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ENGLISH - IRELAND

Planet Youth 2018

Youth and welfare

**A survey of the lives and
living conditions of young people**

– Confidential –

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PLANET
Youth
EVIDENCE BASED DRUG PREVENTION

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To students

This booklet contains many questions which you are being asked to respond to. These questions concern your opinions on various issues, as well as different types of activities you are, or might be, involved in. You have probably never participated in a survey like this, but we still hope you can respond to these questions as conscientiously as possible, because your responses are very important. It is also important that you respond to the questions in a way which best describes your opinion. This is completely different from examinations, **as no answers are more correct than others**. The only important thing here is for your opinions to be made known.

Most of the questions have several options to choose your answer from, and you need to choose only one of them. Put an **X** in the box next to the answer you have chosen. Do not use a very faint pencil, and also, do not fill the box you have chosen completely. If you change your mind, the best thing to do is to completely erase the wrong answer or completely shade the box with the wrong answer, so that no white spaces can be seen. A few of the questions are such that no answers are provided, and you are requested to write your answer. In such cases, you must write very clearly, using capital letters, and put only one letter in each box. It is up to you to decide whether you will respond to each particular question, but we ask that you answer all questions to the best of your ability. If you feel that none of the answers provided to certain questions accurately describes your opinion or accurately suits you, choose the answer that you think is closest to the truth.

This is an anonymous survey. It will be impossible to trace your answers to you, in other words, no one you know, not your teachers, parents, acquaintances or friends, could ever access your personal responses. Make sure you **do not write your name or any personal identification details** on the questionnaire sheets or on the envelope provided with it. When you have finished answering all the questions, put the questionnaire in the envelope, seal it completely, and leave it on your desk. The envelopes will be collected when everyone has finished, all the questionnaires will be collected.

If you have any questions to ask about certain items, close your booklet and raise your hand. An employee or teacher will come to your desk with an unanswered version of the questionnaire to assist you without seeing your answers.

With our kindest regards,

The research team

Planet Youth Galway
Planet Youth Mayo
Planet Youth Roscommon

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PLEASE READ CAREFULLY THE INSTRUCTIONS ON THE PREVIOUS PAGE
BEFORE YOU BEGIN TO ANSWER THE QUESTIONS.

Answer each question by marking X in the respective box

1. Are you male or female?

Male Female

2. Year of birth? (Choose only ONE option)

2000 2001 2002 2003 2004 2005

3. What school year are you in now? (Choose only ONE option)

2nd Year 3rd Year Transition Year 5th Year Leaving Cert

4. I live with... (Choose only ONE option, the one that suits best)

- I live with my mother and father equally
- Mother but not father
- Father but not mother
- Mother and her partner
- Father and his partner
- Grandparent/s and mother/father
- Only Grandparent/s and not mother /father
- I live with friends
- I live on my own
- I live in a different arrangement (foster family, guardian etc.)

5. What is the highest level of schooling your mother completed? (If you are mostly brought up by a fostermother you answer for her)(Choose only ONE option)

- I don't know/doesn't apply
- Graduated from a university
- Started university but didn't finish
- Graduated from technical college or apprenticeship
- Started technical college or apprenticeship but didn't finish
- Graduated from secondary school
- Started secondary school but didn't finished
- Primary school or less

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6. What is the highest level of schooling your father completed? (If you are mostly brought up by a fosterfather you answer for him) (Choose only ONE option, the one that suits best)

- I don't know/doesn't apply
- Graduated from a university
- Started university but didn't finish
- Graduated from technical college or apprenticeship
- Started technical college or apprenticeship but didn't finish
- Graduated from secondary school
- Started secondary school but didn't finished
- Primary school or less

7. What is the main occupation of your mother?

(Choose only ONE option, the one that suits best)

- Mother works at home (takes care of the household)
- Mother works part-time
- Mother works full-time
- Mother works abroad
- Mother is unemployed
- Mother is disabled, not working
- Mother is studying
- Mother is studying and also working
- Don't know/doesn't apply

8. What is the main occupation of your father?

(Choose only ONE option, the one that suits best)

- Father works at home (takes care of the household)
- Father works part-time
- Father works full-time
- Father works abroad
- Father is unemployed
- Father is disabled, not working
- Father is studying
- Father is studying and also working
- Don't know/doesn't apply

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9. Where were you born? (Choose ONE option and write the answer in the spaces if it applies to you)

In Ireland

In another country

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10. Were your parents born and raised in this country? (Choose ONE option in EACH category)

- | | Yes | No |
|---------------------------------|--------------------------|--------------------------|
| a) Mother was born in Ireland | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Mother was raised in Ireland | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Father was born in Ireland | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Father was raised in Ireland | <input type="checkbox"/> | <input type="checkbox"/> |

11. Is English spoken in your home? (Choose only ONE option)

- Yes, only English
- Yes, English together with a different language
- No, only a different language

12. How well off financially do you think your family is in comparison to other families? (Choose only ONE option)

- Much better off
- Considerably better off
- A little better off
- Similar to others
- A little worse off
- Considerably worse off
- Much worse off

13. Which religious community do you belong to? (Choose only ONE option)

- Catholic
- Church of Ireland
- Muslim / Islam
- Orthodox
- Baptist
- An Independent or Autonomous church
- Other
- No Religion

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14. Do you go to school in the area you live in? (Choose only ONE option)

Yes No

15. How good do you think you are at school work, compared to other people your age? (Choose only ONE option)

Excellent	Well above average	Above average	Average	Below average	Well below average	Poor
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. How many whole days have you been absent from school during the last 30 days? (Choose ONE option in EACH category)

	None	1 day	2 days	3-4 days	5-6 days
a) Because of illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Because you mitched	<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"/>

17. How well do the following statements apply to you ? (Choose ONE option in EACH category)

	Applies almost always to me	Applies often to me	Applies sometimes to me	Applies occasionally to me	Applies almost never to me
a) I find schoolwork pointless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) I am bored with schoolwork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) I am poorly prepared for classes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) I feel I do not put enough effort into my schoolwork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) I find schoolwork too easy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) I find schoolwork too hard	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) I feel bad at school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) I want to quit school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) I want to change schools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) I get on badly with the teachers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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18. During the last 7 days, how often did you do any of the following? (Choose ONE option in EACH category)

	Never	Once	Twice	3 times	4 times	5 times	6 times	7 times
a) Stayed at home for a whole evening	<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) Was outside after ten o'clock in the evening	<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) Went outside and returned after midnight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. How easy or hard would it be for you to receive the following from your parents/guardians? (Choose ONE option in EACH category)

	Very difficult	Rather difficult	Rather easy	Very easy
a) Caring and warmth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Talks about personal affairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Advice about schoolwork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Advice about other issues (projects) of yours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Support with other things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20. How easy or hard would it be for you to receive the following from your friends? (Choose ONE option in EACH category)

	Very difficult	Rather difficult	Rather easy	Very easy
a) Caring and warmth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Talks about personal affairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Advice about schoolwork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Advice about other issues (projects) of yours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Assistance with things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

21. How does the following apply to you? (Choose ONE option in EACH category)

	Almost never	Seldom	Sometimes	Often	Almost always
a) I spend time with my parents outside school hours during the week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) I spend time with my parents at the weekends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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22. Do your parents know where you spend Saturday evenings? (Choose only ONE option)

Almost
always

Often

Sometimes

Seldom

Almost
never

23. To what extent do the following statement apply to you? "I feel safe..." (Choose ONE option from EACH subcategory)

	Almost never	Rarely	Sometimes	Often	Almost always
a) at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) at school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) in my neighbourhood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

24. How do the following statements apply to you ? (Choose ONE option in EACH category)

	Applies very well to me	Applies rather well to me	Applies rather poorly to me	Applies very poorly to me
a) My parents find it important that I do well with my schoolwork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) My parents set definite rules about what I can do at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) 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"/>
d) My parents set definite rules about when I should be home in the evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) My parents know who I am with in the evening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) My parents know where I am in the evenings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) My parents know my friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) My parents know the parents of my friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) My parents often talk to the parents of my friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) My parents and the parents of my friends sometimes meet to talk to one another	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) My parents follow what I do in my spare time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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25. How much do the following apply to you? (Choose ONE option in EACH category)

	Always	Often	Neutral	Seldom	Never
a) My parents have friends that live close to our home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) My parents know many of our neighbours by name	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) My parents sometimes visit some of our neighbours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) My neighbours sometimes visit my parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Sometimes we borrow things from our neighbours (e.g. milk or tools)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Our neighbours sometimes borrow things from us (e.g. milk or tools)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

26. How likely or unlikely is it that your neighbours would do something about it if...? (Choose ONE option in EACH category)

	Very likely	Rather likely	Neither	Rather unlikely	Very unlikely
a) ...the teenagers in the neighbourhood were mitching and hanging around	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) ...the teenagers were writing graffiti on houses in the area	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) ...the teenagers were rude to the adults	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) ...if a fight broke out in front of your house	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) ...somebody was breaking into a car or a house on your street	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

27. Please state if and to what extent the following applies to your situation. (Choose ONE option in EACH category)

	Almost never	Seldom	Sometimes	Often	Almost always
a) My parents are poorly-off financially	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) My parents can't afford to have a car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) My parents hardly have enough money to pay for necessities (e.g. food, housing, phone)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) My parents do not have enough money to pay for the hobbies that I would most like to participate in (e.g. sports or music)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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28. How do the following statements apply to you? (Choose ONE option in EACH category)

	Strongly agree	Agree somewhat	Disagree somewhat	Strongly disagree
a) Sometimes it is necessary to smoke cigarettes in order not to be left out of the peer group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Sometimes it is necessary to drink alcohol in order not to be left out of the peer group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Sometimes it is necessary to smoke cannabis in order not to be left out of the peer group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Sometimes it is necessary to mitch classes in order not to be left out of the peer group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

29. How many hours do you sleep on average every night? (Choose only ONE category)

More than 9 hours	About 9 hours	About 8 hours	About 7 hours	About 6 hours	Less than 6 hours
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

30. How well does the following describe your mood in the last week? (Choose ONE option in EACH category)

	Never or almost never	Seldom	Sometimes	Often
a) I was easily annoyed or irritated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) I experienced outbursts of anger that I could not control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) I wanted to break or damage things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) I had a row with someone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) I yelled at somebody or threw things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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31. How do the following statements apply to you? (Choose ONE option in EACH category)

	Very well	Rather well	Rather poorly	Not at all
a) When I think about how I will look in the future, I am pleased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) I most often think that I am ugly and unattractive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) I am happy with my body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) I am happy with the physical changes that have taken place in my body during the past few years	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) I feel physically strong and healthy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) I am content with my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) I am happy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

32. Below are statements about feelings and thoughts. Please choose what best fits your experience of each over the last 2 weeks.

	None of the time	Rarely	Some of the time	Often	All the time
a) I've been feeling optimistic about the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) I've been feeling useful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) I've been feeling relaxed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) I've been dealing well with problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) I've been thinking clearly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) I've been feeling close to other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) I've been able to make up my mind about things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

33. How would you rate your physical health? (Choose ONE option only)

Very good	Good	Moderate	Bad	Very bad
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

34. How would you rate your mental health? (Choose ONE option only)

Very good	Good	Moderate	Bad	Very bad
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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35. To what extent do you agree or disagree with the following statements? (Choose ONE option in EACH category)

	Strongly agree	Agree somewhat	I don't know	Disagree somewhat	Strongly disagree
a) I can break most rules if they don't seem to apply to me	<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 absolute rules 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 them in life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) One can never be certain of anything in life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Sometimes one needs to break rules in order to succeed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Following rules does not ensure success	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

36. How often did you feel any of the following mental or physical discomforts in the last week? (Choose ONE option in EACH category)

	Never or almost never	Seldom	Sometimes	Often
a) Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Sudden fear for no apparent reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) I felt tense	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) I was sad or had little interest in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) I had little appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) I felt lonely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) I cried easily or wanted to cry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) I had sleeping problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) I felt sad or blue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) I was not excited about doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) I was slow or had little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) The future seemed hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) I thought of completing suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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37. Does any of the following apply to you? (Choose ONE option in EACH category)

	Yes	No
a) Has somebody told you that he/she was thinking about suicide?	<input type="checkbox"/>	<input type="checkbox"/>
b) Has anyone of your acquaintance or anyone else you are familiar with attempted suicide?	<input type="checkbox"/>	<input type="checkbox"/>
c) Has anyone of your acquaintances or anyone else you are familiar with died by suicide?	<input type="checkbox"/>	<input type="checkbox"/>
d) Has any of your friends or someone else close to you ever tried to attempt suicide?	<input type="checkbox"/>	<input type="checkbox"/>
e) Has any of your friends or someone else close to you ever died by suicide?	<input type="checkbox"/>	<input type="checkbox"/>
f) Have you ever thought about completing suicide?	<input type="checkbox"/>	<input type="checkbox"/>
g) Have you ever seriously considered completing suicide?	<input type="checkbox"/>	<input type="checkbox"/>
h) Have you ever told anyone that you were thinking about completing suicide?	<input type="checkbox"/>	<input type="checkbox"/>
i) Have you ever made an attempt to complete suicide?	<input type="checkbox"/>	<input type="checkbox"/>
j) Have you made an attempt to complete suicide during last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>

38. During your lifetime have you thought about harming yourself on purpose (such as scratching, cutting, burning, preventing wounds from healing, punching)

Never	Once in lifetime	Twice in lifetime	2-4 times in lifetime	5 times or more often
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

39. During your lifetime have you harmed yourself on purpose (such as scratching, cutting, burning, preventing wounds from healing, punching)

Never	Once in lifetime	Twice in lifetime	2-4 times in lifetime	5 times or more often
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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40. Have you experienced any of the following? (Choose as many OPTIONS as apply to you in EACH category)

	Yes, during last 30 days	Yes, during last 12 months	Yes, more than 12 months ago	NO
a) A serious accident	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) A severe illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) A separation or divorce of your parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) A serious argument with your parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Witnessed your parents having a serious argument	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Witnessed <u>physical</u> violence in your home where an adult was involved	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Witnessed <u>psychological</u> violence/abuse in your home where an adult was involved	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Been involved in physical violence in your home where an adult was involved	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) The death of a parent or sibling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) The death of a friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) A break up with a girlfriend/boyfriend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Been rejected by your friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) A separation from a friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) Received an exceptionally low grade	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) Father or mother lost a job	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p) Been dismissed from class or sent to the principal's office	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q) Been expelled from school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
r) Experienced sexual abuse (victim)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s) Experienced sexual abuse where an adult from the family was involved	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t) Experienced sexual abuse where an adult from outside the family was involved	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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41. How do the following statements apply to you? (Choose ONE option in EACH category)

	Applies very well to me	Applies rather well to me	Applies rather poorly to me	Applies very poorly to me
a) I feel that I am worth at least as much as other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) I feel that I have number of good qualities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) I am inclined to feel that I am a failure	<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 take a positive attitude towards myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) On the whole I am satisfied with myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) I wish I had more respect for myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) At times I think I am no good at all	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) I certainly feel useless at times	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

42. How much do you agree with the following statements? (Choose ONE option in EACH category)

	Strongly agree	Agree somewhat	Disagree somewhat	Strongly disagree
a) There is a great deal of social life available in my neighbourhood/community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) It is good to live in my neighbourhood/community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) In the future I would like to continue to live in the neighbourhood/community that I live in now	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) In the future I would like to move to another city/town in my country	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) In the future I would like to move abroad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

43. Have you, during the last 12 months...? (Choose ONE option in EACH category)

	Yes	No
a) ...moved to a different neighbourhood/community	<input type="checkbox"/>	<input type="checkbox"/>
b) ...changed schools	<input type="checkbox"/>	<input type="checkbox"/>

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44. Have you, during the last 5 years...? (Choose ONE option in EACH category)

	Never	Once	Twice	Three times	Four times	Five times or more
a) ...moved to a different neighbourhood/community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) ...changed schools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

45. How well do the following statements apply to you? (Choose ONE option in EACH category)

	Applies to me very poorly	Applies to me rather poorly	Applies to me rather well	Applies to me very well
a) I believe in god	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) My faith is important to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) I pray to god on a regular basis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) I regularly read the scriptures of my faith	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) I regularly attend religious services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) I regularly take part in religious activities other than services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) I would be able to get support from god if I needed it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) I have sought support from god when I have needed it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) My best friends are religious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Most of my acquaintances are religious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) My mother (foster/stepmother) is religious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) My father (foster/stepfather) is religious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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46. How much, if anything, do you drink of the following drinks every day? (Choose ONE option in EACH category)

	I do not drink it	One cup	Two cups	Three cups	Four cups	Five cups	Six or more cups
a) Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	I do not drink it	One cans /bottles	Two cans /bottles	Three cans /bottles	Four cans /bottles	Five cans /bottles	Six or more cans /bottles
c) Cola drinks (like Coke, Pepsi etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Energy drinks that contain caffeine (like: Red bull, Monster, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

47. Do any of the following people smoke tobacco on a daily basis? (Choose ONE option in EACH category)

	No	Yes	Doesn't apply
a) Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Sibling (one or more)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Best friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

48. How often have you smoked cigarettes in your lifetime? (Choose only ONE option)

Never	1-2 times	3-5 times	6-9 times	10-19 times	20-39 times	40 times or more
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

49. How many cigarettes, on average, have you smoked in the last 30 days? (Choose only ONE option)

- None
- Less than one cigarette per week
- Less than one cigarette per day
- 1-5 cigarettes per day
- 6-10 cigarettes per day
- 11-20 cigarettes per day
- More than 20 cigarettes per day

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50. How often, if ever, have you smoked electronic cigarettes (e-cigarette) in your lifetime? (Choose only ONE option)

Never	1-2 times	3-5 times	6-9 times	10-19 times	20-39 times	40 times or more
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

51. How often have you smoked electronic cigarettes, on average, during the last 30 days? (Choose only ONE option)

Never	Less than once per week	Less than once per day	1-5 times per day	6-10 times per day	11-20 times per day	More than 20 times per day
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

52. How often have you used Snuff, Chewing tobacco or other tobacco inserted in mouth in your lifetime? (Choose only ONE option)

Never	1-2 times	3-5 times	6-9 times	10-19 times	20-39 times	40 times or more
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

53. How often have you used Snuff, Chewing tobacco or other tobacco inserted in mouth during the last 30 days? (Choose only ONE option)

Never	1-2 times	3-5 times	6-9 times	10-19 times	20-39 times	40 times or more
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

54. How often have you used a bong? (Choose ONE option in EACH category)

	Never	1-2 times	3-5 times	6-9 times	10-19 times	20-39 times	40 times 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 30 days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

55. How often have you used the following in your life time? (Choose ONE option in EACH category)

	Never	1-2 times	3-5 times	6-9 times	10-19 times	20-39 times	40 times or more
a) Ritalin, Concerta, Rubifen (or other ADHD medicine) that has been <u>prescribed</u> for you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Ritalin, Concerta, Rubifen (or other ADHD medicine) <u>without a prescription</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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56. How often have you consumed any of the following beverages during the last 30 days? (Choose ONE option in EACH category)

	Never	1-2 times	3-5 times	6-9 times	10-19 times	20-39 times	40 times 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) Alcopops (alcoholic soft drinks)	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
d) Spirits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

57. How often have you had a drink of alcohol of any kind? (Choose ONE option in EACH category)

	Never	1-2 times	3-5 times	6-9 times	10-19 times	20-39 times	40 times or more
a) In your life time	<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 30 days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

58. How often have you got drunk? (Choose ONE option in EACH category)

	Never	1-2 times	3-5 times	6-9 times	10-19 times	20-39 times	40 times or more
a) In your life time	<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 30 days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

59. How often, if ever, have you had 4 (four) or more alcohol drinks (e.g. beer, wine, spirits, shots) in an hour or less? (Choose only ONE option)

Never	1-2 times	3-5 times	6-9 times	10-19 times	20-39 times	40 times or more
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

60. How often, if ever, have you had 5 (five) or more alcohol drinks (e.g. beer, wine, spirits, shots) in an hour or less? (Choose only ONE option)

Never	1-2 times	3-5 times	6-9 times	10-19 times	20-39 times	40 times or more
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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61. Do you drink alcohol in the following places? (Choose ONE option in EACH category)

	Never	Seldom	Sometimes	Often
a) In your home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) In someone else's home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) In the shopping centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Outdoors: for example in the street, in a park, field etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) In a pub or club	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) At a disco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) On a school tour, daytrip or concert	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) In a youth club/centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) During training, rehearsals, or camps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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62. How often (if ever) have you used any of the following drugs? (Choose ONE option in EACH category)

	Never	1-2 times	3-5 times	6-9 times	10-19 times	20-39 times	40 times or more
a) Over the counter sleeping pills or tranquillisers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Cannabis (hashish or marijuana)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Amphetamines (speed)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) LSD (acid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Ecstasy (E-tablets)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Cocaine	<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) Relewine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Mushrooms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Sniffing (e.g. glue)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Anabolic steroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Homemade brews/poteen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Herbal/organic drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) Laughing gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) Headshop drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p) Opioid drugs without a doctor's prescription (for example, Codeine, Morphine, Methadone, Fentanyl, Oxycontin, Hydrocodone and others)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q) Khat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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63. At what age (if ever) did you do any of the following for the first time? (Choose ONE option in EACH category)

	Never	11 years or younger	12 years	13 years	14 years	15 years or older
a) Had a drink of alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Got drunk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Smoked a cigarette	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Smoked cigarettes daily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Used cannabis (hash/marijuana)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Smoked e-cigarette	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Used snuff, Chewing tobacco or other tobacco inserted in mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

64. How often (if ever) have you done any of the following during the last 12 months? (Choose ONE option in EACH category)

	Never	Once	2-5 times	6-9 times	10-13 times	14-17 times	18 times or more
a) Stolen something worth <u>less than</u> €20	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Stolen something worth <u>more than</u> €20	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Used physical violence in order to rob/steal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Broken into a building or a car to steal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Damaged or vandalised things that did not belong to you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Committed another offence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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65. How do you think your parents would react if you did any of the following? (Choose ONE option in EACH category)

	Totally against	Very much against	A bit against	They would not care
a) If you smoked cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) If you got drunk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) If you smoked cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) If you smoked e-cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) If you used snuff, chewing tobacco or other tobacco inserted in mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

66. Please answer the following questions as they apply to you. (Choose ONE option in EACH category)

	Never	Once	2-5 times	6-9 times	10-13 times	14-17 times	18 times or more
a) Have you been a victim of <u>physical</u> violence 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"/>
b) Have you caused <u>physical</u> violence 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) Have you been a victim of <u>sexual</u> violence 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"/>
d) Have you caused <u>sexual</u> violence 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"/>

67. How often, if ever, during last 12 months have you:

	Never	Once	Twice	3-4 time	5 times or more often
a) Been a part of a group teasing anyone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Been a part of a group physically hurting anyone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Been a part of a group starting a fight with another group?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Been teased by a group?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Been attacked by a group?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) 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"/>

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68. How often, if ever, during your lifetime has the following happened?

	Never	Once	Twice	3-4 time	5 times or more often
a) You have SENT nasty or degrading messages to a group or an individual using social media?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) You have RECEIVED nasty or degrading messages from a group or an individual through social media?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

69. How often have you done the following during the last 12 months? (Choose ONE option in EACH category)

	Never	Once	2-5 times	6-9 times	10-13 times	14-17 times	18 times or more
a) Punched somebody	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Knocked somebody over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Kicked somebody	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Hit/slapped somebody	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Held somebody by their neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Threatened somebody with violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

70. How many of your friends do you think have done the following during the last 12 months? (Choose ONE option in EACH category)

	None	A few	Some	Most	Almost all
a) Stolen something worth more than €20	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Broken into a building or a car in order to steal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Damaged or vandalised things that did not belong to them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

71. How many of your friends do you think do the following? (Choose ONE option in EACH category)

	None	A few	Some	Most	Almost all
a) Smoke cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Drink alcohol (beer, wine, or spirits)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Become drunk at least once a month	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Smoke hash or marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Pick fights or look for fights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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72. The following questions are about sports and aerobic activities (Choose ONE option in EACH category)

- | | Almost
never | Once
a week | Twice
a week | 3 times
a week | 4-6 times
a week | Almost
every day |
|-------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a) How often do you participate in sports and physical training in school, outside the compulsory classes (P.E. Class)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b) How often do you engage in sports (practice or compete) <u>with</u> a sports club/team? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c) How often do you exercise or practice sports, outside school and <u>outside</u> a club/team? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d) How often do you exert yourself physically so you exhaust yourself or sweat? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

73. Do you take part in any organised recreational- or extracurricular activities? (Choose only ONE option)

- | Almost
never | Once
a week | Twice
a week | 3 times
a week | 4-6 times
a week | Almost
every day |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

74. In the past week, on how many days have you done a total of 60 min or more of physical activity, which was enough to raise your breathing rate? (Choose only ONE option) *This may include sport, exercise and brisk walking or cycling for recreation or to get to and from places.*

- | Never | Once | Twice | 3 times | 4-6 times | Almost
every day |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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75. How much time on average to you spend each day on the following activities? (Choose only one option)

	Almost no time	1/2 to 1 hour	About 1 hour	About 2 hours	About 3 hours	About 4 hours	About 5 hours	6 hours or more
a) Watching shows, movies or videos	<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) Playing videogames	<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) On social media (e.g. Snapchat, Instagram, Messenger, Facebook, etc.)	<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) Using the internet for other than social media or videogames (e.g. reading, schoolwork)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

76. How often has the following happened? (Choose only one option)

	Never	1-2 times	3-5 times	6-9 times	10-19 times	20-39 times	40 times or more
a) You sent a nude(s) of yourself to someone through social media	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) You asked someone to send you a nude(s) through social media	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) You have been asked to send a a nude picture through social media	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

77. On a scale from 1 to 5 where 1 means no attraction and 5 means a strong attraction. (Choose one option in EACH category that applies best to you)

Where would you place yourself on a scale measuring sexual attraction to the **opposite** sex?

No attraction	1	2	3	4	5	Strong attraction
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Where would you place yourself on a scale measuring sexual attraction to the **same** sex?

No attraction	1	2	3	4	5	Strong attraction
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Municipality serial code: 00000001 upwards (8 digits)

**Please put the questionnaire in the envelope,
seal it and return to the teacher / supervisor.**

**All questionnaires will be destroyed
after the data entry.**

We thank you very much for your participation.

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