[4.29] A modern system for uniform and valid data collection must be developed (reform of the Uniform Police … (ERUBS) STO IV.3.13
[4.30] Probation officers exercising supervision must be rendered capable … STO IV.3.4
[4.31] In order to adopt international programs and provide sufficient training for experts the reinforce-ment of the participation in the international collaboration … STO IV.312
[4.32] Co-operation between the Border Guard, and the Customs and Finance Guard has to be improved … STO IV.3.7
[4.33] It is neces-sary to amend the speci-fication of the criminal act of drug abuse in the Penal Code STO IV.3.1
[4.34] Improve-ments should be made in the results of the detecting, investiga-ting and seizure work of the Customs … STO IV.3.6
[4.35] Uniform college training within the training system of the policing agencies using a compre-hensive … STO IV.3.8
[4.36] Perfor-mance of additional legislative tasks in the service of comba-ting organized crime, affecting … STO IV.3.2
[4.37] Re-inforcing the su-pervision of investi-gations by the prosecu-tion STO IV.3.3
[4.38] To ensure uniformity in the activities of forensic experts nation-wide, it is necessary first and foremost to develop the criteria for establishing drug… STO IV.3.10
[4.39] Facilitating the implement-tation of the tasks and develop-ments undertaken in the course of EU accession… STO IV.3.9

Annex 3 List of participating KEF's

	Type	KEF - city	Institute
I. KÖZÉP-DUNÁNTÚL (MIDDLE-TRANSDANUBIA)			
1	Local	Dunaújváros	Polgármesteri Hivatal
2	Local	Pápa	Családsegítő és Gyermekjóléti Szolgálat
3	Local	Tatabánya	Polgármesteri Hivatal
4	Local	Tata	Tata Város Önkormányzata
5	Local	Székesfehérvár	Székesfehérvár MJV Önkormányzata
6	Local	Veszprém	Ifjúsági Információs és Szolgáltató Iroda
7	Local	Oroszlány	Önkormányzati Szociális Szolgálat
8	County	Székesfehérvár	Fejér Megyei Önkormányzati Hivatal
9	Local	Várpalota	Várpalota Város Önkormányzata
II. NYUGAT-DUNÁNTÚL (WEST-TRANSDANUBIA)			
10	Local	Mosonmagyaróvár	Polgármesteri Hivatal
11	Local	Keszthely-Kertváros	Városi Önkormányzat
12	Local	Nagykanizsa	Egészségügyi Alapellátási Intézmény
13	Local	Győr	Polgármesteri Hivatal
14	Local	Zalaegerszeg	Polgármesteri Hivatal
15	Local	Szombathely	Polgármesteri Hivatal
16	Local	Sopron	Polgármesteri Hivatal
17	County	Győr	Megyei Önkormányzat
IV. KÖZÉP-MAGYARORSZÁG (MIDDLE-HUNGARY)			
18	Local	Budaörs	
19	Local	Érd	Érd Város Önkormányzata
20	Local	Szentendre	Polgármesteri Hivatal
21	Local	Dunakeszi	Dunakeszi Polgármesteri Hivatal
22	Local	Nagykőrös	Toldi Miklós Élelmiszeripari Középiskola
23	Local	Szigetszentmiklós	Szigetszentmiklósi Családsegítő szolgálat
24	Local	Gödöllő	Polgármesteri Hivatal Népjóléti Iroda
V. BUDAPEST – PEST SIDE			
25	City	Budapest 13.	Iránytű Ifjúsági és Tanácsadó Iroda
26	City	Budapest 16.	Budapest Főváros XVI. Kerületi Önkormányzat
27	City	Budapest 18.	XVIII. kerület Polgármesteri Hivatal Okt. Közm. Sport és Ifj. Iroda
28	City	Budapest 21.	Csepeli Családsegítő Szolgálat
VI DÉL-ALFÖLD (SOUTH-PLAIN)			
29	Local	Baja	Polgármesteri Hivatal
30	Local	Békés	
31	Local	Gyula	Egészségügyi Alapellátási Intézmény
32	Local	Békéscsaba	Polgármesteri Hivatal
33	Local	Kalocsa	Polgármesteri Hivatal
34	Local	Kecskemét	Kecskemét Város Önkormányzata
35	Local	Kiskunfélegyháza	Városi Önkormányzat
36	Local	Kiskunhalas	Gyermekjóléti Szolgálat
37	Local	Orosháza	Városi Önkormányzat
38	Local	Szeged	Szeged MJV Önkormányzata
39	Local	Szentes	Családsegítő Központ
40	Local	Hódmezővásárhely	Polgármesteri Hivatal
VII. ÉSZAK-ALFÖLD (NOTRH-PLAIN)			
41	Local	Debrecen	DMJV Polgármesteri Hivatal Kulturális Osztály
42	Local	Nyíregyháza	ÁNTSZ Megyei Intézete Egészségvédelmi Osztály
43	Local	Szolnok	Polgármesteri Hivatal Humán Közszolgáltatások Főosztálya
44	Local	Hajdúböszörmény	Sillye Gábor Művelődési Központ és Közösségi Ház
45	Local	Jászberény	Erzsébet Kórház Gondozóháza
46	Local	Mátészalka	Egyesített Szociális Intézmények
47	Local	Karcag	Polgármesteri Hivatal

48	Local	Törökszentmiklós	Polgármesteri Hivatal
VIII. ÉSZAK-MAGYARORSZÁG (NORTH-HUNGARY)			
49	Local	Ózd	Ózd Városi Önkormányzat
50	Local	Tiszaújváros	Polgármesteri Hivatal Szociális És Egészségügyi Iroda
51	Local	Kazincbarcika	Kazincbarcika Város Önkormányzata
52	Local	Miskolc	Miskolc MJV Polgármesteri Hivatal
53	Local	Salgótarján	JAMK-Ifjúsági Információs és Tanácsadó iroda
54	Local	Hatvan	Művelődési és Ifjúsági Bizottság
55	Local	Eger	Eger MJV Polgármesteri Hivatala
56	Local	Gyöngyös	Vadas Jenő Erdészeti és Vadgazdálkodási Szakképző Iskola
IX. DÉL-DUNÁNTÚL (SOUTH-TRANSDANUBIA)			
57	Local	Dombóvár	Felnőtt Ideggondozó
58	Local	Szekszárd	RÉV Szenvedélybeteg-segítő Szolgálat
59	Local	Pécs	Pécs MJV. Polgármesteri Hivatala
60	Local	Paks	
61	Local	Komló	Óvoda
62	Local	Siófok	Családsegítő Központ
63	Local	Mohács	
64	Local	Kaposvár	

Annex 4 Tables KEF evaluation

Table 1 – Questions about the establishment and functioning of the KEF

1	Which organizations/institutes are represented in your KEF?
2	How frequently did these representatives participate in KEF meetings?
3	Are there other important organizations/institutes on local/district/county/region/small region level carrying out prevention and/or social work/treatment/rehabilitation and/or other activities that are not represented in your KEF?
4	Did your KEF *collect* information on the local/county/regional drug problem?
5	If so, did your KEF collect information on 1. the level of drug use in the community?; 2. the most important risk groups in the community?; 3. policing and court related drug issues?; 4. other relevant topics of the local/county/regional drug problem?
6	Did your KEF *report* on the local/county/regional drug problem?
7	If so, did your KEF *distribute* the report on local/county/regional level?
8	If so, did your KEF *discuss* the report on local/county/regional level?
9	If so, did your KEF *send* the report to the NDI?
10	Did your KEF *collect* information on existing local/county/regional drug prevention activities?
11	Did your KEF *inform* local/county/regional stakeholders about existing local/county/regional prevention activities?
12	Did your KEF *discuss* existing local/county/regional prevention activities with local/county/regional stakeholders?
13	If existing local/county/regional prevention activities were discussed with local/county/regional stakeholders, what were the results of this discussion?
14	Did your KEF *send* the collected information on existing local/county/regional drug prevention activities to the NDI?
15	Did your KEF *collect* information on existing local/county/regional treatment activities?
16	Did your KEF *inform* local/county/regional stakeholders about existing local/county/regional treatment activities?
17	Did your KEF *discuss* existing local/county/regional treatment activities with local/county/regional stakeholders?
18	If existing local/county/regional treatment activities were discussed with local/county/regional stakeholders, what were the results of this discussion?
19	Did your KEF *send* the collected information on existing local/county/regional drug treatment activities to the NDI?
20	Did your KEF make a planning of local/county/regional tasks in line with the national strategy to combat the drug problem?
21	Did KEF members *actively participate* in making the planning?
22	Did your KEF *inform* local/county/regional stakeholders about the planning?
23	Did your KEF *discuss* the planning with local/county/regional stakeholders?
24	Did your KEF *send* the planning to the NDI?
25	Did your KEF make reports of the work done in line with the national strategy to combat the drug problem?
26	Did KEF members actively participate in writing the report?
27	Did your KEF *inform* local/county/regional stakeholders about the report?
28	Did your KEF *discuss* the report with local/county/regional stakeholders?
29	Did your KEF *send* the evaluation report to the NDI?
30	When was this KEF established?
31	What do you consider the *most important tasks* of your KEF on local/county/regional level (*maximum 5 tasks*)?
32	What do you consider the *most successful tasks* on local/county/regional level, since the start of your activities (*maximum 5 tasks*)?
33	Please give the *most important barriers (or limiting or impeding factors)* that disadvantaged your KEF tasks on local/regional level (*maximum 5 limiting factors*).

Table 2 – Questions about the 17 pre-selected short- and mid-term objectives from the National Drug Strategy

1	What, according to you, is the result of this objective?
2	Which member(s) of your organization/institute are responsible for carrying out this objective?
3	You stated that this objective (listed in the national strategy to combat the drug problem) has been achieved/partly achieved/not achieved. What (written) sources (reports, statistics, etc.) did you use to reach this judgement?
4	In discussions with different experts we have identified some other (objectively verifiable) indicators to judge whether this objective described is achieved. These indicators are [list of indicators]. First, do you agree on these indicators? Next, please give your judgement on the indicator.
5	Can you mention other indicators that are suitable to measure the result of this objective and your judgment of these indicators?
6	If you stated that this objective (listed in the national strategy to combat the drug problem) is not achieved, please specify what limiting or restrictive factors contributed to this fact?
7	If you stated that this objective (listed in the national strategy to combat the drug problem) is not achieved, please identify three limiting or restrictive factors to be counterbalanced most urgently to achieve a positive result as soon as possible?
8	When the selected objective (listed in the national strategy to combat the drug problem) has to be realised by 2010: To what extent is it realised already?
9	When the selected objective (listed in the national strategy to combat the drug problem) has to be realised by 2010: Do you expect that it will be realised by 2010?
A	Please give five objectives listed in the national strategy to combat the drug problem that are, in your opinion, the most successful ones of the national strategy and the five actions least successful.
B	Please mention the two strongest points and the two weakest points of the national strategy to combat the drug problem.

Table 3 – Most important tasks of the Local Coordination Forums on Drug Affairs (KEF)

Mentioned important tasks	%
(Creating a sufficient basis for) co-operation on a local level, keeping in contact, co-operation of key persons on local/regional level (who are involved in mapping and solving drug problems); mapping local relations; getting key persons involved; increase co-operation with the media	15%
Giving information about the local drug situation; prevention programmes; treatment; Giving information to the local communities, to the people; Making a website; making databases; Influencing public opinion; Informing prevention workers; Informing other KEFs; Informing parents and students	13%
Developing or co-ordinating work, actions, institutes; building an effective co-ordination structure; community actions; get in contact with local institutes	10%
Creating a local drug strategy, a city strategy, making a map with local drug issues, making a county strategy, informing decision makers about it; specifying work plan or targets	9%
Continuing and/or strengthening KEF; drug prevention activities; making programmes for high-risk groups; creating a drug prevention centre	8%
Conducting a survey study to create local/regional information on drug use; Creating drug related knowledge about local situation	6%
Training experts; securing competence; training KEF-members	6%
Continuing or strengthening the KEF, securing continuity of funding, KEF needs a fulltime worker	5%
Demand and supply reduction (police)	3%
Funding a drug ambulance	2%
More effective working, organisation	2%
School-based prevention; prevention in youth institutes and educational institutes; school-based treatment	2%
Evaluating activities	2%
Workgroups, expert forums	2%
Outreach (get in contact with) the parents; parent participation	2%
KEF promotion	1%
Creating drug-free (leisure) locations for youth	1%
Creating rehabilitation opportunities	1%
Solving drug problems	1%
Reorganisations	1%
Determination of KEF status	1%
Creating low threshold services	1%
Building an effective treatment system (lack of a doctor);	1%
Involvement of health care system	1%
KEF work should be visible	1%
Therapy and rehabilitation, re-integration	1%
Develop problem-solving skills of parents and family workers	1%
Enforcing legal position of KEFs	1%
Increasing sensibility to the drug problem	1%
Exploring local needs	1%

Table 4 – Most successful tasks of the Local Coordination Forums on Drug Affairs

Mentioned successful tasks	%
Developing or starting school-based drug prevention, a (anti) drug strategy in schools or locally, establishing drug prevention programmes; Family-based prevention; information for parents; Drug prevention from kindergarten to adulthood	21%
The mere existence of a KEF; that it is working; that the city know about the KEF; KEF conferences	13%
Organising local actions (summer programme, exhibition, inhabitants forum, games, conferences; drug prevention programmes for students)	12%
Local survey; school survey; creating a local picture; drug use among students; making a drug map; informing the community permanently	11%
Co-operation with the younger ones; co-operation with local organisations; having a continuous dialogue locally; co-operation within or between KEFs; between school drug-coordinators; with the municipality	9%
Expert training, peer training; training of drug workers	8%
Needle exchange programme (regional)	1%
Increasing number of drug workers; of KEF members	1%
Training of drug workers; training of peers	3%
Local co-operation; institute leaders are involved in KEF	1%
Publications	3%
Key persons pay attention to the drug problem; publicity; motivating public opinion	2%
KEF is a participation forum; a think tank	3%
Human resources were increased	1%
Every school a fulltime worker on drugs; every school a health promotion plan	1%
Permanent support of municipality, municipal funding; local drug prevention grants are starting	3%
Starting co-ordination of working on the drug problem	1%
Operating a drug information office (Child Welfare System)	1%

Local needs assessment	1%
Starting a research-based approach	1%
Having a KEF office	1%
Expanding professional communication network (from local to national)	1%
Co-ordination (peer groups, programmes)	1%
Founding a drug consultant centre	1%
Grant money enabled preventive actions	1%
Realising resources	1%
Securing information flow between experts and institutes	1%

Table 5 – Most important barriers to KEF functioning

Lack of experts, of fulltime workers, of human resources; co-ordination work is voluntary and this shapes the working attitudes; KEF members can only work for a short time (also have their own work); no permanent place	22%
Municipality does not fund KEF (anymore); lack of funding possibilities; lack of money (resources); inadequate funding arrangements; Grant Scheme is unclear about money arrangements	20%
Lack of motivation; passivity; lack of decision making; envy; scepticism (of professionals or institutes); changing local culture and situations is difficult. Lack of local motivation or perceived interest in the drug problem; resistance on local level; ignoring drug problem by stakeholders	13%
Lack of institutionalisation; of legal status (not clear); of legal regulation (cannot make decisions); lack of legal autonomy, of identification	8%
Communication problems between experts; inadequate local communication (e.g. between organisations of addiction care and KEFs or to the local world); professional chauvinism; working with psychiatrists is difficult	8%
Lack of information; inadequate information flow from KEFs; inadequate information about KEFs; lack of an information centre	5%
Lack of adequate organisation within the local system; KEF is not a real organisation; KEFs do not have a place in administrative hierarchy; KEF work is unknown	4%
Disinterested decision makers, key persons; congressmen are too busy with other affairs	3%
"The (drug) problem is bigger than the support"; no support; "they don't see this problem"	3%
Lack of a state survey study	1%
Municipal bureaucracy; attitude	1%
Lack of co-operation between KEFs of equal size	1%
Lack of co-operation between local/regional institutes	1%
Inadequate local drug policy	1%
Disorganised working committees	1%
Lack of addiction services	1%
Lack of co-operation	1%
Too much personal changes	1%
Public health should be integrated	1%
No computer	1%
NGOs do not work well and do not co-operate with KEFs	1%
Conflict of interests	1%
Lack of a suitable leader	1%
Political rhetoric (talking, not action)	1%
Difficulties in moving money of grants to KEFs	2%

Annex 5 Achievement of objectives of the National Drug Strategy at National level

Respondent	Respon-sibility	Objec-tive	CCDA Action Plan 2002	Objective National Drug Strategy	Achieved	Sources	Barriers	Change	% achie-ved	Success 2009?
MYFSAEO COORD	MYFSAEO & others	I.1.1.A	Nr. 5	Raising the awareness of families to enable them to recognise and manage drug problems.	Working on it	Telephone line; leaflets	Lack of funding & human resources (HR), know how (capacity)	Raise funding; Raise HR; Improve know how	10	Don't know
INTERIOR	INTERIOR & others				Partly	Annual reports at regional & national level; conferences; more voluntary groups active; more family based interventions; more funding;	Unspecified aim (what type of programs needed), Lack of funding & HR	Raise funding; Raise HR; Convince stakeholders	50	Realised up to 70%
EDUCATION	EDUCATION & others				Partly	Grant scheme exists; there is support for schools to involve parents; unclear whether aim is really achieved; not more voluntary groups active	Lack of funding & HR; ignoring of problem by stakeholders; no inter-institutional protocols; no local priority	Raise funding; Raise HR ; Raise local priority	60	Realised up to 90%
NGO DRUG FIELD1	Others				Partly	Educational materials available; more voluntary groups; more family based programs; more funds available	Unspecified aim; lack of funding; lack of know how; no inter-institutional protocol; no local priority	Specify aim; raise funding; improve know how; improve inter-institutional protocol; raise local priority	40	Not realised
MYFSAEO COORD	INTERIOR & others	I.3.3	Nr. 4	Analysis of the legal environment and making the necessary amendments.	Partly	Analysis is underway	Lack of funding No local priority	Raise funding; Raise local policy priority	40	Don't know
COURT	INTERIOR				Partly	Thousands of opinions of the Court/ codification letters; plans on legal issues; more local (by-)laws, more professionals in enforcing them; more local political support; BUT: current Legal Act too complicated and not homogeneously interpreted, causing different sentences for the same offences!!	Courts do not agree with the lawmakers!!	Unify the Legal Acts (Criminal Code) and assure homogenous interpretation; train judges	N.A.	N.A.
CIVIL NGO	INTERIOR & others				Partly	Positive change due to Strategy; more liberal legal environment; Constitutional Court reduced diversion options; sign to establish renewed legal background	Lack of databases & research (ERUBS; e.g. no difference between dealer & user); no national priority; bad quality of Criminal Law; differences in sentences; lack of data	Improve database & research; raise national priority; legal reform (simplification of Criminal Law)	60	Not realised

							protection (privacy)			
RESEARCH2	Others				Partly	Research NIC on effectiveness of diversion law; new developed strategies of police, border guard, prison service; not more professionals available; not more local support for legislation changes	Unspecified aim; lack of know how; no local priority	Specify aim; improve know how; raise priority	70	Realised
MYFSAEO	MYFSAEO	II.2.12	Nr. 2	Creating such youth-, education- and social-policy which is sensitive to the young's problems. *They improve the social, educational and labour market position of the young, helping those groups being driven towards marginalisation*	Working on it	Part of social legislation	Lack of understanding about the nature of drugs and addiction	Raise awareness	60	Realised
HEALTH	HEALTH & others				Partly	As activities ongoing; not achieved because no mutual policy has been developed	No priority in local policy; Lack of awareness, perhaps because ad-hoc approach in implementing it	Raise priority in local policy; Raise awareness and make roadmap for action	20	Don't know
EDUCATION	EDUCATION & others				Partly	Is a social exclusion issue; not every municipality has funding for this type of action; results are difficult to measure as data is not collected; more legal regulations; more rehab. of marginalised youth to social service and labour market	Lack of funding & HR Funding is done through grant scheme, which is not structural funding	Raise funding	55 depe nding on secto r	Not realised; perhaps parts of it
NDI	NDI & others				Working on it	Grant scheme MYFSAEO	Lack of funding & HR; no inter-institutional protocols	Raise funding & HR: improve inter-institutional protocols	50	Realised
MYFSAEO COORD	MYFSAEO & others	II.2.1	Nr. 2	Operational health promotion programs including drug prevention in all the settings where the young grow up. *(Family, public education, higher education, supplementary educational systems, leisure-time and other communal activities, sports, church life).*	Partly	Written reports	Lack of funding & HR	Raise funding; Raise HR	60	realised
EDUCATION	EDUCATION & others				Partly	Regulations & legislation in place, supported by grant scheme; interactions between	Lack of funding & HR; lack of know how; no inter-institutional protocols	Raise funding; improve inter-institutional protocols	50	Not realised

						local org; more health promotion prg; more funding, also from parents; more professionals involved; 2500-3000 (60%) schools run a program				
NDI	NDI & others				Partly	Annual Report to EMCDDA & other research data; more health promotion prg; more funding, also from parents; more professionals involved; 2500-3000 (60%) schools run a program; not more prevention settings reached	Lack of funding & HR; lack of know how; lack of coordination; lack of shared understanding of problem	Raise funding; improve coordination & improve shared understanding	65	Realised
NGO DRUG FIELD1	Others				Partly	Effects noticed at NGO level; collection of health statistics; Annual report NDI	Lack of funding & HR; lack of know how; ignoring problem by stakeholders; no local priority; no coherence	Raise HR; convince stakeholders; raise local priority	70	Realised
NGO DRUG FIELD2	Others				Achieved	Ministerial reports; statistics; more broad health promotion programmes, more funds spent, more professionals trained			75	Realised
RESEARCH1	Others				Partly	Study for Min Education: 70% of schools have program and increasing; increase nr of programs in schools; but no qualitative indicators	Lack of funding & know how; schools don't know how to use prevention programs		80-100	Not realised if effectiveness is taken into account
NDI	NDI & others	II.2.4/ II.2.7	Nr. 1B ?	School prevention and health promotion should be focused on skills development. It is necessary to have drug prevention integrated into subjects related to health promotion and life management.	Working on it	Research data show increased nr. of programmes, more funding & professionals involved; not more consumers of the programs	Lack of funding & HR Lack of know how; lack of databases & research	Raise HR; improve databases & research; improve shared understanding of drug problem	65	Realised
NGO DRUG FIELD1	EDUCATION & others				Not achieved	NGO experience; NDI report		Specify aims; improve know how; convince stakeholders		Not realised
RESEARCH1	EDUCATION & others				Not achieved	Tables on hours spent on prevention show 3-5 hrs in all. Too little; limited nr of holistic (more effective) programmes; decreasing trend; not more broad programs	Lack of funding; ignoring problem by stakeholders; no priority in local policy; attitude	Change of the rigidness in the school system	10	Not realised

EDUCATION	EDUCATION & others	II.2.6	-	School drug coordinators should be named. *A school drug co-ordinator (teacher, school psychologist, youth nurse, health educator) should be named who, owing to his/her sensitivity and qualifications in the field is assigned this task against remuneration for his/her activities.*	Partly	1700 drug coordinators & 500 mental hygienists in schools have been trained; facultative training with accreditation; percentage of schools with coordinator increased as well as the absolute number; more regulations on drug use in schools; more professionals; more funding	Ignoring problem by stakeholders, especially health Ministry	Convince stakeholders; improve inter-institutional protocols between schools & municipality	50	Realised
NDI	EDUCATION & others				Achieved	National Report on the Public Education System	N.A.	N.A.	N.A.	Realised
RESEARCH1	EDUCATION & others				Partly	Statistical reports; 50% of schools have drug coordinator; 55% of schools have a drug strategy/ regulation; no link between drug coordinator and teachers	Low status of teaching profession blocks motivation & change towards health promotion	Change attitude of school system	90; big incre ase	Realised
MYFSAEO COORD	MYFSAEO	II.3.10	Nr. 3	Organizing drug prevention training courses dealing with health promotion, which address in the problems of adolescence and youth.	Partly		Lack of funding Lack of know how	Raise funding improve know how	70	Don't know
HEALTH	HEALTH until Aug 2004; universities are autonomous				Partly	Programmes have started, but universities are in control		Convince stakeholders (universities)	50	Don't know
MYFSAEO COORD	MYFSAEO & others for developing an instrument for social policy aimed at reintegration of drug users	III.2.6	Nr. 8	The number of criminal acts committed by drug abusers should be reduced. Different kinds of social policy can be used in order to reach this objective. *e.g. protected accommodation and jobs, day-care reintegration programs, etc,)*	Partly	Instrument was developed in 2004	Lack of funding & HR (civil servants); Lack of know how	Raise funding & HR; Improve know how	50	realised
HEALTH2	HEALTH & others				Partly	Reports, conferences	Lack of funding Lack of HR (civil servants) Lack of know how	Raise funding & HR; Improve know how	50	Don't know
JUSTICE/ PRISON	JUSTICE & others				Partly	Impression	Lack of funding & HR; lack of know how	Raise funding & HR; improve know-how	N.A.	N.A.

HEALTH2	HEALTH	III.2.2	Nr. 12 A-F	Increasing the number of drug abusers participating in a helping relationship (from taking up contact through treatment to re-socialisation).	Achieved	Statistics (higher nr. of users/ professionals, more funding), reports, conferences, other publications	Lack of funding Lack of HR (civil servants) Lack of know how	Raise funding & HR; Improve know how	80	Realised
NGO DRUG FIELD1	Others				Not achieved	Grass root level experiences; not more users in helping relationship, not more professionals, not more funding	Lack of funding; lack of know how; lack of databases & research; no inter-institutional protocols (between services)	Raise funding; improve know how; improve databases & research	20	Not realised
MYFSAEO COORD	MYFSAEO & others	III.3.14	Nr. 12F	Programs for high-risk or special populations. E.g. long-term care for those struggling with other psychiatric problems (dual diagnosis, co-morbidity), medical care for HIV+ and AIDS patients, hepatitis carrying drug users, creation and expansion of special programmes for pregnant women and drug-dependent infants.	Partly	Programs were developed	Lack of funding Lack of databases and research No local priority	Raise funding; Improve databases and research; Raise priority in local policy	70	Don't know
HEALTH	HEALTH & others				Partly	Things really happened; screening bus; programme for sex workers; drug counselling & syringe exchange; calls for proposals; local programmes	Lack of funding Not priority among all stakeholders for this type of programme	Raise funding; Convince stakeholders	50	Don't know
HEALTH2	HEALTH & others				Achieved	National Public Health programme adopted incl. HR; reports, statistics (increase nr. programs for at risk groups; professionals; more funding)	Lack of funding	Raise funding	90	realised
JUSTICE / PRISON	PRISON & others				Partly	Research of MYFSAEO shows results; there are special juveniles in prison programs; questionable separation of high-risk prisoners in hospital wards; **dangerous situations** regarding blood donations & lack of HIV/ AIDS screening in prisons	Lack of funding & HR; Lack of know how	Raise funding & HR; Improve know how	65	Depends on success of National Drug Strategy
NGO DRUG FIELD	Others				Not achieved	Reports from national & local treatment centres; not more programs; not more professionals; not more funding; no access to HIV	Lack of funding, HR, know-how, databases & research; ignoring problem by stakeholders, no national & no local priority	Raise funding; convince stakeholders; raise national priority	0-10	Not realised

						testing!				
HEALTH 2	HEALTH & others	III.3.25	Nr. 11	Training and further training courses should be developed and put in place for psychiatrists, addictologists, child psychiatrists and psychologists, clinical and prevention psychologists, addictological consultants and assistants, graduate nurses and other relevant professionals.	Partly	Continuous process; newly developed trainings for psychologists; social workers	Lack of funding & HR; Lack of know how	Raise funding & HR; Improve know how	30	Don't know
JUSTICE / PRISON	PRISON & others				Partly	Applies to prison officers, social workers & counsellors; internal reports of prison program; more trainings available, training more staff; more funding available	Lack of funding & HR; Lack of know how	Raise funding & HR; Improve know how	90	realised
CIVIL NGO4	Others				Partly/ Working on it	Medical & psychological staff is prejudiced towards drug users; trainings have not changed that; people are not in touch with drug users; more people trained, though	Ignoring problem by stakeholders	Raise HR	60	Not realised if prejudice does not change and perceptio n about drug users remains very negative;
INTERIOR	INTERIOR & others	IV.2.10	-	The security of places of entertainment and other areas infected by drugs should be improved.	Not achieved	Some improvement but no real support; unclear aim Police regulations for private clubs; lack of data about drug accidents; not enough inspectors; more funding	Unspecific aim Lack of funding (also from business) No local priority	Specify aim; Raise funding; Convince stakeholders; Raise local priority; Raise national priority	20	Not realised
NATIONAL POLICE	POLICE & others				Partly	Is impression, no written sources; more checks by police; more local (by-)laws; less accidents; not more professionals/ inspectors; not enough funding	Lack of funding & HR	Raise funding & HR; improve know how	60	Not realised
NDI	INTERIOR & others				Not achieved	Annual reports of the Local Coordination Forums (KEF); no reports about functioning available	Lack of HR; lack of know how; ignoring problem by stakeholders; lack of coordination	Raise HR & improve know how; improve coordination	30	Not realised

NGO DRUG FIELD1	Others				Not achieved	NGO experience		Convince stakeholders; raise local priority; fight corruption		Not realised
INTERIOR	INTERIOR & others	IV.2.6	-	Combating trafficking and dealers' networks should be reinforced.	Achieved	Problematic indicators. Concerns better organisation. Unification of police services (e.g. narcotics)	Lack of funding & HR; Lack of supporting data	Raise funding; Raise HR; Improve databases; Convince stakeholders	60	Not realised
NATIONAL POLICE	POLICE & others				Partly	ERÜBS database; police statistics; more arrests for drug offences; more prosecuted traffickers & dealers; not enough police narcotic specialists; more funding (both salaries & operational means)	Lack of funding & HR	Specify aim (make more operational); raise funding & HR; improve know how; improve databases; convince stakeholders	50	Let's be optimistic
COURT	POLICE & others				Partly	Overall improved performance; statistics and number of cases do not say anything; but more trained investigators; better quality intelligence	N.A.	N.A.	60	N.A.
CUSTOMS & BORDER POLICE (VPOP)	VPOP & others				Partly	Better collaboration with police; Statistical reports; ERUBS; operational practice; seizures do not say a lot	Lack of funding & HR; International collaboration	Raise funding & HR; increase international collaboration	70	Realised
RESEARCH2	Others				Not achieved	Aim will not be achieved, but objective can. More arrests, but not more prosecuted offenders; not more specialists in trafficking; more funding	Wrong aim; can never be reached satisfactory		60	Realised
NATIONAL POLICE	POLICE & VPOP	IV.2.1	Nr. 15B Nr. 16	It is necessary to reinforce the protection of Hungary's borders against incoming and transit drugs. A reduction in internal drug production and manufacturing and more intensive control of legal manufacturing should be achieved.	Working on it	Internal reports VPOP show success; increase in round up drug production facilities; not enough police specialists; not enough funding due to general budget cuts	Lack of funding	Raise funding	50	Realised
INTERIOR	INTERIOR & others	IV.2.8	-	The number of violent and anti-property criminal acts related to drugs should show a declining tendency.	Don't know	No good data collection; link between criminal acts and drug related crime (2% of total) is unreliable	N.A.	Specify aim; Convince stakeholders; Raise local priority; Raise national priority	?	Don't know
NATIONAL POLICE	POLICE & Others				Not achieved	Drug related crime is not registered as a separate item, so it is not measured; police is	Unspecified aim Lack of databases and research	Specify aim; raise funding	10	Not realised

						only involved in offences of over FT 20.000; there is no separate registration of drug-related crimes, arrested drug related suspects, prosecuted drug related offenders	No priority in national policy			
COURT	POLICE & others				Not achieved	Number of drug related crimes have increased (those that appear before court as such); good statistics are not available; no database combining data collections; drug related crime is registered if main offence!!	N.A.	More effective Court System is required; Every chain has to cooperate; Criminal Law reform not enough emphasised in Strategy	20	Realised; positive tendency
RESEARCH2	Others				Not achieved	Crime statistics; NIC research among young prisoners; Not more registered drug related crime;	Lack of funding & HR; lack of know how	Raise funding & HR; improve know how	20	Not realised
INTERIOR	INTERIOR & others	IV.2.14	Nr. 15A	Drug-related training should be improved and made general for the internal organisations so that the staff is prepared for solving problems arising in the course of their practical work. The conditions for the EU-compliant operation of policing agencies will have to be established.	Achieved	New programmes established; more training programs delivered training more professionals; more funding	Lack of funding & HR; Ignoring problem by stakeholders	Raise funding; Raise HR; Raise nation priority	55	Realised up to 80
NATIONAL POLICE	POLICE & Others				Not achieved	No continuous training programme at police academy; no initiatives, not even tried despite requests from the operational level; more training courses established, but not in basic training police officers; not enough professionals trained, not enough funding	Lack of funding; No inter-institutional protocols; no national priority	Convince stakeholders; improve inter-institutional protocols; raise national policy	25	Realised
JUSTICE / PRISON	PRISON & others				Partly	Applies to prison officers, social workers & counsellors; internal reports of prison program; more trainings available, training more staff; more funding available; more drug hounds	Lack of funding & HR; Lack of know how	Raise funding & HR; Improve know how	90	Realised
JUSTICE /	Others	I.1.1.D	-	Reintegration of drug	Partly	Participants to reintegration	Lack of funding & HR;	Raise funding & HR;	N.A.	N.A.

PRISON				users released from penitentiaries into the community with the support of a wide-ranging network of institutions in co-operation with the organisations of health and welfare care.		efforts: Prison service, probation officers and local government	Lack of know how	Improve know how		
RESEARCH2	RESEARCH	II.3.1	Nr. 1B	Surveys concerning the prevalence of drug use among the young and its monitoring according to the standard ESPAD methodology. These research projects will be coordinated and supervised by the Drug Research Council to be set up within the framework of the Co-ordination Committee.	Achieved	Surveys carried out			100	Realised
MYFSAEO COORD	MYFSAEO	II.2.1	Nr. 2	Operational health promotion programs including drug prevention in all the settings where the young grow up. *(Family, public education, higher education, supplementary educational systems, leisure-time and other communal activities, sports, church life).*	Partly	Programs are more available; promoted through grant scheme and Phare	Lack of funding	Raise funding	50	Don't know
MYFSAEO COORD	MYFSAEO delegated to NDI	II.3.4	-	The execution of research projects and the evaluation, adaptation and the effectiveness analyses of the appropriate programs are priority tasks.	Partly	N.A.	N.A.	N.A.	N.A.	N.A.
EDUCATION	EDUCATION	II.3.3	-	Development of a system for financially supporting the prevention programmes organised for the young in public education, available for schools.	Partly	Grant scheme is inadequate even though schools get most funding; Is not structural; new system was proposed but due to a budget crisis it was withdrawn by Education Ministry itself	Lack of funding No national priority	Raise funding; Raise national priority	55	Don't know
JUSTICE /	PRISON	III.3.15	-	Expansion of health care	Partly	Internal reporting system	Lack of funding	Raise funding	35	Realised

PRISON	& others			units within penitentiaries and establishment of special withdrawal, therapeutic and after care programs.		penitentiary service				(hope-fully)
NGO DRUG FIELD3	HEALTH & other	III.2.5	Nr. 12B Nr. 12F	The appearance of HIV (AIDS) and the spreading of hepatitis (primarily hepatitis C) must be prevented among intravenous drug users.	Not achieved	Report Ministry of Health; not enough HIV testing for IDU; not enough testing facilities; not enough needle exchange programs; not enough outreach programs	Lack of funding & HR; lack of know how; ignoring of problem by stakeholders; no national priority	Improve know how; convince stakeholders; raise national priority	0	Not realised
VPOP	VPOP & others	IV.2.1	16	It is necessary to reinforce the protection of Hungary's borders against incoming and transit drugs. A reduction in internal drug production and manufacturing and more intensive control of legal manufacturing should be achieved.	Partly	Specialised teams established; from 1/5/04 mobile teams at EU international border; more mobile units at external borders; more investigated cases; more technical equipment; more training; better international cooperation	Lack of funding & HR; insufficient technical support	Raise HR; improve know how; improve int cooperation and criminal intelligence	80	Realised

Annex 6 List of objectives of the National Drug Strategy

The timeframe	The number of the objective	The objective in English
	I. 6.1	**COMMUNITY, COOPERATION Society should become sensitive to the efficient management of the drug issue and local communities should improve their problem-solving capabilities in countering the drug problem.**
I. 1. Long Term Objectives 6. 1. 3.	I. 1. 1.	The development of functioning communities sensitive to the management of the drug problem. In the interest of this the following objectives should be implemented:
LTO	I. 1. 1. A.	Raising the awareness of families to enable them to recognise and manage drug problems.
LTO	I. 1. 1. B.	Development of workplace drug policies, and extension of the drug-free workplace program.
LTO	I. 1. 1. C.	Increasing drug-free entertainment opportunities including the increasing number of safe places of entertainment.
LTO	I. 1. 1. D.	Reintegration of drug users released from penitentiaries into the community with the support of a wide-ranging network of institutions in co-operation with the organisations of health and welfare care.
LTO	I. 1. 1. E.	In the area of caring for the homeless, improving the chance for reintegration by providing supportive care, the management of harm and by including the elements of resocialisation.
LTO	I. 1. 2.	The different characteristics, opportunities and varying resources of local communities necessitate the development of local strategies. The most important organising elements of the drug strategies expressing local characteristics include the followings:
LTO	I. 1. 2. A.	Building up a system of local Co-ordination Forums on Drug Affairs (at city, county and regional levels).
LTO	I. 1. 2. B.	Adaptation of European programs. There are a number of European programs concerning community development, the local management of drug problems or the operation of Local Co-ordination Forums on Drug Affairs which, when adapted in Hungary, could facilitate the implementation of local co-operation.
LTO	I. 1. 3.	Reorganisation of data collection and research. True and fair information means adequate knowledge from the following fields:
LTO	I. 1. 3. A.	(Assessment of/Mapping) the drug scene and the changes therein.
LTO	I. 1. 3. B.	(Mapping the) possible ways of solution and the conditions of their employment and success (e.g. communal prevention, community helping services and the possibility and success of law enforcement)
LTO	I. 1. 3. C.	Indexes developed with the help of proven EU conform, unified indicators.
LTO	I. 1. 3. D.	About the joint efforts and experiences of the European and the international community with respect to the management of the drug problem.
I. 2. Mid-term objectives 6. 1. 4.	I. 2. 1.	Collection of domestic data useful for the community, making international databases accessible.
MTO	I. 2. 2.	Supporting the establishment of drug-free programs and settings: with respect to the local community, the school, the workplace and

		places of entertainment.
MTO	I. 2. 3.	Decreasing the number of disco accidents, by increasing the checks on public roads.
MTO	I. 2. 4.	The establishment and operation of local institutional functional units in order to implement the National Strategy due to the local requirements (county Coordination Forums on Drug Affairs with adequate powers).
MTO	I. 2. 5.	International recommendations and methods developed by various professional organisations (both Hungarian and international) and national authorities.
MTO	I. 2. 6.	Relapse prevention for drug users released from penitentiaries by making available re-socialisation, aftercare programs in adequate quantity and at the appropriate standard (LD VERSION).
MTO	I. 2. 7.	A welfare support system should be developed for cured ex-drug addicts' and for those who are released from penitentiaries or are participating in maintenance treatment. Under welfare targeted programs, accommodation should be provided for them so that they are able to develop and maintain a drug-free lifestyle.
I. 3. Short term objectives 6. 1. 5.	I. 3. 1.	Initiation of communal epidemiological research projects, and their publication, while improving the efficiency of the reporting system.
STO	I. 3. 2.	Administrative steps: establishment of the local Coordination Forums on Drug Affairs, and ensuring their legal and administrative conditions, co-ordination of the work of these committees and assistance to them through the collaboration of the organisational units of the CCDA.
STO	I. 3. 3.	Analysis of the legal environment and making the necessary amendments.
STO	I. 3. 4.	Adjustment to the international environment. This primarily means making the documents of the European Union and the specialised international organisations (UNDCP, WHO) concerning the local community management of drug problems accessible and, when it is needed provide the proper training.
STO	I. 3. 5.	Developing the quantity and the quality of trainings (local drug coordinators & workplace drug experts).
STO	I. 3. 6.	Survey and assessment of those institutions, which are dealing with abusers or youngsters endangered by drug abuse.
STO	**I. 3. 7.**	Establishing local prevention services: establishment of a wide spectrum of leisure-time facilities, which take precedence over (or replace) drug use: drug-free clubs and discotheques, institutions enabling both entertainment and assistance, sports events at night, coping with loafing and street kids.
STO	I. 3. 8.	Facilitation of the operation of local community settings**.**
STO	I. 3. 9.	Creating local forms of checks (e.g. drugs & driving, licensing procedures, etc.).
STO	I. 3. 10.	It is necessary to develop reintegration programs for drug abusers released from penitentiaries**.**
STO	I. 3. 11.	Adjusting to the international environment, promoting international relations. The establishment of the Focal Point - has an outstanding role-, which is the institution for cooperation between Hungary and the European Union.
	II. 6.2	**PREVENTION** **Creation of opportunities to enable the young to develop a productive lifestyle and to reject drugs.**
II. 1. Long Term Objectives 6. 2.	II. 1. 1.	Stop the spreading of drug abuse in the following areas:

3. 1.		
LTO	II. 1. 1. A.	Decreasing the increasing rate of drug abusers and reverse the currently rising tendency.
LTO	II. 1. 1. B.	Decreasing the number of experimental drug users.
LTO	II. 1. 1. C.	The age of the first use of drugs is declining. This tendency has to be stopped and reversed.
LTO	II. 1. 2.	The use of drugs should not be a culturally accepted behaviour among the young.
LTO	II. 1. 3.	The healthy, drug-free lifestyle should become attractive.
LTO	II. 1. 4.	Development of a school health strategy.
II. 2. Mid-term objectives 6. 2. 3. 2.	**II. 2. 1.**	Operational health promotion programs including drug prevention in all the settings where the young grow up. *(Family, public education, higher education, supplementary educational systems, leisure-time and other communal activities, sports, church life).*
MTO	II. 2. 2.	The health promotion programs containing drug prevention modules should cover as wide a range of the Hungarian youth as possible.
MTO	II. 2. 3.	The knowledge of the young about drugs and the consequences of the abuse should be improved. Just as their negative (rejecting) attitude to drugs.
MTO	II. 2. 4.	School prevention and health promotion should be focused on skills development.
MTO	II. 2. 5.	Ensuring financial support for systematic prevention programmes organised for the young in public education, available to schools.
MTO	II. 2. 6.	School drug coordinators should be named. *A school drug co-ordinator (teacher, school psychologist, youth nurse, health educator) should be named who, owing to his/her sensitivity and qualifications in the field is assigned this task against remuneration for his/her activities.*
MTO	II. 2. 7.	It is necessary to have drug prevention integrated into subjects related to health promotion and life management.
MTO	II. 2. 8.	Prevention should be professionally and adequately represented in the local Coordination Forums on Drug Affairs.
MTO	II. 2. 9.	Based on the Drug Strategy of the Hungarian Army, it is necessary to recognise and realise the possibilities of preventive work within the framework of the army to reduce the number of those affected by drugs performing their military service….
MTO	II. 2. 10.	Providing the conditions for the prevention work for those who work on this field. It is important to support the peer supporters in transmitting credible information.
MTO	II. 2. 11.	The opportunities provided by the informational society should be used. Mainly by the existing major systems (Sulinet, TeleCottage, MultiCenter) and also by developing new databases or forums (CD-ROMs, chat forums).
MTO	II. 2. 12.	Creating such youth-, education- and social-policy which is sensitive to the young's problems. *They improve the social, educational and labour market position of the young, helping those groups being driven towards marginalisation*
II. 3. Short term objectives 6. 2. 3. 3.	II. 3. 1.	Surveys concerning the prevalence of drug use among the young and its monitoring according to the standard ESPAD methodology. These research projects will be coordinated and supervised by the Drug Research Council to be set up within the framework of the Co-ordination Committee.
STO	II. 3. 2.	Making surveys on the prevalence and effectiveness of prevention programs.
STO	II. 3. 3.	Development of a system for financially supporting the prevention programmes organised for the young in public education, available for schools.
STO	II. 3. 4.	The execution of research projects and the evaluation, adaptation and the effectiveness analyses of the appropriate programs are priority tasks.

STO	II. 3. 5.	Uniformed quality assurance and accreditation for prevention programs based on the criteria of the departments concerned. This process would be supported by the setting up the Health Promotion and Drug Prevention Accreditation Committee.
STO	II. 3. 6.	Use and access to international experiences and the adaptation of foreign curricula.
STO	II. 3. 7.	Development of the framework of organisation and coordination: Coordination Committee on Drug Affairs- prevention team. Co-ordination Forums on Drug Affairs – representation of those working in the prevention on the local fields.
STO	II. 3. 8.	Reinforcement of local community initiatives on the following fields: Working out the principles of the financing. Supporting community programs. Developing special programs for the young at risk. Supporting (drug) alternative leisure-time and sports programs.
STO	II. 3. 9.	Supporting publications with information, media events, helping phone line services.
STO	II. 3. 10.	Organizing drug prevention training courses dealing with health promotion, which address in the problems of adolescence and youth.
	III. 6.3	**SOCIAL WORK, TREATMENT, REHABILITATION** **Helping individuals and families having come into contact with drugs and struggling with drug problems**
III. 1. Long term objectives. 6. 3. 4. 1.	III. 1. 1.	To stop and reverse the rise of the number of those struggling with drug problems.
LTO	III. 1. 2.	Reduction of the social and health harms and damage caused by drug use.
LTO	III. 1. 3.	Improvement in the availability, receptivity and effectiveness of health and social care in the treatment of drug problems (drug users and members of their families)—the building up of the full continuum of care with an adequate capacity.
LTO	III. 1. 4.	The development of the social care of addicts’**,** state subsidisation of more differentiated institutional care is a top priority.
III. 2. Mid-term Objectives 6. 3. 4. 2.	III. 2. 1.	An improvement must be achieved in the social and professional acceptance of the medical treatment of drug users.
MTO	III. 2. 2.	Increasing the number of drug abusers participating in a helping relationship (from taking up contact through treatment to re-socialisation).
MTO	III. 2. 3.	Development of the so-called “continuum of help” with respect to the following indicators: capacity, accessibility, effectiveness, differentiation, complex bio-psycho-social approach, multidisciplinary treatment staff, community approach.
MTO	III. 2. 3. A.	Capacity
MTO	III. 2. 3. B.	The accessibility of those treatment places, which are easy to access, free of stigmatisation, and can provide the early stages of the treatment.
MTO	III. 2. 3. C.	The effectiveness of the treatment in complex bio-psycho-social view.
MTO	III. 2. 3. D.	Differentiation: the forms of intervention must be identified and applied, which match the best severity and type of the given

		condition.
MTO	III. 2. 3. E.	Complex bio-psycho-social approach.
MTO	III. 2. 3. F.	Multidisciplinary treatment staff.
MTO	III. 2. 3. G.	Community approach.
MTO	III. 2. 4.	Cooperation between health and social care must...
MTO	III. 2. 5.	The appearance of HIV (AIDS) and the spreading of hepatitis (primarily hepatitis C) must be prevented among intravenous drug users.
MTO	III. 2. 6.	The number of criminal acts committed by drug abusers should be reduced. Different kinds of social policy can be used in order to reach this objective. *e.g. protected accommodation and jobs, day-care reintegration programs, etc,)*
MTO	III. 2. 7.	The magnitude of drug abuse among the homeless should be reduced and proper care for the health-harm should be guaranteed in all areas of the institutions dealing with the homeless.
MTO	III. 2. 8.	Health harm and risk related to drug use should be reduced.
MTO	III. 2. 9.	Quality assurance and evaluation for health care and social (state, municipal and voluntary) institutions dealing with drug users should be developed and applied.
MTO	III. 2. 10.	Development of quality control for the voluntary organisations dealing with the rehabilitation of drug users or with certain elements of rehabilitation.
MTO	III. 2. 11.	The principles of financing should be reconsidered: Besides the National Health Insurance Fund, other sources should be involved.
MTO	III. 2. 12.	Setting up the local Coordination Forums on Drug Affairs. Here we are emphasizing their tasks related to treatment and rehabilitation.
MTO	III. 2. 13.	A wide range of professional further training courses (accredited courses when needed, for instance in the training of specialised physicians, credit-giving courses) must be realised.
MTO	III. 2. 14.	Special blocs should be introduced into undergraduate education (of physicians, psychologists, social workers, nurses, and higher-level nurses) about the drug problem and the treatment of drug problems.
MTO	III. 2. 15.	Scientific research and the feedback of these findings. Adequate funding and prioritised funding tender facilities are needed
III. 3. Short term objectives 6. 3. 4. 3.	III. 3.	Increase the treatment capacity of institutions of therapy and rehabilitation operated by the state, municipalities, voluntary and church organisations. The following treatment options, facilities are mostly welcomed:
STO	III. 3. 1.	Outreach programs.
STO	III. 3. 2.	Low-threshold services, harm reduction programs on the following fields:
STO	A.	Substitutive treatment (Methadone, Buprenorphine, LAAM). In the short term, the establishment and operation of at least one maintenance treatment centre per region is called for

STO	B.	The establishment and operation of at least one consultation centre per county is called for.
STO	III. 3. 3.	The establishment and operation of at least one drug outpatient clinic per county is called for. I.e.: drug outpatient clinics, TAMASZ centre for care service.
STO	III. 3. 4.	Providing medication (Naltrexone), which maintains substance-free life for opiate users, subsidised by the National Health Insurance Fund, supplemented with appropriate forms of psychological and social care.
STO	III. 3. 5.	The recognition of emergency conditions by the expert or layman meeting an intoxicated drug user, and providing sufficient care.
STO	III. 3. 6.	Extending the impatient treatment by establishing detoxification and addictology ward per region. Besides -as a model experiment- the establishment of an addictology ward independent of traditional hospital structures.
STO	III. 3. 7.	Day hospitals for people struggling with severe drug problems.
STO	III. 3. 8.	Establishing institutions of long-term therapy, therapeutic communities. In short term the beds should be increased by about 200 beds.
STO	III. 3. 9.	Improving the rehabilitation and resocialization capacity.
STO	III. 3. 10.	Organizing community programs in which ex drug abusers and their relatives are taking part. With this the initiation of the self initiated self-help groups could be realized.
STO	III. 3. 11.	Creating protected jobs in order to support the occupational re-socialisation.
STO	III. 3. 12.	Organizing post gradual training on drugs for general practitioners (family doctors).
STO	III. 3. 13.	It is necessary to establish child addictology wards according to the regional needs, to financially and professionally reinforce the child psychiatric system and, over the long-term, therapeutic institutions, the possibility for treating teenagers and adolescents will have to be guaranteed through amending legal regulations in force.
STO	III. 3. 14.	Programs for high-risk or special populations. E.g. long-term care for those struggling with other psychiatric problems (dual diagnosis, co-morbidity), medical care for HIV+ and AIDS patients, hepatitis carrying drug users, creation and expansion of special programmes for pregnant women and drug-dependent infants.
STO	III. 3. 15.	Expansion of health care units within penitentiaries and establishment of special withdrawal, therapeutic and after care programs.
STO	III. 3. 16.	Specialised healthcare for those drug abusers, who are under preliminary arrest, living in correctional institutions and under the supervision of probation officers, must also be ensured.
STO	III. 3. 17.	Improving the financial principals of the treatment of drug abusers and addicts.
STO	III. 3. 18.	Data protection. Appoint data protection officers and training them at places of treatment.
STO	III. 3. 19.	Records, statistical systems are needed to record the minimum data on the individual clients in a uniform approach adjusted to EU standards. In this way a more reliable picture can be gained on the number and composition of drug patients entering treatment and the changes therein.
STO	III. 3. 20.	Improving the collaboration between those subcommittees of the Coordination Committee on Drug Affairs which are involved in therapy. And ensuring the interdepartmental collaboration.
STO	III. 3. 21.	Establishing Local Coordination Forums on Drug Affairs and creating the local therapeutic coordination criteria.
STO	III. 3. 22.	Continuing the development of guidelines by professional colleges with respect to therapeutic protocols.
STO	III. 3. 23.	Development and aggregation of accreditation criteria – commencement of accreditation: accreditation of places of treatment and treatment programs based on professional criteria with the collaboration of the State Public Health Service.

STO	III. 3. 24.	Developing educational programs and ensuring their financing.
STO	III. 3. 25.	Training and further training courses should be developed and put in place for psychiatrists, addictologists, child psychiatrists and psychologists, clinical and prevention psychologists, addictological consultants and assistants, graduate nurses and other relevant professionals.
STO	III. 3. 26.	It is necessary to reinforce the independent addictological profession within psychiatry and it is suggested to set up an independent College of the Addictology Profession.
	IV. 6. 4.	**SUPPLY REDUCTION** **To reduce the possibility of access to drugs.**
IV. 1. Long term objectives 6. 4. 4. 1.	IV. 1. 1.	Access to illegal drugs and other substance abuse must be reduced.
LTO	IV. 1. 2.	Cross-border illegal trafficking of drugs and psychotropic substances should be reduced and control of legal substances and their precursors be increased.
LTO	IV. 1. 3.	Production of illegal substances within the country should be reduced and domestic production of legal drugs and their precursors should be placed under even more intensive control.
LTO	IV. 1. 4.	Domestic distribution of illegal substances should be reduced and the number optional places for drug dealing should be reduced.
LTO	IV. 1. 5.	The number of drug infected places should be reduced or eliminated if possible.
LTO	IV. 1. 6.	The possibility of drafting a unified anti-drug law should be taken into consideration, which would handle current legal regulations within a unified framework and would complement them with the legal issues related to health and social care, along with an unambiguous settlement of data protection issues and reporting obligations.
IV. Mid-term Objectives 6. 4. 4. 2.	IV. 2. 1.	It is necessary to reinforce the protection of Hungary's borders against incoming and transit drugs. A reduction in internal drug production and manufacturing and more intensive control of legal manufacturing should be achieved.
MTO	IV. 2. 2.	The effectiveness of detection by the Customs and Finance Guard should be improved and the technical, professional and staff capacities of the organisation should be increased.
MTO	IV. 2. 3.	The investigating and detecting work of the Police should be improved primarily in drug cases .related to trafficking and in cases where drug use and other crimes are interrelated.
MTO	IV. 2. 4.	By enforcing legal regulations, the illegal drug market should be successfully constrained.
MTO	IV. 2. 5.	There should be a reduction in money laundering and associated possibilities.
MTO	IV. 2. 6.	Combating trafficking and dealers' networks should be reinforced.
MTO	IV. 2. 7.	Public security should be improved by reducing access to drugs and in parallel with calling a halt to the growth in drug use.
MTO	IV. 2. 8.	The number of violent and anti-property criminal acts related to drugs should show a declining tendency.
MTO	IV. 2. 9.	The organisational and operational conditions of institutions active in supply reduction should be rendered suitable for the effective

		performance of their functions.
MTO	IV. 2. 10.	The security of places of entertainment and other areas infected by drugs should be improved.
MTO	IV. 2. 11.	Legal drugs and precursors should be placed under more intensive control.
MTO	IV. 2. 12.	Cooperation between policing, economic and health authorities should be improved.
MTO	IV. 2. 13.	It is necessary to improve international co-operation in the enforcement of drug laws and practical cooperation between law enforcement agencies against cross-border international drug crime.
MTO	IV. 2. 14.	Drug-related training should be improved and made general for the internal organisations so that the staff is prepared for solving problems arising in the course of their practical work. The conditions for the EU-compliant operation of policing agencies will have to be established.
IV. 3. Short term objectives 6. 4. 4. 3.	IV. 3. 1.	It is necessary to amend the specifications of the criminal act of drug abuse in the Penal Code.
STO	IV. 3. 2.	Performance of additional legislative tasks in the service of combating organised crime affecting primarily the area of the Penal Code.
STO	IV. 3. 3.	Reinforcing the supervision of investigations by the prosecution.
STO	IV. 3. 4.	Probation officers exercising supervision must be rendered capable of coping with their new and increased functions.
STO	IV. 3. 5.	It is necessary to improve the detecting, investigating, examining and seizure efficiency of the Police.
STO	IV. 3. 6.	Improvements should be made in the effectiveness of the detecting, investigating and seizure work of the Customs and Finance Guard.
STO	IV. 3. 7.	The cooperation between the Border Guard, and the Customs and Finance Guard has to be improved in order to detect the drug trafficking through border crossing points.
STO	IV. 3. 8.	Uniform college training within the training system of the policing agencies using a comprehensive approach to the acquisition of knowledge related to drug-related crime, the recognition of drug abuse and drug prevention.
STO	IV. 3. 9.	Facilitating the implementation of the tasks and development projects undertaken in the course of the EU accession negotiations and those the newly arising under the National Program for Taking Over the Acquis as approved by the Government (ANP).
STO	IV. 3. 10.	To ensure uniformity in the activities of forensic experts nationwide, it is necessary first and foremost to develop the criteria for establishing drug dependency by the appropriate professional bodies.
STO	IV. 3. 11.	Treatment programs should be put in place for drug user convicts in penitentiaries.
STO	IV. 3. 12.	In order to adopt international programs and provide sufficient training for experts the reinforcement of the participation in the international collaboration must be reinforced.
STO	IV. 3. 13.	A modern system for uniformed and valid data collection must be developed (reform of the Uniform Police and Prosecution Criminal Statistics/ERÜBS).
STO	IV. 3. 14.	The appropriate working groups of the Co-ordination Committee on Drug Affairs (working groups on supply reduction, laboratories, epidemiology, etc.) should represent the professional needs of this field (supply reduction)
STO	IV. 3. 15.	Organisations in charge of supply reduction tasks should be represented in the Local Co-ordination Forums on Drug Affairs.

STO	IV. 3. 16.	Legally traded drugs and psychotropic substances should be more intensively controlled and there should be genuine co-operation at departmental and local levels between policing, health and economic authorities.
STO	IV. 3. 17.	There must be some special kinds of improvements done to achieve a more intensive control of narcotics, psychotropic substances and precursors.