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The European School Survey Project on Alcohol and Other Drugs

# The Icelandic ESPAD Country Report 2007

## Research design and methodological results

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## **Section I: Background and research design**

### **A Introduction**

#### A1 Purposes of the survey

The primary purpose of the survey is to gather information about adolescent substance use in order to study trends over time and compare with the situation in other countries. This information will be used for the purposes of public policy formation and academic research.

#### A2 Principal investigator and institution

Thoroddur Bjarnason, University of Akureyri.

#### A3 Institutions supporting the 2007 ESPAD Survey

Icelandic Institute of Public Health  
University of Akureyri, Iceland  
The University of Akureyri Research Fund  
The KEA Research Foundation, Iceland  
Icelandic Center for Prevention Research

#### A4 Researchers involvement in the 2007 ESPAD

Andrea Hjalmsdottir, Atli Hafthorsson, Gunnhildur Helgadóttir, Hildigunnur Olafsdóttir, Inga D. Sigfusdóttir, Johann Asmundsson, Kjartan Olafsson, Rannveig Thorisdóttir, Sigrun Adalbjarnardóttir, Stefan H. Jonsson, Thorolfur Thorlindsson.

#### A5 Ethical considerations.

All relevant ethical safeguards were met in conducting the study. In accordance with Icelandic law the study was reported to the Icelandic Data Protection Authority.

### **B Population of students from which sample was drawn**

#### B1 Geographical area(s) where survey was conducted

The survey was conducted in the whole country of Iceland.

#### B2 If applicable, explain why these specific areas were chosen

Not applicable.

#### B3 Grade/levels surveyed

Grade 10.

#### B4 Approximate percent of children born in 1991 who were in school in March 2007

According to the Icelandic Statistical Bureau there were 4.557 individuals who were 15 years old on December 1, 2006. There were 4.494 students registered in 10<sup>th</sup> grade in the school year 2006–2007.

## **C Sample**

### C1 Number and types of schools in the country

There are 126 general schools with 10<sup>th</sup> grade students in Iceland.

### C2 Number and types of schools chosen

All 126 general schools with 10<sup>th</sup> grade students in Iceland.

### C3 Number and types of students chosen

All 4,494 students in 10<sup>th</sup> grade in Iceland were targeted for participation.

### C4 Method of sampling. Step-by-step description of the sampling procedure

All students in the country.

### C5 Representativeness of the sample

The sample is representative of all students in the country, all regions and types of schools.

### C6 Weights

The sample is self-weighted, all students present in class on the day of administration were included in the sample.

## **D Field procedures**

### D1 Step-by-step description of the data collection procedure

Prior to the survey, a letter was sent to all Icelandic schools that included the 10th grade. The principals were asked to appoint a teacher as a contact person for the ESPAD survey. The contact teachers were asked to send a list of all classes in the school to the research team. Using these class lists, the research team prepared a survey package for each 10<sup>th</sup> grade class in the country. The packages contained the appropriate number of questionnaires and confidentiality envelopes, a letter to the teachers and a classroom report. For each school, all classroom packages were placed in a box, along with a letter to the contact person and a label for returning the boxes. In most schools the boxes were sent by certified mail and the survey was administered by school authorities. Research assistants transported the boxes to the three schools where they administered the survey. Data were collected under the same conditions as a written test and students sealed their questionnaires in the confidentiality envelopes upon completion. The contact person returned the boxes via certified mail to the University of Akureyri Research Institute, where boxes were opened and the questionnaires optically scanned.

### D2 Number and type of people collecting the data

In most cases the questionnaires were administered by teachers. However, research assistants administered the questionnaires in three countries upon request from the principals. In these schools the teachers left the classroom during survey administration.

### D3 Instructions given to the students

Students were told that participation was voluntary but the importance of the survey was stressed. They were also given cards with the address of the Icelandic ESPAD website and information about when preliminary results would be available.

### D4 Time period when data were collected

Most of the schools (79%) collected data during the target week of February 26 – March 2, 2007. The remaining 11% of the schools collected data in the period March 5 – March 22.

### D5 Comments from the survey leaders about the data collection procedure in the class-rooms

No serious problems were reported by the survey leaders.

## **E Data collection instrument**

### E1 ESPAD items (core and module) used in the Icelandic questionnaire

The questionnaires included all the ESPAD core questions. It also included the module questions B1, B2, B3, B5, C1, C2, O10a.

### E2 Description (number and subjects) of non-ESPAD questions in the questionnaire

The questionnaire also included questions on school grade (ICE01), media use (ICE02–IC04), future plans (ICE05), work with school (ICE06), sport participation (ICE07), tobacco use (ICE08–ICE10), obtaining alcohol (ICE11), drug education (ICE12–ICE14), boyfriend or girlfriend living in home (ICE15), small island questions on origin and migration (ICE16–ICE23) and additional parental relations (ICE24).

### E3 Describe the translation process and its results

Nearly all items used in the questionnaire have been used multiple times in Iceland. Only a handful of new or changed ESPAD questions were translated by the research team.

### E4 Describe the possible pre-testing of the questionnaire and its results

The questionnaire was almost identical to several questionnaires previously administered to the same age groups in Iceland. It was therefore not formally pre-tested this time, but several adolescents and adults read it through and commented on it.

### E5 Describe possible cultural adjustments of questions

None.

### E6 Copy of the questionnaire and English translation

See Appendix 3 for Icelandic questionnaire.

See Appendix 4 for English translation of the Icelandic questionnaire.

## **F. Data processing**

### F1 Describe the quality check of the data entry

The questionnaires were scanned. The optical data processing system was programmed to prompt for unusual entry when more than one mark was found for a question allowing only one answer. Random checks were conducted throughout the scanning process to assume consistent quality. Questionnaires were flagged if they met some specific criteria. All flagged questionnaires were collected and examined in one session by the research team.

### F2 Describe the possible weighting of the data

The data were not weighted.

## **Section II: Methodological results**

### **A School co-operation**

#### A1 Schools and classes willingness to participate in the study

Most schools were quite willing to participate in the study. However, more schools were reluctant to participate than in earlier waves of the ESPAD study, primarily because a research team led by Inga D. Sigfusdottir and Jon Sigfusson at Reykjavik University decided to administer ESPAD questions to the same age group in the same semester in competition with the official 2007 ESPAD project. Nevertheless 123 of the 126 schools ultimately agreed to participate in the Icelandic 2007 ESPAD study.

#### A2 Refusals or other reasons for not participating

Three schools and refused to participate in the survey.

#### A3 Possible number of classes replaced because of non-participation

Not applicable.

### **B Student co-operation**

#### B1 Refusals

Seven students refused to participate. The parents of thirteen students refused to allow their children to participate.

#### B2 Unusable data

A total of 14 questionnaires (0.4%) were excluded because of obviously bad data.

#### B3 Response rates

About 82% of all students registered in 10<sup>th</sup> grade participated in the survey.

#### B4 Overall assessment of student co-operation

Student co-operation was very good overall.

### **C Student comprehension**

#### C1 Average time and average time span for completing the questionnaire

Information not available.

#### C2 Survey leaders comments about possible disturbances during completion

About 82% of the survey leaders did not report any disturbances during administration and an additional 13% reported disturbances from only a few students. Giggles and eye contact with other students were the most commonly reported disturbances.

#### C3 Survey leaders comments about the interest, comprehension and seriousness of students

No serious problems were reported.

#### C4 Comments on any specific problems

No serious problems were reported.

#### C5 Overall assessment of student comprehension

There are no indications of problems with student comprehension.

**Tables 1 a-g.** Sampling frame, sampling, response rates and participating students.

**1a).** Sampling frame.

School types	Number of schools	Number of classes
General	126	N/A
<b>Totals</b>	126	N/A

**1b).** Sample size.

School types	Number of schools	Number of classes	Number of students		
			Boys	Girls	All
General	126	N/A	2,332	2,162	4,494
<b>Totals</b>	126	N/A	2,332	2,162	4,494

**1c).** Participating schools, classes and students.\*

School types	Number of schools	Number of classes	Number of students		
			Boys	Girls	All
General	123	237	1,867	1,752	3,678
<b>Totals</b>	123	237	1,867	1,752	3,678

\* Note: Use information from the class room reports.

**1d).** Response rates % (participating students as percentage of students in national population).

<b>Boys</b>	80,1
<b>Girls</b>	81,0
<b>All students</b>	81,8

**Note:** Response rate is higher for ‘all students’ because of missing data on gender.

1e). Number of students that refused to participate.\*

	<b>Absolute numbers</b>
<b>Boys</b>	4
<b>Girls</b>	3
<b>All students</b>	7

\* Note: Use information from the class room reports.

1f). When relevant: Number of students whose parents denied participation.\*

	<b>Absolute numbers</b>
<b>Boys</b>	8
<b>Girls</b>	5
<b>All students</b>	13

\* Note: Use information from the class room reports.

1g). Number of participating students from the target population.

	<b>Absolute numbers</b>
<b>Boys</b>	1,867
<b>Girls</b>	1,752
<b>All students</b>	3,678

**Tables 2-7: Information from the class room reports. (Absolute numbers)**

**Table 2.** Did you notice any disturbances during completion of the forms?

	<b>Absolute numbers</b>
No	194
Yes, from a few students	31
Yes, from less than half of the students	4
Yes, from about half of the students	5
Yes, from more than half of the students	3

**Table 3.** What kind of disturbances?

	<b>Absolute numbers</b>
Giggles or eye makings to the class mates	23
Loud comments	13
Other kinds of comments	3

**Tables 4 – 7.** Information not available

# **Appendix 3**

## **The Icelandic ESPAD 2007 Questionnaire**



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**Kæri nemandi,**

Takk fyrir að svara þessum spurningalista – **við vitum að það eru margar kannanir í gangi núna** og það getur verið þreytandi að svara svipuðum spurningum í mörgum spurningalistum. Við erum þess vegna mjög ánægð að þú skulir taka þátt í okkar rannsókn.

Með því að svara spurningunum hjálpar þú okkur að skilja hvernig það er að vera unglíngur á Íslandi miðað við önnur lönd í Evrópu. Þessa dagana er verið að leggja svona spurningalista fyrir meira en **100.000 nemendur í fjörutíu löndum**.

Vegna þess að rannsóknin er alþjóðleg geta sumar spurningarnar átt illa við um íslenska unglíngi. Stundum getur líka verið erfitt að velja bara eitt svar og stundum passar ekkert svar nákvæmlega. Það er samt mikilvægt að þú veljir það svar sem þér finnst að passi helst fyrir þig.

### **Það sem þú þarft að vita**

Svör þín verða trúnaðarmál og enginn á að vita hver svaraði hvaða lista. Þess vegna mátt þú ekki skrifa nafnið þitt á spurningalistann. Þegar þú hefur svarað öllum spurningum skal þú setja spurningalistann í umslagið og líma vel fyrir.

Það er ekki skylda að taka þátt í rannsókninni. Ef þú treystir þér ekki til að svara einverri spurningu skaltu sleppa henni. Við vonum samt að þú svarir þeim öllum. Öll íslensku umslögin verða opnuð í einu og spurningalistarnir verða lesnir beint inn í tölvu. Enginn í skólanum þínum mun sjá spurningalistann þinn.

Best er að nota dökkkan blýant eða bláan eða svartan penna til að svara. Settu kross í reitinn sem þú hefur valið því annars getum við ekki talið svar þitt með. **Ekki fylla alveg út í reitina sem þú merkir – gerðu bara X.**

Þú getur fengið meiri upplýsingar um ESPAD rannsóknina á slóðinni [www.espad.is](http://www.espad.is). Þar getur þú líka bráðum séð hvað kom út úr könnuninni sem þú ert að fara að svara.

Þakka þér kærlega fyrir að taka þátt!

**Starfsfólk Rannsóknarseturs forvarna við Háskólann á Akureyri**

## Eftirfarandi spurningar eru um bakgrunn þinn og daglegt líf

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### 1. Ert þú strákur eða stelpa?

- Strákur  
 Stelpa

### 2. Hvaða ár ert þú fædd(ur)?

- 1989  
 1990  
 1991  
 1992  
 1993

### 3. Í hvaða bekk ert þú?

8. bekk  
 9. bekk  
 10. bekk

### 4. Hversu oft (ef nokkru sinni) gerir þú eftirfarandi?

Merktu í einn reit í hverri línu.

	Aldrei	Nokkrum sinnum á ári	1-2 sinnum í mánuði	A.m.k. vikulega	Nánast daglega
a) Spilar tölvuleiki	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Tekur þátt í íþróttum eða líkamsrækt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Lest bækur þér til skemmtunar (ekki skólabækur)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Ferð út á kvöldin (t.d. á ball, kaffihús, í partí)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Sinnir áhugamálum (t.d. spilar á hljóðfæri, syngur, teiknar, skrifar)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Ert á ferðinni með vinum (t.d. í verslunarmiðstöð, úti á götu eða á opnu svæði)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Notar internetið til skemmtunar (t.d. spjall, sækja tónlist, spila leiki)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Spilar á spilakassa sem gefa peninga í vinning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 5. Hversu oft (ef nokkru sinni) gerir þú eftirfarandi?

Merktu í einn reit í hverri línu.

	Aldrei	Nokkrum sinnum á ári	1-2 sinnum í mánuði	A.m.k. vikulega	Nánast daglega
a) Lest dagblöðin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Hlustar á tónlist í útvarpinu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Hlustar á annað í útvarpinu (t.d. fréttir, spjallþætti)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Hlustar á tónlist sem þú velur sjálf/ur (t.d. af geisladiski, netinu, iPod)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Horfir á bíómynd eða framhaldspátt á sjónvarpsstöð	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Horfir á bíómynd eða framhaldspátt á vídeó eða DVD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Horfir á bíómynd eða framhaldspátt af netinu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Skrifar á þína eigin bloggsíðu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Lest bloggsíður annarra	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 6. Hversu lengi ert þú fyrir framan sjónvarp eða tölvu á venjulegum degi?

Merktu í einn reit í hverri línu.

	Ekkert	Hálftíma eða minna	Um 1 klukku tíma	Um 2 klukku tíma	Um 3 klukku tíma	Um 4 klukku tíma	5 eða fleiri klukku tíma
a) Sjónvarp (t.d. sjónvarpsstöð, vídeó, DVD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Tölvu (t.d. skólaverkefni, á netinu, bíómyndir, tölvuleiki)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 7. Bloggsíður hjá hverjum lest þú yfirleitt?

Merktu við allt sem við á.

- Ég les yfirleitt aldrei blogg annarra
- Einhverjum í fjölskyldunni minni
- Besta vini/bestu vinum
- Kunningjum eða skólafélögum
- Ungu fólki sem ég þekki lítið eða ekkert
- Fullorðnu fólki sem ég þekki lítið eða ekkert
- Annað, hvað?

**8. Hversu marga daga hefur þú misst af einni eða fleiri kennslustundum Á SÍÐUSTU 30 DÖGUM?**Merktu í einn reit í hverri línu.

	Engan dag	1 dag	2 daga	3-4 daga	5-6 daga	7 eða fleiri daga
a) Vegna veikinda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Skrópaðir	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Af öðrum ástæðum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**9. Hvaða einkunn lýsir best meðaleinkunn þinni á síðustu jólaprófum?**Merktu aðeins í einn reit.

Um 5 eða lægra	Um 6	Um 7	Um 8	Um 9	Um 10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**10. Hvað finnst þér líklegt að þú gerir næsta vetur?**Merktu í einn reit í hverri línu.

	Mjög ólíklegt	Frekar ólíklegt	Hvorki né	Frekar líklegt	Mjög líklegt
a) Farir að vinna fulla vinnu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Farir í framhaldsskóla til að taka stúdentspróf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Farir í framhaldsskóla til að stunda iðnnám (t.d. rafvirkjun, gullsmíði, hárgreiðslu)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**11. Hvað vinnur þú marga tíma í launaðri vinnu með skólanum Á VIKU?**Merktu aðeins í einn reit.

Vinn ekki í vetur	1-4 klukkutíma	5-9 klukkutíma	10-14 klukkutíma	15-19 klukkutíma	20-24 klukkutíma	25 klukkutíma eða meira
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**12. Hversu oft í viku gerir þú eftirfarandi?**Merktu í einn reit í hverri línu.

	Aldrei	Sjaldnar en vikulega	Einu sinni í viku	Tvisvar í viku	Þrisvar í viku	4-5 sinnum í viku	Nánast daglega
a) Tekur þátt í leikfimi eða sundi í skólanum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Æfir eða keppir með íþróttafélagi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Stundar íþróttir eða æfingar <u>hvorki</u> á vegum skólans <u>né</u> íþróttafélags	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Hér er spurt um sigarettur og annað tóbak

### 13. Hversu erfitt væri fyrir þig að útvega þér sigarettur ef þú vildir?

Merktu aðeins í einn reit.

Útilokað	Mjög erfitt	Frekar erfitt	Frekar auðvelt	Mjög auðvelt	Ég veit það ekki
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 14. Hvenær (ef nokkru sinni) gerðir þú eitthvað af eftirtöldu í fyrsta skipti?

Merktu í einn reit í hverri línu.

	Aldrei	9 ára eða yngri	10 ára	11 ára	12 ára	13 ára	14 ára	15 ára	16 ára eða eldri
a) Reyktir fyrstu sigarettuna	<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) Reyktir sigarettur daglega	<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"/>

### 15. Hversu oft (ef nokkru sinni) UM ÆVINA hefur þú reykt sigarettur eða notað annað tóbak?

Merktu í einn reit í hverri línu.

	Aldrei	1-2 sinnum	3-5 sinnum	6-9 sinnum	10-19 sinnum	20-39 sinnum	40 sinnum eða oftar
a) Reykt sigarettur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Notað munntóbak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Notað neftóbak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 16. Hversu mikið (ef nokkuð) hefur þú reykt að jafnaði SÍÐUSTU 30 DAGA?

Merktu aðeins í einn reit.

Ekkert	Minna en 1 sigarettu á viku	Minna en 1 sigarettu á dag	1-5 sigarettur á dag	6-10 sigarettur á dag	11-20 sigarettur á dag	Meira en 20 sigarettur á dag
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 17. Hversu oft (ef nokkru sinni) hefur þú notað annað tóbak SÍÐUSTU 30 DAGA?

Merktu í einn reit í hverri línu.

	Aldrei	1-2 sinnum	3-5 sinnum	6-9 sinnum	10-19 sinnum	20-39 sinnum	40 sinnum eða oftar
a) Munntóbak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Neftóbak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 18. Reykir einhver heima hjá þér?

Merktu við allt sem við á.

Það reykir enginn heima hjá mér	Pabbi reykir	Mamma reykir	Eitthvert systkini reykir	Einhver annar á heimilinu reykir
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Hér er spurt um áfengi – t.d. bjór, áfenga gosdrykki, léttvín og sterkt áfengi

### 19. Hversu erfitt væri fyrir þig að útvega þér eftirtalið ef þú vildir?

Merktu í einn reit í hverri línu.

	Útilokað	Mjög erfitt	Frekar erfitt	Frekar auðvelt	Mjög auðvelt	Ég veit það ekki
a) Bjór	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Áfengan síder (cider)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Áfenga gosdrykki (t.d. Breezer)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Léttvín (t.d. hvítvín, rauðvín)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Sterkt áfengi (t.d. vodka, gin, viskí)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 20. Hvenær (ef nokkru sinni) gerðir þú eitthvað af eftirtöldu í fyrsta skipti?

Merktu í einn reit í hverri línu.

	Aldrei	9 ára eða yngri	10 ára	11 ára	12 ára	13 ára	14 ára	15 ára	16 ára eða eldri
a) Drakkst bjór (a.m.k. 1 glas)	<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) Drakkst áfengan síder (a.m.k. 1 glas)	<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) Drakkst áfengan gosdrykk (amk. 1 glas)	<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) Drakkst léttvín (a.m.k. 1 glas)	<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) Drakkst sterkt áfengi (a.m.k. 1 drykk)	<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) Varðst drukkin/n	<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"/>

### 21. Hversu oft (ef nokkru sinni) hefur þú drukkið áfengi af einhverju tagi?

Merktu í einn reit í hverri línu.

	Aldrei	1-2 sinnum	3-5 sinnum	6-9 sinnum	10-19 sinnum	20-39 sinnum	40 sinnum eða oftar
a) Um ævina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Síðustu 12 mánuði	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Síðustu 30 daga	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 22. Hvað er langt síðan þú drakkst SÍÐAST áfengi?

Merktu aðeins í einn reit.

Aldrei	1-7 dagar	8-14 dagar	15-30 dagar	Einn mánuður til eitt ár	Meira en eitt ár
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**23. Hversu oft (ef nokkru sinni) hefur þú orðið drukkin/n?**Merktu í einn reit í hverri línu.

	Aldrei	1-2 sinnum	3-5 sinnum	6-9 sinnum	10-19 sinnum	20-39 sinnum	40 sinnum eða oftar
a) Um ævina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Síðustu 12 mánuði	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Síðustu 30 daga	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**24. Hversu drukkin/n varstu síðast þegar þú drakkst áfengi (ef nokkru sinni)?**Merktu aðeins í einn reit.

Ekkert drukkinn/n	1	2	3	4	5	6	7	8	9	Mjög drukkinn/n
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

 Ég drekk aldrei áfengi**25. Hugsaðu um SÍÐUSTU 30 DAGA. Hversu oft (ef nokkru sinni) hefur þú drukkið fimm eða fleiri áfenga drykki í röð? (Einn drykkur er t.d. ein bjórdós, eitt glas af léttvíni, einn drykkur af sterku áfengi).**Merktu í einn reit.

Aldrei	1 skipti	2 skipti	3-5 skipti	6-9 skipti	10 skipti eða oftar
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**26. Hugsaðu um SÍÐUSTU 30 DAGA. Í hversu mörg skipti (ef nokkru sinni) hefur þú drukkið eftirtalið?**Merktu í einn reit í hverri línu.

	Aldrei	1-2 sinnum	3-5 sinnum	6-9 sinnum	10-19 sinnum	20-39 sinnum	40 sinnum eða oftar
a) Bjór	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Áfengan síder (cider)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Áfenga gosdrykki (t.d. Breezer)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Léttvín (t.d. hvítvín, rauðvín)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Sterkt áfengi (t.d. blandað eða óblandað vodka, gin, viskí)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Hér er spurt um SÍÐASTA SKIPTIÐ sem þú drakkst áfengi (ef nokkru sinni)

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27. Hugsaðu um SÍÐASTA SKIPTIÐ sem þú drakkst áfengi af einhverju tagi. Hvaða tegundir af áfengi drakkstu þann dag? Merktu við allt sem við á.

- Ég drekk aldrei áfengi
- Bjór
- Áfengan síder (cider)
- Áfengan gosdrykk (t.d. Breezer, Woody's)
- Léttvín (t.d. hvítvín, rauðvín)
- Sterkt áfengi (t.d. blandað eða óblandað vodka, gin, viskí)

28. Drakkstu einhvern bjór SÍÐAST þegar þú drakkst áfengi?

Merktu aðeins í einn reit.

- |                                  |                                       |                              |                          |                          |                              |
|----------------------------------|---------------------------------------|------------------------------|--------------------------|--------------------------|------------------------------|
| Nei, ég drekk <u>aldrei</u> bjór | Nei, ég drakk ekki bjór <u>síðast</u> | Já, minna en eina dós/flösku | Já, 1-2 dósir/flöskur    | Já, 3-4 dósir/flöskur    | Já, meira en 4 dósir/flöskur |
| <input type="checkbox"/>         | <input type="checkbox"/>              | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>     |

29. Drakkstu einhvern áfengan síder (cider) SÍÐAST þegar þú drakkst áfengi?

Merktu aðeins í einn reit.

- |   |  |                              |                          |                          |                              |
|---|--|------------------------------|--------------------------|--------------------------|------------------------------|
| Nei, ég drekk <u>aldrei</u> áfengan síder | Nei, ég drakk ekki áfengan síder <u>síðast</u> | Já, minna en eina dós/flösku | Já, 1-2 dósir/flöskur    | Já, 3-4 dósir/flöskur    | Já, meira en 4 dósir/flöskur |
| <input type="checkbox"/>                  | <input type="checkbox"/>                       | <input type="checkbox"/>     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>     |

30. Drakkstu áfengan gosdrykk (t.d. Breezer, Woody's) SÍÐAST þegar þú drakkst áfengi?

Merktu aðeins í einn reit.

- |  |   |                          |                          |                          |                          |
|--|---|--------------------------|--------------------------|--------------------------|--------------------------|
| Nei, ég drekk <u>aldrei</u> áfenga gosdrykki | Nei, ég drakk ekki áfengan gosdrykk <u>síðast</u> | Já, minna en eina flösku | Já, 1-2 flöskur          | Já, 3-4 flöskur          | Já, meira en 4 flöskur   |
| <input type="checkbox"/>                     | <input type="checkbox"/>                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

31. Drakkstu eitthvað léttvín (t.d. hvítvín, rauðvín) SÍÐAST þegar þú drakkst áfengi?

Merktu aðeins í einn reit.

- |                                     |  |                          |                          |                          |                          |
|-------------------------------------|--|--------------------------|--------------------------|--------------------------|--------------------------|
| Nei, ég drekk <u>aldrei</u> léttvín | Nei, ég drakk ekki léttvín <u>síðast</u> | Já, minna en tvö glös    | Já, 2-3 glös             | Já, 4-6 glös             | Já, meira en 6 glös      |
| <input type="checkbox"/>            | <input type="checkbox"/>                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

32. Drakkstu eitthvað sterkt áfengi (t.d. blandað eða óblandað vodka, gin, viskí) SÍÐAST þegar þú drakkst áfengi? Merktu aðeins í einn reit.

- |   |  |                          |                          |                          |                          |
|---|--|--------------------------|--------------------------|--------------------------|--------------------------|
| Nei, ég drekk <u>aldrei</u> sterkt áfengi | Nei, ég drakk ekki sterkt áfengi <u>síðast</u> | Já, minna en tvo drykki  | Já, 2-3 drykki           | Já, 4-6 drykki           | Já, meira en 6 drykki    |
| <input type="checkbox"/>                  | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



## Hér eru nokkrar viðbótarspurningar um áfengi og fleira

### 33. Hversu oft (ef nokkru sinni) um ævina hefur þú fengið áfengi á eftirfarandi hátt?

Merktu í einn reit í hverri línu.

	Aldrei	Einu sinni	Tvisvar sinnum	3-5 sinnum	6-9 sinnum	10 sinnum eða oftar
a) Þú sjálf/ur farið inn í vínbúð og keypt áfengi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Foreldrar þínir keypt áfengi fyrir þig í vínbúð	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Einhver annar keypt áfengi fyrir þig í vínbúð	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Vinir eða kunningjar gefið þér áfengi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Þú útvegað þér heimabruggað áfengi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Þú útvegað þér smyglað áfengi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Þú tekið áfengi heima hjá þér án þess að foreldrar þínir vissu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 34. Hversu oft á SÍÐUSTU 12 MÁNUÐUM lentir þú í eftirtöldu vegna ÞINNAR EIGIN ÁFENGISNEYSLU?

Merktu í einn reit í hverri línu.

	Aldrei	1-2 sinnum	3-5 sinnum	6-9 sinnum	10-19 sinnum	20-39 sinnum	40 sinnum eða oftar
a) Lent í slagsmálum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Orðið fyrir slysi eða meiðslum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Lent í vandræðum við foreldra þína	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Lent í vandræðum við vini þína	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Staðið þig illa í skóla eða vinnu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Einhverju verið stolið eða rænt frá þér	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Lent í vandræðum við lögregluna	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Lent á spítala eða slysadeild	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Haft samfarir án þess að nota smokk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Haft samfarir sem þú sást eftir næsta dag	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 35. Hefur þú einhvern tíma notað róandi lyf eða svefnlyf vegna þess að læknir sagði þér að gera það?

Merktu aðeins í einn reit.

- |                          |                            |                            |
|--------------------------|----------------------------|----------------------------|
| Nei, aldrei              | Já, í minna en þrjár vikur | Já, í meira en þrjár vikur |
| <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/>   |

## Hér er spurt um ýmis vímuefni

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### 36. Hversu erfitt væri fyrir þig að útvega þér hass eða marjúana (kannabis) ef þú vildir?

Merktu aðeins í einn reit.

Útilokað	Mjög erfitt	Frekar erfitt	Frekar auðvelt	Mjög auðvelt	Ég veit það ekki
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 37. Hversu oft (ef nokkru sinni) hefur þú notað hass eða marjúana (kannabis)?

Merktu í einn reit í hverri línu.

	Aldrei	1-2 sinnum	3-5 sinnum	6-9 sinnum	10-19 sinnum	20-39 sinnum	40 sinnum eða oftar
a) Um ævina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Síðustu 12 mánuði	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Síðustu 30 daga	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 38. Hvenær (ef nokkru sinni) prófaðir þú hass eða marjúana (kannabis) í fyrsta skipti?

Merktu aðeins í einn reit.

Aldrei	9 ára eða yngri	10 ára	11 ára	12 ára	13 ára	14 ára	15 ára	16 ára eða eldri
<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"/>

### 39. Hversu oft UM ÆVINA hefur þú haft TÆKIFÆRI til að prófa hass eða marjúana EN EKKI PRÓFAÐ?

Merktu aðeins í einn reit.

Aldrei	1-2 sinnum	3-5 sinnum	6-9 sinnum	10-19 sinnum	20-39 sinnum	40 sinnum eða oftar
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 40. Hversu erfitt væri fyrir þig að útvega þér eftirtalin efni ef þú vildir?

Merktu í einn reit í hverri línu.

	Útilokað	Mjög erfitt	Frekar erfitt	Frekar auðvelt	Mjög auðvelt	Veit ekki
a) Svefntöflur eða róandi lyf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Amfetamín eða spítt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) E-töflu (alsælu, ecstasy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Efni til að „sniffa“ (t.d. lím)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**41. Hversu oft (ef nokkru sinni) hefur þú notað e-töflu (alsælu, ecstasy)?**Merktu í einn reit í hverri línu.

	Aldrei	1-2 sinnum	3-5 sinnum	6-9 sinnum	10-19 sinnum	20-39 sinnum	40 sinnum eða oftar
a) Um ævina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Síðustu 12 mánuði	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Síðustu 30 daga	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**42. Hversu oft (ef nokkru sinni) hefur þú „sniffað“ (t.d. lím) til að komast í vímu?**Merktu í einn reit í hverri línu.

	Aldrei	1-2 sinnum	3-5 sinnum	6-9 sinnum	10-19 sinnum	20-39 sinnum	40 sinnum eða oftar
a) Um ævina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Síðustu 12 mánuði	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Síðustu 30 daga	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**43. Hversu oft (ef nokkru sinni) hefur þú notað eftirtalin efni um ævina?**Merktu í einn reit í hverri línu.

	Aldrei	1-2 sinnum	3-5 sinnum	6-9 sinnum	10-19 sinnum	20-39 sinnum	40 sinnum eða oftar
a) Svefntöflur eða róandi lyf (án lyfseðils frá lækni)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Amfetamín eða spítt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) LSD eða sýru	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Krakk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Kókaín	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Relevín	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Heróín	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Sveppi sem valda vímu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Smjörkýru (GHB)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Anabólíska stera (t.d. bola)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Vímuefni með sprautu í æð	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Áfengi með pillum til að auka vímu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**44. Hvenær (ef nokkru sinni) gerðir þú eitthvað af eftirtöldu í fyrsta skipti?**

Merktu í einn reit í hverri línu.

	Aldrei	9 ára eða yngri	10 ára	11 ára	12 ára	13 ára	14 ára	15 ára	16 ára eða eldri
a) Prófaðir amfetamín eða spítt	<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) Prófaðir svefntöflur/róandi lyf (án lyfseðils frá lækni)	<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) Prófaðir e-töflu (alsælu, 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"/>
d) Prófaðir að „sniffa“ (t.d. lím) til að komast í vímu	<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) Prófaðir áfengi með pillum til að auka vímu	<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"/>

**45. Hversu oft á SÍÐUSTU 12 MÁNUÐUM lentir þú í eftirtöldu vegna ÞINNAR EIGIN neyslu á ólöglegum vímuefnum? (t.d. neyslu á hassi eða marjúana, e-töflu, amfetamíni).**

Merktu í einn reit í hverri línu.

	Aldrei	1-2 sinnum	3-5 sinnum	6-9 sinnum	10-19 sinnum	20-39 sinnum	40 sinnum eða oftar
a) Lent í slagsmálum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Orðið fyrir slysi eða meiðslum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Lent í vandræðum við foreldra þína	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Lent í vandræðum við vini þína	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Staðið þig illa í skóla eða vinnu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Einhverju verið stolið eða rænt frá þér	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Lent í vandræðum við lögregluna	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Lent á spítala eða slysadeild	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Haft samfarir án þess að nota smokk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Haft samfarir sem þú sást eftir næsta dag	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**46. Hugsaðu um SÍÐUSTU 30 DAGA. Hversu miklum peningum hefur þú eytt í tóbak, áfengi eða hass eða marjúana (kannabis)?**

Merktu í einn reit í hverri línu.

	Engum peningum	300 kr. eða minna	400-600 krónur	700-1500 krónur	1600-3000 krónur	3000-7000 krónur	Meira en 7000 krónur
a) Tóbak (t.d. sigarettur)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Áfengi (t.d. bjór, léttvín, sterkt áfengi)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Hass eða marjúana (kannabis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Hér er spurt um skoðanir þínar og viðhorf

### 47. Hversu hátt hlutfall nemenda í 10. bekk á Íslandi telur þú að geri eftirtalið?

Merktu í einn reit í hverri línu.

	0-9%	10-19%	20-29%	30-39%	40-49%	50-59%	60-69%	70-79%	80-89%	90-100%
a) Reyki daglega	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Drekki áfengi mánaðarlega eða oftar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 48. Hversu mikla fræðslu hefur þú fengið frá starfsmönnum skólans um eftirfarandi?

Merktu í einn reit í hverri línu.

	Enga	Of litla	Hæfilega	Of mikla
a) Tóbak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Áfengi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Önnur vímuefni	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 49. Hversu mikla fræðslu hefur þú fengið frá foreldrum eða öðrum fullorðnum ættingjum um eftirfarandi?

Merktu í einn reit í hverri línu.

	Enga	Of litla	Hæfilega	Of mikla
a) Tóbak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Áfengi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Önnur vímuefni	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 50. Hversu margir af vinum þínum heldur þú að geri eftirtalið?

Merktu í einn reit í hverri línu.

	Engir	Fáir	Nokkrir	Flestir	Allir
a) Reyki sígarettur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Drekki áfengi (bjór, léttvín, sterkt áfengi)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Verði drukkinnir	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Reyki hass eða marijúana (kannabis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Taki svefntöflur eða róandi lyf (án lyfseðils læknis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Noti e-töflur (alsælu eða ecstasy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Noti sniffefni til að komast í vímu (t.d. lím)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**51. Gerir eitthvert eldri systkina þinna eftirtalið?**Merktu í einn reit í hverri línu.

	Já	Nei	Veit ekki	Á ekki eldri systkini
a) Reykir sígarettur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Drekkur áfengi (bjór, léttvín, sterkt áfengi)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Verður drukkin/n	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Reykir hass eða marijúana (kannabis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Tekur svefntöflur eða róandi lyf án lyfseðils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Notar e-töflur (alsælu eða ecstasy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) „Sniffar“ (t.d. lím) til að komast í vímu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**52. Hversu mikla hættu telur þú vera á því að fólk skaði sig á eftirtöldu?**Merktu í einn reit í hverri línu.

	Engin hætta	Lítill hætta	Nokkur hætta	Mikil hætta	Veit ekki
a) Að reykja sígarettur öðru hverju	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Að reykja pakka eða meira af sígarettum á dag	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Að drekka 1-2 áfenga drykki á næstum hverjum degi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Að drekka 4-5 áfenga drykki á næstum hverjum degi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Að drekka fimm eða fleiri áfenga drykki um hverja helgi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Að prófa hass eða marijúana einu sinni eða tvisvar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Að reykja hass eða marijúana öðru hverju	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Að reykja hass eða marijúana reglulega	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Að prófa e-töflu (alsælu, ecstasy) einu sinni eða tvisvar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Að nota e-töflu (alsælu, ecstasy) reglulega	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Að prófa amfetamín eða spítt einu sinni eða tvisvar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Að nota amfetamín eða spítt reglulega	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**53. Ef þú hefðir prófað hass, heldurðu að þú hefðir sagt frá því í þessum spurningalista?**Merktu í einn reit.

Ég er búinn að segja að ég hef prófað hass

Já, örugglega

Já, líklega

Nei, líklega ekki

Nei, örugglega ekki

## Eftirfarandi spurningar eru um bakgrunn þinn

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### 54. Hverjir búa á sama heimili og þú?

(Ef þú býrð á fleiri en einu heimili svarar þú fyrir það heimili sem þér finnst þitt aðalheimili)  
Merktu við allt sem við á.

- Ég bý ein/n
- Faðir
- Stjúpfaðir, fósturfaðir eða kærasti foreldris
- Móðir
- Stjúpmóðir, fósturmóðir eða kærasta foreldris
- Eldri systkini (stjúpsystkini eða fóstursystkini)
- Yngri systkini (stjúpsystkini eða fóstursystkini)
- Afi og/eða amma
- Aðrir ættingjar fjölskyldu minnar
- Kærasta mín/kærasti minn
- Aðrir sem ekki eru hluti af fjölskyldunni

### 55. Hver er menntun foreldra þinna? (Ef þú ert alin/n upp hjá fósturföður eða fósturmóður svarar þú fyrir hann eða hana). Merktu í einn reit í hverri línu.

	Lauk grunnskóla eða minna	Hóf nám í framhaldsskóla	Lauk námi í framhaldsskóla	Hóf nám í háskóla	Lauk námi í háskóla	Veit ekki	Á ekki við
a) Menntun föður þíns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Menntun móður þinnar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 56. Hversu gott hefur fjölskylda þín það peningalega miðað við aðrar fjölskyldur í landinu?

Merktu í einn reit.

Miklu betra	Töluvert betra	Svolítið betra	Svipað og aðrar	Svolítið verra	Töluvert verra	Miklu verra
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 57. Hefur þú einhvern tímann um ævina búið í öðru landi í eitt ár eða lengur? Merktu við allt sem við á.

Nei, aldrei	Já, þegar ég var 12 ára eða yngri	Já, þegar ég var 13 ára eða eldri
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 58. Svaraðu eftirfarandi spurningum eftir því sem þær eiga við um þig

Merktu í einn reit í hverri línu.

	Á höfuðborgar-svæðinu	Í sjávarþorpi	Í öðru þéttbýli	Í sveit	Í útlöndum
a) Hvar áttu heima núna?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Hvar finnst þér líklegast að þú munir búa í framtíðinni?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Hvar vildir þú helst búa?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

59. Er móðir þín af íslenskum uppruna? Merktu í einn reit.

- Já, hún er af íslenskum uppruna
- Nei, en hún fæddist samt á Íslandi
- Nei, hún flutti til Íslands áður en ég fæddist
- Nei, hún flutti til Íslands þegar ég var tólf ára eða yngri
- Nei, hún flutti til Íslands þegar ég var þrettán ára eða eldri
- Nei, hún hefur aldrei búið á Íslandi

60. Er faðir þinn af íslenskum uppruna? Merktu í einn reit.

- Já, hann er af íslenskum uppruna
- Nei, hann fæddist samt á Íslandi
- Nei, en hann flutti til Íslands áður en ég fæddist
- Nei, hann flutti til Íslands þegar ég var tólf ára eða yngri
- Nei, hann flutti til Íslands þegar ég var þrettán ára eða eldri
- Nei, hann hefur aldrei búið á Íslandi

61. Hvaða tungumál talar fjölskyldan heima hjá þér? Merktu í einn reit.

- |                          |                                      |                             |                                      |                          |
|--------------------------|--------------------------------------|-----------------------------|--------------------------------------|--------------------------|
| Alltaf íslensku          | Oftast íslensku en stundum annað mál | Jafnt íslensku og annað mál | Stundum íslensku en oftast annað mál | Aldrei íslensku          |
| <input type="checkbox"/> | <input type="checkbox"/>             | <input type="checkbox"/>    | <input type="checkbox"/>             | <input type="checkbox"/> |

62. Hversu líklegt er að þú munir í framtíðinni flytja til útlanda? Merktu í einn reit.

	Mjög ólíklegt	Frekar ólíklegt	Hvorki né	Frekar líklegt	Mjög líklegt
a) Í eitt ár eða meira	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Fyrir fullt og allt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

63. Hversu stolt/ur ert þú af því að vera Íslendingur? Merktu í einn reit.

- |                          |                          |                          |                          |                                      |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------------------|
| Alls ekki stolt/ur       | Ekki mjög stolt/ur       | Frekar stolt/ur          | Mjög stolt/ur            | Á ekki við því ég er ekki íslensk/ur |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>             |

64. Hvað af eftirtöldu skiptir þig mestu máli? Merktu í einn reit.

- |                                    |                           |                          |                          |
|------------------------------------|---------------------------|--------------------------|--------------------------|
| Bærinn eða staðurinn þar sem ég bý | Landssvæðið þar sem ég bý | Ísland                   | Evrópa                   |
| <input type="checkbox"/>           | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> |



## Eftirfarandi spurningar eru um samband þitt við foreldra þína

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### 65. Hversu oft á eftirfarandi við um þig?

Merktu í einn reit í hverri línu.

	Nær aldrei	Sjaldan	Stundum	Oft	Nær alltaf
a) Ég á auðvelt með að fá hlýju og/eða umhyggju frá mömmu og/eða pabba	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Ég á auðvelt með að fá andlegan stuðning frá mömmu og/eða pabba	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Ég á auðvelt með að fá hlýju og/eða umhyggju frá besta vini eða vinkonu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Ég á auðvelt með að fá andlegan stuðning frá besta vini eða vinkonu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Ég segi foreldrum mínum hvar ég er á kvöldin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Ég geri það sem ég vil þótt foreldrar mínir banni það	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Ég sleppi því að segja foreldrum mínum frá því sem ég ætla að gera ef ég held að þau myndu banna mér það	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Ég get treyst á að mamma og/eða pabbi hjálpi mér ef ég lendi í vandræðum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 66. Hversu oft á eftirfarandi við um foreldra þína?

Merktu í einn reit í hverri línu.

	Nær aldrei	Sjaldan	Stundum	Oft	Nær alltaf
a) Þau setja ákveðnar reglur um hvað ég má gera heima	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Þau setja ákveðnar reglur um hvað ég má gera utan heimilis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Þau vita með hverjum ég er á kvöldin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Þau vita hvar ég er á kvöldin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Þau þekkja bekkjarfélagi mína	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Þau þekkja bestu vini mína	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Þau þekkja foreldra bekkjarfélagi minna	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Þau þekkja foreldra bestu vini minna	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Þau hvetja mig til að gera mitt besta í öllu sem ég geri	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Þau verða óvingjarnleg og kuldaleg við mig ef ég geri eitthvað sem þau eru á móti	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Þau láta mig sjálfa(n) skipuleggja það sem mig langar til að gera	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Hér eru nokkrar spurningar um hvernig þér líður og hvað hefur komið fyrir þig

### 67. Hér fyrir neðan eru ýmsar staðhæfingar um tilfinningar þínar til sjálfs þín.

Merktu í einn reit í hverri línu.

	Mjög sammála	Frekar sammála	Frekar ósammála	Mjög ósammála
a) Ég er ánægð/ur með sjálfa/n mig	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Stundum finnst mér ég einskis virði	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Mér finnst ég hafa marga góða eiginleika	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Ég get gert margt jafn vel og aðrir	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Mér finnst ég ekki hafa margt til að vera stolt/ur af	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Stundum finnst mér ég sannarlega vera gagnslaus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Mér finnst ég vera a.m.k. jafn mikils virði og aðrir	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Ég vildi óska að ég gæti borið meiri virðingu fyrir sjálfum/sjálfri mér	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Þegar allt kemur til alls finnst mér ég vera misheppnaður/misheppnuð	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Ég hef jákvæða afstöðu til sjálfs mín	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 68. Síðustu SJÖ DAGA, hversu oft hefur þú fundið fyrir eftirfarandi?

Merktu í einn reit í hverri línu.

	Sjaldan eða aldrei	Stundum	Mörgum sinnum	Yfirleitt alltaf
a) Ekki haft neina matarlyst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Átt erfitt með að einbeita þér að því sem þú vildir	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Verið þunglynd/ur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Þurft að hafa mikið fyrir hlutunum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Verið dapur/döpur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Ekki getað unnið (heima, í skóla eða vinnu)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 69. Hversu sammála ertu eftirfarandi fullyrðingum?

Merktu í einn reit í hverri línu.

	Mjög sammála	Frekar sammála	Veit ekki	Frekar ósammála	Mjög ósammála
a) Flestar reglur má brjóta ef manni finnst þær ekki eiga við	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Ég fylgi þeim reglum sem mér sjálfum/sjálfri sýnist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Í rauninni eru mjög fáar reglur algildar í lífinu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Það er erfitt að treysta neinu því allt er svo breytilegt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Í rauninni veit enginn til hvers er ætlast af honum í lífinu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Maður getur aldrei verið viss um neitt í lífinu	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**70. Hefur þú einhvern tímann gert eitthvað af eftirtöldu?**Merktu í einn reit í hverri línu.

	Aldrei	Einu sinni	Tvisvar sinnum	3-4 sinnum	5 sinnum eða oftar
a) Strokið að heiman í meira en einn dag	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Hugsað um að meiða sjálfa/n þig	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Reynt að fremja sjálfsmorð	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**71. Hversu oft hefur þú gert eftirtalið síðustu 12 mánuði?**Merktu í einn reit í hverri línu.

	Aldrei	1-2 sinnum	3-5 sinnum	6-9 sinnum	10-19 sinnum	20-39 sinnum	40 sinnum eða oftar
a) Þú varst með hóp að stríða einstaklingi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Þú varst með hóp að meiða einstakling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Þú varst með hóp sem réðist á annan hóp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Þú byrjaðir á slagsmálum við einhvern	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Þú stalst einhverju sem var meira en 2.000 króna virði	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Þú braust inn til að stela	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Þú skemmdir eitthvað viljandi sem þú áttir ekki	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Þú seldir eitthvað sem þú vissir að væri stolið	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**72. Hversu oft hefur þú orðið fyrir eftirtöldu síðustu 12 mánuði?**Merktu í einn reit í hverri línu.

	Aldrei	1-2 sinnum	3-5 sinnum	6-9 sinnum	10-19 sinnum	20-39 sinnum	40 sinnum eða oftar
a) Heill hópur stríddi þér einum/einni	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Heill hópur réðist á þig eina/einn og meiddi þig	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Þú varst með hóp sem annar hópur réðist á	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Einhver byrjaði á slagsmálum við þig	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Einhver stal frá þér einhverju sem var meira en 2.000 króna virði	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Einhver braust inn heima hjá þér til að stela	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Einhver skemmdi viljandi eitthvað sem þú áttir	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Þú keyptir eitthvað sem þú vissir að væri stolið	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Kærar þakkir fyrir þátttökuna!</b>
---------------------------------------

ESPAD á Íslandi  
Rannsóknarsetur forvarna  
Háskólanum á Akureyri  
Sólborg við Norðurslóð  
600 Akureyri

[www.espad.is](http://www.espad.is)

**Appendix 4**  
**The Icelandic ESPAD 2007 Questionnaire**  
***English back-translation***

+



**Kæri nemandi,**

Takk fyrir að svara þessum spurningalista – **við vitum að það eru margar kannanir í gangi núna** og það getur verið þreytandi að svara svipuðum spurningum í mörgum spurningalistum. Við erum þess vegna mjög ánægð að þú skulir taka þátt í okkar rannsókn.

Með því að svara spurningunum hjálpar þú okkur að skilja hvernig það er að vera unglingsur á Íslandi miðað við önnur lönd í Evrópu. Þessa dagana er verið að leggja svona spurningalista fyrir meira en **100.000 nemendur í fjörutíu löndum**.

Vegna þess að rannsóknin er alþjóðleg geta sumar spurningarnar átt illa við um íslenska unglings. Stundum getur líka verið erfitt að velja bara eitt svar og stundum passar ekkert svar nákvæmlega. Það er samt mikilvægt að þú veljir það svar sem þér finnst að passi helst fyrir þig.

### **Það sem þú þarft að vita**

Svör þín verða trúnaðarmál og enginn á að vita hver svaraði hvaða lista. Þess vegna mátt þú ekki skrifa nafnið þitt á spurningalistann. Þegar þú hefur svarað öllum spurningum skal þú setja spurningalistann í umslagið og líma vel fyrir.

Það er ekki skylda að taka þátt í rannsókninni. Ef þú treystir þér ekki til að svara einverri spurningu skaltu sleppa henni. Við vonum samt að þú svarir þeim öllum. Öll íslensku umslögin verða opnuð í einu og spurningalistarnir verða lesnir beint inn í tölvu. Enginn í skólanum þínum mun sjá spurningalistann þinn.

Best er að nota dökkkan blýant eða bláan eða svartan penna til að svara. Settu kross í reitinn sem þú hefur valið því annars getum við ekki talið svar þitt með. **Ekki fylla alveg út í reitina sem þú merkir – gerðu bara X.**

Þú getur fengið meiri upplýsingar um ESPAD rannsóknina á slóðinni [www.espad.is](http://www.espad.is). Þar getur þú líka bráðum séð hvað kom út úr könnuninni sem þú ert að fara að svara.

Þakka þér kærlega fyrir að taka þátt!

**Starfsfólk Rannsóknarseturs forvarna við Háskólann á Akureyri**

**The following questions are about your background and daily life**

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**1. Are you a boy or a girl? (ESP01)**

- Boy  
 Girl

**2. What year were you born? (ESP02)**

- 1989  
 1990  
 1991  
 1992  
 1993

**3. In what class are you? (ICE01)**

8. bekk  
 9. bekk  
 10. bekk

**2. How often (if ever) do you do the following? (ESP03)**

Mark one box in each line.

	Never	A few times a year	1-2 times a month	At least weekly	Almost daily
a) Play computer games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Participate in sports or exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Read books for fun (not schoolbooks)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Go out in the evenings (e.g. to a disco, coffee house or party)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Attend hobbies (e.g. play an instrument, sing, draw or write)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Go around with friends (e.g. mall, in the street or open area)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Use the internet for fun (e.g. chat, download music, play games)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Play slot machines that give money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**3. How often (if ever) do you do the following? (ICE02)**

Mark one box in each line.

	Never	A few times a year	1-2 times a month	At least weekly	Almost daily
a) Read newspapers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Listen to music on the radio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Listen to other things on the radio (e.g. news, chat shows)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Listen to music you pick yourself (e.g. from a CD, the internet or iPod)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Watch a movie or a tv-series on television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Watch a movie or a tv-series on video or DVD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Watch a movie or a tv-series off the internet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Write your own blog page	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Read the blog pages of others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**4. How much time to you spend in front of a television or computer in a usual day? (ICE03)**

Mark one box in each line.

	None	Half an hour or less	About 1 hour	About 2 hours	About 3 hours	About 4 hours	5 or more hours
a) Sjónvarp (t.d. sjónvarpsstöð, vídeó, DVD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Tölvu (t.d. skólaverkefni, á netinu, bíómyndir, tölvuleiki)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**5. Whos blog pages do you usually read? (ICE04)**

Mark all that apply.

- I usually don't read other people's blog pages
- Someone in my family
- My best friend/best friends
- Acquaintances or school mates
- Young people I don't know much or don't know at all
- Grownup people I don't know much or don't know at all
- Someone else, who?



**6. How many days have you missed one or more class periods IN THE PAST 30 DAYS? (ESP04)**

Mark one box in each line.

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

**7. What grade best describes your average grade on the last Christmas exams? (ESP05)**

Mark only one box.

About 5 or less	About 6	About 7	About 8	About 9	About 10
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**8. What do you think is likely you will be doing next winter? (ICE05)**

Mark one box in each line.

	Very unlikely	Rather unlikely	Neither nor	Rather likely	Very likely
a) Will work full-time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Will attend a gymnasium to obtain the student's-exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Will attend a trade school to learn a trade (e.g. electrician, goldsmith, hairdressing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**9. How many hours to you work at a paid job with school EACH WEEK? (ICE06)**

Mark only one box.

Don't work this winter	1-4 hours	5-9 hours	10-14 hours	15-19 hours	20-24 hours	25 hours or more
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**10. How often each week do you do the following? (ICE07)**

Mark one box in each line.

	Never	Less than weekly	Weekly	Twice a week	Three times a week	4-5 times a week	Almost daily
a) Take part in gym or swimming at school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Train or compete with a sports club	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Do sports or exercises that are <u>neither</u> associated with school <u>nor</u> sports club	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## These questions are about cigarettes and other tobacco

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### 11. How difficult would it be for you to obtain cigarettes if you wished to? (ESP06)

Mark only one box.

Impossible	Very difficult	Rather difficult	Rather easy	Very easy	I do not know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 12. When (if ever) did you do the following for the first time? (ESP09)

Mark one box in each line.

	Never	9 years or younger	10 years	11 years	12 years	13 years	14 years	15 years	16 years or older
a) Smoked the first 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) Smoked cigarettes daily	<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"/>

### 13. How often (if ever) IN YOUR LIFETIME have you smoked cigarettes or used other tobacco? (ESP07)

Mark one box in each line.

	Never	1-2 times	3-5 times	6-9 times	10-19 times	20-39 times	40 times or more
a) Smoked cigarettes (ESP07)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Used mouth tobacco (ESP_O10a)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Used nose tobacco (ICE08)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 14. How much (if any) have you smoked cigarettes on average in the LAST 30 DAYS? (ESP08)

Mark only one box.

Nothing	Less than 1 cigarette per week	Less than 1 cigarette per day	1-5 cigarettes per day	6-10 cigarettes per day	11-20 cigarettes per day	More than 20 cigarettes per day
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 15. How often (if ever) have you used other types of tobacco in the LAST 30 DAYS? (ICE09)

Mark one box in each line.

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

### 16. Does somebody smoke in your home? (ICE10)

Mark all that apply.

Nobody smokes in my home	Dad smokes	Mom smokes	A brother or sister smokes	Somebody else in the home smokes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**These questions are about alcohol – e.g. beer, alcoholic soda, wine and strong alcohol**

**17. How difficult would it be for you to get the following if you wanted? (ESP10)**

Mark one box in each line.

	Impossible	Very difficult	Rather difficult	Rather easy	Very easy	I do not know
a) Beer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Alcoholic cider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Alcoholic soda (e.g. Breezer)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Wine (e.g. white wine, red wine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Strong alcohol (e.g. vodka, gin, whiskey)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**18. When (if ever) did you do the following for the first time? (ESP19)**

Mark one box in each line.

	Aldrei	9 years or younger	10 years	11 years	12 years	13 years	14 years	15 years	16 years or older
a) Drank beer (at least 1 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) Drank alcohol cider (at least 1 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"/>
c) Drank alcoholic soda (at least 1 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"/>
d) Drank wine (at least 1 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"/>
e) Drank strong alcohol (at least 1 drink)	<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) Varðst drukkin/n	<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"/>

**19. How often (if ever) have you had alcohol of some kind to drink? (ESP11)**

Mark one box in each line.

	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) 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) Last 30 days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**20. How long is it since you LAST drank alcohol? (ESP13)**

Mark only one box.

Never	1-7 days	8-14 days	15-30 days	On month to one year ago	More than 1 year ago
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**21. How often (if ever) have you been drunk? (ESP18)**

Mark one box in each line.

	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) 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) Last 30 days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**22. How drunk were you the last time you drank alcohol (if ever)? (ESP14f)**

Mark only one box.

Not drunk at all										Extremely drunk
	1	2	3	4	5	6	7	8	9	10
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I never drink alcohol

**23. Think about the LAST 30 DAYS. How often (if ever) have you drunk five or more alcoholic drinks in a row? (ESP17)**

(One drink is e.g. one can of beer, one glass of wine, one drink of strong alcohol. (ESP17))

Mark only one box.

Never	Once	Twice	3-5 times	6-9 times	10 times or more
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**24. Think about the LAST 30 DAYS. How many times (if ever) have you drunk the following? (ESP12)**

Mark one box in each line.

	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) Alcoholic cider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Alcoholic soda (e.g. Breezer)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Wine (e.g. white wine, red wine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Strong alcohol (e.g. vodka, gin, whiskey)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**These questions are about THE LAST TIME you drank alcohol (if ever)**

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**25. Think about the LAST TIME you drank alcohol of any kind. What sorts of alcohol did you drink on that day? Mark all that apply. (ESP14)**

- I never drink alcohol
- Beer
- Alcoholic cider
- Alcoholic soda (e.g. Breezer, Woody's)
- Wine (t.d. white wine, red wine)
- Strong alcohol (e.g. vodka, gin, whisky)

**26. Did you drink any beer the LAST TIME you drank alcohol? (ESP14a)**

Mark only one box.

- |                               |   |                               |                          |                          |                               |
|-------------------------------|---|-------------------------------|--------------------------|--------------------------|-------------------------------|
| No, I <u>never</u> drink beer | No, I did not drink beer <u>last time</u> | Yes, less than one can/bottle | Yes, 1-2 cans/bottles    | Yes, 3-4 cans/bottles    | Yes, more than 4 cans/bottles |
| <input type="checkbox"/>      | <input type="checkbox"/>                  | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>      |

**27. Did you drink any alcoholic cider the LAST TIME you drank alcohol? (ESP14b)**

Mark only one box.

- |  |  |                               |                          |                          |                               |
|--|--|-------------------------------|--------------------------|--------------------------|-------------------------------|
| No, I <u>never</u> drink alcoholic cider | No, I did not drink alcoholic cider <u>last time</u> | Yes, less than one can/bottle | Yes, 1-2 cans/bottles    | Yes, 3-4 cans/bottles    | Yes, more than 4 cans/bottles |
| <input type="checkbox"/>                 | <input type="checkbox"/>                             | <input type="checkbox"/>      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>      |

**28. Did you drink any alcoholic soda the LAST TIME you drank alcohol? (ESP14c)**

Mark only one box.

- |   |  |                           |                          |                          |                          |
|---|--|---------------------------|--------------------------|--------------------------|--------------------------|
| No, I <u>never</u> drink alcoholic soda | No, I did not drink alcoholic cider <u>last time</u> | Yes, less than one bottle | Yes, 1-2 bottles         | Yes, 3-4 bottles         | Yes, more than 4 bottles |
| <input type="checkbox"/>                | <input type="checkbox"/>                             | <input type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**29. Did you drink any wine (e.g. white wine, red wine) the LAST TIME you drank alcohol? (ESP14d)**

Mark only one box.

- |                               |   |                          |                          |                          |                          |
|-------------------------------|---|--------------------------|--------------------------|--------------------------|--------------------------|
| No, I <u>never</u> drink wine | No, I did not drink wine <u>last time</u> | Yes, less than 2 glasses | Yes, 2-3 glasses         | Yes, 4-6 glasses         | Yes, more than 6 glasses |
| <input type="checkbox"/>      | <input type="checkbox"/>                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**30. Did you drink any strong alcohol (e.g. vodka, gin, whisky) the LAST TIME you drank alcohol? (ESP14e)**

Mark only one box.

- |   |   |                          |                          |                          |                          |
|---|---|--------------------------|--------------------------|--------------------------|--------------------------|
| No, I <u>never</u> drink strong alcohol | No, I did not drink strong alcohol <u>last time</u> | Yes, less than 2 glasses | Yes, 2-3 glasses         | Yes, 4-6 glasses         | Yes, more than 6 glasses |
| <input type="checkbox"/>                | <input type="checkbox"/>                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Here are a few additional questions about alcohol and more**

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**31. How often (if ever) have you gotten alcohol in the following way? (ICE11)**

Mark one box in each line.

	Never	Once	Twice	3-5 times	6-9 times	10 times or more
a) You went yourself into a liquorstore and bought alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Your parents bought alcohol for you in a liquorstore	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Someone else bought alcohol for you in a liquorstore	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Friends or acquaintences gave you alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) You obtained homebrewed alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) You obtained smuggled alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) You took alcohol at home without your parents knowledge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**32. How often in the LAST 12 MONTHS did the following happen to you because of YOUR OWN ALCOHOL USE? (ESP21)**

Mark one box in each line.

	Never	1-2 times	3-5 times	6-9 times	10-19 times	20-39 times	40 times or more
a) Got into a fight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Trouble with your parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Trouble with your friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Done poorly at school or work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Something was stolen from you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Trouble with the police	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Went to hospital or emergency room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Had sex without using a condom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Had sex you regretted the next day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**33. Have you ever used sleeping pills or tranquilisers because a doctor told you to? (ESP22)**

Mark only one box.

- No, never
- Yes, for less than three weeks
- Yes, for more than three weeks

## These questions are about various drugs

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### 34. How difficult would it be for you to obtain hashish or marijuana (cannabis) if you wanted (ESP23)?

Mark only one box.

Impossible	Very difficult	Rather difficult	Rather easy	Very easy	I do not know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 35. How often (if ever) have you used hashish or marijuana (cannabis) (ESP24)?

Mark one box in each line.

	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) 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) Last 30 days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 36. When (if ever) did you use hashish or marijuana (cannabis) for the first time? (ESP25)

Mark only one box.

Never	9 years or younger	10 years	11 years	12 years	13 years	14 years	15 years	16 years or older
<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"/>

### 37. How often in your LIFETIME have you have had a CHANCE to try hashish or cannabis BUT DIDN'T TRY IT? (ESP26)

Mark only one box.

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"/>

### 38. How difficult would it be for you to obtain the following substances if you wanted to? (ESP27)

Mark one box in each line.

	Impossible	Very difficult	Rather difficult	Rather easy	Very easy	I do not know
a) Sleeping pills or tranquilisers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Amphetamine or speed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) E-tablet (ecstasy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Substances to "sniff" (e.g. glue)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**39. How often (if ever) have you used an e-tablet (ecstasy)? (ESP28)**

Mark one box in each line.

	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) 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) Last 30 days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**40. How often (if ever) have you "sniffed" (e.g. glue) in order to get high? (ESP29)**

Mark one box in each line.

	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) 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) Last 30 days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**41. How often (if ever) have you used the following substances in your lifetime? (ESP30)?**

Mark one box in each line.

	Never	1-2 times	3-5 times	6-9 times	10-19 times	20-39 times	40 times or more
a) Sleeping pills or tranquilisers (without a prescription from a doctor)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Amphetamine or speed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) LSD or acid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Crack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Cokaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Relevin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Mushrooms that get you high	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Butter acid (GHB)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Anabolic sterroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Drugs injected into a vein with a syringe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Alcohol with pills to increase high	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**42. When (if ever) did you do the following for the first time? (ESP31)**

Mark one box in each line.

	Aldrei	9 years or younger	10 years	11 years	12 years	13 years	14 years	15 years	16 years or older
g) Tried amphetamine or speed	<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"/>
h) Tried sleeping pills or tranquilisers (without a prescription from a doctor)	<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) Tried an e-pill (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"/>
d) Tried "sniffing" (e.g. glue) 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) Tried alcohol with pills to increase 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"/>

**43. How often in the LAST 12 MONTHS did the following happen to you because of YOUR OWN USE of illegal drugs (e.g. use of hashish, cannabis, e-tablet, amphetamine)? (ESP32)**

Mark one box in each line.

	Never	1-2 times	3-5 times	6-9 times	10-19 times	20-39 times	40 times or more
a) Got into a fight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Trouble with your parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Trouble with your friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Done poorly at school or work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Something was stolen from you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Trouble with the police	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Went to hospital or emergency room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Had sex without using a condom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Had sex you regretted the next day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**44. Think about the LAST 30 DAYS. How much money have you spent on tobacco, alcohol, or hashish or marijuana (cannabis)? (ESP33)**

Mark one box in each line.

	None	300 kr. or less	400-600 krónur	700-1500 krónur	1600-3000 krónur	3000-7000 krónur	More than 7000 krónur
a) Tobacco (e.g. cigarettes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Alcohol (e.g. beer, wine, strong alcohol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Hashish or marijuana (cannabis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## These questions are about your views and attitudes

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### 45. What percentage of students in 10th grade in Iceland do you think do the following? (ICE12)

Mark one box in each line.

	0-9%	10-19%	20-29%	30-39%	40-49%	50-59%	60-69%	70-79%	80-89%	90-100%
a) Smoke daily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Drink alcohol at least every month	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 46. How much education have you got from school staff about the following? (ICE13)

Mark one box in each line.

	Enga	Of litla	Hæfilega	Of mikla
b) Tóbak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Áfengi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Önnur vímuefni	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 47. How much education have you got from your parents or other adult relatives about the following? (ICE14)

Mark one box in each line.

	Enga	Of litla	Hæfilega	Of mikla
b) Tóbak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Áfengi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Önnur vímuefni	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 48. How many of your friends do you think do the following? (ESP34)

Mark one box in each line.

	None	Few	Some	Most	All
a) Smoke cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Drink alcohol (beer, wine, strong alcohol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Become drunk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Smoke hashish or marijuana (cannabis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Take sleeping pills or tranquilisers (without a doctors prescription)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Use e-tablets (ecstasy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Use sniffs substances to get high (e.g. glue)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**49. Does any of your older siblings do the following? (ESP35)**

Mark one box in each line.

	Yes	No	Don't know	Don't have older siblings
a) Smokes cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Drinks alcohol (beer, wine, strong alcohol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Becomes drunk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Smokes hashish or marijuana (cannabis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Takes sleeping pills or tranquilisers (without a doctors prescription)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Uses e-tablets (ecstasy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Uses sniffs substances to get high (e.g. glue)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**50. How much danger do you think there is that people harm themselves by doing the following? (ESP36)**

Mark one box in each line.

	No danger	Little danger	Some danger	Much danger	Don't know
a) By smoking cigarettes occasionally	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) By smoking a pack of cigarettes or more each day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) By drinking 1-2 alcoholic drinks almost every day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) By drinking 4-5 alcoholic drinks almost every day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) By drinking five or more alcoholic drinks every weekend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) By trying hashish or marijuana once or twice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) By smoking hashish or marijuana once in a while	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) By smoking hashish or marijuana regularly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) By trying an e-tablet (ecstasy) once or twice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) By using e-tablets (ecstasy) regularly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) By trying amphetamine or speed once or twice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) By using amphetamine or speed regularly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**51. If you had tried hashish, do you think you would have said so in this questionnaire? (ESP44)**

Mark only one box.

I already said I have tried hashish

Yes, definitely

Yes, likely

No, likely not

No, definitely not

**The following questions are about your background**

**52. Who lives in the same home as you? (ESP40)**

(I you live in more than one home you should answer for the home you feel is your main home)

Mark all that apply.

- I live alone
- Father
- Stepfather, fosterfather or boyfriend of a parent
- Mother
- Stepmother, fostermother or girlfriend of a parent
- Older sibling (stepsibling or fostersibling)
- Younger sibling (stepsibling or fostersibling)
- Grandfather and/or grandmother
- Other relatives of my family
- My girlfriend/boyfriend (ICE15)
- Others who are not part of the family

**53. What is your parents education? (If you are raised by a fosterfather or fostermother you should answer for him or her). Mark one box in each line.**

	Finished compulsory school or less	Started gymnasium or trade school	Finished gymnasium or trade school	Started university	Finished university	Don't know	Doesn't apply
a) Your fathers education (ESP37)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Your mothers education (ESP38)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**54. How good does your family have it in money compared to other families in the country?(ESP39)**

Mark only one box.

Much better	Notably better	A little better	Similar to others	A little worse	Notably worse	Much worse
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**55. Have you ever in your life lived in another country for one year or more? (ICE16)**

Mark all that apply.

No, never	Yes, when I was 12 years or younger	Yes, when I was 12 years or older
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**56. Answer the following questions as they apply to you (ICE17)**

Mark one box in each line.

	In the capital region	In a fishing village	In another urban area	In the countryside	Abroad
a) Where do you live now?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Where do you think you will most likely live in the future?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Where would you most want to live?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

57. Is your mother of Icelandic origin? (ICE18) Mark only one box.

- Yes, she is of Icelandic origin
- No, but she was born in Iceland
- No, she moved to Iceland before I was born
- No, she moved to Iceland when I was twelve years or younger
- No, she moved to Iceland when I was thirteen years or older
- No, she has never lived in Iceland

58. Er faðir þinn af íslenskum uppruna? (ICE19) Mark only one box.

- Yes, he is of Icelandic origin
- No, but he was born in Iceland
- No, he moved to Iceland before I was born
- No, he moved to Iceland when I was twelve years or younger
- No, he moved to Iceland when I was thirteen years or older
- No, he has never lived in Iceland

59. What language does your family speak in your home? (ICE20) Mark only one box.

- |                          |  |  |  |                          |
|--------------------------|--|--|--|--------------------------|
| Always Icelandic         | Usually Icelandic but sometimes another language | Equally Icelandic and another language | Sometimes Icelandic but usually another language | Never Icelandic          |
| <input type="checkbox"/> | <input type="checkbox"/>                         | <input type="checkbox"/>               | <input type="checkbox"/>                         | <input type="checkbox"/> |

60. How likely is it that you will move abroad in the future? (ICE21)? Mark one box in each line.

	Very unlikely	Rather unlikely	Neither nor	Rather likely	Very likely
a) For a year or more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) For good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

61. How proud are you of being Icelandic? (ICE22)? Mark only one box.

- |                          |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| Nott at all proud        | Not very proud           | Rather proud             | Very proud               | Doesn't apply because I am not Icelandic |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>                 |

62. What of the following is most important to you? (ICE23) Mark only one box.

- |                                |                          |                          |                          |
|--------------------------------|--------------------------|--------------------------|--------------------------|
| The town or place where I live | The region where I live  | Iceland                  | Europe                   |
| <input type="checkbox"/>       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**The following questions are about your relationship with your parents**

**63. How often does the following apply to you?**

Mark one box in each line.

	Almost never	Seldom	Sometimes	Often	Almost always
a) It is easy for me to get warmth and/or caring from mom and/or dad <b>(ESP42)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) It is easy for me to get mental support from mom and/or dad <b>(ESP42)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) It is easy for me to get warmth and/or caring from my best friend <b>(ESP2)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) It is easy for me to get mental support from my best friend <b>(ESP42)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) I tell my parents where I am in the evenings <b>(ICE24)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) I do what I want to even though my parents forbid it <b>(ICE24)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) I don't tell my parents about what I am about to do if I think they would forbid it <b>(ICE24)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) I can trust that my mom and/or dad will help me if I get into trouble <b>(ICE24)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**64. How often does the following apply to your parents? (ICE42 continued)**

Mark one box in each line.

	Almost never	Seldom	Sometimes	Often	Almost always
a) They set definite rules about what I can do at home <b>(ESP42)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) They set definite rules about what I can do outside of home <b>(ESP42)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) They know with whom I am in the evenings <b>(ESP42)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) They know where I am in the evenings <b>(ESP42)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) They know my classmates <b>(ICE24)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) They know my best friends <b>(ICE24)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) They know my classmates' parents <b>(ICE24)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) They know my best friends' parents <b>(ICE24)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) They encourage me to do my best in everything <b>(ICE24)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) They become unfriendly and cold if I do something they don't want <b>(ICE24)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) They let me organize what I want to do myself <b>(ICE24)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Here are a few questions about how you feel and what has happened to you**

**65. Below are various statements about your feelings towards yourself (ESP\_B1)**

Mark one box in each line.

	Strongly agree	Rather agree	Rather disagree	Strongly disagree
a) I am happy with myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Sometimes I feel worthless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) I feel I have many good qualities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) I can do many things as well as others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) I don't feel I have many things to be proud of	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Sometimes I feel really useless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) I think I am at least as much worth as others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) I wish I could have more respect for myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) Everything considered I feel I am a failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p) I have a positive attitude towards myself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**66. In the past SEVEN DAYS, how often have you experienced the following? (ESP\_B2)**

Mark one box in each line.

	Seldom or never	Sometimes	Often	Usually always
a) Not had any appetite for food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Had difficulties concentration on what you wanted to do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Been depressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Had to put a lot of effort into doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Been sad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Been unable to work (at home, in school, at work)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**67. How much do you agree with the following statements? (ESP\_B3)**

Mark one box in each line.

	Strongly agree	Rather agree	Don't know	Rather disagree	Strongly disagree
c) Most rules can be broken if one doesn't feel they apply	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) I follow the rules I want to follow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) There are really very few universal rules in life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) It is difficult to trust anything because everything changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Nobody really knows what is expected of him in life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) One can never be certain of anything in life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**68. Have you ever done any of the following? (ESP\_B5)**

Mark one box in each line.

	Never	Once	Twice	3-4 times	5 times or more
b) Run away from home for more than one day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Thought about hurting yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Tried to commit suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**69. How often have you done the following in the past 12 months? (ESP\_C1)**

Mark one box in each line.

	Never	1-2 times	3-5 times	6-9 times	10-19 times	20-39 times	40 times or more
a) You were in a group teasing an individual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) You were in a group hurting an individual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) You were in a group that attacked another group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) You started a fight with somebody	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) You stole something that was worth more than 2,00 krónur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) You broke in to steal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) You damaged something on purpose that you did not own	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) You sold something you knew was stolen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**70. How often has the following happened to you in the past 12 months? (ESP\_C2)**

Mark one box in each line.

	Never	1-2 times	3-5 times	6-9 times	10-19 times	20-39 times	40 times or more
a) A whole group teased you alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) A whole group attacked you alone and hurt you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) You were in a group that was attacked by another group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Someone started a fight with you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Someone stole from you something that was worth more than 2,00 krónur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Someone broke into your house to steal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Somewone damaged on purpose something that you owned	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) You bought something you knew was stolen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Thank you very much for your participation!**



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