Trimbos
instituut

How to Strengthen the Coordination of Drug Policy Formulation and Evaluation in Hungary

Report based on the mid-term Evaluation of the Hungarian National Strategy to Combat Drugs

© 2006, Trimbos Institute

This project is funded by the MATRA Pre-Accession Projects Program of the Netherlands Ministry of Foreign Affairs and Development Cooperation.

Authors
Franz Trautmann
Maurice Gallà
André van Gageldonk

Translation
Linda Deszö

Lay-out and editing
Yvonne Borghans

© November 2005, Trimbos Institute – The Netherlands

Trimbos Institute
Netherlands Institute of Mental Health and Addiction
Unit International Affairs
P.O. Box 725
NL-3500 AS Utrecht
The Netherlands
Tel: +31.30.297.1100
Fax: +31.30.297.1111
E-mail: ftrautmann@trimbos.nl
Web: www.trimbos.nl

Table of contents

1. Introduction 4
1.1. Key aspects of the National Drug Strategy 4
1.2. Key elements of the (national) drug policy coordination structure 5
1.3. Approach 11
2. Findings on the functioning of the CCDA 12
2.1. Strong points of CCDA 12
2.2. Weak points of CCDA 12
3. Conclusions – options for adaptations for the CCDA 13
3.1. The issue of the CCDA being a too 'heavy' structure 13
3.2. The lack of decision-making power 15
3.3. The division of tasks and responsibilities 17
3.4. The management infrastructure 19
3.5. Expert input 20
3.6. Lack of transparency of policy implementation 21
4. Some observations on local drug policy coordination 21

1. Introduction

This evaluation of the Hungarian National Strategy to Combat Drugs[1] (hereinafter referred to as the National Drug Strategy) is based on an agreement of the Hungarian Coordination Committee on Drug Affairs (CCDA) 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 (MCYS), now the Ministry of Youth, Family, Social Affairs en Equal Opportunities (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 execution and follows their effectiveness.[2] This 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 Institute of 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 coordination of policy evaluation and formulation of drugs policy is strengthened.

So, 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. This report contains a discussion of options and recommendations for how to improve the coordination of drugs policy based on findings from result 1, i.e. the actual evaluation and a separate information collection (see below). Following the terms of reference of the project the focus of this report is primarily on the national coordination structure. The findings and recommendations of the actual evaluation of the National Drug Strategy can be found in a separate report.[3]

1.1. 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. The National Drug Strategy is meant to serve as a general framework for the Hungarian drug policy till 2010 defining objectives in the field of demand and supply reduction. The National Drug Strategy is divided in the following four result areas, representing important drug policy fields:

---

[1] Parliament of the Republic of Hungary (2000). National Strategy to Combat the Drug Problem. Budapest, Hungary [EN].

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

[3] Gallà, M. & A. van Gageldonk & F. Trautmann & H. Verbraeck (2006). *Evaluation of the implementation of the national strategy to combat drugs – Report of the external mid-term evaluation.* Trimbos Institute, Utrecht, The Netherlands.

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**).

In each of these areas an extensive list of short, medium and long-term objectives has been defined. The National Drug Strategy also focuses on conditions and practicalities how to realise these objectives. One of the key issues here is an outline of the coordination structure, both on national and local/regional level.

1.2. Key elements of the (national) drug policy coordination structure

According the National Drug Strategy two structures play a key role in the coordination of the Hungarian drug policy. One is, on the national level, the Coordination Committee on Drug Affairs (CCDA). On the local – and in some cases regional – level the structure of so-called local Coordination Fora on Drug Affairs (KEFs) are responsible for drug policy coordination. The establishment of an infrastructure of KEFs has been one key Action in the National Strategy. The Ministry of Children, Youth and Sport (MCYS), now the Ministry of Youth, Family, Social Affairs en Equal Opportunities (MYFSAEO), plays a key role in Hungarian drug policy as it is responsible for harmonising “the implementation of the National Drug Strategy and the governmental programmes with the concerned ministers, it participates in their execution and follows their effectiveness.”[4]

1.2.1. The Ministry of Youth, Family, Social Affairs en Equal Opportunities (MYFSAEO)

The tasks of the Minister of Children, Youth and Sports regarding the coordination of drug affairs have been stipulated in a government decree[5] from 2002. The tasks are:

- To harmonize the implementation of the National Strategy to Combat the Drug Problem and the governmental programmes with the concerned ministers, participates in their execution and follows their effectiveness;
- In cooperation 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 sectorial tasks the Minister;
- The Minister is the chairman of the Coordination Committee on Drug Affairs;
- The Minister cooperates in the harmonization of the nation-wide programmes that popularize the healthy lifestyle and prevent drug consumption;

[4] Hungarian Government (2002). *Government Decree about the remit and the competence of the Minister of Children, Youth and Sports.* 157/2002. (VII.11.). Budapest, Hungary.
[5] Ibid. .

- The Minister cooperates – relying upon the relating governmental decisions – in the implementation of the tasks concerning the provision of the drug users and drug addicts;
- The Minister cooperates with civil organizations, institutions, Churches and denominations and in the higher education centres – in cooperation 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 Children, Youth and Sports (MYS), now the Ministry of Youth, Family, Social Affairs en Equal Opportunities (MYFSAEO), and its background institute, the National Institute for Drug Prevention (NDI).

Within the Ministry of Children, Youth and Sports, 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;
- Exercises professional control over the drug co-ordination tasks of the Mobilitás and the work of the National Drug Prevention Institute;

In 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 (NDI). 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 new system of the Coordination Fora on Drug Affairs (KEFs). These KEFs operate as local coordination points in drug affairs with the participation of representatives of the local government, police, schools, medical services and NGOs.

1.2.2. The Coordination Committee on Drug Affairs (CCDA)

Several other ministries play a role in drug policy. These ministries cooperate in the framework of a Coordination Committee on Drug Affairs (CCDA), which is chaired by the MCYS / MYFSAEO. 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 Coordination Committee (*see Figure 1*). The task of the Coordination Committee on Drug Affairs has been adopted in a special Governmental Decree[6]. Its tasks are to examine the implementation of the Drugs Strategy, to coordinate the operation of individual departments and public institutions and to assist in the approximation of sectorial approaches.

By the same decree the CCDA Membership has been established. It 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.

In the National Drug Strategy the following is stated over the CCDA: "In order to implement its objectives, the Government recently regulated the framework of operation of the Coordination Committee on Drug Affairs, which thereby satisfies international and professional recommendations:

- It determined a high political level for the operation of the Coordination Committee on Drug Affairs (president: 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) enabling it thereby to directly enforce its decisions;
- To facilitate the activity of the Coordination Committee on Drug Affairs, it set up a sectoral infrastructure, which is guaranteed within the Ministry for Youth and Sports Affairs;
- It provides budgetary funds for the smooth operation of the Coordination Committee on Drug Affairs."[7]

---

[6] Hungarian Government (1998). *Government Decree on the Tasks of the Coordination Committee on Drug Affairs.* 1039/1998. (III.31.). Budapest, Hungary.
[7] National Strategy to Combat the Drug Problem (2000), p.5 [EN].

The CCDA has been set up in the late nineties "to coordinate the actions taken against the spreading of drug consumption in Hungary and its tasks should include the development of a comprehensive, coordinated and multidisciplinary national drug strategy based on a balance between demand, supply and harm reduction and the activities of local communities and voluntary organisations besides the role assumed by the state."[8] One of the tasks of the CCDA has been to develop the National Drug Strategy. After its adoption the CCDA, which meets approximately four times a year, had to control and monitor the implementation of the Drugs Strategy, to coordinate the operation of individual departments and public institutions and to assist in the approximation of sectoral approaches. The CCDA has to report annually to the Government on developments in the Hungarian drug situation and on the assessment of the implementation of the Drugs Strategy. It "will carry out the screening and efficiency examination of the strategy and the institutions implementing it every three years. It will draw up a report on its findings for the Government and Parliament. To implement this objective, the Coordination Committee will make use of the findings of the National Drug Information Centre and Methodological Institute and other scientific and research institutes."[9]

The CCDA is chaired jointly by the MYFSAEO and the Minister of Health, Social and Family Affairs (MH). The former ministry is responsible for the secretariat of the Coordination Committee. Besides the MYFSAEO several other line ministries are involved in policy formulation in this area. These ministries cooperate in the framework of a Coordination Committee on Drug Affairs (CCDA).

The CCDA has a number of subcommittees. The Decree establishing the CCDA mentioned the establishment of one of these subcommittees, 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). This Committee was changed into the Expert committee on Epidemiology. The responsible Ministries for this Expert Committee are the Ministry of Health and the Ministry of Youth, Family, Social Affairs and Equal Opportunities.

The tasks of the other Expert Committees have not been adopted in a Governmental Decree:

- **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

[8] National Strategy to Combat the Drug Problem (2000), p.30 [EN].
[9] National Strategy to Combat the Drug Problem (2000), p.36-37 [EN].

Figure 1 – Organigram of the Coordination Committee on Drug Affairs

Government of the Republic of Hungary

Coordination Committee on Drug Affairs (CCDA)
president: Minister of Youth and Sports
co-president: Minister of Health

Secretariat of CCDA:
Deputy State Secretary to the Minister of Youth and Sports

Members

MI | MH | MA | ME | MD | MJ | MYS | MFA | PMO | MEdu | MF | CNSS | MSFA

SPHS | National Police Headquarters | CFG | Supreme Court | SPPO

Committees of Experts

Legal | Epidem. | Health | Social | Supply reduction | IT | Prevention | Labor. | Local gov.

CFDA
CFDA
CFDA
CFDA
CFDA
CFDA
CFDA
CFDA
CFDA
CFDA
CFDA
CFDA

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

1.2.3. The Coordination Fora on Drug Affairs (KEFs)

On the local – and in some cases regional – level the structure of the local KEFs is responsible for drug policy coordination. In the National Drug Strategy they are mentioned as "the engine of the drug policy of the local community is the Coordination Forum on Drug Affairs, which is called to coordinate local measures and initiatives and to create a forum for the institutions 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."[10]

The establishment of an infrastructure of KEFs has been one key Action in the National Strategy. These KEFs operate as local coordination points in drug affairs with the participation of representatives of the local government and all services and organisations fulfilling tasks in the fields of demand and supply reduction, i.e. police, schools, medical services, governmental and non-governmental organisations active in drug prevention, care and treatment. According to the National Drug Strategy these KEFs have a crucial role in carrying out the National Strategy on the local level. The above mentioned Hungarian Institute of Drug Prevention (NDI), set up in 2001 under the auspices of the Ministry of Children, Youth and Sport, 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 Coordination Forums on KEFs.

According the National Drug Strategy these KEFs "with 8-10 members will collect the information related to the local drug problem, monitor changes, determine the most important risk groups, define the targets of communal prevention, the possibilities of therapy and keep record of the capacities of prevention, community development and therapy. They are to ensure availability of information concerning local services to members of the local community. Annually, they will draw up a plan on local tasks in line with the objectives of the National Strategy and, at the end of the year, draw up a report on the work done. The report will be made known to the members of the local community and forwarded to the Coordination Committee on Drug Affairs, to enable them to draw up the country report.

The KEFs will:

- explore data;
- assess the situation;
- map out the tasks to be done;
- ensure information flow;
- draw up recommendations for local public administration;
- assist in mobilising local resources;
- coordinate the activities of local agents;
- filter out overlaps;
- maximise the efficiency of service providers;
- join national programs;
- give feed-back to the local and national level."[11]

[10] National Strategy to Combat the Drug Problem (2000), p.41 [EN].
[11] National Strategy to Combat the Drug Problem (2000), p.43 [EN].

“The local Coordination Forums on drug affairs have an important role to play in the instruments of implementation. Their annual reports will be aggregated by the Coordination Secretariat subordinated to the Committee. The Secretariat will initiate or itself conduct research and data collection as prescribed in relation to monitoring (indicators and instruments of monitoring). Based on these data and interviews with key personalities in the field, it will establish the experiences of the implementation and impact of the National Strategy as well as the difficulties arising in the course of implementation. It will forward these findings to the Coordination Committee, which will attempt to cope with the problems through departmental level coordination. The Secretariat of the Coordination Committee will draw up an annual report on the implementation of the National Strategy and the changes taking place in the drug situation in Hungary and in the operation of the institutions dealing with the management of the drug problem. The Coordination Committee will discuss these findings and use them for its own report to be drawn up for the Government.

The Coordination Committee will annually assess the progress of implementing the National Strategy and will carry out the screening and efficiency examination of the strategy and the institutions implementing it every three years. It will draw up a report on its findings for the Government and Parliament.”[12]

The National Drug Prevention Institute (NDI) is the driving force behind the promotion of the establishment of the Local Coordination Forums on Drug Affairs. The NDI has contacted a large number of Municipalities, counties and regions in Hungary since it was established, resulting in the establishment of 77 KEFs by the end of 2004. 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. The KEFs have a limited budget, an unpaid KEF coordinator and no other KEF staff.

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[13].

1.3. Approach

Envisaged result 2 of the MATRA project 'Evaluation of the implementation of the National strategy to combat drugs' is strengthening the coordination of policy evaluation and formulation. To collect the information necessary for reaching this result we have done open interviews with key stakeholders (i.e. mainly representatives from the organisations involved in the CCDA) and organised a seminar to discuss the appreciation of the CCDA. Also in the data collection for result 1 (evaluation of the National Drug Strategy), especially in the interviews with national key stakeholders at national level we asked a number of questions on the functioning of the coordination structure.

Different options have been brought forward and discussed. To ensure the necessary political commitment to the project results we have informed the CCDA and other key stakeholders on a regular basis on the progress of our work on project result 2. The findings from the

[12] National Strategy to Combat the Drug Problem (2000), p.39 [EN].
[13] Ibid p.39.

information collection are the basis for this report in which different options are presented how to improve drugs policy coordination in Hungary.

2. Findings on the functioning of the CCDA

Overall the interviews and discussions with key stakeholders showed a general agreement on the – main – strong and weak points of the existing structure and functioning of the CCDA. There has been disagreement on some minor points. According to some key stakeholders, for instance, the CCDA does not meet frequently enough (4 times a year). According to others the CCDA is meeting too frequently.

2.1. Strong points of CCDA

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.

2.2. Weak points of CCDA

The following weak points were mentioned by a majority of the interviewed stakeholders:

- 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.

3. Conclusions – options for adaptations for the CCDA

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 a clear need for 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. There are at least a number of options that can be considered to make the decision-making process more effective.

3.1. The issue of the CCDA being a too 'heavy' structure

This aspect is worth to be considered more closely. The CCDA is seen by different key stakeholders 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 seen as not flexible enough for efficient policy making when developments require a timely response. At the same time all stakeholders we have spoken see clear advantages of the inclusiveness of the CCDA: all important ministries and stakeholders are represented, which contributes to effectiveness ('short lines') and facilitates information exchange between and information provision to all relevant stakeholders.

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. By this the advantage named by different key stakeholders can be maintained, i.e. that all members can be involved in discussing the relevant drug policy issues and are informed about relevant developments in the drugs (policy) field and aware of the different views represented by the organisations partaking in the CCDA. On the other hand, for setting up an organisational structure that effectively can contribute to the coordination of drug affairs 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'. 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 Dutch inter-ministerial working party to monitor the effectuation of drug policy (AWUD, 'Ambtelijke Werkgroep Uitvoering Drugsbeleid', i.e. the Official Working Party on Drug Policy Implementation) could serve as an example for this revised working structure. In the Netherlands a new government generally produces a framework program on drug policy for the coming years. Within this framework program intermediate adaptations and additions can be made based on current developments and needs. To do so the AWUD has been installed in which representatives from the Ministry of Health, Welfare and Sport, Ministry of Justice, Ministry of Interior and Kingdom Relations, Ministry of Foreign Affairs and Ministry of Finances participate. These Ministries are the core ministries in Dutch drug policy, though some drug policy issues can of course also be found within the domains of other ministries. All other ministries can participate whenever issues are put on the agenda that call for their attention. The Ministry of Health Welfare and Sport (VWS) acts as the secretariat and the National Drugs Coordinator is chairperson of the Working Group which meets once per month. The agenda of these regular meeting is based on recent findings and developments covered by monitoring and research (National Drugs Monitor and Focal Point, etc.), by the media and by questions and resolutions in the parliament. This Working Party is reporting via the involved ministries to the Parliament. Findings from the AWUD can through discussions in a Parliamentary committee result in a policy proposal or an adaptation of the framework program. For major issues policy papers are made up, sometimes in the format of a letter to the Parliament, and are sent to Parliament for discussion and proposed action. Recent examples are the so-called Cannabis letter on an integrative approach on cannabis, an Action plan on Ecstasy and a letter on an experiment with heroin treatment. These papers/letters can be seen as action plans on urgent drug policy issues.

Following this example the National Strategy in Hungary – based on a broad agreement between stakeholders – could work as a 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:

- 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. Points worth considering in a discussion about how to proceed with these sub-sommittees of the CCDA are the following:

- Are all eight themes on which expert committees have been formed (epidemiology, judicial affairs, health, social affairs, security affairs, prevention, forensic science and local authorities) important enough to legitimate a separate structural sub-committee or could the number of structural sub-committees better be reduced.
- One option to do so could be to follow the division in four tracks chosen in the EU Drug Strategy, i.e. demand reduction, supply reduction, monitoring and research, and, finally, international affairs. This could be helpful for having/keeping the Hungarian drug policy in line with the EU framework.
- As there might be urgent issues popping up which need deeper discussion and expert input an option taken into account might be to work in certain cases with ad-hoc expert committees which are disbanded after the discussion on that specific issue has been settled. This might lead to a more committed contribution / input of experts.

3.2. The lack of decision-making power

The lack of decision-making power of the CCDA has been mentioned by the majority of the key stakeholders. According to them 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.

Different options have been mentioned by the consulted key stakeholders. Giving the CCDA a decision making power, e.g. by a governmental decree, at least on certain issues, has been mentioned different times but nearly at the same time refused as an unrealistic and by principal wrong option. Giving the CCDA decision-making power would raise the issue of public administration and the structure of decision making between inter-ministerial bodies. Most of the CCDA members are not elected political officials but civil servants of public

administration. Though the governmental decree on the CCDA stipulates that the CCDA includes *full-mandated representatives* of the member organisations[14] the mandate of the participating individuals necessarily will have to be limited. The members do not have the political mandate to take genuine policy decisions as this is the privilege of the government.

This means that – as concluded by many key stakeholders – the CCDA cannot be a decision-making but – at the best – a decision-preparing body. Policy decisions are factually taken on the political level, i.e. in the parliament, by the government. The coordination of drug policy is a political, governmental responsibility, which in Hungary is – for an important part – in the hands of the MYFSAEO. 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. It might be good to specify what input has to be taken up by the CCDA (or the executive committee). Can only politics (i.e. government, Parliament/Parliamentary Committee) give input, or can also policy makers (i.e. civil servants), experts and policy executors give input? Or can even media and the general public address the CCDA? Can the CCDA (or the executive committee) itself decide whether and how to deal with input (on certain issues)? Can the CCDA (or the executive committee) act only on input from outside or on its own initiative, for instance by requesting expert's review on a certain issue?
- Where does the output go to? Is the CCDA exclusively serving the government or Parliament, e.g. by preparing policy plans, monitoring the implementation of policy plans, etc.? A clear routing of CCDA output, a procedure where certain data 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)? How has the government or the Parliament or maybe the Parliamentary Committee responsible for drug issues to deal with this input? Again a clear procedure how output of the CCDA has to be followed-up/dealt with is important. One element in this procedure could be for instance the requirement of a formal written argumentation from addressed bodies (i.e. government, Parliament, Ministries and other organisations represented in the CCDA) in case they decide not to follow-up recommendations by the CCDA.
- 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 to agreed standards and rules about the state of affairs of

[14] Hungarian Government (1998). *Government Decree on the Tasks of the Coordination Committee on Drug Affairs.* 1039/1998. (III.31.). Budapest, Hungary.

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. The latter should include issues as to whom in the organisation the representative is accountable, procedures for preparing CCDA meetings, rules for reporting and feed-back, etc. To allow the members of the CCDA to operate as mandated representatives the issues on the agenda of a CCDA meeting have to be thoroughly prepared in all member organisations so that the representatives speak for their organisation. To facilitate their mandated status the members of the CCDA should be the ones who are responsible for the coordination of drug affairs in the organisation they stand for. In case members (have to) send a replacement this person should be the vice-coordinator of drug affairs.

One point mentioned by different stakeholders in connection with the perceived lack of decision-making power of the CCDA is that the CCDA does not have a budget for the implementation of policy plans nor a say over this budget. However, this is not so much a problem, when there is general agreement that the main role of the CCDA is to facilitate drug policy coordination by – among others – preparing policy plans. Policy plans – presented to the government – should of course include a proposed budget necessary for implementing the plans and a proposal for who should be responsible for the implementation. It is then the responsibility of the government to decide on the policy plan, on the budget that should be attached to it and the Ministry responsible for implementing the plan.

The other thing is that the CCDA decides over the budget for implementing the National Drug Strategy as agreed by the Parliament. It is of vital importance to clearly define for which purposes this budget should be used, as it is not enough for financing for structural implementation of the National Drug Strategy in its current form.

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.

3.3. The division of tasks and responsibilities

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.

However, an explicit division and assignment of responsibilities and tasks is not only an important CCDA-internal issue. As it can be seen from the mid-term evaluation of the National Drug Strategy[15] for an effective policy making – covering planning, implementation, monitoring and evaluation – it is of general importance to clearly divide responsibilities – sub-territories of the drug policy field – and ascribe tasks to certain players in this policy field.

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 at present. 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:

---

[15] Gallà, M. & A. van Gageldonk & F. Trautmann & H. Verbraeck (2006). *Evaluation of the implementation of the national strategy to combat drugs – Report of the external mid-term evaluation.* Trimbos Institute, Utrecht, The Netherlands.

- 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.

Again, as already mentioned when discussing the place and responsibility of the CCDA in the policy making process, clearly distinguishing the responsibilities of the different players and defining their respective tasks is not the actual solution to the problems discussed here. It is nothing more and nothing less than creating conditions for a more effective coordination of the policy preparation work. To benefit from these conditions it is necessary that all players take their responsibilities and fulfil their tasks.

3.4. The management infrastructure

To make the management infrastructure work better a number of smaller and bigger measures can 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. Prerequisite to do this effectively is staff tasked with information provision. This could be for instance a secreriat of the (executive committee of the) CCDA, placed under the Ministerial Commissioner charged with the coordination of drug affairs.

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) deserve serious attention as they impede the CDDA to fulfil its task of facilitating drug policy coordination (by preparing policy plans and by creating conditions for / monitoring policy implementation). It is of vital importance that for instance policy plans are prepared and discussed in detail by the CCDA. Input from experts and professionals working in the field followed by debate among / commitment from the (representatives from the) CCDA member organisations are elementary stages in policy formulation. Here again, an executive committee chaired by the Ministerial Commissioner responsible for the coordination of drug affairs could play an important role. It would be their responsibility to prepare 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 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 second

factor is on the political level, for instance changes in government. About the latter there is not so much to do. It is part 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. However, there are possibilities to have an effect on the first factor. Measures in human resource management can help to a certain degree to limit this problem, 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. Such human resource management measures should be developed and implemented in a structured way by having in place general procedures and guidelines binding for one organisation as a whole. To realise this it will be necessary to not only develop such a human resource management program but also to train staff, especially management and heads of units, and to monitor and control its implementation.

3.5. Expert input

Under 3.3 (The division of tasks and responsibilities) some things have already been said about how to assure expert input necessary for taking well-founded policy decisions. A clear division (and assignment) of responsibilities and tasks between (to) the different layers of stakeholders in the field of drug policy is one of the most important things to do here. Expert input can best be realised through the sub-committees of the CCDA, taking into account what has been suggested under 3.3. 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 areas 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. A yearly presentation and discussion of the state of affairs of the drugs problem is a useful thing to do, taking the occasion of the REITOX National Report of Hungary and the EMCDDA Report but also including all other relevant monitoring and information sources. In case of noteworthy latest monitoring findings also incidental discussions in the CCDA should be scheduled using expert input.
- 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. It might be worth considering to have one or two representatives from the municipal policy makers – e.g. one mayor chosen by and thereby representing a yet to install council / association of municipalities – and one or two representatives from the local KEFs – e.g. one KEF coordinator chosen and thereby representing a yet to install council / association of KEFs – included in the CCDA structure. The first, the representative(s) of the municipal politicians, could in fact be a member of the broad CCDA. Both – municipality and KEF – representatives are included in the sub-committee on Local Affairs.

3.6. Lack of transparency of policy implementation

To tackle one key issue mentioned 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.

4. Some observations on local drug policy coordination

Though the focus of this report is primarily on the national coordination structure some general observations on features of the local drug policy coordination are made here as they have a bearing on the successful implementation of the National Drug Strategy. 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 fully acknowledged in the National Drug Strategy by defining the establishment of an infrastructure of local Coordination Fora on Drug Affairs (KEFs) as a key action in the National Strategy. Hence, when discussing how to strengthen 'the coordination of drug policy formulation and evaluation' it is reasonable to make at least remarks on features of the local coordination structure that are affecting the implementation of the National Drug Strategy. These remarks are based on the data collected for the actual evaluation of the National Drug Strategy (result 1 of the MATRA project), in which the functioning of the KEFs has been a prominent issue. An extensive discussion can be found in the report on this evaluation of the National Drug Strategy[16].

Some comments made on features of local drug policy coordination which are decisive for the functioning of KEFs have also been made on the national drug policy coordination structure:

- The KEFs have no real decision-making power necessary for genuine coordination of drug policy on the local level. As with the CCDA this has to be explained by the fact that the KEF members do not have the political mandate to take policy decisions. 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. There is no solution in the sense of giving the KEFs real decision making power. To

[16] Gallà, M. & A. van Gageldonk & F. Trautmann & H. Verbraeck (2006). *Evaluation of the implementation of the national strategy to combat drugs – Report of the external mid-term evaluation.* Trimbos Institute, Utrecht, The Netherlands.

avoid misunderstandings about the function of the KEFs and to allow them 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 (under 3.2). 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.

- At least in some KEFs 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. As with the CCDA a clear division (and assignment) of responsibilities and tasks between (to) the members of a KEF is a crucial thing to do. 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 substantial number of KEF coordinators mentioned as factor hindering the implementation of actions stipulated in the National Drug Strategy the lack of budgetary means. The budget they have is limited and meant just for running the KEF organisation but not for implementing programs. The budget for the latter should come from the locally available structural budget for demand and supply reduction programs.
- The above named three 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. This has both advantages and disadvantages. Responsibilities taken on a voluntary basis generally are based on stronger, genuine commitment than responsibilities taken by obligation.

This does not mean that there are no regulations at all. In 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*"[17]. 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*"[18]. Finally, the

---

[17] 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.

[18] Ibid. Section 8, sub 2.

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"*.

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. 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. 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.[19] 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.

[19] Gallà, M. & A. van Gageldonk & F. Trautmann & H. Verbraeck (2006). *Evaluation of the implementation of the national strategy to combat drugs – Report of the external mid-term evaluation.* Trimbos Institute, Utrecht, The Netherlands.