



REVISED FINAL VERSION

STUDENT QUESTIONNAIRE

Before you start, please read this

This questionnaire is part of an international study on alcohol, drugs and tobacco use among students your age. The survey is performed this year in more than 30 European countries. The Swedish Council for Information on Alcohol and Other Drugs, CAN, SWEDEN initiated the project, and it is supported by the Pompidou Group at the Council of Europe. This is the third study. The first one was done in 1995 and the second in 1999.

In your country the survey is done by The results will be presented in a national report as well as in an international comparison of the results from all participating countries. The report will not include any results of single classes.

Your class has been randomly selected to take part in this study. You are one out of about 2.800 students in, participating in the study.

This is an anonymous questionnaire - it does not include your name or any other information, which would identify you individually. When you have finished the questionnaire, please put it in the enclosed envelope and seal it yourself. Do not write your name on that either. Your teacher/survey administrator will collect the envelopes after completion.

If the study is to be successful, it is important that you answer each question as thoughtfully and frankly as possible. Remember your answers are totally confidential.

The study is completely voluntary. If there is any question, which you would find objectionable for any reason, just leave it blank.

This is not a test. There are no right or wrong answers. If you do not find an answer that fits exactly, mark the one that comes closest. Please, mark the appropriate answer to each question by making an "X" in the box.

We hope you will find the questionnaire interesting. If you have a question, please raise your hand and your teacher/survey administrator will assist you.

Thank you in advance for your participation.

BEFORE BEGINNING BE SURE TO READ THE INSTRUCTIONS ON THE COVER.
Please mark your answer to each question by making an "X" in the appropriate box.

The first questions ask for some background information about yourself and the kinds of things you might do.

1. **What is your sex?**

- 1 Male
2 Female

2. **When were you born?**

Year 19

3. **How often (if at all) do you do each of the following?**

Mark one box for each line.

	Never	A few times a year	Once or twice a month	At least once a week	Almost every day
a) Ride around on a moped or motorcycle just for fun.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Play computer games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Use the Internet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Actively participate in sports, athletics or exercising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Read books for enjoyment (do not count schoolbooks)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Go out in the evening (to a disco, cafe, party etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Other hobbies (play an instrument, sing, draw, write etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Play on slot machines (the kind in which you may win money)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5

4. **During the LAST 30 DAYS how many whole days of school have you missed?**

Mark one box for each line.

	None	1 day	2 days	3-4 days	5-6 days	7 days or more
a) Because of illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Because you skipped or "cut"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) For other reasons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5	6

5. **Which of the following best describes your average grade in the end of the last term?**

- 1 A (93-100)
2 A- (90-92)
3 B+ (87-89)
4 B (83-86)
5 B- (80-82)
6 C+ (77-79)
7 C (73-76)
8 C- (70-72)

The next major section of this questionnaire deals with cigarettes, alcohol and various other drugs. There is a lot of talk these days about these subjects, but very little accurate information. Therefore, we still have a lot to learn about the actual experiences and attitudes of people your age.

We hope that you can answer all questions, but if you find one, which you feel you cannot answer honestly, we would prefer that you leave it blank.

The following questions are about CIGARETTE SMOKING.

6. On how many occasions (if any) during your lifetime have you smoked cigarettes?

Number of occasions						
0	1-2	3-5	6-9	10-19	20-39	40 or more
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1	2	3	4	5	6	7

7. How frequently have you smoked cigarettes during the LAST 30 DAYS?

1 Not at all

2 Less than 1 cigarette per week

3 Less than 1 cigarette per day

4 1-5 cigarettes per day

5 6-10 cigarettes per day

6 11-20 cigarettes per day

7 More than 20 cigarettes per day

The next questions are about ALCOHOLIC BEVERAGES – including beer, wine and spirits.

8. On how many occasions (if any) have you had any alcoholic beverage to drink?

Mark one box for each line.

	Number of occasions						
	0	1-2	3-5	6-9	10-19	20-39	40 or more
a) In your lifetime.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) During the last 12 months.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) During the last 30 days.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5	6	7

9. Think back over the LAST 30 DAYS. On how many occasions (if any) have you had any of the following to drink?

Mark one box for each line.

	Number of occasions						
	0	1-2	3-5	6-9	10-19	20-39	40 or more
a) Beer (do not include low alcohol beer).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Wine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Spirits (whisky, cognac, shot drinks etc) (also include spirits mixed with soft drinks)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5	6	7

10. The last time you had an alcoholic drink, did you drink any beer/lager/stout? If so, how much? (Do not include low alcohol beer).

- 1 I never drink beer
- 2 I did not drink beer on my last drinking occasion
- 3 Less than a regular bottle or can (<50 cl)
- 4 1-2 regular bottles or cans (50-100 cl)
- 5 3-4 regular bottles or cans (101-200 cl)
- 6 5 or more regular bottles or cans (\geq 200 cl)

11. The last time you had an alcoholic drink, did you drink any cider? If so, how much? (Do not include low alcohol cider).

- 1 I never drink cider
- 2 I did not drink cider on my last drinking occasion
- 3 Less than a regular bottle or can (<50 cl)
- 4 1-2 regular bottles or cans (50-100 cl)
- 5 3-4 regular bottles or cans (101-200 cl)
- 6 5 or more regular bottles or cans (\geq 200 cl)

12. The last time you had an alcoholic drink, did you drink any alcopop? If so, how much?

- 1 I never drink alcopops
- 2 I did not drink alcopops on my last drinking occasion
- 3 Less than a regular bottle or can (<50 cl)
- 4 1-2 regular bottles or cans (50-100 cl)
- 5 3-4 regular bottles or cans (101-200 cl)
- 6 5 or more regular bottles or cans (\geq 200 cl)

13. The last time you had an alcoholic drink, did you drink any wine? If so, how much?

- 1 I never drink wine
- 2 I did not drink wine on my last drinking occasion
- 3 Less than a glass (<15 cl)
- 4 1-2 glasses (15-30 cl)
- 5 Half a bottle (37 cl)
- 6 A bottle or more (\geq 75 cl)

14. The last time you had an alcoholic drink, did you drink any spirits? If so, how much?

- 1 I never drink spirits
- 2 I did not drink spirits on my last drinking occasion
- 3 Less than a drink (<5 cl)
- 4 1-2 drinks (5-10 cl)
- 5 3-5 drinks (11-25 cl)
- 6 6 drinks or more (\geq 30 cl)

15. Think of the last day on which you drank alcohol. Where were you when you drank?

Mark all that apply.

- I never drink alcohol
- At home
- At someone else's home
- Out on the street, in a park, beach or other open area
- At a bar or a pub
- In a disco
- In a restaurant
- Other places (please describe)

16. Think back over the LAST 30 DAYS. How many times (if any) have you bought beer, wine or spirits in a store (grocery store, liquor store, kiosk or gas station) for your own consumption?

Mark one box for each line.

	Number of occasions						
	0	1-2	3-5	6-9	10-19	20-39	40 or more
a) Beer (do not include low alcohol beer).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Wine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Spirits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5	6	7

17. Think back once more over the LAST 30 DAYS. How many times (if any) have you had five or more drinks in a row? (A "drink" is a glass of wine (ca 15 cl), a bottle or can of beer (ca 50 cl), a shot glass of spirits (ca 5 cl) or a mixed drink.)

- None
- 1
- 2
- 3-5
- 6-9
- 10 or more times

18. How likely is it that each of the following things would happen to you personally, if you drink alcohol?

Mark one box for each line.

	Very likely	Likely	Unsure	Unlikely	Very unlikely
a) Feel relaxed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Get into trouble with police.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Harm my health.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Feel happy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Forget my problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Not be able to stop drinking.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Get a hangover	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Feel more friendly and outgoing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Do something I would regret	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Have a lot of fun	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Feel sick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5

19. On how many occasions (if any) have you been drunk from drinking alcoholic beverages?

Mark one box for each line.

	Number of occasions						
	0	1-2	3-5	6-9	10-19	20-39	40 or more
a) In your lifetime.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) During the last 12 months.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) During the last 30 days.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5	6	7

20. Please indicate on this scale from 1 to 10 how drunk you would say you were the last time you were drunk.

Somewhat merry only					Heavily intoxicated to the point of being unable to stand on my feet				
01	02	03	04	05	06	07	08	09	10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 <input type="checkbox"/>	I have never been drunk								

21. How many drinks do you usually need to get drunk? (A "drink" is a glass of wine (ca 15 cl), a bottle or can of beer (ca 50 cl), a shot glass of spirits (ca 5 cl) or a mixed drink.)

01 I never drink alcohol

02 I have never been drunk

03 1-2 drinks

04 3-4 drinks

05 5-6 drinks

06 7-8 drinks

07 9-10 drinks

08 11-12 drinks

09 13 drinks or more

The next questions ask about some other drugs.

22. Have you ever heard of any of the following drugs?

Mark one box for each line.

	Yes	No
a) Tranquillisers or sedatives (give names that apply)	<input type="checkbox"/>	<input type="checkbox"/>
b) Marijuana or hashish	<input type="checkbox"/>	<input type="checkbox"/>
c) LSD	<input type="checkbox"/>	<input type="checkbox"/>
d) Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>
e) Crack	<input type="checkbox"/>	<input type="checkbox"/>
f) Cocaine	<input type="checkbox"/>	<input type="checkbox"/>
g) Relewin	<input type="checkbox"/>	<input type="checkbox"/>
h) Heroin	<input type="checkbox"/>	<input type="checkbox"/>
i) Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>
j) GHB	<input type="checkbox"/>	<input type="checkbox"/>
k) Methadone.....	<input type="checkbox"/>	<input type="checkbox"/>
l) "Magic mushrooms"	<input type="checkbox"/>	<input type="checkbox"/>
	1	2

23. Have you ever wanted to try any of the drugs mentioned in question 22?

- 1 Yes
 2 No

24. On how many occasions (if any) have you used marijuana (grass, pot) or hashish (hash, hash oil)?

Mark one box for each line.

	Number of occasions						
	0	1-2	3-5	6-9	10-19	20-39	40 or more
a) In your lifetime.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) During the last 12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) During the last 30 days.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5	6	7

25. On how many occasions (if any) have you sniffed a substance (glue, aerosols etc) to get high?

Mark one box for each line.

	Number of occasions						
	0	1-2	3-5	6-9	10-19	20-39	40 or more
a) In your lifetime.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) During the last 12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) During the last 30 days.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5	6	7

Tranquillisers and sedatives, like (give examples that are appropriate) are sometimes prescribed by doctors to help people to calm down, get to sleep or to relax. Pharmacies are not supposed to sell them without a prescription.

26. Have you ever taken tranquillisers or sedatives because a doctor told you to take them?

- 1 No, never
 2 Yes, but for less than 3 weeks
 3 Yes, for 3 weeks or more

27. Have you ever used any of the following drugs?

Mark one or more boxes for each line.

	No	Yes, during the last 30 days	Yes, during the last 12 months	Yes, during lifetime
a) Tranquillisers or sedatives (without a doctor's prescription).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) LSD or some other hallucinogens.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Crack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Relewin.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) "Magic mushrooms"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) GHB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Drugs by injection with a needle (like heroin, cocaine, amphetamine).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Alcohol together with pills.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) Alcohol and marijuana/hashish at the same time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) Anabolic steroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	1	1	1

28. On how many occasions in your lifetime (if any) have you used any of the following drugs?

Mark one box for each line.

	Number of occasions						
	0	1-2	3-5	6-9	10-19	20-39	40 or more
a) Tranquillisers or sedatives (without a doctor's prescription)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) LSD or some other hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Crack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Relevin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) "Magic mushrooms"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) GHB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Drugs by injection with a needle (like heroin, cocaine, amphetamine).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Alcohol together with pills.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) Alcohol and marijuana/hashish at the same time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) Anabolic steroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5	6	7

29. When (if ever) did you FIRST do each of the following things?

Mark one box for each line.

	Never	11 years	12 years	13 years	14 years	15 years	16 years
		old or less	old	old	old	old	old
a) Drink beer (at least one glass).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Drink wine (at least one glass).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Drink spirits (at least one glass).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Get drunk on alcohol.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Smoke your first cigarette.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Smoke cigarettes on a daily basis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Try amphetamines.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Try tranquillisers or sedatives (without a doctor's prescription)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Try marijuana or hashish.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Try LSD or other hallucinogen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Try crack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Try cocaine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) Try heroin.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) Try ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) Try "magic mushrooms"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p) Try GHB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q) Try drugs by injection with a needle (like heroin, cocaine, amphetamine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r) Try inhalants (glue, etc) to get high	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s) Try alcohol together with pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t) Try anabolic steroids.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5	6	7

We want to find out how people begin to take drugs. We want you to think back to the very first occasion (if any) on which you took any of them and tell us about it. (Let us say again that any information you choose to give us about this will be very strictly confidential to the researchers. Your name is not on this questionnaire and nobody will attempt to find it out).

30. What was the FIRST drug (if any) that you have ever tried?

- 01 I have never tried any of the substances listed below
- 02 Tranquillisers or sedatives without a doctor's prescription
- 03 Marijuana or hashish
- 04 LSD
- 05 Amphetamines
- 06 Crack
- 07 Cocaine
- 08 Relevin
- 09 Heroin
- 10 Ecstasy
- 11 "Magic mushrooms"
- 12 GHB
- 13 I don't know what it was

31. How did you get this substance?

- 01 I have never used any of the substances listed in question 30
- 02 Given to me by an older brother or sister
- 03 Given to me by a friend, a boy or a girl, older than me
- 04 Given to me by a friend my own age or younger
- 05 Given to me by someone I have heard about but did not know personally
- 06 Given to me by a stranger
- 07 It was shared around a group of friends
- 08 Bought from a friend
- 09 Bought from someone I have heard about but did not know personally
- 10 Bought from a stranger
- 11 Given to me by one of my parents
- 12 Took it at home without my parents permission
- 13 None of these (please describe briefly how you did get it).....
.....

32. Which was the reason(s) for you to try this drug?

Mark all that apply.

- 1 I have never used any of the substances listed in question 30
- 1 I wanted to feel high
- 1 I did not want to stand out from the group
- 1 I had nothing to do
- 1 I was curious
- 1 I wanted to forget my problems
- 1 Other reason(s), please specify.....
- 1 Don't remember

33. In which of the following places do you think you could easily buy marijuana or hashish if you wanted to?

Mark all that apply.

- I don't know of any such place
- Street, park etc
- School
- Disco, bar etc
- House of a dealer
- Other(s), please specify

34. How much do you think PEOPLE RISK harming themselves (physically or in other ways), if they.....

Mark one box for each line.

	No risk	Slight risk	Moderate risk	Great risk	Don't know
a) smoke cigarettes occasionally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) smoke one or more packs of cigarettes per day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) have one or two drinks nearly every day.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) have four or five drinks nearly every day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) have five or more drinks each weekend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) try marijuana or hashish (cannabis, pot, grass) once or twice.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) smoke marijuana or hashish occasionally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) smoke marijuana or hashish regularly.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) try LSD once or twice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) take LSD regularly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) try an amphetamine (uppers, pep pills, bennie, speed) once or twice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) take amphetamines regularly.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) try cocaine or crack once or twice.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) take cocaine or crack regularly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) smoke crack once or twice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p) smoke crack regularly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q) try ecstasy once or twice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r) take ecstasy regularly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s) try GHB once or twice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t) take GHB regularly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
u) try drugs by injection with a needle once or twice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
v) take drugs by injection with a needle regularly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
x) try inhalants (glue etc) once or twice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
y) take inhalants (glue etc) regularly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5

35. How difficult do you think it would be for you to get each of the following, if you wanted?

Mark one box for each line.

	Impossible	Very difficult	Fairly difficult	Fairly easy	Very easy	Don't know
a) Cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Beer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Wine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Liquor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Marijuana or hashish (cannabis, pot, grass)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) LSD or some other hallucinogen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Amphetamines (uppers, pep pills, bennies, speed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Tranquillisers or sedatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Crack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Heroin (smack, horse)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) "Magic mushrooms"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) GHB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) Inhalants (glue etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p) Anabolic steroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5	6

36. How many of your friends would you estimate

Mark one box for each line.

	None	A few	Some	Most	All
a) smoke cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) drink alcoholic beverages (beer, wine, spirits)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) get drunk at least once a week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) smoke marijuana (pot, grass) or hashish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) take LSD or some other hallucinogen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) take amphetamines (uppers, pep pills, bennies, speed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) take tranquillisers or sedatives (without a doctor's prescription)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) take cocaine or crack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) take ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) take heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) take inhalants (glue etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) take "magic mushrooms"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) take GHB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) take alcohol together with pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) take anabolic steroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5

37. Have you ever had any of the following problems?

Mark all that apply for each line.

	Never	Yes, because of my alcohol use	Yes, because of my drug use	Yes for reasons other than alcohol or drug use
a) Quarrel or argument.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Scuffle or fight.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Accident or injury.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Loss of money or other valuable items.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Damage to objects or clothing you owned.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Problems in your relationship with your parents.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Problems in your relationship with your friends.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Problems in your relationship with your teachers.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Performed poorly at school or work.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Victimized by robbery or theft.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Trouble with police.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Hospitalised or admitted to an emergency room.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) Engaged in sexual intercourse you regretted the next day.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) Engaged in sexual intercourse without a condom.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	1	1	1

38. Do you think that heavy drinking influences the following problems?

Mark one box for each line.

	Yes, con- siderably	Yes, quite a lot	Yes, to some extent	Yes, but only a little	No
a) Traffic accidents.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Other accidents.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Violent crime.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Family problems.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Health problems.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Relationship problems.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Financial problems.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5

39. Does any of your older siblings.....?

Mark one box for each line.

	Yes	No	Don't know	Don't have any older siblings
a) smoke cigarettes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) drink alcoholic beverages (beer, wine, spirits).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) get drunk.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) smoke marijuana or hashish (pot, grass).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) take tranquillisers or sedatives (without a doctor's prescription).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) take ecstasy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4

The next questions ask about your parents. If mostly foster parents raised you, stepparents, or others answer for them. For example, if you have both a stepfather and a natural father, answer for the one that was the most important in raising you.

40. What is the highest level of schooling your father completed?

- 1 Completed primary school or less
- 2 Some secondary school
- 3 Completed secondary school
- 4 Some college or university
- 5 Completed college or university
- 6 Don't know, or does not apply

41. What is the highest level of schooling your mother completed?

- 1 Completed primary school or less
- 2 Some secondary school
- 3 Completed secondary school
- 4 Some college or university
- 5 Completed college or university
- 6 Don't know, or does not apply

42. How well off is your family compared to other families in your country?

- 1 Very much better off
- 2 Much better off
- 3 Better off
- 4 About the same
- 5 Less well off
- 6 Much less well off
- 7 Very much less well off

43. Which of the following people live in the same household with you?

Mark all that apply.

- 1 I live alone
- 1 Father
- 1 Stepfather
- 1 Mother
- 1 Stepmother
- 1 Brother(s) and/or sister(s)
- 1 Grandparent(s)
- 1 Other relative(s)
- 1 Non-relative(s)

44. How satisfied are you usually with.....

	Very satisfied	Satisfied	Neither satis- fied or not satisfied	Not so satisfied	Not at all satisfied
a) your relationship to your mother?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) your relationship to your father?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) your relationship to your friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5

45. Do your parents know where you spend Saturday nights?

- 1 Know always
- 2 Know quite often
- 3 Know sometimes
- 4 Usually don't know

46. If you have ever used marijuana or hashish, do you think that you would have said so in this questionnaire?

- 1 I already said that I have used it
- 2 Definitely yes
- 3 Probably yes
- 4 Probably not
- 5 Definitely not

47. If you have ever used heroin, do you think that you would have said so in this questionnaire?

- 1 I already said that I have used it
- 2 Definitely yes
- 3 Probably yes
- 4 Probably not
- 5 Definitely not

The next section includes questions about your parents' thoughts about alcohol and drug use.

A1. If you wanted to smoke (or already do), do you think your father and mother would allow you to do so?

Mark one box for each line.

	Would allow (allows me) to smoke	Would not (does not) allow smoking at home	Would not (does not) allow smoking at all	Don't know
a) Father.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Mother.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4

A2. What do you think your mother's reaction would be if you do the following things?

Mark one box for each line.

	She would not allow it	She would dis- courage it	She would not mind	She would approve of it	Don't know
a) Get drunk.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Use marijuana/hashish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Use ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5

A3. What do you think your father's reaction would be if you do the following things?

Mark one box for each line.

	He would not allow it	He would dis- courage it	He would not mind	He would approve of it	Don't know
a) Get drunk.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Use marijuana/hashish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Use ecstasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5

A4. How satisfied are you usually with

Mark one box for each line.

	Very satisfied	Satisfied	Neither satisfied or not satisfied	Not so satisfied	Not at all satisfied
a) the financial situation of your family?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) your health?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) yourself?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5

A5. How often do the following statements apply to you?

Mark one box for each line.

	Almost always	Often	Some- times	Seldom	Almost never
a) My parents set definite rules about what I can do at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) My parents set definite rules about what I can do outside the home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) My parents know whom I am with in the evenings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) My parents know where I am in the evenings.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) I can easily get warmth and caring from my mother and/or father ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) I can easily get emotional support from my mother and/or father ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) I can easily borrow money from my mother and/or father.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) I can easily get money as a gift from my mother and/or father.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) I can easily get warmth and caring from my best friend.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) I can easily get emotional support from my best friend.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5

A6/ B1. How much money do you usually spend a week for your personal needs without your parents' control?

..... National currency

The following questions are about yourself and things you might do.

B2. What house work do you usually do at home?

- I do shopping
- I take care of younger sisters/brothers
- I take care of pets
- I cook
- I clean the house/apartment
- I do laundry
- I wash dishes
- I work on the household plot of land (garden)
- I take care of farm animals
- I care about elder family members
- I take out the trash
- I don't usually do any house work

B3. How much TV or video do you estimate you watch on an average weekday?

- 1 None
- 2 Half-hour or less
- 3 About 1 hour
- 4 About 2 hours
- 5 About 3 hours
- 6 About 4 hours
- 7 5 hours or more

B4. How good do you think you are at schoolwork, compared to other people your age?

- 1 Excellent, I am probably one of the very best
- 2 Well above average
- 3 Above average
- 4 Average
- 5 Below average
- 6 Well below average
- 7 Poor, I am probably one of the worst

The following section is about what you think of yourself.

C1. Below is a list of statements dealing with your general feelings about yourself.

Mark one box for each line to indicate if you agree or disagree.

	Strongly agree	Agree	Disagree	Strongly disagree
a) On the whole, I am satisfied with myself.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) At times I think I am no good at all.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) I feel that I have a number of good qualities.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) I am able to do things as well as most other people.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) I feel I do not have much to be proud of.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) I certainly feel useless at times.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) I feel that I'm a person of worth, at least on an equal plane with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) I wish I could have more respect for myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) All in all, I am inclined to feel that I am a failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) I take a positive attitude toward myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4

C2. During the LAST 7 DAYS, how often

Mark one box for each line.

	Rarely or never	Some- times	Several times	Most of the times
a) have you lost your appetite, you did not want to eat.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) have you had difficulty in concentrating on what you want to do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) have you felt depressed.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) have you felt that you had to put great effort and pressure to do the things you had to do.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) have you felt sad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) couldn't you do your work (at home, at work, at school)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4

C3. How much do you agree or disagree with the following statements?

Mark one box for each line.

	Totally agree	Rather agree	Don't know	Rather disagree	Totally disagree
a) You can break most rules if they don't seem to apply	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) I follow whatever rules I want to follow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) In fact there are very few rules absolute in life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) It is difficult to trust anything, because everything changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) In fact nobody knows what is expected of him/her in life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) You can never be certain of anything in life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5

The following questions concern behaviours, which may be against some social rules or the law. We hope that you will answer all the questions. Nevertheless, if you come across a question, which you cannot answer honestly, we prefer that you leave it unanswered. Remember that your answers are anonymous.

C4. During the LAST 12 MONTHS, how often have you

Mark one box for each line.

	Number of occasions						
	0	1-2	3-5	6-9	10-19	20-39	40 or more
a) hit one of your teachers.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) gotten mixed into a fight at school or at work.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) taken part in a fight where a group of your friends were against another group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) hurt somebody badly enough to need bandages or a doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) used any kind of weapon to get something from a person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) taken something not belonging to you, worth over (the equivalent of) \$ 10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) taken something from a shop without paying for it.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) set fire to somebody else's property on purpose.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) damaged school property on purpose.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) gotten into trouble with the police for something you did	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5	6	7

C5. Has any of the following ever happened to you?

Mark one box for each line.

	Not at all	Once	Twice	3-4 times	5 or more times
a) Run away from home for more than one day.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Thought of harming yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5

The following questions concern behaviours, which may be against some social rules or the law. We hope that you will answer all the questions. Nevertheless, if you come across a question, which you cannot answer honestly, we prefer that you leave it unanswered. Remember that your answers are anonymous.

D1. During the LAST 12 MONTHS, how often have you

Mark one box for each line.

	Number of occasions						
	0	1-2	3-5	6-9	10-19	20-39	40 or more
a) participated in a group teasing an individual...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) participated in a group bruising an individual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) participated in a group starting a fight with another group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) started a fight with another individual.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) stolen something worth (give a rounded sum approx equivalent to 2-3 movie theatre tickets).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) broken into a place to steal.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) damaged public or private property on purpose.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) sold stolen goods.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5	6	7

D2. During the LAST 12 MONTHS, how often have you

Mark one box for each line.

	Number of occasions						
	0	1-2	3-5	6-9	10-19	20-39	40 or more
a) been individually teased by a whole group of people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) been bruised by a whole group of people.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) been in a group that was attacked by another group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) had someone start a fight with you individually	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) had something worth (give a rounded sum approx equivalent to 2-3 movie theatre tickets) stolen from you.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) had someone break into your home to steal something.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) had someone damage your belongings on purpose.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) bought stolen goods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5	6	7

The last section of the questionnaire includes some questions about alcohol and moist snuff.

O1. Now think back over the LAST 30 DAYS. On how many occasions (if any) have you had any *home made* or *smuggled* alcohol to drink?

Mark one box for each line.

	Number of occasions						
	0	1-2	3-5	6-9	10-19	20-39	40 or more
a) Home made beer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Home made wine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Home made spirits.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Smuggled beer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Smuggled wine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Smuggled spirits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5	6	7

O2. On how many occasions (if any) have you used moist snuff?

Mark one box for each line.

	Number of occasions						
	0	1-2	3-5	6-9	10-19	20-39	40 or more
a) In your lifetime.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) During the last 12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) During the last 30 days.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5	6	7

O3. How much moist snuff have you used during the LAST 30 DAYS?

- 1 None at all
- 2 Less than 1 box per week
- 3 1 box per week
- 4 2 boxes per week
- 5 3 boxes per week
- 6 4 or more boxes per week