

Hello!

Thank you for helping us with this survey.

By answering these questions you will help us understand more about the ways in which young people live. The survey is being sent to S2 and S4 classes in schools all over Scotland.

Your answers will be looked at by the Survey team and by no-one else. They will not be seen by your parents or teachers. There is no need to write your name on the questionnaire. After you have filled it in, you can put it in the envelope provided and seal it.

Please take your time to read each question carefully in turn and answer it as honestly as you can. Remember that we are only interested in *your* opinion. It is not a test and there are no right or wrong answers. You may find some questions that don't relate to your life right now but please answer them anyway when asked.

Things you need to know

For most questions you will be asked to tick the box that best fits your answer. Please tick just one box for each question or part of a question, otherwise we won't be able to count your answer. If it is difficult to choose just one answer, please think about what is true most of the time.



**SCOTTISH SCHOOLS ADOLESCENT LIFESTYLE AND SUBSTANCE USE
SURVEY (SALSUS)**

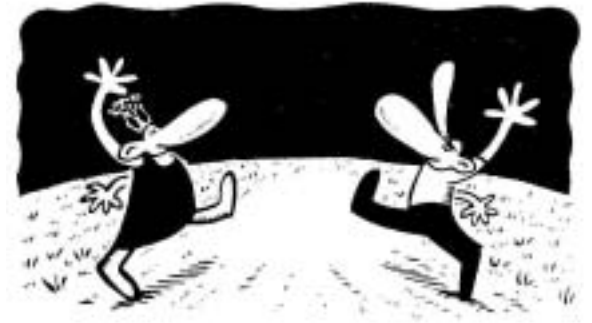
Spring 2002

SECONDARY 4 PUPILS

First - a few details about yourself

1 Are you a boy or a girl?

- 1 Boy
- 2 Girl



2 What class are you in?

- 1 Secondary 2
- 2 Secondary 4

3 What month were you born?

<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"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jan (01)	Feb (02)	Mar (03)	Apr (04)	May (05)	June (06)	July (07)	Aug (08)	Sept (09)	Oct (10)	Nov (11)	Dec (12)

4 What year were you born?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1985	1986	1987	1988	1989	1990

5 Do you know the postcode for your home address?

If you do, tick 'yes' and write it down, if not tick 'no'

- 1 Yes, my postcode is
- 2 No

Do not write in the last 2 letters of your postcode

6 What do you think you will be doing when you leave school?

(tick one box)

- 1 University
- 2 Further Education College
- 3 Apprenticeship/Trade
- 4 Youth Training/Skill Seekers
- 5 Working
- 6 Unemployed
- 7 Don't know

These next two questions are about physical activity

Physical activity is any activity that increases your heart rate and makes you get out of breath some of the time.

Physical activity can be done in sports, school activities, playing with friends, or walking to school.

Some examples of physical activity are running, walking quickly, cycling, dancing, skateboarding, swimming, football, and gymnastics.

For these next two questions, add up all the time you spend in physical activity each day.

7 Over the past 7 days, on how many days were you physically active for a total of at least 60 minutes per day?

- 0 days
- 1
- 2
- 3
- 4
- 5
- 6
- 7 days

8 Over a typical or usual week, on how many days are you physically active for a total of at least 60 minutes per day?

- 0 days
- 1
- 2
- 3
- 4
- 5
- 6
- 7 days

Now we'd like to ask about food and eating

9 During a normal week, how often do you usually have breakfast (with cereal, bread or cooked food)?

- 1 Every day
- 2 4 to 6 days a week
- 3 1 to 3 days a week
- 4 Hardly ever / Never

10 How many times a week do you usually eat or drink ?

Please tick one box for each line

	(1) <i>never</i>	(2) <i>less than once a week</i>	(3) <i>once a week</i>	(4) <i>2-4 days a week</i>	(5) <i>5-6 days a week</i>	(6) <i>once a day, every day</i>	(7) <i>every day, more than once</i>
Fruits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweets (candy or chocolate)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cakes, biscuits, pastries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Potato crisps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chips/fried potatoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coke or other soft drinks that contain sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any alcoholic drink	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11 Some young people go to school or to bed hungry because there is not enough food at home. How often does this happen to you?

1 Always

2 Often

3 Sometimes

4 Never

12 At present are you on a diet or doing something else to lose weight?

1 No, my weight is fine

2 No, but I should lose some weight

3 No, because I need to put on weight

4 Yes

These next questions are about smoking tobacco

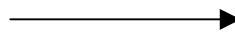
13 Do you smoke cigarettes at all nowadays?

1 Yes

2 No

14 Now read the following statements carefully and tick the box next to the one which best describes you

1 I have never smoked



Go to Question 15

2 I have only ever tried smoking once

3 I used to smoke sometimes but I never smoke a cigarette now

4 I sometimes smoke cigarettes now but I don't smoke as many as one a week

5 I usually smoke between one and six cigarettes a week

6 I usually smoke more than six cigarettes a week

Go to Question 16

15 Just to check, read the statements below carefully and tick the box next to the one which best describes you

- 1 I have never tried smoking a cigarette, not even a puff or two
- 2 I did once have a puff or two of a cigarette, but I never smoke now
- 3 I do sometimes smoke cigarettes



16 **If you DO NOT smoke**
Answer here

How do you think your family would feel if you started smoking?

- 1 They would stop me
- 2 They would try and persuade me not to smoke
- 3 They would do nothing
- 4 They would encourage me to smoke
- 5 I don't know

Now go to Q 19

If you DO smoke
Answer here

How does your family feel about your smoking?

- 1 They stop me _____
- 2 They try and persuade me not to smoke
- 3 They do nothing
- 4 They encourage me to smoke
- 5 I don't know _____
- 6 They don't know I smoke

↓
17 How do you think your family would feel if they knew that you smoked?

- 1 They would stop me
- 2 They would try and persuade me not to smoke
- 3 They would do nothing
- 4 They would encourage me to smoke
- 5 I don't know

18 Are you allowed to smoke at home if you want to? ←

- 1 Yes
- 2 No
- 3 I don't know

19 How many cigarettes do you usually smoke in a week?
(If you do not smoke write 0 (zero) cigarettes a week)

I smoke..... cigarettes a week

These next questions (from Q20-Q24) are for people who SMOKE ONE OR MORE CIGARETTES A WEEK

If you DO NOT SMOKE OR SMOKE LESS THAN ONE CIGARETTE A WEEK go to Q25 on page 9

20 How long is it since you started smoking at least one cigarette a week?

- 1 Less than 3 months
- 2 3-6 months
- 3 6 months to 1 year
- 4 More than one year

21 How easy or difficult would you find it to give up smoking altogether if you wanted to?

- 1 Very difficult
- 2 Fairly difficult
- 3 Fairly easy
- 4 Very easy

22 Would you like to give up smoking?

- 1 Yes
- 2 No

23 Have you ever tried to give up smoking?

1 Yes

2 No

24 Where do you **USUALLY** get your cigarettes from? *(Please tick more than one box if you OFTEN get cigarettes from different people or places.)*

1 I buy them from a supermarket

2 I buy them from a newsagent, tobacconist or a sweet shop

3 I buy them from a garage shop

4 I buy them from some other type of shop

5 I buy them from a machine

6 I buy them from friends or relatives

7 I buy them from someone else

8 Friends give them to me

9 My brother or sister gives them to me

10 My mother or father gives them to me

11 I take them

12 I get them in some other way

EVERYONE ANSWER NOW

25 How many of your friends smoke?

- 1 All or almost all
- 2 More than half
- 3 Half
- 4 Less than half
- 5 Almost none
- 6 None

26 Do any of the following people smoke?

Please tick one box for each line

	(0)	(1)	(2)	(3)	(4)
	<i>Don't have or don't see this person</i>	<i>Smokes daily</i>	<i>Smokes sometimes</i>	<i>Does not smoke</i>	<i>Don't know</i>
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Best friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

27 When you smoke how often are you in the following situations?

	(1)	(2)	(3)	(4)
	<i>Never</i>	<i>Seldom</i>	<i>Sometimes</i>	<i>often</i>
I never smoke <input type="checkbox"/>				
Alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With your father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With your mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With your brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
With your sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

28 Have you ever called Smokeline, the free telephone helpline for advice on smoking?

- 1 Yes, within the last 12 months
- 2 Yes, more than 12 months ago
- 3 No

29 Cigarettes are advertised in many different places. Have you seen adverts for cigarettes in any of these places over the last six months?

Please tick one box for each line

	(1) Yes	(2) No	(3) Don't know
On posters/billboards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
On television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In magazines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In newspapers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At the cinema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The next few questions are about you, your health and how you feel

30 Would you say your health is.....?

- 1 Excellent
- 2 Good
- 3 Fair
- 4 Poor

31 In the last 6 months: how often have you had the following...?
Please tick one box for each line

	(1) <i>About every day</i>	(2) <i>More than once a week</i>	(3) <i>About every week</i>	(4) <i>About every month</i>	(5) <i>Hardly ever</i>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach-ache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back ache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling low	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability or bad temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulties in getting to sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling dizzy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck and Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Afraid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired and exhausted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



32 Do you think your body is.....?

- 1 Much too thin
- 2 A bit too thin
- 3 About the right size
- 4 A bit too fat
- 5 Much too fat

33 How much do you weigh without clothes?
(Answer either in kilograms OR stones and pounds)
I weigh.....kilograms

OR

I weigh.....stone.....pounds.lb

OR

I don't know what I weigh



34 How tall are you without shoes?
(Answer either in metres or feet and inches)

I am.....metre.....centimetres tall

OR

I am.....feet.....inches tall

OR

I don't know how tall I am

The following questions deal with your physical development

35 Would you say that your growth spurt in height ("growth spurt" means more growth than usual):

- 1 Has not yet started to develop
- 2 Has barely started to develop
- 3 Development definitely underway
- 4 Development seems completed

36 And how about the growth of your body hair (meaning underarm and pubic hair)? Would you say that your body hair growth:

- 1 Has not yet started to develop
- 2 Has barely started to develop
- 3 Development definitely underway
- 4 Development seems completed

37 Have you noticed any skin changes, especially spots?

- 1 Has not yet started to develop
- 2 Has barely started to develop
- 3 Development definitely underway
- 4 Development seems completed

More questions on physical development

If you are a GIRL please answer the questions in column A

If you are a BOY please answer the questions in column B

A GIRLS ONLY answer here

38 Have you noticed that your breasts have begun to grow?

- 1 Has not yet started to develop
- 2 Has barely started to develop
- 3 Development definitely underway
- 4 Development seems completed

39 Have you begun to menstruate (have periods)?

- 1 No, I have not yet begun to menstruate
- 2 Yes, I began at the age of:

years months

B BOYS ONLY answer here

38 Have you noticed a deepening of your voice?

- 1 Has not yet started to develop
- 2 Has barely started to develop
- 3 Development definitely underway
- 4 Development seems completed

39 Have you begun to grow hair on your face?

- 1 Has not yet started to develop
- 2 Has barely started to develop
- 3 Development definitely underway
- 4 Development seems completed

EVERYONE ANSWER NOW

40 Do you think your development is/was any earlier or later than most other boys/girls your age?

- 1 Much earlier
- 2 Somewhat earlier
- 3 About the same
- 4 Somewhat later
- 5 Much later

41 For each of the statements below, please tick the box that best describes how often you have felt like this in the past few weeks.

	(1)	(2)	(3)	(4)
	<i>Never</i>	<i>Sometimes</i>	<i>Often</i>	<i>Almost always</i>
I like the way things are going for me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My life is going well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I would like to change many things in my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I wish I had a different kind of life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have a good life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel good about what's happening to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

These next questions are about use of alcohol

42 Have you ever had a proper alcoholic drink – a whole drink, not just a sip?
Please don't count drinks labelled low alcohol

- 1 Yes Go to next question
- 2 No Go to Q63 on page 22

43 How often do you **USUALLY** have an alcoholic drink?

- 1 Almost every day
- 2 About twice a week
- 3 About once a week
- 4 About once a fortnight
- 5 About once a month
- 6 Only a few times a year

44 When did you last have an alcoholic drink? *(Tick one box)*






- 1 Today
 - 2 Yesterday
 - 3 Some other time during the last seven days
 - 4 1 week, but less than 2 weeks ago
 - 5 2 weeks, but less than 4 weeks ago
 - 6 1 month, but less than six months ago
 - 7 6 months ago or more
- Go to next question
- Go to Q58 on page 19

45 During the last 7 days, how much beer, lager and cider have you drunk?

Please don't count drinks labelled low alcohol.

- 1 Have not drunk beer, lager or cider in the last 7 days Go to Q48
- 2 Less than half a pint Go to Q48
- 3 Half a pint or more Go to next question

46 Write in the boxes below the number of pints, half pints, large cans, small cans and bottles of beer, lager and cider drunk in the last 7 days.

<input type="checkbox"/>	pints	
<input type="checkbox"/>	half pints	
<input type="checkbox"/>	large cans	
<input type="checkbox"/>	small cans	
<input type="checkbox"/>	bottles	





47 Do you usually drink normal strength or strong beer? *If you usually drink both normal and strong beer, please tick the type you drank most recently.*

- 1 Normal strength beer
- 2 Strong beer

48 During the last 7 days how much shandy have you drunk?

- 1 Have not drunk shandy in the last 7 days **Go to Q50**
- 2 Less than half a pint **Go to Q50**
- 3 Half a pint or more **Go to next question**

49 Write in the boxes below the number of pints, half pints, large cans and small cans of shandy drunk in the last 7 days.

<input type="text"/>	pints	
<input type="text"/>	half pints	
<input type="text"/>	large cans	
<input type="text"/>	small cans	

50 During the last 7 days, how much wine have you drunk?

1

Less than a glass

Go to Q 52

2

One glass or more

Go to next question

51 Write in the box below the number of glasses of wine drunk in the last 7 days.

<input type="text"/>	Glasses	
----------------------	---------	---

52 During the last 7 days, how much martini and sherry have you drunk?

- 1 Have not drunk martini or sherry in the last 7 days Go to Q54
- 2 Less than a glass Go to Q54
- 3 One glass or more Go to next question

53 Write in the box below, the number of glasses of martini and sherry drunk in the last 7 days.

Glasses 

54 During the last seven days, how much spirits (e.g. whisky, vodka, gin) and liqueurs have you drunk?

By a glass we mean a single pub measure.

- 1 Have not drunk spirits or liqueurs in the last 7 days Go to Q56
- 2 Less than a glass Go to Q56
- 3 One glass or more Go to next question

55 Write in the box below, the number of glasses of spirits (e.g. whisky, Vodka, gin) and liqueurs drunk in the last 7 days.

Glasses 

56 During the last 7 days, how much alcopops (e.g. Hooch, Two Dogs, etc) or pre-mixed alcoholic drinks (e.g. Bacardi Breezer, Metz, Smirnoff Ice, V2 etc) have you drunk?


1 Have not drunk alcopops or pre-mixed alcoholic drinks in the last 7 days Go to Q58

2 Less than a bottle Go to Q58

3 One bottle or more Go to next question

57 Write in the boxes below the number of cans and bottles of alcopops (e.g. Hooch, Two Dogs, etc) and pre-mixed alcoholic drinks (e.g. Bacardi Breezer, Metz, Smirnoff Ice, V2 etc) drunk in the last 7 days.

Cans 

Bottles 

EVERYONE WHO HAS EVER HAD AN ALCOHOLIC DRINK ANSWER NOW

58 Have you ever had so much alcohol that you were really drunk?

1 No, never

2 Yes, once

3 Yes, 2-3 times

4 Yes, 4-10 times

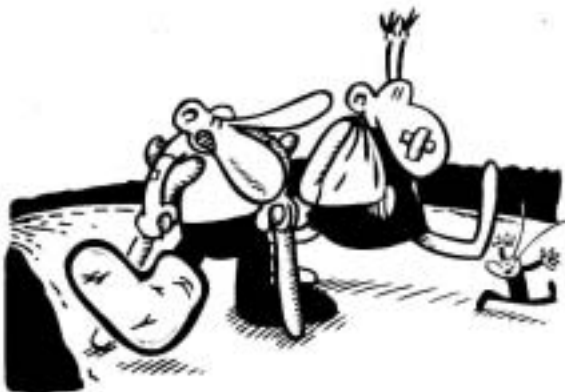
5 Yes, more than 10 times

59 During the last 30 days, how many times did you have five or more drinks on the same occasion?

- 1 4 or more times
- 2 3 times
- 3 twice
- 4 once
- 5 I have not had 5 or more drinks on the same occasion in the last 30 days
- 6 I have never had 5 or more drinks on the same occasion

60 In the past year, as a result of drinking alcohol have you ...
(Please tick one box for each)

	(1) No	(2) Once	(3) Twice or more
Had an argument or fight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Visited an A&E department	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been admitted to hospital overnight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had an injury that needed to be seen by a Doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stayed off school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been sick (vomited)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had unprotected sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tried any drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Now we are going to ask you about the availability of alcohol

61 When you drink alcohol, where are you USUALLY?

- 1 In a pub or bar
- 2 In a club or disco
- 3 At a party with friends
- 4 At my home
- 5 At someone else's home
- 6 Out on the street, in a park or other outdoor area
- 7 Somewhere else

62 If you buy alcohol, where do you USUALLY buy it?

- 1 I never buy alcohol
- 2 In a pub or bar
- 3 In a club or disco
- 4 From an off-licence
- 5 From a shop
- 6 From a supermarket
- 7 From a friend/relative
- 8 From someone else

EVERYONE ANSWER NOW

63 If you DO NOT drink alcohol

Answer here

How do you think your family would feel if you started drinking?

- 1 They would be upset or angry
- 2 They wouldn't mind
- 3 I don't know

If you DO drink alcohol

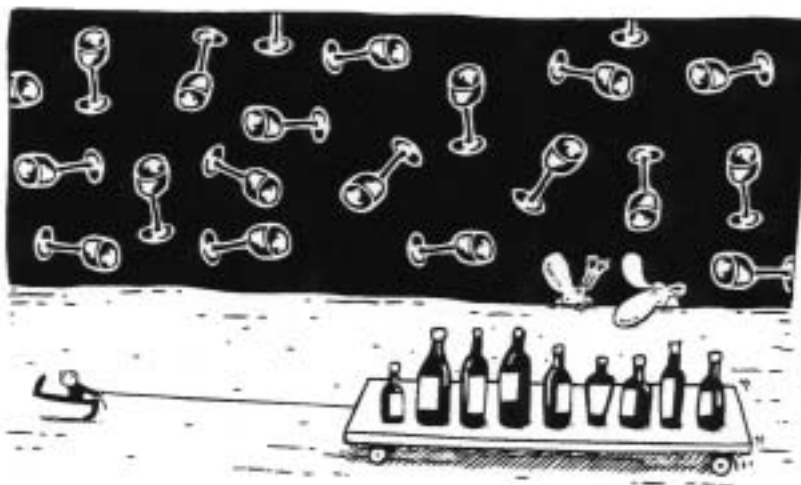
Answer here

How does your family feel about you drinking alcohol?

- 1 They don't like it
- 2 They don't mind
- 3 They don't know I drink alcohol
- 4 I don't know

64 Are you allowed to drink alcohol at home?

- 1 Yes, always
- 2 Yes, sometimes
- 3 No, never



FAMILY AND WHERE YOU LIVE

65 Now we'd like to ask you about who you live with. Not everyone lives with both their parents. Sometimes people live with just one parent, sometimes they have two homes or two families. Please fill in column A for your main or your only home. Fill in column B if you have a second home (not including holiday or summer houses).

A



Please tick all the people who live here.

Adults:

- 1 Mother
 - 2 Father
 - 3 Stepmother (or father's girlfriend)
 - 4 Stepfather (or mother's boyfriend)
 - 5 Grandmother
 - 6 Grandfather
 - 7 I live in a foster or children's home
 - 8 Someone or somewhere else: *please write it down*
-

Children:

Please say how many brothers and sisters live here (including half, step or foster brothers and sisters). *Please write in the number or write 0 (zero) if there are none.*

Number of brothers

Number of sisters

66 Do you stay here.....

- 1 All the time
- 2 Most of the time
- 3 Half the time

B



Please tick all the people who live here.

Adults:

- 1 Mother
 - 2 Father
 - 3 Stepmother (or father's girlfriend)
 - 4 Stepfather (or mother's boyfriend)
 - 5 Grandmother
 - 6 Grandfather
 - 7 I live in a foster or children's home
 - 8 Someone or somewhere else: *please write it down*
-

Children:

Please say how many brothers and sisters live here (including half, step or foster brothers and sisters). *Please write in the number or write 0 (zero) if there are none.*

Number of brothers

Number of sisters

66 Do you stay here.....

- 1 Half the time
- 2 Regularly but less than half the time
- 3 At weekends
- 4 Sometimes
- 5 Hardly ever

These next questions are about your parents' jobs

67 **Father**

Does your father have a job?

- 1 Yes
- 2 No
- 3 Don't know
- 4 Don't have or don't see father

If YES, please say in what place he works
(for example: hospital, bank, restaurant)

.....

Please write down exactly what job he does there
(for example: teacher, bus driver)

.....

If NO, why does your father not have a job?
(Please tick the box that best describes the situation)

- 1 He is sick, or retired, or a student
- 2 He is looking for a job
- 3 He takes care of others, or is full-time in the home
- 4 I don't know

68 **Mother**

Does your mother have a job?

- 1 Yes
- 2 No
- 3 Don't know
- 4 Don't have or don't see mother

If YES, please say in what place she works
(for example: hospital, bank, restaurant)

.....

Please write down exactly what job she does there
(for example: teacher, bus driver)

.....

If NO, why does your mother not have a job?
(Please tick the box that best describes the situation)

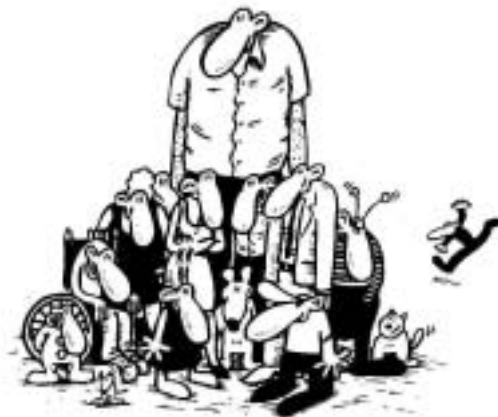
- 1 She is sick, or retired, or a student
- 2 She is looking for a job
- 3 She takes care of others, or is full-time in the home
- 4 I don't know

69 Are you: (please tick all that apply)

- 1 Bangladeshi
- 2 Black - African
- 3 Black - Caribbean
- 4 Black - other
- 5 Chinese
- 6 Indian
- 7 Pakistani
- 8 White
- 9 Other (please say what)
.....

70 How well off do you think your family is?

- 1 Very well off
- 2 Quite well off
- 3 Average
- 4 Not very well off
- 5 Not at all well off



71 How much does your mother really know about.....? Please tick one box for each line

	(1)	(2)	(3)
<i>don't have or don't see mother</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<i>She knows a lot</i>	<i>She knows a little</i>	<i>She doesn't know anything</i>

Who your friends are	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How you spend your money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Where you are after school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Where you go at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What you do with your free time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

72 How much does your father really know about.....? Please tick one box for each line

	(1)	(2)	(3)
<i>don't have or don't see father</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<i>He knows a lot</i>	<i>He knows a little</i>	<i>He doesn't know anything</i>

Who your friends are	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How you spend your money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Where you are after school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Where you go at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What you do with your free time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

73 When you went out during the last year, how often did your mother know...?
Please tick one box for each line

	(1)	(2)	(3)	(4)
<i>don't have or don't see mother</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<i>always</i>	<i>usually</i>	<i>sometimes</i>	<i>never</i>

Where you were going	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Who you were going out with	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What you were doing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What time you would be home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

74 When you went out during the last year, how often did your father know...?

Please tick one box for each line

	(1)	(2)	(3)	(4)
	always	usually	sometimes	never
Where you were going	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Who you were going out with	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What you were doing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What time you would be home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

don't have or
don't see father

75 How much money of your own do you have most weeks to spend as you like?

- 1 Nothing
- 2 Less than £1 a week
- 3 £1 or more but less than £5 a week
- 4 £5 or more but less than £10 a week
- 5 £10 or more but less than £20 a week
- 6 £20 or more a week

76 Does your family own a car, van or truck?

- 1 No
- 2 Yes, one
- 3 Yes, two or more

77 During the past 12 months, how many times did you travel away on holiday with your family?

- 0 Not at all
- 1 Once
- 2 Twice
- 3 More than twice



78 Do you have your own bedroom for yourself?

- 1 No
- 2 Yes

79 How many computers (PCs or Macs) does your family own?

- 0 None
- 1 One
- 2 Two
- 3 More than two

The next questions are about drugs

80 Have you ever been offered any of the following drugs?

Please tick one box for each line

	(1)	(2)
	Yes	No
Cannabis, (Marijuana, Dope, Hash, Blow, Joints)	<input type="checkbox"/>	<input type="checkbox"/>
Gas, Glue or other solvents (Tipp-Ex, Lighter Fuel, Aerosols) (to inhale or sniff)	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines (Speed, Whizz, Sulph)	<input type="checkbox"/>	<input type="checkbox"/>
LSD (Acid, Tabs, Trips)	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy ('E', Eccies, XTC)	<input type="checkbox"/>	<input type="checkbox"/>
Semeron (Sems, Semmies)	<input type="checkbox"/>	<input type="checkbox"/>
Poppers (Amyl Nitrates, Liquid Gold, Rush)	<input type="checkbox"/>	<input type="checkbox"/>
Tranquillisers (Downers, Jellies, Valium, Temazepam, Eggs)	<input type="checkbox"/>	<input type="checkbox"/>
Heroin (Smack, Skag, Gear, 'H')	<input type="checkbox"/>	<input type="checkbox"/>
Magic Mushrooms (Shrooms)	<input type="checkbox"/>	<input type="checkbox"/>
Methadone (Linctus, Physeptone, Meth)	<input type="checkbox"/>	<input type="checkbox"/>
Crack (Rock, Stone)	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine (Coke, Charlie, 'C')	<input type="checkbox"/>	<input type="checkbox"/>
Anabolic Steroids (Roids)	<input type="checkbox"/>	<input type="checkbox"/>
Other drugs that would not be given to you by a doctor or chemist (please tick box and write below the name of the drug)	<input type="checkbox"/>	<input type="checkbox"/>
.....		

81 Have you ever used or taken any of the drugs listed above (even if only once)?

1 Yes

2 No -----Go to Q90 on page 33

82 When was the last time you ever used or took any of the following?

Please tick one box for each line

	(1)	(2)	(3)	(4)
	<i>In the last month</i>	<i>In the last year</i>	<i>More than a year ago</i>	<i>Never</i>
Cannabis, (Marijuana, Dope, Hash, Blow, Joints)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gas, Glue or other solvents (Tipp-Ex, Lighter Fuel, Aerosols) (to inhale or sniff)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamines (Speed, Whizz, Sulph)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LSD (Acid, Tabs, Trips)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy ('E', Eccies, XTC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Semeron (Sems, Semmies)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poppers (Amyl Nitrates, Liquid Gold, Rush)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tranquillisers (Downers, Jellies, Valium, Temazepam, Eggs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin (Smack, Skag, Gear, 'H')	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Magic Mushrooms (Shrooms)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methadone (Linctus, Physeptone, Meth)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crack (Rock, Stone)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine (Coke, Charlie, 'C')	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anabolic Steroids (Roids)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other drugs that would not be given to you by a doctor or chemist (please tick box and write below the name of the drug)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

.....

83 The last time you used drugs, were you also drinking alcohol?

1 Yes

2 No

84 The last time you used drugs, who did you get them from?

1 My brother or sister

2 A friend of my own age

3 A friend older than me

4 A friend younger than me

5 My boyfriend / girlfriend

6 My mother or father

7 Someone I knew of, but didn't know personally

8 A stranger

9 Someone else

85 The last time you used drugs, did you use them all yourself or did you sell or give some to someone else?

1 Used it all myself

2 Sold some of it

3 Gave some of it away

86 Where were you the last time you used drugs?

- 1 At home
- 2 In someone else's home
- 3 At a party
- 4 At a club, disco or rave
- 5 At school
- 6 Out on the street, in a park or other outdoor area
- 7 Other place (please tick in the box and write in below where you were)

.....

87 Would you like to stop using drugs altogether?

- 1 Yes, I would like to give up now
- 2 Yes, I would like to give up in the future
- 3 No
- 4 Not sure

88 Have you ever felt that you needed to get help because you were using drugs?

- 1 Yes
- 2 No

89 If you felt that you needed to get help because you were using drugs, would you know where to go?

- 1 Yes
- 2 No

EVERYONE ANSWER NOW

90 Have you ever refused a drug that was offered to you?

- 1 Yes
- 2 No
- 3 Never been offered any drugs

91 How often do you usually use drugs?

- 1 I have never even tried drugs
- 2 I have ever only taken drugs once
- 3 I used to take drugs sometimes but I never do now
- 4 I take drugs a few times a year
- 5 I take drugs once or twice a month
- 6 I take drugs at least once a week
- 7 I take drugs most days

92 How easy would it be for you to get illegal drugs if you wanted to?

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

93 Would you know where to go if you wanted to get more information about drugs?

1 Yes

2 No

3 Don't know

94 If yes, where would you go?

1 Your doctor

2 Advice organisations

3 Magazines

4 Drop-in centre

5 Counsellor

6 Teacher

7 Telephone helpline

8 Youth worker

9 Female family member

10 Male family member

11 Friends

12 Books

13 TV/Radio

14 Internet/Web

95

Please read the following statements about drugs and say if you agree or disagree with each one. Tick one box for each statement

	(1) <i>Agree</i>	(2) <i>Disagree</i>	(3) <i>Don't know</i>
Taking drugs is exciting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking drugs harms your health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know enough about the dangers of drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most young people will try out drugs at some time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin is addictive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What adults tell us about drugs is true	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People take drugs to relax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin is more dangerous than cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All people who sell drugs should be punished	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking cocaine is dangerous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People who take drugs want to escape from reality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People who take heroin are junkies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People my age who take drugs need help and advice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People who take drugs are stupid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injecting drugs can lead to HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All people who take drugs should be punished	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

96 At what age did you first do the following things?

If there is something you have not done, choose the 'never' category.

Drink alcohol (more than a small amount) Never I was years old

Write in the box how old you were

Get drunk Never I was years old

Write in the box how old you were

Smoke a cigarette (more than a puff) Never I was years old

Write in the box how old you were

Use drugs Never I was years old

Write in the box how old you were

97 How much money do you usually spend each week on tobacco, alcohol or drugs?

Please tick one box for each line

	(0)	(1)	(2)	(3)	(4)	(5)
	nothing	Less than £1 a week	£1 or more but less than £5 a week	£5 or more but less than £10 a week	£10 or more but less than £20 a week	£20 or more a week

Tobacco

Alcohol

Drugs

These next questions are about relationships with family and friends

98 How easy is it for you to talk to the following persons about things that really bother you?

Please tick one box for each line

	(0) <i>don't have or see this person</i>	(1) <i>very easy</i>	(2) <i>easy</i>	(3) <i>difficult</i>	(4) <i>very difficult</i>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stepfather (or mother's boyfriend)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stepmother (or father's girlfriend)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elder brother (s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elder sister (s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

99 At present, how many close male and female friends do you have?

Please tick one box each column

Males		Females	
0 <input type="checkbox"/>	None	0 <input type="checkbox"/>	None
1 <input type="checkbox"/>	One	1 <input type="checkbox"/>	One
2 <input type="checkbox"/>	Two	2 <input type="checkbox"/>	Two
3 <input type="checkbox"/>	Three or more	3 <input type="checkbox"/>	Three or more

100 How many days a week do you usually spend time with friends right after school?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0 days	1	2	3	4	5 days

101 How many evenings a week do you usually spend out with your friends?

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0 evenings	1	2	3	4	5	6	7 evenings

102 How easy is it for you to talk to the following persons about things that really bother you? *Please tick one box for each line*

	(1)	(2)	(3)	(4)	(5)
	<i>very easy</i>	<i>easy</i>	<i>difficult</i>	<i>very difficult</i>	<i>don't have</i>
Best friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friends of the same sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friends of the opposite sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

103 Have you ever had sexual intercourse (sometimes this is called "making love," "having sex," or "going all the way")?

1 Yes

2 No

104 How old were you when you had sexual intercourse for the first time?

1 I have never had sexual intercourse

2 11 years old or younger

3 12 years old

4 13 years old

5 14 years old

6 15 years old

7 16 years old

105 The last time you had sexual intercourse did you or your partner use a condom?

- 1 I have never had sexual intercourse
- 2 Yes
- 3 No

106 The last time you had sexual intercourse, what method(s) did you or your partner use to prevent pregnancy?

I have never had sexual intercourse Go to the next question

No method was used to prevent pregnancy Go to the next question

	(1) Yes	(2) No
A condom	<input type="checkbox"/>	<input type="checkbox"/>
Birth control pill (the pill)	<input type="checkbox"/>	<input type="checkbox"/>
Emergency contraception ('morning after' pill)	<input type="checkbox"/>	<input type="checkbox"/>
Spermicidal spray or foam	<input type="checkbox"/>	<input type="checkbox"/>
Withdrawal	<input type="checkbox"/>	<input type="checkbox"/>
Some other method - please say what	<input type="checkbox"/>	<input type="checkbox"/>
Not sure	<input type="checkbox"/>	

Now here are some questions about school

107 How do you feel about school at present?

- 1 I like it a lot
- 2 I like it a bit
- 3 I don't like it very much
- 4 I don't like it at all

108 In your opinion, what does your class teacher(s) think about your school performance compared to your classmates?

- 1 Very good
- 2 Good
- 3 Average
- 4 Below average

109 Here are some statements about the pupils in your class(es). Please show how much you agree or disagree with each one. *Please tick one box for each line*

	(1)	(2)	(3)	(4)	(5)
	<i>Strongly agree</i>	<i>Agree</i>	<i>Neither agree nor disagree</i>	<i>Disagree</i>	<i>Strongly disagree</i>
The pupils in my class(es) enjoy being together	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most of the pupils in my class are kind and helpful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other pupils accept me as I am	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

110 How pressured (stressed) do you feel by the schoolwork you have to do?

- 1 Not at all
- 2 A little
- 3 Some
- 4 A lot

111 In the last 12 months have you had any lessons, video or discussions in class on the following topics? *Please tick one box for each line*

	(1) Yes	(2) No	(3) Don't know
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Solvent abuse/glue sniffing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

112 How useful have you found the lessons, videos or discussions you have had during the last 12 months about drugs?

- 1 Have not had any in the last year
- 2 Very useful
- 3 Fairly useful
- 4 Not very useful
- 5 Not useful at all
- 6 Don't know

113 **During this school year, how many times did you skip or skive school?**

- 0 Not at all
- 1 Once
- 2 Twice
- 3 3 times
- 4 4 times
- 5 5 times
- 6 Between 6 and 10 times
- 7 More than 10 times

114 **Have you been excluded since you started secondary school?**

- 1 Yes - answer questions in box
- 2 No - go to next question

i. How many times were you excluded? (tick ONE box on EACH line)				
	<i>(0)</i>	<i>(1)</i>	<i>(2)</i>	<i>(3)</i>
	<i>Never</i>	<i>Once or twice</i>	<i>3 or 4 times</i>	<i>5 times or more</i>
in first year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
in second year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
in third year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
in fourth year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii. What is the longest single period you have been excluded for?				
1 <input type="checkbox"/> 1 or 2 days				
2 <input type="checkbox"/> Up to one week				
3 <input type="checkbox"/> Up to 2 weeks				
4 <input type="checkbox"/> More than 2 weeks				

Now we'd like to ask about some leisure activities

115 About how many hours a day do you usually watch television (including videos) in your free time? Please tick one box for weekdays and one box for weekend

Weekdays		Weekend	
1	<input type="checkbox"/> None at all	1	<input type="checkbox"/> None at all
2	<input type="checkbox"/> About half an hour a day	2	<input type="checkbox"/> About half an hour a day
3	<input type="checkbox"/> About 1 hour a day	3	<input type="checkbox"/> About 1 hour a day
4	<input type="checkbox"/> About 2 hours a day	4	<input type="checkbox"/> About 2 hours a day
5	<input type="checkbox"/> About 3 hours a day	5	<input type="checkbox"/> About 3 hours a day
6	<input type="checkbox"/> About 4 hours a day	6	<input type="checkbox"/> About 4 hours a day
7	<input type="checkbox"/> About 5 hours a day	7	<input type="checkbox"/> About 5 hours a day
8	<input type="checkbox"/> About 6 hours a day	8	<input type="checkbox"/> About 6 hours a day
9	<input type="checkbox"/> About 7 or more hours a day	9	<input type="checkbox"/> About 7 or more hours a day

116 About how many hours a day do you usually use a computer (for playing games, emailing, chatting or surfing the internet) in your free time?

Please tick one box for weekdays and one box for weekend

Weekdays		Weekend	
1	<input type="checkbox"/> None at all	1	<input type="checkbox"/> None at all
2	<input type="checkbox"/> About half an hour a day	2	<input type="checkbox"/> About half an hour a day
3	<input type="checkbox"/> About 1 hour a day	3	<input type="checkbox"/> About 1 hour a day
4	<input type="checkbox"/> About 2 hours a day	4	<input type="checkbox"/> About 2 hours a day
5	<input type="checkbox"/> About 3 hours a day	5	<input type="checkbox"/> About 3 hours a day
6	<input type="checkbox"/> About 4 hours a day	6	<input type="checkbox"/> About 4 hours a day
7	<input type="checkbox"/> About 5 hours a day	7	<input type="checkbox"/> About 5 hours a day
8	<input type="checkbox"/> About 6 hours a day	8	<input type="checkbox"/> About 6 hours a day
9	<input type="checkbox"/> About 7 or more hours a day	9	<input type="checkbox"/> About 7 or more hours a day

117 About how many hours a day do you usually spend doing school homework out of school hours? Please tick one box for weekdays and one box for weekend

Weekdays

- 1 None at all
- 2 About half an hour a day
- 3 About 1 hour a day
- 4 About 2 hours a day
- 5 About 3 hours a day
- 6 About 4 hours a day
- 7 About 5 hours a day
- 8 About 6 hours a day
- 9 About 7 or more hours a day

Weekend

- 1 None at all
- 2 About half an hour a day
- 3 About 1 hour a day
- 4 About 2 hours a day
- 5 About 3 hours a day
- 6 About 4 hours a day
- 7 About 5 hours a day
- 8 About 6 hours a day
- 9 About 7 or more hours a day

118 How many days a week are you involved in any kind of club or organisation (e.g., youth club, swimming/athletics club, choir, dance group etc.)

- 1 Every day of the week
- 2 5 or 6 days a week
- 3 3 or 4 days a week
- 4 Once or twice a week
- 5 Less than once a week
- 6 Not at all



119 Here is a list of things that teenagers sometimes do in their free time, when they aren't at school. What about you? Please tick one box for each line

When I'm not at school I

	(1) <i>Every day</i>	(2) <i>Most days</i>	(3) <i>Weekly</i>	(4) <i>Less often</i>	(5) <i>Never</i>
see my friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
listen to tapes or music	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
look around the shops	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
read comics or magazines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
read books	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
go to watch sport matches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
go to the cinema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
hang around the street	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
do a hobby, art or play a musical instrument	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
go to a friend's house	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
go to concerts or gigs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
go to the church, mosque or temple	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
do nothing much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



THANK YOU VERY MUCH FOR FILLING IN THIS QUESTIONNAIRE