



European Monitoring Centre
for Drugs and Drug Addiction

ESPAD

The European School Survey Project on Alcohol
and Other Drugs

ESPAD Report 2019

Master questionnaire

ESPAD

The European School Survey Project on
Alcohol and Other Drugs
www.espad.org

Questionnaire on substance use

2019

Read this first please!

This questionnaire is part of an international study on substance use among European students. It will be answered by more than 100,000 students in over 35 countries. The study is called ESPAD.

This is a totally anonymous questionnaire. You should not state your name or any other information which identifies you. You should place your completed questionnaire in the enclosed envelope and seal it yourself. Your [TEACHER/SURVEY LEADER] will collect the envelopes after completion.

Your class has been randomly selected to take part in this study. In [COUNTRY] the survey is carried out by [ORGANISATION]. It is voluntary to take part. If there is any question you find objectionable for any reason, just leave it blank. It is important that you answer as thoughtfully and frankly as possible. The results will not be presented by single classes or schools and remember your answers are totally anonymous.

If you do not find an answer that fits exactly, indicate the one that comes closest. Please, mark the appropriate answer to each question by making an "X" in the box. If you have a question, please raise your hand and your [TEACHER/SURVEY LEADER] will assist you.

Thank you in advance for your participation! Please begin.

LOGO
FIELD WORK
ORGANISATION

Contact info to the organisation responsible
for the field work/national survey



C01 What is your sex?

- 1 Male
 2 Female

C02 When were you born?

Year

Month *

(Mark 01 for January, 02 for February ...
 ... 12 for December)

* Optional

C03 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) Play computer games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Actively participate in sports, athletics or exercising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Read books for enjoyment (do not count schoolbooks)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) 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"/>
(e) Other hobbies (play an instrument, sing, draw, write)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) Go around with friends to shopping centres, streets, parks, etc. just for fun	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) Use the Internet for leisure activities (chats, music, games, social networks, videos 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

C04 During the LAST 30 DAYS on how many days have you missed one or more lessons?

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

The following questions are about tobacco smoking (cigarettes, which include rolled cigarettes and EXCLUDE e-cigarettes)

C05 How difficult do you think it would be for you to get cigarettes (excluding e-cigarettes) if you wanted?

- 1 Impossible
- 2 Very difficult
- 3 Fairly difficult
- 4 Fairly easy
- 5 Very easy
- 6 Don't know

C06 On how many occasions (if any) during your lifetime have you smoked cigarettes (excluding e-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

C07 How often have you smoked cigarettes (excluding e-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

C08 When (if ever) did you FIRST do each of the following things?

Mark one box for each line.

	Never	9 years old or less	10 years old	11 years old	12 years old	13 years old	14 years old	15 years old	16 years or older
(a) Smoke your first cigarette (excluding e-cigarettes).....	<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"/>
(b) Smoke cigarettes on a daily basis (excluding e-cigarettes).....	<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"/>
	1	2	3	4	5	6	7	8	9

The next questions are about smoking and nicotine products: e-cigarettes (including e-cigs, vaps and mods), water pipe (shisha), moist snuff (snus) and 'heat-not-burn' tobacco.

C09 Have you ever used e-cigarettes?

Mark all that apply

- 1 Yes, in the last 30 days
- 1 Yes, in the last 12 months
- 1 Yes, more than 12 months ago
- 1 Never

C10 How often have you smoked e-cigarettes during the LAST 30 DAYS?

- 1 Not at all
- 2 Less than once per week
- 3 At least once a week
- 4 Almost every day or every day

C11 When (if ever) did you FIRST do each of the following things?

Mark one box for each line.

	Never	9 years old or less	10 years old	11 years old	12 years old	13 years old	14 years old	15 years old	16 years or older
(a) Use your first e-cigarette	<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"/>
(b) Use e-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"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5	6	7	8	9

C12 When you first tried e-cigarettes (if ever), what was your relationship with tobacco?

- 1 I have never tried e-cigarettes
- 2 I had never used tobacco
- 3 I had occasionally used tobacco
- 4 I was regularly using tobacco

OC01 Why did you try e-cigarettes for the first time?

Mark all that apply

- 1 I have never tried e-cigarettes
- 1 To stop smoking cigarettes
- 1 Out of curiosity
- 1 Because my friends/other people offered an e-cigarette to me
- 1 None of the above reasons

OC02 The first time you used e-cigarettes what did your e-cigarette contain?

Mark all that apply

- 1 I have never tried e-cigarettes
- 1 Nicotine
- 1 Flavouring
- 1 Don't know

C13 Have you ever used water pipe, moist snuff (snus) *, 'heat-not-burn' tobacco * ?

Mark all that apply

	Yes, in the last 30 days	Yes, in the last 12 months	Yes, more than 12 months ago	Never
(a) Water pipe (shisha).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Moist snuff (snus) *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) 'Heat-not-burn' tobacco *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	1	1	1

* Optional

The next questions are about alcoholic beverages – including beer, cider, premixed drinks, wine and spirits

C14 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) Beer.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Cider*.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Premixed drinks (spritz, <i>OTHER NATIONAL EXAMPLES</i>) *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Wine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Spirits.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5	6

* Optional

C15 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

C16 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Cider*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Premixed drinks (spritz, <i>OTHER NATIONAL EXAMPLES</i>) *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Wine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) 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

* Optional

The following questions are about the last day you drank alcohol

C17 When was the last day you drank alcohol?

- 1 I never drink alcohol
- 2 1-7 days ago
- 3 8-14 days ago
- 4 15-30 days ago
- 5 1 month-1 year ago
- 6 More than 1 year ago

C18 Think of the LAST DAY that you drank any alcohol. Which of the following beverages did you drink on that day?

Mark all that apply.

- 1 I never drink alcohol
- 1 Beer
- 1 Cider*
- 1 Premixed drinks (spritz, *OTHER NATIONAL EXAMPLES*)*
- 1 Wine
- 1 Spirits

* Optional

C18a If you drank beer that last day you drank any alcohol, how much did you drink?

- 1 I never drink beer
- 2 I did not drink beer on the last day that I drank alcohol
- 3 <50 cl
- 4 50–100 cl
- 5 101–200 cl
- 6 >200 cl

OC18b If you drank cider that last day you drank any alcohol, how much did you drink? *

- 1 I never drink cider
- 2 I did not drink cider on the last day that I drank alcohol
- 3 <50 cl
- 4 50–100 cl
- 5 101–200 cl
- 6 >200 cl

* Optional

OC18c If you drank premixed drinks (spritz, *OTHER NATIONAL EXAMPLES*) that last day you drank any alcohol, how much did you drink? *

- 1 I never drink premixed drinks
- 2 I did not drink premixed drinks on the last day that I drank alcohol
- 3 <50 cl
- 4 50–100 cl
- 5 101–200 cl
- 6 >200 cl

* Optional

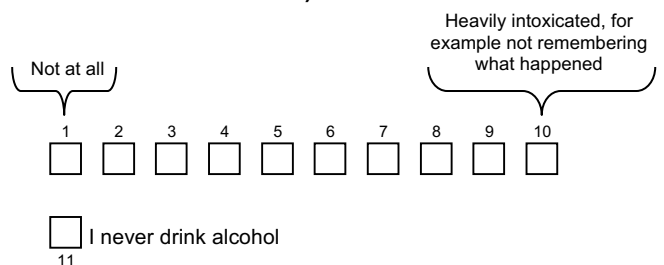
C18d If you drank wine that last day you drank any alcohol, how much did you drink?

- 1 I never drink wine
- 2 I did not drink wine on the last day that I drank alcohol
- 3 <20 cl
- 4 20–40 cl
- 5 41–74 cl
- 6 >74 cl

C18e If you drank spirits that last day you drank any alcohol, how much did you drink?

- 1 I never drink spirits
- 2 I did not drink spirits on the last day that I drank alcohol
- 3 <8 cl
- 4 8–15 cl
- 5 16–24 cl
- 6 >24 cl

C18f Please indicate on this scale from 1 to 10 how drunk you would say you were that last day you drank alcohol. (If you felt no effect at all you should mark “1”.)



The next question is about alcohol consumption during the last 30 days

C19 Think back again over the LAST 30 DAYS. How many times (if any) have you had five or more drinks on one occasion?

“A `drink` is defined as 1 glass/bottle/can of beer (33 cl), 1 glass of wine (ca 15 cl), 1 glass of spirits (ca 4 cl), 1 glass/bottle of cider (33 cl), 1 glass/bottle of premixed drinks (spritz, alcopops etc. (33 cl).” (optional: cider, premixed drinks).

[THE GIVEN DEFINITION OF ‘DRINK’ MUST BE ADAPTED BY EACH COUNTRY]

- 1 None
- 2 1
- 3 2
- 4 3–5
- 5 6–9
- 6 10 or more times

The next questions are also about alcohol

C20 On how many occasions (if any) have you been intoxicated from drinking alcoholic beverages, for example staggered when walking, not being able to speak properly, throwing up or not remembering what happened?

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

C21 When (if ever) did you FIRST do each of the following things?

Mark one box for each line.

	Never	9 years old or less	10 years old	11 years old	12 years old	13 years old	14 years old	15 years old	16 years old or older
(a) Drink alcohol (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"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) 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"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5	6	7	8	9

C22 In the LAST 12 MONTHS, how often did you drink ...

Mark one box for each line.

	Never	Seldom	Sometimes	Mostly	Always
(a) because it helps you enjoy a party?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) because it helps you when you feel depressed or nervous?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) to cheer up when you're in a bad mood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) because you like the feeling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) to get high?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) because it makes social gatherings more fun?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) to fit in with a group you like?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(h) because it improves parties and celebrations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(i) to forget about your problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(j) because it's fun?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(k) to be liked?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(l) so you won't feel left out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5

Tranquillisers and sedatives, like [INSERT NATIONALLY RELEVANT EXAMPLES], 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.

C23 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

The next questions ask about cannabis (marijuana or hashish)

C24 How difficult do you think it would be for you to get cannabis if you wanted?

- 1 Impossible
- 2 Very difficult
- 3 Fairly difficult
- 4 Fairly easy
- 5 Very easy
- 6 Don't know

C25 On how many occasions (if any) have you used cannabis?

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

C26 When (if ever) did you FIRST try cannabis?

- 1 Never
- 2 9 years old or less
- 3 10 years old
- 4 11 years old
- 5 12 years old
- 6 13 years old
- 7 14 years old
- 8 15 years old
- 9 16 years or older

OC03 Have you ever had the possibility to try cannabis without trying it?

- 1 No
- 2 Once or twice
- 3 3 times or more

OC04 Have you ever used cannabis mixed with tobacco?

- 1 Never
- 2 Rarely
- 3 From time to time
- 4 Fairly often
- 5 Very often

OC05 During the past 12 MONTHS, did you use the following type(s) of cannabis?

Mark one box for each line.

	Never	Rarely	From time to time	Fairly often	Very often
(a) Cannabis resin.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Weed/skunk.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Cannabis oil.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5

C27 Have you used cannabis during the LAST 12 MONTHS?

1 No

2 Yes → **Has the following happened to you during the LAST 12 MONTHS?**

Mark one box for each line.

	Never	Rarely	From time to time	Fairly often	Very often
(a) Have you smoked cannabis before midday?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Have you smoked cannabis when you were alone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Have you had memory problems when you smoked cannabis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Have friends or members of your family told you that you ought to reduce or stop your cannabis use?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Have you tried to reduce or stop your cannabis use without succeeding?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) Have you had problems because of your use of cannabis (argument, fight, accident, bad result at school, etc)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5

The next questions ask about other drugs

C28 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) Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Methamphetamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) 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"/>
(d) Ecstasy	<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"/>
(f) Crack*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) Optional drug*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5	6

* Optional

C29 On how many occasions (if any) have you ever used...?

Mark one box for each line.

	Number of occasions		
	0	1-2	3 or more
(a) Ecstasy in your lifetime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Ecstasy during the last 12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Amphetamines in your lifetime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Amphetamines during the last 12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Methamphetamines in your lifetime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) Methamphetamines during the last 12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) Cocaine in your lifetime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(h) Cocaine during the last 12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(i) Crack in your lifetime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(j) Crack during the last 12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(k) Heroin in your lifetime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(l) Heroin during the last 12 months	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3

C30 On how many occasions (if any) have you used inhalants [INSERT NATIONAL RELEVANT EXAMPLES] to get high?

Mark one box for each line.

	Number of occasions		
	0	1-2	3 or more
(a) In your lifetime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) During the last 12 months.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) During the last 30 days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3

C31 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 or more
(a) LSD or some other hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) "Magic mushrooms"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) GHB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) [INSERT NATIONAL FICTITIOUS DRUG].....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Drugs by injection with a needle (like heroin, cocaine, amphetamine).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3

C32 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 or more
(a) Tranquillisers or sedatives (without a doctor's prescription).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Anabolic steroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Alcohol together with pills (medicaments) in order to get high	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Painkillers in order to get high	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Optional drug*.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3

* Optional

OC06 When (if ever) did you FIRST do each of the following things?

Mark one box for each line.

	Never	9 years old or less	10 years old	11 years old	12 years old	13 years old	14 years old	15 years old	16 years old or older
(a) 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"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Try amphetamines or methamphetamines.....	<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"/>
(c) Try cocaine or crack	<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"/>
(d) Try ecstasy	<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"/>
(e) Try inhalants [NATIONAL RELEVANT EXAMPLES] in order to get high.....	<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"/>
(f) Try alcohol together with pills (medicaments) in order to get high	<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"/>
	1	2	3	4	5	6	7	8	9

C33 New substances that imitate the effects of illicit drugs [such as cannabis or ecstasy] may now be sometimes available. They are sometimes called ['legal highs', 'ethno botanicals', 'research chemicals'] and can come in different forms, for example – herbal mixtures, powders, crystals or tablets.

On how many occasions (if any) have you used such substances?

Mark one box for each line.

		Number of occasions			
		0	1-2	3 or more	Don't know / not sure
(a) In your lifetime		<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"/>
		1	2	3	4

C34 If you have used such new substances in the LAST 12 MONTHS, what was the appearance/form of the new substance/s?

Mark one or more boxes.

- 1 I have not used such substances in the last 12 months
- 1 Herbal smoking mixtures with drug-like effects
- 1 Powders, crystals or tablets with drug-like effects
- 1 Liquids with drug-like effects
- 1 Other

OC07 On how many occasions in your lifetime (if any) have you used any of the following substances?

Mark one box for each line.

		Number of occasions		
		0	1-2	3 or more
(a) Synthetic cannabinoids [INSERT RELEVANT EXAMPLES].....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Synthetic cathinones [INSERT RELEVANT EXAMPLES].....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Optional substance*.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Optional substance*.....		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		1	2	3

* Optional

C35 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) try e-cigs once or twice?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) have one or two drinks nearly every day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) have four or five drinks nearly every day?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) have five or more drinks in one occasion nearly each weekend?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5

C36 Again: 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) try cannabis once or twice?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) smoke cannabis occasionally?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) smoke cannabis regularly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) try ecstasy once or twice?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) take ecstasy regularly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) 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"/>
(g) take amphetamines regularly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(h) try synthetic cannabinoids once or twice?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5

OC08 During the LAST 12 MONTHS have you experienced the following?

Mark all that apply

	Never	Yes, while using alcohol	Yes, while using drugs	Yes, but NOT while using alcohol/drugs
(a) Physical fight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Accident or injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Damaged or lost objects or clothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Serious arguments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Victimized by robbery or theft.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) Trouble with police.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) Hospitalised or admitted to an emergency room because of severe intoxication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(h) Hospitalised or admitted to an emergency room because of accident or injury.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(i) Engaged in sexual intercourse without a condom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(j) Being a victim of unwanted sexual advance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(k) Deliberately hurt yourself.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(l) Driven a moped, car or other motor vehicle.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(m) Being involved in an accident while driving yourself.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(n) Been swimming in deep water (swimming pool, river, lake or sea).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	1	1	1

The next questions ask about Social Media

C37 During the LAST 7 DAYS, how many hours (if any) did you spend on Social Media communicating with others on the Internet? [using for example WhatsApp, Twitter, Facebook, Skype, Blogs, Snapchat, Instagram, Kik etc) – TO BE ADAPTED BY EACH COUNTRY]

Mark one box for each line.

	None	Half an hour or less	About 1 hour	About 2-3 hours	About 4-5 hours	6 hours or more
(a) On a school day.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) On a non-school day (weekend, holidays)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5	6

C38 How much do you agree or disagree with the following statements on Social Media communicating with others on the Internet? [using for example WhatsApp, Twitter, Facebook, Skype, Blogs, Snapchat, Instagram, Kik etc) – TO BE ADAPTED BY EACH COUNTRY]

Mark one box for each line.

	Strongly agree	Partly agree	Neither nor	Partly disagree	Strongly disagree
(a) I think I spend way too much time on Social Media.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) I get in bad mood when I cannot spend time on Social Media	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) My parents say that I spend way too much time on Social Media.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5

The next questions ask about gaming

C39 During the LAST 30 DAYS, how many hours (if any) did you play games using a computer, tablet, console, smartphone or other electronic device (strategy, puzzle, adventure, football, war games, etc)?

Mark one box for each line.

	None	Half an hour or less	About 1 hour	About 2-3 hours	About 4-5 hours	6 hours or more
(a) On a school day.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) On a non-school day (weekend, holidays)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5	6

C40 During the LAST 7 DAYS, on how many days (if any) were you playing games using a computer, tablet, console, smartphone or other electronic device (strategy, puzzle, adventure, football, war games, etc)?

- 1 None
- 2 1 day
- 3 2 days
- 4 3 days
- 5 4 days
- 6 5 days
- 7 6 days
- 8 7 days

C41 How much do you agree or disagree with the following statements about gaming on a computer, tablet, console, smartphone or other electronic device?

Mark one box for each line.

	Strongly agree	Partly agree	Neither nor	Partly disagree	Strongly disagree
(a) I think I spend way too much time playing games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) I get in bad mood when I cannot spend time on games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) My parents say that I spend way too much time on gaming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5

The next questions ask about gambling for money (slot machines, playing card or dice, lotteries, sport bookmakers, etc) both on the Internet and not on the Internet (in traditional settings)

C42 How often (if ever) did you gamble for money in the LAST 12 MONTHS?

- 1 I have not gambled for money during the last 12 months
- 2 Monthly or less
- 3 2-4 times a month
- 4 2-3 times or more a week

C43 How much time (if any) did you spend gambling for money on a TYPICAL DAY in the LAST 12 MONTHS?

- 1 I have not gambled for money during the last 12 months
- 2 Less than 30 minutes
- 3 Between 30 minutes and 1 hour
- 4 Between 1 and 2 hours
- 5 Between 2 and 3 hours
- 6 3 hours or more

C44 How often (if ever) did you gamble for money more than 2 hours (on a single occasion) in the LAST 12 MONTHS?

- 1 I have not gambled for money during the last 12 months
- 2 Never
- 3 Less than monthly
- 4 Monthly
- 5 Weekly
- 6 Daily or almost daily

C45 If you have gambled for money in the LAST 12 MONTHS, which games have you played?

Mark one box for each line.

	I have not played these games	Monthly or less	2-4 times a month	2-3 times or more a week
(a) Slot machines (fruit machine, new slot, etc) ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Play card or dice (poker, bridge, dice, etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Lotteries (scratch, bingo, keno, etc)...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Betting on sports or animals (horses, dogs etc)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4

C46 If you have gambled for money in the LAST 12 MONTHS, how often did you use the INTERNET?

- 1 I have not gambled for money during the last 12 months
- 2 I never used the Internet to gamble for money
- 3 Seldom
- 4 Sometimes
- 5 Mostly
- 6 Always

Now think again about gambling for money in general

C47 Have you ever felt the need to bet more and more money?

- 1 No
- 2 Yes

C48 Have you ever had to lie to people important to you about how much you gambled?

- 1 No
- 2 Yes

The next questions ask about your parents. If mostly foster parents, step-parents or others brought you up answer for them. For example, if you have both a stepfather and a natural father, answer for the one that is the most important in bringing you up

C49 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
- 7 Does not apply

C50 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
- 7 Does not apply

C51 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

C52 Which of the following people live in the same house in which you stay most of the time?

Mark all that apply.

- | | |
|---|--|
| 1 <input type="checkbox"/> I live alone | 1 <input type="checkbox"/> Brother(s) |
| 1 <input type="checkbox"/> Father | 1 <input type="checkbox"/> Sister(s) |
| 1 <input type="checkbox"/> Stepfather | 1 <input type="checkbox"/> Grandparent(s) |
| 1 <input type="checkbox"/> Mother | 1 <input type="checkbox"/> Other relative(s) |
| 1 <input type="checkbox"/> Stepmother | 1 <input type="checkbox"/> Non-relative(s) (e.g. when living in a boarding school or equivalent) |

C53 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 parent(s) 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 parent(s) 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 parent(s) 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 parent(s) 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 borrow money 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 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"/>
	1	2	3	4	5

C54 We are interested in how you feel about the following statements.
Read each statement carefully. Indicate how you feel about each statement.

Mark one box for each line.

	Very strongly disagree	2	3	4	5	6	Very strongly agree
(a) My family really tries to help me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) I get the emotional help and support I need from my family.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) I can talk about my problems with my family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) My family is willing to help me make decisions	<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

C55 We are interested in how you feel about the following statements.
Read each statement carefully. Indicate how you feel about each statement.

Mark one box for each line.

	Very strongly disagree	2	3	4	5	6	Very strongly agree
(a) My friends really try to help me.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) I can count on my friends when things go wrong	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) I have friends with whom I can share my joys and sorrows.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) I can talk about my problems with my friends	<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

C56 Does your mother or your father know where you spend Saturday nights?

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

C57 If you had ever used cannabis, 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 questions are about yourself and what you think about others

O01 Which of the following best describes your average grade at the end of the last term?

- 1 (Highest marks)
- 2 etc...

O02 How satisfied are you usually with ...

Mark one box for each line.

	Very satisfied	Satisfied	Neither nor	Not so satisfied	Not at all satisfied	There is no such person
(a) your relationship with your mother?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) your relationship with your father?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) your relationship with your friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5	6

O03 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 discourage 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) Smoke cigarettes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Use cannabis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Use ecstasy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5

O04 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 discourage 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) Smoke cigarettes.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Use cannabis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Use ecstasy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5

O05 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, cider, premixed drinks, wine, spirits)?	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
(d) smoke cannabis?.....	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
(f) take ecstasy?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) use inhalants?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5

006 This question is about alcohol consumption during the LAST 7 DAYS.

Please pay attention to the sizes of the bottles and glasses!

Please answer every question. If you have not had a beverage, indicate „0“.

a. On how many days (if any) have you had any alcoholic drink?

In the last 7 days I have had **alcoholic drinks** on days
(0 = none, 7 = every day)

b. How many bottles or glasses of beer have you had?

In the last 7 days I have had glasses or bottles of **beer**
(0 = haven't had any beer)



1 small bottle or
1 small glass of beer
= 0.33l

c. How many glasses of wine or sparkling wine have you had?

In the last 7 days I have had glasses of **wine or sparkling wine**
(0 = haven't had any wine or sparkling wine)



1 small glass of
wine or
sparkling wine
= 0.1l

d. How many glasses of spirits have you had?

In the last 7 days I have had glasses of **spirits**
(0 = haven't had any spirits)



1 glass of spirits
= 0.04l

e. How many glasses of alcoholic mixed drinks have you had?

In the last 7 days I have had glasses of **alcoholic mixed drinks**
(0 = haven't had any alcoholic mixed drinks)



1 glass of alcoholic
mixed drink
= 0,33l

O07 Think back over the LAST 30 DAYS. On how many occasions (if any) have you bought beer, cider, premixed drinks, wine or spirits in a store (grocery store, liquor store, kiosk or petrol station) for your own consumption (off-premises)?

Mark one box for each line.

	Number of occasions					
	0	1-2	3-5	6-9	10-19	20 or more
(a) Beer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Cider*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Premixed drinks (spritz, OTHER NATIONAL EXAMPLES) *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Wine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Spirits.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5	6

* Optional

O08 Think back once more over the LAST 30 DAYS. On how many occasions (if any) have you drunk beer, cider, premixed drinks, wine or spirits in a pub, bar, restaurant or disco (on-premises)?

Mark one box for each line.

	Number of occasions					
	0	1-2	3-5	6-9	10-19	20 or more
(a) Beer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Cider*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Premixed drinks (spritz, OTHER NATIONAL EXAMPLES) *	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Wine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Spirits.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5	6

* Optional

O09 Think of that last day on which you drank alcohol. Where were you when you drank?

Mark all that apply.

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

The next two questions are about energy drinks

O10 On how many occasions (if any) have you had any energy drink **[INSERT NATIONAL EXAMPLES]**?

(Don't include so called "sports drinks" **[INSERT NATIONAL EXAMPLES]**)

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

O11 On how many occasions (if any) have you been drinking energy drinks and alcohol during a single session? (Don't include so called "sports drinks" [INSERT NATIONAL EXAMPLES])

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

Now follow some more questions about the Internet and ONLINE games

O12 Please read the statements below regarding Internet use. Please indicate how often these statements apply to you.

Mark one box for each line.

	Never	Seldom	Sometimes	Often	Very often
(a) How often do you find it difficult to stop using the Internet when you are online?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) How often do you continue to use the Internet despite your intention to stop?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) How often do others (e.g. parents, friends) say you should use the Internet less?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) How often do you prefer to use the Internet instead of spending time with others (e.g. parents, friends).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) How often are you short of sleep because of the Internet?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) How often do you think about the Internet, even when not online?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) How often do you look forward to your next Internet session?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(h) How often do you think you should use the Internet less often?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(i) How often have you unsuccessfully tried to spend less time on the Internet?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(j) How often do you rush through your (home) work in order to go on the Internet?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(k) How often do you neglect your daily obligations (work, school or family life) because you prefer to go on the Internet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(l) How often do you go on the Internet when you are feeling down?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(m) How often do you use the Internet to escape from your sorrows or get relief from negative feelings?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(n) How often do you feel restless, frustrated, or irritated when you cannot use the Internet?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5

O13 Please read the statements below regarding online gaming. The question REFERS TO ONLINE GAMES exclusively, but we use the expression 'game' in each statement for simplicity's sake. Please indicate how often these statements apply to you.

Mark one box for each line.

	Never	Seldom	Sometimes	Mostly	Always
(a) When you are not gaming, how often do you think about playing a game or think about how would it feel to play at that moment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) How often do you play longer than originally planned?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) How often do you feel depressed or irritable when not gaming only for these feelings to disappear when you start playing?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) How often do you feel that you should reduce the amount of time you spend gaming?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) How often do the people around you complain that you are gaming too much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) How often do you fail to meet up with a friend because you were gaming? .	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) How often do you daydream about gaming?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(h) How often do you lose track of time when gaming?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(i) How often do you get restless or irritable if you are unable to play games for a few days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(j) How often do you unsuccessfully try to reduce the time you spend on gaming?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(k) How often do you argue with your parents because of gaming?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(l) How often do you neglect other activities because you would rather game?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1	2	3	4	5

The next questions are about PERFORMANCE ENHANCERS

M01 Have you ever used in your life on your own initiative (without been prescribed by a doctor) any stimulant substance with the purpose to improve your performance in your study? For instance to keep you awake and studying during the whole night or to study faster. Don't include coffee, tea or cola refreshments, or energy drinks.

1 No
 2 Yes

M02 If you have used such stimulant substance (without a doctor's prescription) with the purpose to improve your performance in study, where did you obtain the substance/s?

Mark all that apply.

1 Never used
 1 Offered by a family member, a friend or an acquaintance
 1 By a street dealer
 1 Through the Internet
 1 From a pharmacy without a medical prescription
 1 In a smart shop [if you have it in your country]*

* Optional