ADOLESCENT SUBSTANCE USE AND RISK BEHAVIOURS IN THE MEDITERRANEAN REGION

Fourth MedSPAD regional report

Elisa Benedetti, Rodolfo Cotichini,
Sabrina Molinaro
and the MedSPAD Group

Pompidou Group
Groupe Pompidou

COUNCIL OF EUROPE
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Council of Europe

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MedNET is the Pompidou Group's Mediterranean network for co-operation on drugs and addictions set up in 2006.

MedNET (coe.int)

The precious and unique expertise of the European School Survey Project on Alcohol and Other Drugs (ESPAD) Co-ordinator and ESPAD Project Manager and the team of the Institute of Clinical Physiology, National Research Council of Italy contributed significantly to the project.

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Preface

The Council of Europe is the continent's leading human rights organisation. It comprises 46 member states, 27 of which are members of the European Union. All Council of Europe member states have signed up to the European Convention on Human Rights, a treaty designed to protect human rights, democracy and the rule of law.

The Pompidou Group provides a multidisciplinary forum at the wider European level for policy makers, professionals and researchers to exchange experiences and information on drug use and drug trafficking. Formed at the suggestion of French President Georges Pompidou in 1971, it became a Council of Europe enlarged partial agreement in 1980 open to countries outside the Council of Europe.

On 16 June 2021, the Committee of Ministers of the Council of Europe adopted the revised Pompidou Group statute, which extends its mandate to include addictive behaviours related to licit substances (such as alcohol or tobacco) and new forms of addictions (such as internet gambling and gaming). The new mandate focuses on human rights while reaffirming the need for a multidisciplinary approach to address the drug challenge, which can only be tackled effectively if policy, practice and science are linked.

To better reflect both its identity as a Council of Europe entity and its broadened mandate, the Pompidou Group changed its official name from the "Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs" to the "Council of Europe International Co-operation Group on Drugs and Addictions". As of 2022, it encompasses 41 out of 46 member states of the Council of Europe, Mexico, Morocco and Israel, and the European Commission.

MedNET is the Mediterranean network of the Pompidou Group for co-operation on drugs and addictions. It comprises 18 countries from the northern and southern rims of the Mediterranean. MedSPAD is the Mediterranean School Survey Project on Alcohol and other Drugs.

This is the fourth regional report from MedSPAD, and it provides insights into substance use and risk behaviours among adolescents and the socio-economic and policy context in the Mediterranean region. It follows the work presented in the 2019 report "An insight into alcohol, tobacco and other drugs in the Mediterranean region: socio-economic, policy context and patterns of use among adolescents", which covered 13 countries.

For this report, 11 countries – Croatia, Cyprus, Egypt, France, Greece, Italy, Malta, Morocco, Portugal, Spain and Tunisia – provided raw survey data estimating the perceived availability and risk of substances, early onset of substance use, and prevalence of the use of alcohol, tobacco, other substances, gambling, gaming and social media use.

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1. This should not be interpreted as recognition of a State of Palestine, without prejudice to the position of each Council of Europe member state on this issue.

Chapter 1

Socio-economic context

1.1. Demographic aspects

The countries participating in the MedSPAD project are very heterogeneous demographically (see Tables 1.1.1 and 1.1.2). This should be taken into consideration while interpreting the prevalence estimates concerning substance use and addictive behaviours presented in this report.

Country populations range from 102.3 million in Egypt to 0.5 million in Malta. The average population size of the 11 MedSPAD countries is 32 million: Malta, Cyprus, Croatia, Portugal, Greece and Tunisia fall below the average while Egypt, France, Italy, Morocco and Spain are above the average. The majority of MedSPAD countries recorded a positive population growth in the survey year, with the exception of Croatia, Greece and Italy, which are experiencing population declines.

Most of the population in the MedSPAD region (70%) lives in urban areas. The share of urban population varies across countries: the highest rates (above 80%) were observed in France, Malta and Spain, while the lowest (below 60%) were observed in Croatia and Egypt. This is significant, as some of the highest levels of drug use and the most problematic consumption practices can be found in cities, although scientific evidence about the association between urbanisation and adolescent drug use and risk behaviour is mixed (EMCDDA 2015).

Table 1.1.1. Population, growth and urbanisation in MedSPAD countries

Country	Year (a)	Population total (b)	Population growth (annual %) (c)	Urban population (% of the total) (d)
Croatia	2019	4065253	-0.6	57.2
Cyprus	2019	1198574	0.8	66.8
Egypt	2020	102334403	1.9	42.8
France	2019	67248926	0.2	80.7
Greece	2019	10721582	-0.1	79.4
Italy	2019	59729081	-1.2	70.7
Malta	2019	504062	3.9	94.7
Morocco	2020	36910558	1.2	63.5
Portugal	2019	10286263	0.0	65.8
Spain	2019	47134837	0.7	80.6
Tunisia	2020	11818618	1.1	69.6
Average	---	31995651	0.7	70.2

Source: World Development Indicators, World Bank (available at: https://datacatalog.worldbank.org/dataset/world-development-indicators)

Notes:

a) Data refer to the year of survey in each country or to the last available year

b) Population is based on the *de facto* definition of population, which counts all residents regardless of legal status or citizenship, except for refugees not permanently settled in the country of asylum, who are generally considered part of the population of the country of origin

c) Annual population growth rate for year t is the exponential rate of growth of midyear population from year t-1 to t, expressed as a percentage

d) Urban population refers to people living in urban areas as defined by national statistical offices. It is calculated using World Bank population estimates and urban ratios from the United Nations World Urbanization Prospects

The age profile of societies in the MedSPAD region is changing rapidly. In particular, a clear difference can be observed between the countries of the northern and southern rim of the Mediterranean. Demographic ageing is particularly characteristic of northern MedSPAD countries, with a shrinking proportion of young people.

In southern MedSPAD countries, the share of those younger than 15 years old is much higher, with a much lower proportion of people over 64.

On average, over 18.5% of the population in the MedSPAD region is under the age of 15. Italy and Portugal have the lowest percentage of young people, while the highest percentage is in Egypt, with one third of the population under the age of 15. The average share of the potentially economically active population (15-64 years) in MedSPAD countries is 64.7%, ranging from 60.8% in Egypt to 69.2% in Cyprus. The share of the population over 65 is on average 16.8%, with the lowest share in Egypt and the highest in Italy. Such developments are likely to have profound implications, not least on the national healthcare systems, and are therefore to be taken into consideration to interpret the data contained in this report.

Table 1.1.2. Share of population by age class in MedSPAD countries

Country	Year (a)	Share pop. <15 (%) (b)	Share pop. 15-64 (%) (c)	Share pop. 65+ (%) (d)
Croatia	2019	14.6	64.6	20.9
Cyprus	2019	16.7	69.2	14.1
Egypt	2020	33.9	60.8	5.3
France	2019	17.8	61.8	20.4
Greece	2019	13.9	64.2	21.9
Italy	2019	13.2	63.8	23.0
Malta	2019	14.3	64.9	20.8
Morocco	2020	26.8	65.6	7.6
Portugal	2019	13.3	64.4	22.4
Spain	2019	14.6	65.8	19.7
Tunisia	2020	24.3	66.8	8.9
Average	---	18.5	64.7	16.8

Source: World Development Indicators, World Bank (available at: https://datacatalog.worldbank.org/dataset/world-development-indicators)
Notes:
a) Data refer to the year of survey in each country or to the last available year
b) Population between the ages 0 to 14 as a percentage of the total population
c) Total population between the ages 15 to 64 potentially economically active
d) Population age 65 and above as a percentage of the total population

1.2. Education

Table 1.2.1. presents the situation of education in MedSPAD countries: the average adult (people aged 15 years and above) literacy rate is 90.8%, with the highest rate in Italy (99.2 %) and the lowest in Egypt (71.2%). Average enrolment in secondary school is quite high at 103.1%, ranging from Morocco (82.5%) to Spain (126%)[2].

These indicators of educational opportunities and attainment are key to contextualising MedSPAD data, not only because they are collected through surveys conducted in schools, but also because educational outcomes are important for evaluating the prospects of further intellectual growth and the social and economic development of the MedSPAD region.

2. School enrolment ratio in secondary school is the ratio of total enrolment, regardless of age, to the population that officially corresponds to the level of education considered. This means that the measure can also include students with age exceeding the official age range, creating a ratio of more than 100%.

Table 1.2.1. Literacy rate and enrolment in secondary schools in MedSPAD countries

Country	Year (a)	Literacy rate, adult total (% of people age 15 and above) (b)	Year (a)	School enrolment, secondary (% gross) (c)
Croatia	2011	99.1	2019	100.1
Cyprus	2011	98.7	2019	100.9
Egypt	2017	71.2	2019	89.5
France	N/A	N/A	2019	104.3
Greece	2018	97.9	2019	108.1
Italy	2018	99.2	2019	101.2
Malta	2018	94.5	2019	108.0
Morocco	2018	73.8	2020	82.5
Portugal	2018	96.1	2019	120.6
Spain	2018	98.4	2019	126.0
Tunisia	2014	79.0	2016	92.9
Average	---	90.8	---	103.1

Source: World Development Indicators, World Bank (available at: https://datacatalog.worldbank.org/dataset/world-development-indicators)
Notes:
a) Data refer to the year of survey in each country or to the last available year
b) Literacy rate, adult total (% of people age 15 and above): last available data for Croatia and Cyprus refer to 2011, while for Tunisia data refer to 2014
c) School enrolment, secondary (% gross): last available data for Tunisia refer to 2016

1.3. Health

Life expectancy at birth and expenditure on health are reported in Table 1.3.1. The average life expectancy in MedSPAD countries is 80.2 years: the lowest is in Egypt (72.2) while the highest is in Spain (83.8). This indicator is one of the most frequently used to describe the health status of a population. In particular, improvements in life expectancy at birth can be attributed to a number of factors, including improved living standards and better education, as well as greater healthcare investments and access to quality health services. Average health expenditure in the MedSPAD region was US$2 767, with high variability among countries, from US$425 in Morocco to US$5 493 in France.

Table 1.3.1. Life expectancy and health expenditure in MedSPAD countries

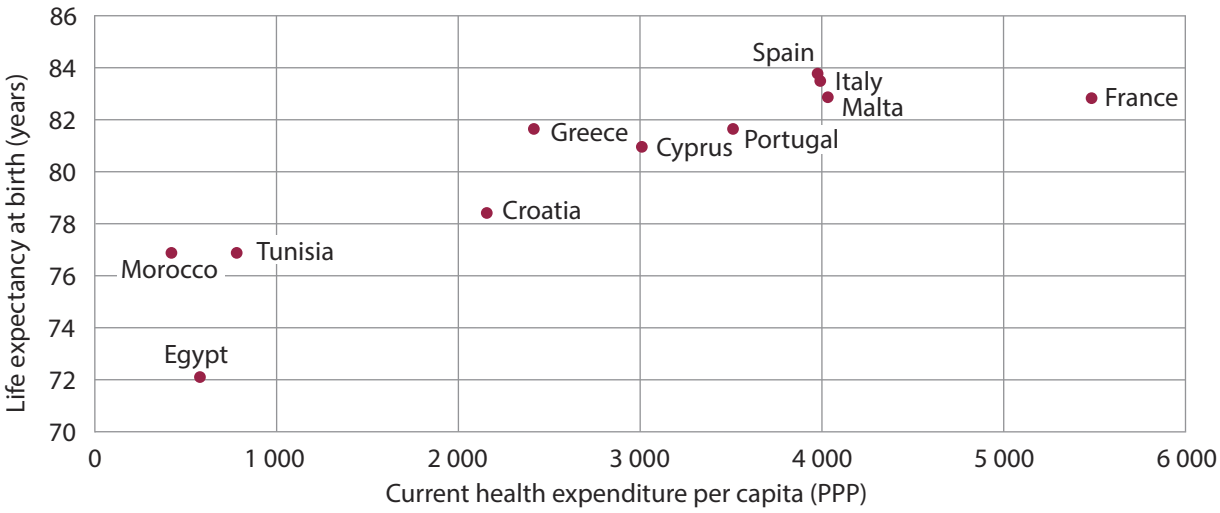
Country	Year (a)	Life expectancy at birth (years) (b)	Current health expenditure per capita (PPP) (c)
Croatia	2019	78.4	2168
Cyprus	2019	81.0	3017
Egypt	2019	72.0	582
France	2019	82.8	5493
Greece	2019	81.6	2419
Italy	2019	83.5	3998
Malta	2019	82.9	4040
Morocco	2019	76.7	425
Portugal	2019	81.7	3518

Country	Year (a)	Life expectancy at birth (years) (b)	Current health expenditure per capita (PPP) (c)
Spain	2019	83.8	3984
Tunisia	2019	76.7	789
Average	---	80.1	2767

Source: World Development Indicators, World Bank (available at: https://datacatalog.worldbank.org/dataset/world-development-indicators)
Notes:
a) Data refer to the year of survey in each country or to the last available year
b) Life expectancy at birth indicates the number of years a newborn infant would live if prevailing patterns of mortality at the time of its birth were to stay the same throughout its life
c) Current expenditures on health per capita expressed in international dollars at purchasing power parity

Higher health spending per capita is generally associated with higher life expectancy at birth, although this relationship tends to be less pronounced in countries with the highest health spending per capita. As shown in Figure 1.3.1., Spain stands out for having a relatively high life expectancy given a comparable level of health expenditure to that of Italy and Malta, which have a lower life expectancy. Similarly, France has a relatively low life expectancy considering its higher level of health expenditure compared with other MedSPAD countries.

Figure 1.3.1. Life expectancy and health expenditure in MedSPAD countries



Source: World Development Indicators, World Bank (available at: https://datacatalog.worldbank.org/dataset/world-development-indicators)
Notes:
a) Data refer to the year of survey in each country or to the last available year
b) Life expectancy at birth indicates the number of years a newborn infant would live if prevailing patterns of mortality at the time of its birth were to stay the same throughout its life
c) Current expenditures on health per capita expressed in international dollars at purchasing power parity

1.4. Labour force

Table 1.4.1 presents data on unemployment in the general population and specifically among youth, paying attention to differences between males and females. The average unemployment rate across the total population of the region is 10.1%, with the highest value observed in Greece (17.3%) and the lowest in Malta (3.3%). The average rate of youth employment is substantially higher (24.1%), with the highest value recorded in Tunisia (38.1%) and the lowest in Malta (9.4%).

A gender gap of 4.4 percentage points can be observed, with an average unemployment rate of 13.1% among females and 8.7% among males. The highest level of female unemployment is found in Tunisia (24%), and that of male unemployment is in Greece (14%). The lowest unemployment rate for both females and males is observed in Malta (F=4%; M=3.3%).

A similar gender gap is also observed among young people: the average youth unemployment among females is 28.2% but is 22.7% among males. The highest level of female youth unemployment is in Egypt (57.8%) and for males is in Tunisia (37.2%). As with the total population, the lowest youth unemployment levels are registered in Malta for both genders (F=8%; M=10.6%).

Interestingly, it is only in France that the unemployment rate among females is slightly lower than among males (F=8.3%; M=8.5%). In all other countries the female unemployment rate is always higher than that among males. Although in most countries the difference between the two values is between 1 and 3 percentage points, the difference peaks in Tunisia and Egypt, with an observed gap of 10.4 and 17.8 percentage points, respectively.

Among youth, the rate among females is lower than among males in only three countries (Cyprus, France and Malta), while in all other countries the opposite prevails. The gap between female and male rates among youth is higher than that observed in the general population, with a range between 1 and 8 percentage points, except in the case of Egypt, where the difference between female and male youth unemployment is 42.6 percentage points (F=57.8%; M=15.2%).

Labour market conditions have an impact on different spheres of life such as career prospects and subjective well-being, but they have also been linked to patterns of youth drug consumption and attitudes towards drugs via several mechanisms, in particular uncertainty about future income and lack of opportunities (Ayllón and Ferreira-Batista 2018).

Table 1.4.1. Unemployment rates in MedSPAD countries

Country	Year (a)	Unemployment, youth (%) (b)			Unemployment (%) (c)		
		Total	Male	Female	Total	Male	Female
Croatia	2019	16.7	14.6	19.8	6.6	6.2	7.2
Cyprus	2019	15.9	17.8	13.9	7.1	6.3	8.0
Egypt	2020	23.4	15.2	57.8	9.2	5.8	23.6
France	2019	19.5	20.7	18.1	8.4	8.5	8.3
Greece	2019	35.2	33.5	37.2	17.3	14.0	21.5
Italy	2019	29.2	27.8	31.2	9.9	9.1	11.1
Malta	2019	9.4	10.6	8.0	3.6	3.3	4.0
Morocco	2020	26.6	26.3	27.5	11.5	10.9	13.2
Portugal	2019	18.3	15.6	21.4	6.5	5.8	7.1
Spain	2019	32.7	31.1	34.6	14.1	12.4	16.0
Tunisia	2020	38.1	37.2	40.2	16.6	13.7	24.0
Average	---	24.1	22.7	28.2	10.1	8.7	13.1

Source: World Development Indicators, World Bank (available at: https://datacatalog.worldbank.org/dataset/world-development-indicators)
Notes:
a) Data refer to the year of survey in each country or to the last available year
b) Youth unemployment refers to the share of the labour force ages 15-24 without work but available for and seeking employment
c) Unemployment refers to the share of the labour force that is without work but available for and seeking employment

1.5. Income

Income indicators are reported in Table 1.5.1. The average gross domestic product (GDP) per capita among MedSPAD countries is US$30 743, ranging from US$6 986 in Morocco to US$46 018 in France.

The Gini index, a measure of income distribution in populations that indicates economic inequalities, is an average of 33 across the MedSPAD region, and ranges from 28.9 in Croatia to 39.5 in Morocco. An alternative indicator of income inequality, the income share held by the highest 10% of the population, follows similar trends, with an average value of about 25.9%, ranging from 22.2% in Croatia to 31.9% in Morocco.

Economic conditions and income inequality have been shown to be related to adverse population health outcomes by several studies, with some research suggesting that income inequality increases status anxiety, leading in turn to unhealthy coping mechanisms such as substance use, including among young people. Although there is no overall agreement on the strength of this association, it is important to consider differences in both economic well-being and income inequality among countries.

Table 1.5.1. Income indicators in MedSPAD countries

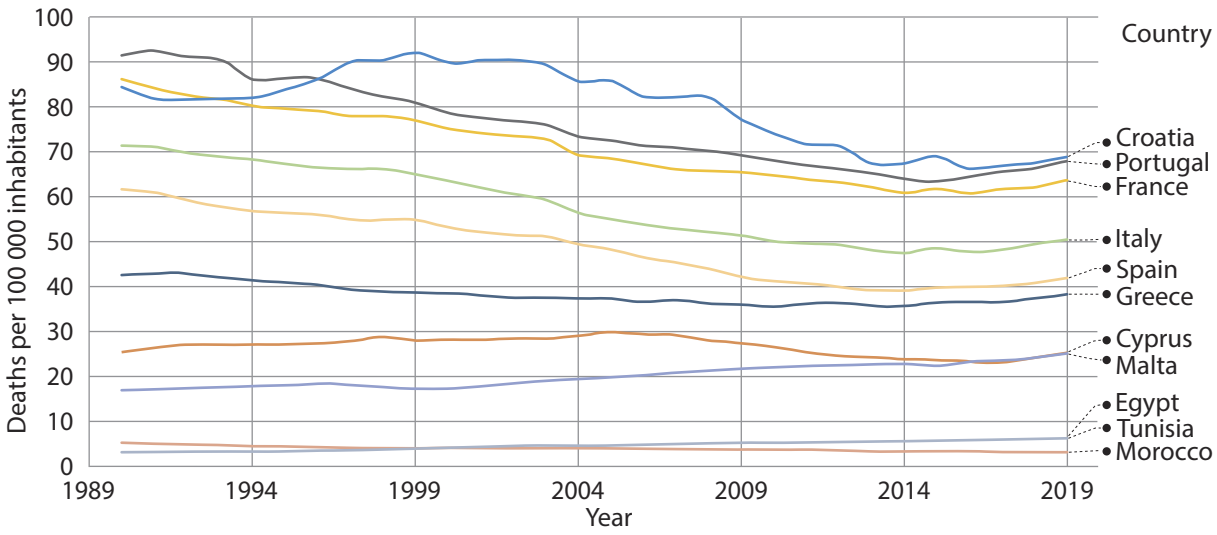
Country	Year (a)	GDP per capita (PPP) (b)	Year (a)	Gini index (c)	Year (a)	Income share held by highest 10% (%) (d)
Croatia	2019	29336	2019	28.9	2019	22.2
Cyprus	2019	41522	2019	31.2	2019	25.5
Egypt	2020	11951	2017	31.5	2017	26.9
France	2019	46018	2018	32.4	2018	26.7
Greece	2019	29698	2019	33.1	2019	24.9
Italy	2019	42708	2018	35.2	2018	25.9
Malta	2019	43951	2019	31.0	2019	24.8
Morocco	2020	6986	2013	39.5	2013	31.9
Portugal	2019	34946	2019	32.8	2019	26.0
Spain	2019	40802	2019	34.3	2019	24.9
Tunisia	2020	10260	2015	32.8	2015	25.6
Average	---	30743	---	33.0	---	25.9

Source: World Development Indicators, World Bank (available at: https://datacatalog.worldbank.org/dataset/world-development-indicators)
Notes:
a) Data refer to the year of survey in each country or to the last available year
b) GDP per capita expressed in international dollars at purchasing power parity (PPP). Data are in constant 2011 international dollars
c) Gini index measures the extent to which the distribution of income among individuals or households within an economy deviates from a perfectly equal distribution. A Gini index of 0 represents perfect equality, while an index of 100 implies perfect inequality
d) Percentage share of income or consumption is the share that accrues to subgroups of population indicated by deciles or quintiles

1.6. Substance-related health aspects

In order to provide a more comprehensive framework for the analysis of MedSPAD results we can consider, along with socio-economic elements, aspects related to substance use and health. Alcohol, tobacco and drugs are considered risk factors for health, as they are potential causes of disease or death. The following figures present trends on alcohol, tobacco and drug-related deaths from 1990 to 2019 for the countries in the MedSPAD area, provided by the Global Burden of Disease, a global collaborative research project. The data presented refer to cases in which the misuse of one of these substances was a risk factor for death.

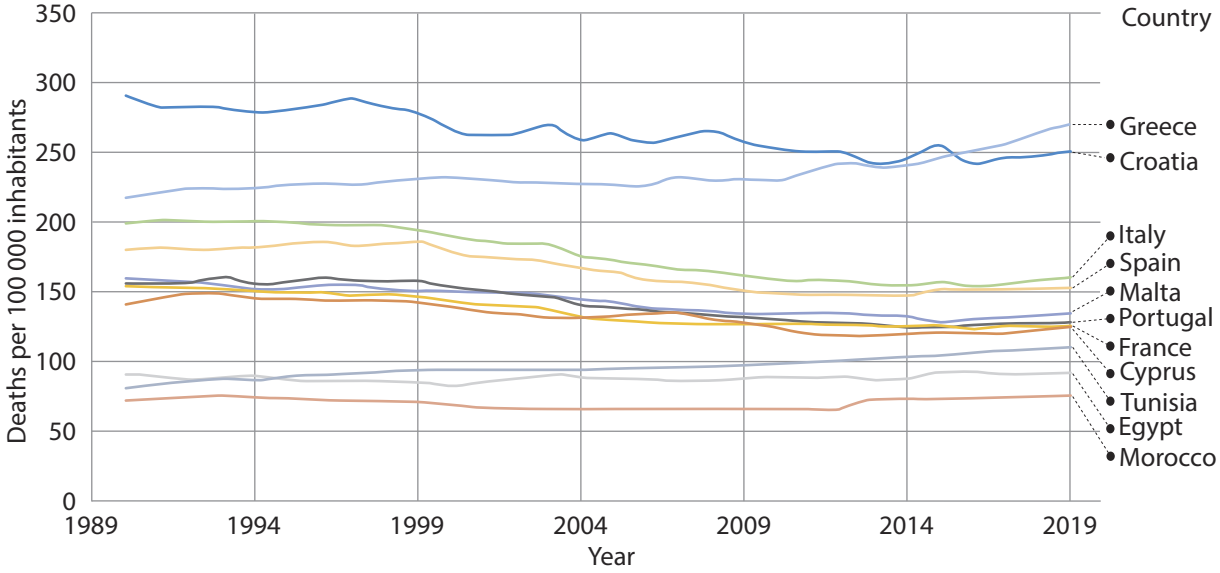
Figure 1.6.1. Alcohol-attributable deaths in MedSPAD countries (a)



Source: Institute for Health Metrics and Evaluation (IHME). GBD Compare Data Visualization. Seattle, WA: IHME, University of Washington, 2020.
Notes:
a) All deaths due to causes attributable to alcohol use as a risk factor

Data on alcohol-related deaths in the MedSPAD region present differently across countries: southern MedSPAD countries have the lowest rates in the period considered, while northern MedSPAD countries have higher death rates. With the exception of Croatia, all other northern MedSPAD countries show a declining trend from 1990 to 2015/2016, when the rates started to rise again. Croatia has had the highest alcohol-related death rate since 1997, but the gap with the other countries has progressively closed since then.

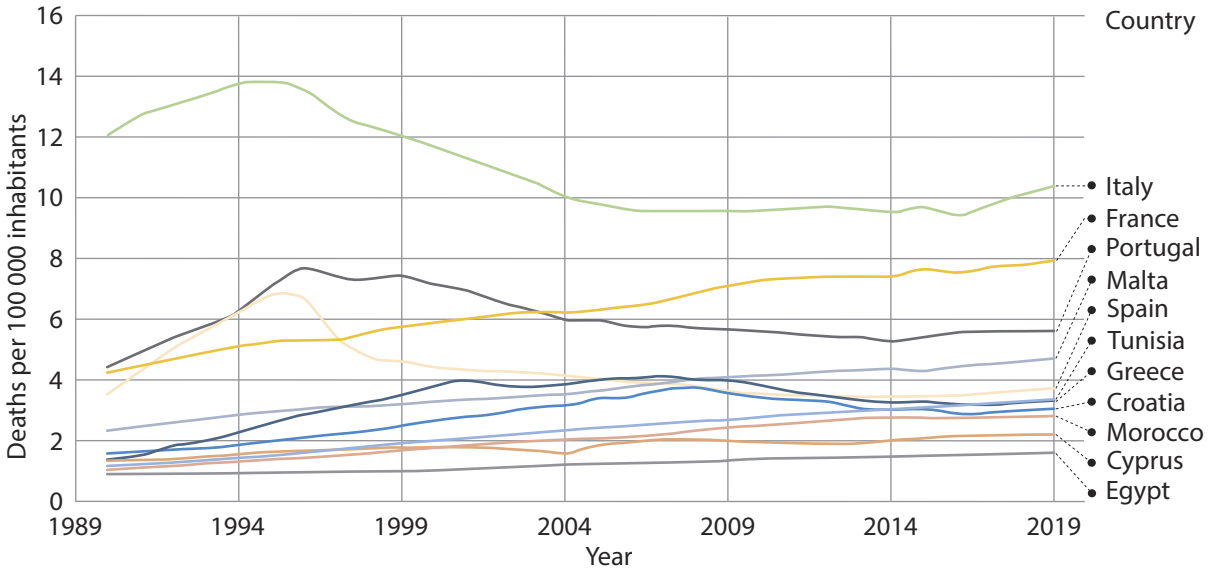
Figure 1.6.2. Tobacco-attributable deaths in MedSPAD countries (a)



Source: Institute for Health Metrics and Evaluation (IHME). GBD Compare Data Visualization. Seattle, WA: IHME, University of Washington, 2020.
Notes:
a) All deaths due to causes attributable to tobacco use as a risk factor

Figure 1.6.2. shows the trend of tobacco-related deaths from 1990 to 2019 in MedSPAD countries. Croatia and Greece have a higher level of deaths and different trends compared to other northern MedSPAD countries, where rates declined from 1999 to 2015/2016 and then started to progressively increase. In particular, rates increased in Greece during the considered period, with a higher rate in 2019 than in 1990. Among southern MedSPAD countries, Tunisia has the highest rate of tobacco-related deaths, with a constantly increasing trend from 1990 to 2019: in this period, the number of registered tobacco-related deaths increased from 79.7 to 109.5 per 100 000 inhabitants.

Figure 1.6.3. Drug-attributable deaths in MedSPAD countries (a)



Source: Institute for Health Metrics and Evaluation (IHME). GBD Compare Data Visualization. Seattle, WA: IHME, University of Washington, 2020.
Notes:
a) All deaths due to causes attributable to drug use as a risk factor

Figure 1.6.3. shows trends in the number of drug-related deaths, which are much lower than those related to tobacco and alcohol. Northern MedSPAD countries have higher rates and different trends than in southern MedSPAD countries. Among northern MedSPAD countries, Italy has the highest rate, with a peak reached in 1995: despite the increase registered since 2017, its lowest level was reached in 2019. Spain and Portugal also had a peak in 1995 and 1996 respectively, when their rates started to decline. On the contrary, rates in France and Malta kept increasing throughout the considered period. In southern MedSPAD countries, rates are lower but have constantly increased over the considered period: in 2019, Tunisia had the highest number of drug-related deaths while Egypt had the lowest.

Chapter 2

Policies on alcohol, tobacco, drugs and gambling

This chapter provides an overview of the public policies in place in each MedSPAD country in relation to alcohol, tobacco, drugs and gambling. In so doing, the definition of public policy used is that as one generally indicating a system of laws, regulatory measures and priorities related to psychoactive substances and promulgated by a governmental entity or its representatives. It must be noted that the extent and quality of implementation of these policies are not assessed here.

2.1. Alcohol policy

The World Health Organization (WHO), in its 2010 global strategy to reduce the harmful use of alcohol, identified some policy options that could be useful instruments in the reduction of the harmful use of alcohol and its related public health problems. In this section, some of these have been taken into consideration to contextualise MedSPAD results on alcohol consumption.

Nearly all MedSPAD countries for which information was provided by the respective MedSPAD representatives have adopted a written national policy on alcohol (Table 2.1.1). National alcohol policies may either be separate documents or part of a broader public health policy, such as one on substance abuse. Cyprus, France, Malta, Spain and Portugal have policies in place that were adopted or revised in the last 5 years, and in Greece the current policy on alcohol is part of a broader national public health policy approved in 2020. The other five countries have alcohol policies that were adopted or revised before 2017, or that are no longer in force, as is the case in Croatia, where the last national strategy was in force from 2011 to 2016. In Tunisia, the legal framework concerning alcohol dates back to 1959, while Egypt has a law in force that was last revised in 1976.

Almost all MedSPAD countries for which information is available have a national monitoring system collecting data on alcohol consumption and its health and social consequences, with the exception of Egypt. All MedSPAD countries apply excise taxes (inland taxes applied on the sale of, or on production for the sale of, specific products) on beer, wine and spirits. In some countries (Croatia, Cyprus, Italy and Spain), wine is the only alcohol product for which a tax is not foreseen.

Table 2.1.1. National alcohol policy, monitoring systems and excise taxes in the MedSPAD countries

Country	Written national policy		National monitoring system(s)	Excise tax
	Present	Adopted/Revised	Present	On beer/wine/spirits
Croatia	No	-	Yes	Yes/No/Yes
Cyprus	Yes	2010/2020	Yes	Yes/No/Yes
Egypt	Yes	1956/1976	No	Yes/Yes/Yes
France	Yes	2018/2022	Yes	Yes/Yes/Yes
Greece	Yes	2020	Yes	Yes/Yes/Yes
Italy	Yes	2001/2007/2012 Action Plan (2007/2009)	Yes	Yes/No/Yes
Malta	Yes	2018	Yes	Yes/Yes/Yes
Morocco	-	-	-	-
Portugal	Yes	2013/2020	Yes	Yes/Yes/Yes
Spain	Yes	1999/2000/2009/2017	Yes	Yes/No/Yes
Tunisia	Yes	1959	Yes	Yes/Yes/Yes

Source: Data retrieved from World Health Organization (Global status report on alcohol and health 2018) and integrated with information provided by the MedSPAD

committee members

All MedSPAD countries have set a minimum age for the purchase of alcohol (Table 2.1.2). In the majority of countries, the threshold is set at 18 years. The only two exceptions are Malta, where alcohol can be bought at the age of 17, and Egypt, which has set a higher limit of 21 years. In 2020, the drinking age in Cyprus was raised from 17 to 18 years.

Almost all countries have set a maximum limit for legal blood alcohol concentration (BAC) when driving, with the exception of Egypt, which does not rule on the matter (Table 2.1.2). All MedSPAD countries for which information is available have set a general limit of 0.05%, with more restrictions for young people and professional drivers. Spain has the highest limit for young people and professionals (0.03%), while France and Portugal have set a limit of 0.02% of BAC. Malta has imposed a limit of 0.02% for youth and of 0% for professional drivers. All other MedSPAD countries have a zero tolerance policy concerning both young people and professional drivers.

Table 2.1.2. National minimum age for sales and maximum legal blood alcohol concentration (BAC)

Country	Legal minimum age for sales		Max. legal blood alcohol concentation (BAC) when driving (%)		
	Off-premise	On-premise	General	Young	Professional
Croatia	18	18	0.05	0	0
Cyprus	18	18	0.05	0	0
Egypt	21	21	No	No	No
France	18	18	0.05	0.02	0.02
Greece	18	18	0.05	0.02	0.02
Italy	18	18	0.05	0	0
Malta	17	17	0.05	0.02	0
Morocco	-	-	-	-	-
Portugal	18	18	0.05	0.02	0.02
Spain	18	18	0.05	0.03	0.03
Tunisia	18	18	0.05	0.05	0

Source: Data retrieved from World Health Organization (Global status report on alcohol and health 2018) and integrated with information provided by the MedSPAD committee members

WHO has identified some policy instruments that can be effective for limiting alcohol use by reducing the actual availability of alcohol at the population level. These include the imposition of time limits (both in terms of hours and days when alcohol can be purchased) and restrictions concerning locations (limiting sales to specific places or imposing limitations on the concentration of alcohol depending on location). These can be combined with policies that prohibit alcohol sales at specific events, to intoxicated persons and in petrol stations, and have been taken into consideration to provide an overview of alcohol policies in MedSPAD countries.

Croatia, Cyprus and Greece are the only countries with no restrictions concerning regulation of hours of sale. Almost all MedSPAD countries for which information is available have no restriction for days of sale, with the exception of Egypt. Restrictions on the location and density of alcohol outlets are not applied in Croatia, Greece or Malta. All other MedSPAD countries have limitations concerning the location of outlets, and France has also set a limit on the density of alcohol outlets, while also setting a limit on their presence in specific areas. Italy, Malta and Portugal have introduced restrictions concerning the sale of alcohol products during specific events, to intoxicated persons and in petrol stations, while Croatia has only ruled out sale to intoxicated persons, and Spain restricts sale during specific events.

WHO has also identified marketing restrictions that can be effective in reducing the harmful use of alcohol. All MedSPAD countries for which information is available have legally binding regulations on both alcohol advertising and product placement, with the exception of Croatia, where product placement is not regulated, and Greece, where no limits are set. France, Italy, Malta, Portugal and Spain have also regulated sponsorship and sales promotion of alcohol products, while Egypt has not imposed rules on sales promotion.

Tunisia is the only country that has applied a total ban on alcohol marketing, prohibiting the advertising, product placement, sponsorship and sales promotion of these products. France, Greece and Portugal have imposed the introduction of health warnings in both advertisements and on the containers that alcohol is sold in.

Table 2.1.3. National restrictions for on-/off-premise sales, legally binding regulations and required health warnings on alcohol products

Country	Restrictions for on-/off-premise sales of alcoholic beverages (any)			Legally binding regulations on alcohol				Legally required health warning labels on alcohol	
	Hours, days	Places, density	Specific events/ intoxicated persons/ petrol stations	Adver-tising	Placement	Sponsor-ship	Sales promotion	Advertis-ments	Containers
Croatia	No, No	No, No	No/Yes/ No	Yes	No	No	No	No	No
Cyprus	No, No	Yes, No	-	Yes	Yes	No	No	No	No
Egypt	Yes, Yes	Yes, No	-	Yes	Yes	Yes	No	No	No
France	Yes, No	Yes, Yes	-	Yes	Yes	Yes	Yes	Yes	Yes
Greece	No, No	No, No	No/No/No	No	No	Yes	Yes	Yes	Yes
Italy	Yes, No	Yes, No	Yes/Yes/ Yes	Yes	Yes	Yes	Yes	No	No
Malta	Yes, No	No, No	Yes/Yes/ Yes	Yes	Yes	Yes	Yes	No	No
Morocco	-	-	-	-	-	-	-	-	-
Portugal	Yes, No	Yes, No	Yes/Yes/ Yes	Yes	Yes	Yes	Yes	Yes	Yes
Spain	Yes, No	Yes, No	Yes/No/ No	Yes	Yes	Yes	Yes	No	No
Tunisia	Yes, Yes	Yes, No	-	Total ban	Total ban	Total ban	Total ban	-	No

Source: Data retrieved from World Health Organization (Global status report on alcohol and health 2018) and integrated with information provided by the MedSPAD committee members

Legislative changes to alcohol policies

As shown in Table 2.1.4, the national policies on alcohol of MedSPAD countries have not undergone significant changes in the past 5 years (2017-2022).

In particular, in 2020 Cyprus raised the minimum legal age for alcohol purchase from 17 to 18 years and increased penalties for sale to minors. The restrictions are aimed at protecting underage youth. Moreover, age verification and drunkenness were clarified in the relevant law.

In 2018, Malta reduced the maximum BAC for drivers from 0.08% to 0.05%, and down to 0.02% for new drivers and particular groups of motorists. Furthermore, since 2017 subsidiary legislation on alcohol consumption has come into force in certain localities that forbids the consumption of alcohol in public places other than designated areas, as well as the carrying of opened bottles containing alcohol.

In the past five years, Spain has added limits on underage consumption and supply of alcoholic beverages and limitations on advertising and promotion of alcoholic beverages to minors.

Lastly, Tunisia modified the price of alcohol products through a decree law issued in 2022 on industrial product security and market surveillance.

Table 2.1.4. Legislative changes to alcohol policies in the MedSPAD countries

Country	Legislative changes (2017-2022)
Croatia	No changes
Cyprus	Yes, in 2022 the age restriction for the sale of alcohol increased from 17 to 18 years. Also, stricter penalties for the sale of alcohol to underaged were introduced. Finally, age verification and drunkenness were clarified in law.
Egypt	No changes
France	No changes
Greece	No changes
Italy	No changes
Malta	Yes, in 2018 there was a decline in the national maximum legal BAC limit when driving a vehicle. Since 2017, subsidiary legislation has been introduced, which for certain localities no longer permits the consumption of alcohol in public places other than designated areas, and the carrying of opened bottles containing alcohol.
Morocco	-
Portugal	No changes
Spain	Yes, limits on underage consumption and supply of alcoholic beverages and limitations on advertising and promotion of alcoholic beverages to minors.
Tunisia	Yes, in 2022 a national law on industrial product security and market surveillance changed prices of alcohol products

Source: Information provided by the MedSPAD committee member

2.2. Tobacco policy

Almost all MedSPAD countries for which information is available have a written national policy on tobacco (Table 2.2.1), with the exception of Malta and Croatia, where there has not been an action plan since 2016.

In all MedSPAD countries where a national policy is in place, this was approved or revised in recent years, indicating particular attention to this topic. The only exception is Egypt, where the last revisions of national tobacco policies were implemented in 2007. The majority of MedSPAD countries have a national monitoring system in place, with the exception of Cyprus, where it is only partial, and Croatia and Greece, which do not have it.

Table 2.2.1. National tobacco policy, monitoring systems and excise taxes in the MedSPAD countries

Country	Written national policy		National monitoring system(s)	Excise tax
	Present	Adopted/Revised	Present	
Croatia	No	-	No	Yes
Cyprus	Yes	2021	Yes	Yes
Egypt	Yes	1981/2007	Yes	Yes
France	Yes	2018-2022	Yes	Yes
Greece	Yes	2020	No	Yes
Italy	Yes	1975/1995/2003/2016 Action Plan on Prevention 2020-2025	Yes	Yes
Malta	No	-	Yes	Yes

Country	Written national policy		National monitoring system(s)	Excise tax
	Present	Adopted/Revised	Present	
Morocco	-	-	-	-
Portugal	Yes	2017/2020	Yes	Yes
Spain	Yes	1995/2005/2006/2007/ 2010/2011/2014/2017	Yes	Yes
Tunisia	Yes	1998/2014	Yes	Yes

Source: Information provided by MedSPAD committee members

As shown in Table 2.2.2, all MedSPAD countries for which information is available have set 18 years as the legal minimum age for purchasing tobacco products. Moreover, all have legally binding regulations on tobacco advertising, product placement, sponsorship and sales promotion, with the exception of Egypt, where product placement is not regulated. In particular, Croatia and Italy have imposed a total ban on all forms of tobacco advertising, while Egypt has done so only for sponsorship and sales promotion. Tunisia has regulated product placement while imposing a total ban on advertising, sponsorship and promotion.

All MedSPAD countries allowing tobacco advertising have imposed the obligation of including health warnings on tobacco packaging.

Table 2.2.2. National restrictions for sales, legally binding regulations and required health warnings on tobacco products

Country	Legal minimum age for sales	Legally binding regulations on tobacco				Legally required health warning labels on tobacco	
		Advertising	Placement	Sponsorship	Sales promotion	Advertisements	Containers
Croatia	18	Total ban	Total ban	Total ban	Total ban	Total ban	Yes
Cyprus	18	Yes	Yes	Yes	Yes	Yes	Yes
Egypt	18	Yes	No	Total ban	Total ban	Yes	Yes
France	18	Yes	Yes	Yes	Yes	Yes	Yes
Greece	18	Yes	Yes	Yes	Yes	Yes	Yes
Italy	18	Total ban	Total ban	Total ban	Total ban	Total ban	Yes
Malta	18	Yes	Yes	Yes	Yes	Yes	Yes
Morocco	-	-	-	-	-	-	-
Portugal	18	Yes	Yes	Yes	Yes	Yes	Yes
Spain	18	Yes	Yes	Yes	Yes	Yes	Yes
Tunisia	18	Total ban	Yes	Total ban	Total ban	Yes	Yes

Source: Data retrieved from World Health Organization (Tobacco product regulation: basic handbook, 2018) and integrated with information provided by the MedSPAD committee members

Legislative changes to tobacco policies

In the last 5 years (2017-2022), legislative changes concerning tobacco products have been introduced in Croatia, Cyprus, Greece, Malta and Tunisia (Table 2.2.3).

In 2017, Croatia laid down measures to restrict the use of tobacco and related products, by mandating that warnings appear on the packaging of tobacco and related products. It also introduced preventive measures against smoking in order to meet its obligations under the WHO Framework Convention on Tobacco Control.

In the same year, Cyprus introduced limitations concerning the places where smoking is allowed and introduced restrictions on electronic cigarette use comparable to those established for tobacco products.

In the meantime, Malta reformed its tobacco policy, making illegal the use of any tobacco products in private vehicles in the presence of minors.

In Spain, since 2018 many municipalities have adhered to the initiative of banning smoking and cigarette butts on their beaches for public health and ecology. In 2022, on 481 beaches in the Spanish territory, smoking was banned.

More recently, the Greek legislation on e-cigarettes and e-liquids underwent significant revisions through a law passed in 2020, including on how information related to harm should be displayed on the devices used.

In Tunisia, an update of the legislation was done in 2021 by the Ministry of Health and it was submitted to the government for approval. Moreover, Tunisia and the World Health Organization co-signed an agreement to reinforce the application of some MPOWER measures.[3]

Table 2.2.3. Legislative changes to tobacco policies in the MedSPAD countries

Country	Legislative changes (2017-2022)
Croatia	Yes, in 2017 measures restricting the use of tobacco and related products were introduced, by mandating that warnings appear on the packaging of tobacco and related products. It also introduced preventive measures against smoking in order to meet the obligations imposed by the WHO Framework Convention on Tobacco Control.
Cyprus	Yes, in 2017 a new bill banned smoking in all work areas, hospitals, schools, playgrounds for children, and all their open areas. Also, legislative amendment further relaxed the rules, allowing smoking in "open areas" – defined as any enclosed space with one side permanently open – and removed the obligation for a permanent partition between open and closed areas if 30%, or more, of the outside smoking area is open. In addition, it introduced restrictions on e-cigarette use similar to those on tobacco products.
Egypt	No changes
France	No changes
Greece	Yes, pertaining to e-cigarettes and specifically to the way information about the risks of use should be displayed on the device (Law 2715/2020 Articles 35 and 36). Essentially, e-cigarettes can be presented as less harmful compared to conventional cigarettes, based on the available scientific evidence.
Italy	No changes
Malta	Yes, in 2017 it became illegal for any person to consume or allow to consume, at any time, a tobacco product in a private vehicle in the presence of a minor.
Morocco	-
Portugal	No changes
Spain	Yes, since 2018 many municipalities adhere to the idea of banning smoking and cigarette butts on their beaches for public health and ecology. In 2022, on 481 beaches in the Spanish territory, smoking was banned.
Tunisia	Yes, in 2021 the Ministry of Health proposed an update of the legislation. Moreover, Tunisia is part of the World Health Organization Framework Convention on Tobacco Control with a commitment of applying and implementing MPOWER measures proposed.

Source: Information provided by MedSPAD committee members

2.3. Drug policy

In order to offer a comprehensive framework to contextualise MedSPAD results on adolescent consumption of substances, this section proposes an overview of the drug-related policies in force in MedSPAD countries, including and comparing the legal framework for drug consumption, possession and supply on the basis of the

3. These measures are intended to assist in the country-level implementation of effective interventions to reduce the demand for tobacco, contained in the WHO Framework Convention on Tobacco Control (WHO FCTC).

model of analysis proposed by the EMCDDA ("Penalties for drug law offences in Europe at a glance" dataset). The section also includes information about drug strategies, their coverage and the presence of national monitoring systems in MedSPAD countries, and a summary of the legislative changes to drugs policies implemented in the last 5 years (2017-2022).

A specific focus on cannabis is provided, considering its legal status in each MedSPAD country, its possible use for medical purposes and the legislative changes that have taken place from 2017 to 2022.

Almost all MedSPAD countries for which information is available have a national drug strategy or action plan in place (Table 2.3.1), with the exception of Croatia, where both the National Drug Abuse Control Plan and the National Strategy on Combating Drug Abuse expired in 2017, and Italy, where a new action plan on addictions is currently being developed for the period 2022-2025.

In all MedSPAD countries, these policy documents cover any illicit drugs. The exceptions are Cyprus, where the national strategy has broad coverage including not only licit and illicit drugs, but also gambling, and Portugal, which includes alcohol in its National Plan for the Reduction of Addictive Behaviours and Dependencies. With the exception of Tunisia, all MedSPAD countries have a national drug monitoring system. Although Tunisia does not have a drug monitoring system, in 2019 it started collecting data from facilities and drafted a protocol to implement an information system on drug use.

Table 2.3.1. Written national drug strategies, related coverage and national monitoring systems in the MedSPAD countries

Country	Written national strategy/ Action plan in place		National monitoring system(s)	Coverage
	Present	Adopted/Revised	Present	
Croatia	No	-	Yes	-
Cyprus	Yes	National Strategy 2021-2028	Yes	Licit and illicit substances as well as gambling
Egypt	Yes	-	Yes	Any illicit drugs
France	Yes	1970	Yes	Any illicit drugs
Greece	Yes	2020	Yes	Any illicit drugs
Italy	Yes	1990/2014/2017 Action Plan 2017-2020 (new action plan for 2022-2025 is being written)	Yes	Any illicit drugs
Malta	Yes	2008	Yes	Any illicit drugs
Morocco	-	-	-	-
Portugal	Yes	2013-2020	Yes	Any illicit drugs and alcohol
Spain	Yes	1975, 1980, 2000, 2003, 2004, 2007, 2008, 2010, 2011, 2015, 2018, 2019	Yes	Any illicit drugs
Tunisia	Yes	-	No	Any illicit drugs

Source: Information provided by MedSPAD committee members

Punishment for drug consumption

Table 2.3.2 shows the punishments foreseen for drug consumption-related offences in each MedSPAD country for which the information is available. With the exception of Italy, where the use of drugs is not mentioned as an offence in the national legislation, penalties are foreseen in all other MedSPAD countries.

However, in Croatia, Spain and Portugal, the consumption of drugs is not punished with incarceration but with administrative sanctions, such as a fine. In all other countries, the use of drugs can be punished with imprisonment. Moreover, in Egypt and France incarceration is associated with the payment of a fine. In Greece, drug use may be

omitted from the offender's record, subject to the discretion of the prosecutor/judge. In all MedSPAD countries, except Croatia, the law provides treatment for addiction as an alternative to punishment.

In Malta, drug legislation only classes as an offence the use of opium, the production and supply of which are considered illegal. In four MedSPAD countries (Egypt, France, Malta and Portugal) penalties vary by the drug consumed, while in Croatia, Cyprus, Greece and Spain they do not. Only in Egypt does the penalty vary depending on the quantity of drugs consumed.

Table 2.3.2. Legal framework for drug consumption in the MedSPAD countries

Country	Punishment for offence	Alternatives to punishment for offence	Penalty varies by drug	Penalty varies by quantity
Croatia	Without incarceration	No	No	N/A
Cyprus	Incarceration possible	Treatment for addiction	No	N/A
Egypt	Incarceration and a fine	Treatment for addiction	Yes	Yes
France	Incarceration and a fine	Treatment for addiction	Yes	N/A
Greece	Incarceration	Treatment for addiction	No	N/A
Italy	None	N/A	N/A	N/A
Malta	Incarceration possible (only for opium)	Treatment for addiction	Yes	N/A
Morocco	-	-	-	-
Portugal	Without incarceration	Counselling or treatment for addiction	Yes	N/A
Spain	Without incarceration	Treatment for addiction (minors) Re-education activities	No	N/A
Tunisia	Incarceration and a fine	Treatment for addiction	No	Yes

Source: Data retrieved from EMCDDA ("Penalties for drug law offences in Europe at a glance" dataset) and integrated with information provided by the MedSPAD committee members

Punishment for drug possession for personal use

Table 2.3.3 presents the legal framework for drug possession in MedSPAD countries. In contrast to consumption, the possession of drugs is considered as an offence in all MedSPAD countries for which information is available.

In Italy, Spain and Portugal, drug possession is not a criminal offence punishable with incarceration, while in all other countries incarceration for drug possession is possible. Egypt and France also allow for the possibility of paying a fine, while in Tunisia the drug policy reform carried out in 2017 allows for a reduction in penalties. In all MedSPAD countries, treatment for addiction may be used as an alternative to punishment for a drug offence.

Penalties vary depending on the drug possessed in the majority of MedSPAD countries, with the exceptions of Croatia and Spain. In Greece, the cultivation of cannabis can be classified as a personal use offence, but not the cultivation of other drugs. The quantity of drugs possessed is considered a criterion for determining the magnitude of the penalty only in Greece, Egypt, Malta and Portugal. In Cyprus, France, Italy and Spain, quantity is a factor considered alongside others by the courts to establish the type of crime, namely to distinguish between drug possession and supply.

Table 2.3.3. Legal framework for drug possession for personal use in the MedSPAD countries

Country	Punishment for offence	Alternatives to punishment for offence	Penalty varies by drug	Penalty varies by quantity
Croatia	Incarceration possible	Treatment for addiction	No	No
Cyprus	Incarceration possible	Treatment for addiction	Yes	No
Egypt	Incarceration and a fine	Treatment for addiction	Yes	Yes

Country	Punishment for offence	Alternatives to punishment for offence	Penalty varies by drug	Penalty varies by quantity
France	Incarceration and a fine	Treatment for addiction	Yes	No
Greece	Incarceration	Treatment for addiction	No	Yes
Italy	Without incarceration	Treatment for addiction	Yes	No
Malta	Incarceration possible	Treatment for addiction	Yes	Yes
Morocco	-	-	-	-
Portugal	Without incarceration	Counselling or treatment for addiction	Yes	Yes
Spain	Without incarceration	Treatment for addiction (minors) Re-education activities	No	No
Tunisia	Incarceration and a fine	Treatment for addiction	No	Yes

Source: Data retrieved from EMCDDA ("Penalties for drug law offences in Europe at a glance" dataset) and integrated with information provided by the MedSPAD committee members

Punishment for drug supply

Table 2.3.4 illustrates the legal framework for drug supply-related offences in MedSPAD countries for which information is available. The possession or the production of drugs with the intention of distribution and supply is considered a criminal offence in all countries. Differences exist concerning the length of imprisonment and fines involved. The harshest penalties are foreseen in Egypt, where drug supply, in defined circumstances, can lead to execution.

In the majority of MedSPAD countries, treatment for addiction can be considered an alternative to punishment, with the exception of Cyprus, Egypt and Tunisia.

In Egypt, Italy, Malta, Portugal and Spain, the penalties foreseen for drug supply-related offences vary by drug and quantity. In Cyprus, penalties vary depending on the drug supplied, in Greece they vary depending only on drug quantity and in the remaining MedSPAD countries neither the type of drug nor its quantity are taken into consideration while determining penalties.

Table 2.3.4. Legal framework for supply in the MedSPAD countries

Country	Punishment for offence	Alternatives to punishment for offence	Penalty varies by drug	Penalty varies by quantity
Croatia	Imprisonment: 1 to 15 years	For minor cases or addiction: fines, community service, probation, treatment	No	No
Cyprus	Fine and/or imprisonment (up to life imprisonment)	No alternative	Yes	No
Egypt	Life imprisonment and fine: 100 000 EP to 500 000 EP Execution	No alternative	Yes	Yes
France	Imprisonment: 5 years to life imprisonment	For sentences up to 5 years: probation order that may include treatment	No	No
Greece	Imprisonment: 8 years	Treatment	No	Yes
Italy	Imprisonment: 6 months to 20 years and a fine	Community service and/or treatment	Yes (depending on the potency of the substance)	Yes
Malta	Imprisonment: 6 months to life imprisonment	Treatment	Yes	Yes
Morocco	-	-	-	-

Country	Punishment for offence	Alternatives to punishment for offence	Penalty varies by drug	Penalty varies by quantity
Portugal	Imprisonment: 1 to 12 years	Treatment	Yes	Yes
Spain	Imprisonment: 1 to 6 years (possibility of aggravating circumstances)	For sentences up to 5 years: suspension if detoxication treatment undertaken	Yes	Yes
Tunisia	Imprisonment: 6 years to life imprisonment	-	No	No

Source: Data retrieved from EMCDDA ("Penalties for drug law offences in Europe at a glance" dataset) and integrated with information provided by the MedSPAD committee members

Focus on cannabis

As cannabis is the drug most often mentioned in reports of drug law offences, and acknowledging the increased debate on the laws controlling the use of cannabis, especially in Europe, this section focuses on cannabis to examine the differences in approach across MedSPAD countries. Table 2.3.5 provides information on the legal treatment of the use, possession or supply of cannabis along with the national legislation on cannabis or cannabis-based products used for therapeutic purposes.

In all MedSPAD countries for which information is available, the supply of cannabis is considered a criminal offence, with the exception of Malta, where it is not considered an offence in defined circumstances. The law now allows for the registration of cannabis associations, as long as they respect existing regulations. There are also differences among MedSPAD countries concerning the legal treatment of the use and possession of cannabis. In Cyprus, Egypt, France, Greece and Tunisia both use and possession are considered criminal offences while in Italy and Portugal they are considered non-criminal offences, punished with administrative sanctions. Lastly, in Malta and Spain the consumption and possession of cannabis are not considered an offence, in defined circumstances. For example, in Malta the use of cannabis is considered an offence only if it takes place in public or in the presence of minors, while for possession the penalties vary by quantity; for minors, the possibility of placing them in a treatment programme is considered.

Table 2.3.5. Current legal status of cannabis in the MedSPAD countries

Country	Current legal status of cannabis			National legislation allows the medical use of cannabis and cannabinoids (year of legislation)
	Use	Possession	Supply	
Croatia	No offence	Minor offence	Criminal offence	Yes (2019)
Cyprus	Criminal offence	Criminal offence	Criminal offence	Yes (2019)
Egypt	Criminal offence	Criminal offence	Criminal offence	No
France	Criminal offence	Criminal offence	Criminal offence	Undergoing experimental phase. To date, the bill/law has not been adopted.
Greece	Criminal offence	Criminal offence	Criminal offence	Yes (2021)
Italy	Non-criminal offence	Non-criminal offence	Criminal offence	Yes (2006)
Malta	No offence in defined circumstances	No offence in defined circumstances	No offence in defined circumstances	Yes (2015)
Morocco	-	-	-	-
Portugal	Non-criminal offence	Non-criminal offence	Criminal offence	Yes (2018)
Spain	No offence in defined circumstances	No offence in defined circumstances	Criminal offence	Yes (2022)
Tunisia	Criminal offence	Criminal offence	Criminal offence	No

Source: Data retrieved from EMCDDA ("Penalties for drug law offences in Europe at a glance" dataset) and integrated with information provided by the MedSPAD committee members

The medical use of cannabis and cannabinoids is allowed in all MedSPAD countries, with the exception of Egypt and Tunisia. The most recent legislative initiatives concerning medical cannabis have been advanced in Greece, France and Spain. In Greece, a law passed in 2021 set the framework for the production, export and distribution of medical cannabis products with a tetrahydrocannabinol (THC) content of more than 0.2%. The new regulation aimed to ensure the safe and unhindered availability of medicinal cannabis products for specific pathologies under the control of the National Organization for Medicines. In France, the law ruling on the medical use of cannabis-related products is undergoing an experimental phase and has not been approved yet. The Spanish Parliament took a first step in June 2022 to legalise the medical use of cannabis for certain conditions with a doctor's prescription, to be purchased in pharmacies only.

Legislative changes to drug policies

In some MedSPAD countries for which information is available, drug laws have changed in the last 5 years, with the exception of Cyprus, Egypt, Italy and Portugal (Table 2.3.6). Since 2019, Croatia has allowed the possession of drugs for medical, veterinary, research and teaching purposes. In 2020, France established fines for the personal use and possession of illicit psychoactive substances, as requested by law enforcement officials, instead of prosecution and detention. In 2019, Malta amended its list of proscribed substances and included new psychoactive substances under the definition of a "drug".

In Spain, meanwhile, stricter sanctions for certain behaviours have been put in place, in particular concerning driving under the influence of alcohol or other psychoactive substances. In addition, new drugs have been brought under the purview of Spanish legislation. The Tunisian drug policy changed through legislative reform implemented in 2017, with a reduction of penalties, in particular with regard to drug consumption and possession.

Table 2.3.6. Legislative changes to drug policies in the MedSPAD countries (2017-2022)

Country	Legislative changes (2017-2022)
Croatia	Yes, from 2019 possession of drugs for medical, veterinary, scientific research and teaching purposes is permitted
Cyprus	No changes
Egypt	No changes
France	Yes, since 1 September 2020. personal use/possession of illicit psychoactive substances can result in an immediate fine of €200 issued by law enforcement officials, in lieu of detention and prosecution.
Greece	Yes, Law 4801/2021 set the framework for production, export and distribution of medicinal cannabis products of the *Cannabis sativa L.* species with THC content of more than 0.2%. The new regulation also aimed to ensure the safe and unhindered availability of medicinal cannabis products, under the control of the National Medicinal Drugs Organization, to meet the prescription needs of people with multiple sclerosis and epilepsy and those suffering from neuropathic or oncological pain.
Italy	No changes
Malta	Yes, Act No. V of 2019 amended the list of proscribed substances in the Medical and Kindred Professions Ordinance and the Dangerous Drugs Ordinance by including new psychoactive substances in the definition of "drug".
Morocco	-
Portugal	No changes
Spain	Yes, greater sanctions for certain behaviours, particularly those leading to serious illness resulting in death, in particular when the driver of a motor vehicle or moped is under the influence of toxic drugs, narcotics, psychotropic drugs or alcoholic beverages or is speeding. Also, some new drugs have been controlled and included under the Spanish legislation.
Tunisia	Yes, the 1992 law was revised in 2017, giving judges the right to apply Article 53 of the criminal code to reduce penalties, not only for consumption, detention and consumer intent (Article 4 of Act 92-52), but also for being present in places where consumption is taking place (Article 8 of Act 92-52)

Source: Information provided by MedSPAD committee members

Most MedSPAD countries have undertaken legislative changes concerning the legal treatment of cannabis in the last 5 years, reflecting the greater attention to this topic at international level (Table 2.3.7). Specifically, from 2019 onwards Croatia has allowed the production, manufacturing, possession and trade of plants from which

drugs can be derived for medical, veterinary, research and teaching purposes. The production of industrial hemp is also allowed, with workers recorded in a ministerial register.

In 2019, Cyprus adopted policy measures on medical cannabis, although these have not come into force yet.

In 2020, Malta introduced changes to its drug legislation concerning the cultivation of cannabis in defined circumstances: the cultivation of up to four cannabis plants per household, away from public view, does not constitute an offence. Moreover, in 2021 the new Responsible Use of Cannabis Act established and amended various rules relating to cannabis, such as the possibility of legally carrying up to 7 g of cannabis and the establishment of a non-criminal penalty when the quantity in possession is between 7 g and 28 g. Some limitations are still in force, in particular concerning minors and consumption in public places. Furthermore, individuals with a criminal record for cannabis possession can now apply for its removal. Finally, the law now allows the possibility of establishing cannabis associations.

In Portugal, the legislation has changed with regard to the use and possession of cannabis for medical reasons as in Spain, where in 2022 the medical use of cannabis was legalised for certain conditions and under specific requirements.

Finally, in Tunisia the legislative reform approved in 2017 of the 1992 law includes cannabis among the drugs for which the possibility of a penalty reduction is foreseen, but the substance does not receive special treatment.

Table 2.3.7. Legislative changes to cannabis policies in the MedSPAD countries (2017-2022)

Country	Legislative changes (2017-2022)
Croatia	Yes, from 2019 it has been permissible to grow, for medical, veterinary, scientific research and teaching purposes, cannabis plants from which drugs can be obtained, and to manufacture, possess and trade drugs, cannabis plants and parts of cannabis plants from which drugs and new psychoactive substances and substances that can be used can be obtained. The production of industrial hemp is allowed. Legal and natural persons who grow industrial hemp are obliged to register in the Register of Industrial Hemp Producers kept by the Ministry of Agriculture before starting production.
Cyprus	Yes, regulations for medicinal cannabis were adopted in 2019 but have not yet come into force
Egypt	No changes
France	No changes
Greece	Yes, Law 4801/2021 set the framework for production, export and distribution of medicinal cannabis products of the *Cannabis sativa L.* species with THC content of more than 0.2%. The new regulation also aimed to ensure the safe and unhindered availability of medicinal cannabis products, under the control of the National Medicinal Drugs Organization, to meet the prescription needs of people with multiple sclerosis and epilepsy and those suffering from neuropathic or oncological pain.
Italy	No changes
Malta	Yes, Act IV of 2020 amended the articles relating to the cultivation of the cannabis plant in the Dangerous Drugs Ordinance, Cap. 101 of the Laws of Malta and of the Drug Dependence (Treatment not Imprisonment Act), Chapter 537 of the Laws of Malta. This amendment meant that when a Court of Law is satisfied that the cultivation of the cannabis plant was made for the exclusive use of the offender, such cultivation shall not be considered as an offence of selling or dealing in a drug against the law. Following this, the new Responsible Use of Cannabis Act, ACT No. LXVI of 2021. established Chapter 628 of the Laws of Malta (Authority on the Responsible Use of Cannabis Act) and amended various laws relating to certain cannabis activities. Adults can now legally carry up to 7 g of cannabis. Adults caught carrying between 7 g and 28 g will appear before a tribunal rather than a criminal court. Public smoking of cannabis in public remains illegal. Persons caught consuming cannabis in public will appear before a justice commissioner and can be fined up to €235. Consuming cannabis in front of a minor results in fines of between €300 and €500. Those under the age of 18 who are found to be in possession will go before a commission for justice for the recommendation of a care plan rather than face arrest. Up to four cannabis plants can be cultivated per household as long as they are not visible to the public. In addition, persons with a criminal record for cannabis possession can now apply for the removal of these records, and the law allows for the possibility of the formation of cannabis associations.
Morocco	-
Portugal	Yes, in 2019 the legislation has changed for what concerns use and possession for medical use

Country	Legislative changes (2017-2022)
Spain	Yes, the Spanish Parliament took a first step on 21 June 2022 to legalise the medicinal use of cannabis for certain conditions such as cancer, endometriosis, diseases of the nervous system (neuropathic), multiple sclerosis, some forms of epilepsy, nausea and vomiting from chemotherapy, with a doctor's prescription and only through purchase in pharmacies
Tunisia	Yes, the law of 1992 was revised in 2017, giving judges the right to apply Article 53 of the criminal code to reduce penalties, not only for consumption, detention and consumer intent (Article 4 of Law 92-52), but also for being present in places where consumption is taking place (Article 8 of Law 92-52)

Source: Information provided by MedSPAD committee members

Drug seizures and population in prison for drug-related offences

The quantities of illicit drugs seized by law enforcement agencies are an important indicator of the size of drug markets in each country. However, these have to be treated carefully, as quantities seized may fluctuate from one year to another (for example due to a small number of large seizures) or because of double-counting that might occur within a country between various law enforcement agencies.

Table 2.3.8 reports the quantities of drugs seized in kilograms; there are however a number of other drug seizures which are reported in doses or tablets that have not been included.

The country with the highest quantity of drugs seized was Spain in which the amount of drug seized in 2019 was 431.2 tons, followed by Egypt where in 2015 the total quantity of drugs seized (comprising herbal cannabis and cannabis resin, heroin, opium, cocaine, khat, vodo) was 395.2 tons.

Cannabis products (herbal cannabis and resin) were the most commonly seized drug across the MedSPAD countries for which data are available, with the exception of Portugal where cannabis accounts for 25% of all recorded drugs. The countries which seized the highest quantity of cannabis were Egypt, where in 2015 were seized 394.4 tons of cannabis, and Spain where in 2019 the seizures of this drug amounted to 389.4 tons.

Concerning the prison population, people charged with or convicted for offences related to the prohibition of drugs represent a sizeable proportion of people in prison, ranging from the 32.1 % recorded in Tunisia in 2017 to the 5.5% recorded in Croatia in 2019.

Analysing drug laws as such is possible thanks to the public information available, but describing and commenting on their implementation is very difficult due to the lack of data. This outcome indicator is an important element helping to provide a more accurate picture of the implementation of national drug laws and policies than the text of laws alone.

Table 2.3.8. Drug seizures and prison population in MedSPAD countries

Country	Drug seizures (a)			Prison population		
	Year	All recorded drugs (Kg)	Cannabis (Kg)	Year	Total number of inmates (including pre-trial detainees)	% of prisoners sentenced for drug offences
Croatia (b, c)	2019	2466.0	2379.5	2019	3533	5.5
Cyprus (b, c)	2019	342.6	287.6	2019	829	27.3
Egypt (d)	2015	395170.0	394440.0	2004	34415	N/A
France (b, c)	2019	121851.0	104292.0	2019	70651	18.6
Greece (b, c)	2019	20511.6	19106.1	2019	10972	29.4
Italy (b, c)	2019	54451.0	44637.5	2019	60971	31.5
Malta (b, c)	2019	1255.7	507.3	2019	793	25.2
Morocco	-	-	-	-	-	-
Portugal (b, c)	2019	14798.1	3726.0	2019	12793	17.7

Country	Drug seizures (a)			Prison population		
	Year	All recorded drugs (Kg)	Cannabis (Kg)	Year	Total number of inmates (including pre-trial detainees)	% of prisoners sentenced for drug offences
Spain (b, c)	2019	431156.4	389377.3	2019	58372	17.0
Tunisia (d)	2016	17340.0	7670.0	2017	20755	32.1

Notes:

a Drug seizures refer to all seizures made in each country during the year by all law enforcement agencies (police, customs, national guard, etc.). The drugs seized include: Cannabis (Herbal; Oil; Plants; Resin); Hallucinogens (DMT; Ketamine; Psilocybin/Psilocin/PsyMushroom); Opioids (Buprenorphine; Codeine; Fentanils; Heroin; Methadone; Morphine; Opium; Oxycodone; Tramadol); Stimulants (Amphetamine; Cocaine; Crack; Khat; MDMA; Methamphetamine)

b Drug seizures: EMCDDA's Statistical Bulletin 2022 (available at: https://www.emcdda.europa.eu/data/stats2022/szr_en)

c Prison population: Prisons and Prisoners in Europe 2020 (available at: https://wp.unil.ch/space/files/2021/06/210329_Key_Findings_SPACE_I_2020.pdf)

d Information provided by the MedSPAD committee member of the country

2.4. Gambling policy

This report presents for the first time MedSPAD results on adolescent gambling. In particular, Egypt, Morocco and Tunisia collected for the first time information about the engagement of students in gambling activities in their MedSPAD surveys. For the purpose of providing some policy elements useful for contextualising the data collected and comparing them across countries, this section presents an overview of gambling policies in the MedSPAD region.

Table 2.4.1 reports on the presence of written national policies and national monitoring systems, focusing on both land-based and online gambling products. Most MedSPAD countries have a written national policy regulating both land-based and online gambling. Croatia and Malta are the only exceptions, while Egyptian regulations are only concerned with land-based gambling. All MedSPAD countries, except Tunisia, have a national monitoring system on gambling. In Croatia, the monitoring system only considers data related to hospitalisations due to gambling addiction, while Egypt includes only land-based gambling data.

Table 2.4.1. Written national policy on land-based and online gambling and national monitoring systems in the MedSPAD countries

Country	Written national policy Land-based gambling		Written national policy Online gambling		National monitoring system on gambling
	Present	Adopted/Revised	Present	Adopted/Revised	Present
Croatia	No	-	No	-	Yes
Cyprus	Yes	2016/2017/2019	Yes	2019	-
Egypt	Yes	1957	No	-	Yes for land-based
France	Yes	2010	Yes	2010	Yes
Greece	Yes	2011/2019	Yes	2011/2019	Yes
Italy	Yes	1948/1992/2002/2006/2011/ 2016/2017/2018/2019 Action Plan (2013-2015) From 2017, regional plans have been adopted	Yes	2005/2009/2011	Yes
Malta	No	-	No	-	Yes
Morocco	-	-	-	-	-
Portugal	Yes	2013-2020	Yes	2013-2020	Yes
Spain	Yes	2007, 2011, 2012, 2013, 2014, 2015, 2017, 2018, 2020, 2021	Yes	2007, 2011, 2012, 2013, 2014, 2015, 2017, 2018, 2020, 2021	Yes
Tunisia	Yes	1974	Yes	-	No

Source: Information provided by MedSPAD committee members

In all MedSPAD countries, the gambling market is subject to some forms of restriction. In Croatia and Portugal, the gambling market is a public monopoly, while Italy has a particular form of public monopoly managed by the Autonomous Administration of State Monopolies, which is granted the power to issue licences to private gambling operators and regulate other gambling matters. France has set up a private monopoly with closed regulation licensing.

Cyprus, Greece, Malta and Spain regulate their gambling market as an open regulation licensing system.

In Egypt and Tunisia, gambling is not allowed for citizens: in Egypt it is permitted only in hotels and tourism facilities for foreign citizens; in Tunisia a closed regulation licensing system is in place, though gambling is prohibited for Tunisian citizens.

Table 2.4.2 reports on the value of national gambling turnover in MedSPAD countries where this information is available. The national gambling turnover is calculated as the total gross amount wagered by gamblers, expressed in national currency. Caution must be used in interpreting information, as there is no common standard for reporting the size of gambling markets, and sometimes countries calculate the turnover generated from gambling differently: for example, some may exclude certain gambling products or calculate the land-based gambling turnover and the online gambling turnover differently. The biggest gambling market is in Italy, which in 2019 accounted for €110.5 billion, among the largest in the world. The total amount wagered in the Italian gambling market reached around €88 billion in 2020, decreasing sharply over 2019 due to the impact of the coronavirus (Covid-19) pandemic.

Table 2.4.2. Type of legal gambling market and value of national gambling turnover in the MedSPAD countries

Country	Type of legal gambling market	Value of national turnover (in national currency)
Croatia	Public monopoly with licensing system	HRK373.9 million (2020)
Cyprus	Open regulation licensing	-
Egypt	Only allowed in hotels and tourism facilities for non-Egyptian citizens	-
France	Private monopoly, closed regulation licensing	€11 100 million (2019)
Greece	Open regulation licensing	-
Italy	Public monopoly with licensing system	€110 500 million (2019)
Malta	Open regulation licensing	€96 million (2020) a)
Morocco	-	-
Portugal	Public monopoly	€319.3 million (2019) b)
Spain	Open regulation licensing	€4 963.6 million (2020)
Tunisia	Prohibited for Tunisian citizens; closed regulation licensing	-

Source: Information provided by MedSPAD committee members

Notes:

Prohibition: total ban on gambling; public monopoly: government-controlled monopoly; Private monopoly: monopoly managed by companies/foundations/associations with exclusive licences based on selection processes; closed regulation licensing: market based on licences limited only to domestic gambling operators; open regulation licensing: market based on licences opened also to external gambling operators.

a) This figure refers to the total activity of the National Lottery operator, Maltco Lotteries Limited (Maltco). This is measured in terms of sales across three game categories, namely draw-based games, instant games and sports games. This figure excludes turnover from other gambling operators. Data from: Malta Gaming Authority Annual Report, 2019. https://www.mga.org.mt/wp-content/uploads/MGA-Annual-Report-2019.pdf

b) This figure includes only land-based gambling

In almost all MedSPAD countries in which gambling is permitted by law, the minimum age for gambling is 18 years. Greece is the only country where the legal age is 21 years. Cyprus and Malta have different age limits for casinos: in Cyprus, access to casinos is allowed only from the age of 21, while in Malta the age limit for casinos is set at 25 years only for Maltese citizens.

In all MedSPAD countries that allow gambling, legally binding regulations exist on advertising and on the introduction of health warnings, both for land-based and online gambling. Croatia, in particular, has a total ban

on advertising in radio and television shows, and requires the provision of printed materials for children and youth as well as public information on the development of gambling addiction and on the counselling and treatment services available.

All MedSPAD countries have established restrictions on the location of gambling sites. For example, Croatia has imposed limitations on sport betting venues, which should be located at least 200 metres away from primary and secondary schools. In Malta, Portugal and Spain, there are limitations concerning "vulnerable areas" such as school surroundings or health centres, and the same type of restriction is imposed in Italy as well as through regional or local regulations. In Egypt and Tunisia, gambling is allowed only in casinos.

Only Italy, Portugal and Spain have imposed restrictions on operating hours for land-based gambling. In Italy, the restrictions in place vary by national territory and are regulated through legislative measures at regional or local level. In Spain, gambling is permitted only during specific time slots, whereas in Portugal time limitations depend on the gambling venue.

Table 2.4.3. Legal minimum age for gambling, national restrictions for advertising, and health warnings and restrictions on gambling sites in the MedSPAD countries

Country	Legal minimum age for gambling	Legally binding regulations on gambling	Legally required health warnings on gambling		Restrictions on gambling sites (locations)		Restrictions on gambling sites (operating hours)	
		Advertising	Land-based	Online	Land-based	Online	Land-based	Online
Croatia	18	Yes	Yes	Yes	Yes	No	No	No
Cyprus	18	Yes	-	-	-	-	-	-
Egypt	-	No	No	No	No a)	-	-	-
France	18	Yes	Yes	Yes	Yes	Yes	No	No
Greece	21	Yes	Yes	Yes	Yes	Yes	-	-
Italy	18	Yes	Yes	Yes	Yes (Regional/ local regulations) b)	No	Yes (Regional/ local regulations)	No
Malta	18	Yes	No	No	Yes b)	No	No	No
Morocco	-	-	-	-	-	-	-	-
Portugal	18	Yes	Yes	Yes	Yes b)	No	Yes	No
Spain	18	Yes	Yes	Yes	Yes b)	No	Yes	No
Tunisia	-	No	-	-	Yes	-	-	-

Source: Information provided by MedSPAD committee members

Notes:

a) Gambling is only allowed in hotels and tourism facilities for non-Egyptian citizens

b) The location of gambling sites is forbidden in specific vulnerable areas (e.g. schools, banks, hospitals, etc.)

All northern MedSPAD countries have a national plan and public funds for the prevention of gambling-related problems. Gambling is included among the behavioural addictions treated by public addiction treatment services.

Given their particular legal framework for gambling, Egypt and Tunisia have neither a national plan nor funds dedicated to gambling and they do not consider gambling a behavioural addiction to be addressed by addiction treatment services.

Table 2.4.4. National plan and funds for gambling prevention and gambling treatment in the MedSPAD countries

Country	National plan and funds for gambling prevention	Gambling included among behavioural addictions treated by addiction treatment services
Croatia	Yes	Yes
Cyprus	Yes	Yes
Egypt	No	No
France	Yes	Yes
Greece	Yes	Yes
Italy	Yes	Yes
Malta	Yes	Yes
Morocco	-	-
Portugal	Yes	Yes
Spain	Yes	Yes
Tunisia	No	No

Source: Information provided by MedSPAD committee members

Table 2.4.5 shows the legal status of each type of gambling product in MedSPAD countries, both for land-based and online modes. With the exception of Tunisia, where only casino games are permitted in physical places, and Egypt, where all offline and online gambling activities are prohibited, in all other MedSPAD countries the gambling products considered are legal. In Croatia, Italy, Malta, Portugal and Spain, the distribution of gambling products is permitted both through land-based and online distribution channels, while in France casino games and entertainment machines are only allowed in physical places. In Cyprus, online gambling products are not considered legal.

Table 2.4.5. Land-based and online gambling products considered legal in the MedSPAD countries

Country	Lotteries (Lotto, etc.)	Instant lotteries (scratch cards, etc.)	Bingo	Card games (poker, blackjack, etc.)	Sports betting/ sports lotteries/ animal betting	Betting on other events	Casino games (roulette, etc.)	Entertainment machines (slot machines, video lottery terminals, etc.)	Other games (roulette, dice, etc.)
	Land-based/ online	Land-based/ online	Land-based/ online	Land-based/ online	Land-based/ online	Land-based/ online	Land-based/ online	Land-based/ online	Land-based/ online
Croatia	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes
Cyprus	-/No	-/No	-/No	-/No	-/Yes	-/No	-/No	-/No	-/No
Egypt	No/-	No/-	No/-	No/-	No/-	No/-	No/-	No/-	No/-
France	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/No	Yes/No	Yes/Yes
Greece	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes
Italy	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes
Malta	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes
Morocco	-	-	-	-	-	-	-	-	-
Portugal	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes
Spain	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes	Yes/Yes
Tunisia	-	-	-	-	-	-	Yes/-	-	-

Source: Information provided by MedSPAD committee members

Legislative changes to gambling policies

In the last five years (2017-2022), changes to gambling legislation have been introduced in the five MedSPAD countries for which information is available (Table 2.4.6).

In 2019, the French national lottery was privatised alongside the creation of a national, public and independent authority tasked to conduct research on gambling and carry out activities to prevent it. In Greece, a law passed in 2019 and a ministerial decision of 2020 strengthened the role of the Greek Independent Administrative Authority for Gambling and set out rules for, among others, advertising and public information about the possible harms of gambling to health.

In Italy, some changes occurred in 2017 with the reduction of the number of slot machines that can be present within the national territory and in 2018, with the modification of the rules concerning advertising and health warnings, and the introduction of a monitoring system for the regulation of the operating hours of land-based gambling products and venues. Furthermore, in 2019 new measures concerning gambling were introduced, in particular in relation to the fight against organised crime and the protection of minors.

In 2018, Malta approved a new Gaming Act, replacing the previous legislation on gambling. The regulations introduced aim to prevent the participation of minors and vulnerable people in gambling activities. In Spain, legislative reform passed in 2021 imposed restrictions on gambling advertising and a limit to the opening hours and locations of gambling sites. Moreover, sponsorship of sport teams has been limited.

Table 2.4.6. Legislative changes to gambling policies in MedSPAD countries (2017-2022)

Country	Legislative changes (2017-2022)
Croatia	No changes
Cyprus	No changes
Egypt	No changes
France	Yes, privatisation of the state lottery monopoly (Française des Jeux) in 2019 alongside the creation of the Gaming National Authority (ANJ), a public independent authority with extended mandates on research and prevention
Greece	Yes Law 4635/2019 and Ministerial Decision No. 792/2020 strengthened the role of the Greek Independent Administrative Authority for Gambling and set the rule for, *inter alia*, advertising and informing about gambling risks.
Italy	Yes, in 2017 a reduction in number of slot machines, in 2018 changes in advertising rules and health warnings and monitoring of rules on times for land-based gambling. In 2019 increase in taxation, rules on the fight against organised crime, illegal gambling and the protection of minors.
Malta	Yes, Lotteries and Other Games Act and other subsidiary legislation repealed by the Act XVI of 2018 – Gaming Act, 2018. The Gaming Player Protection Regulations (of the Gaming Act CAP. 583) were introduced in 2018. The regulations are aimed, *inter alia*, at ensuring that gambling operators safeguard the players to prevent participation of minors in gambling and protect vulnerable persons.
Morocco	-
Portugal	No changes
Spain	Yes, in 2021 the advertising of the game and the opening hours and locations of the bookmakers have been restricted (the number of opening hours and opening hours have been limited). The sponsorship of sports teams has also been restricted.
Tunisia	No changes

Source: Information provided by MedSPAD committee members

Chapter 3

Substance use among adolescents

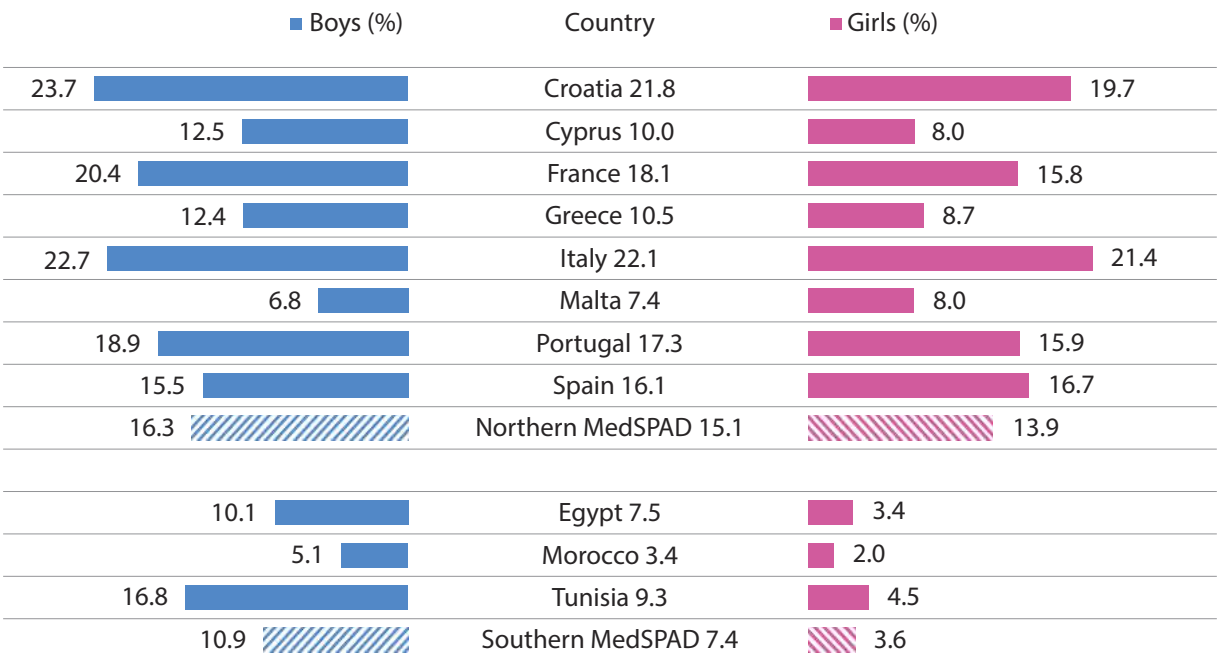
3.1. Cigarettes

Early onset of cigarette use

Nearly one in six students (15.1%) in northern MedSPAD countries had smoked cigarettes at age 13 years or younger. Prevalence varies considerably across countries: from 7.4% in Malta, 10% in Cyprus and 10.5% in Greece to 21.8% in Croatia and 22.1% in Italy. On average and in almost all countries except for Spain and Malta, the highest rates of early onset of cigarette smoking were recorded among boys.

The average among southern MedSPAD students who began smoking cigarettes at age 13 years or younger was 7.4%. Tunisia had a rate of 9.3%, with a 12.3% difference between genders, while Egypt and Morocco presented rates of 7.5% and 3.4%, respectively (Figure 3.1.1).

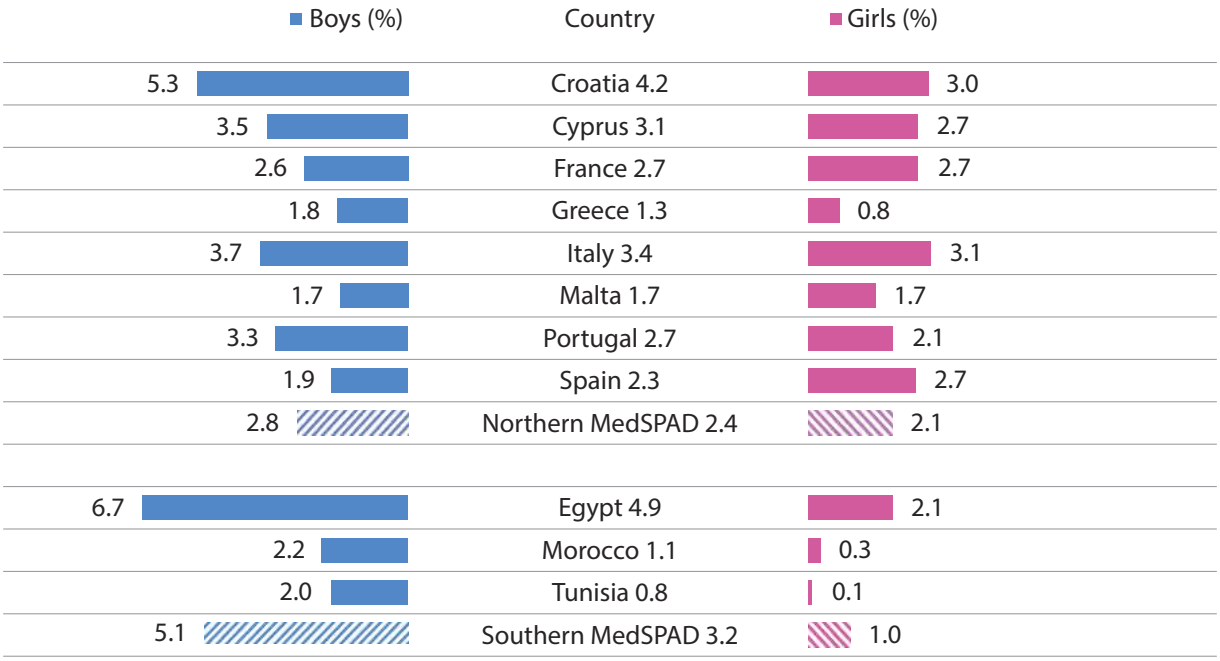
Figure 3.1.1. Cigarettes: prevalence of students using at age 13 years or younger (percentage)



On average, in northern MedSPAD countries, 2.4% of students reported that they started smoking cigarettes on a daily basis at the age of 13 years or younger (Figure 3.1.2). With a rate of 3.4% and 4.2% respectively, Italy and Croatia presented the highest rates. In all northern MedSPAD countries, the gender difference was less than 2.5 percentage points, with early onset of daily smoking rates higher among boys, except for Spain and France.

The average rate of early onset of daily smoking in southern MedSPAD countries was 3.2%. In Egypt, 4.9% of students started smoking cigarettes daily at the age of 13 or younger. In Morocco, this stood at 1.1% of students and in Tunisia, the rate was 0.8%. The rate was higher among boys than girls in the three countries, with the highest difference recorded in Egypt.

Figure 3.1.2. Cigarettes: prevalence of students using daily at age 13 years or younger (percentage)



Cigarette use

On average, 38.3% of northern MedSPAD students reported smoking cigarettes in their lifetime, and 19.1% reported smoking in the past 30 days (Table 3.1.1). Italy, Croatia and France recorded a higher lifetime prevalence and 30-day use prevalence. In all northern MedSPAD countries, lifetime prevalence was higher among boys than girls, except for Italy, Spain and Malta. The situation was reversed when addressing current cigarette use: prevalence was higher among girls than boys in all countries, with the exception of Cyprus.

Table 3.1.1. Cigarettes: use in lifetime, past 12 months and past 30 days (percentage)

Country	Lifetime use			Past 12 month use			Past 30 day use		
	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls
Croatia	53.9	55.1	52.6	-	-	-	29.4	28.9	29.9
Cyprus	28.1	33.4	23.9	-	-	-	14.3	17.6	11.8
France	44.8	45.5	44.1	-	-	-	21.7	21.1	22.2
Greece	32.5	33.3	31.7	-	-	-	15.1	14.9	15.2
Italy	55.4	54.1	56.9	-	-	-	32.4	30.6	34.2
Malta	22.4	20.9	23.9	-	-	-	10.5	9.5	11.5
Portugal	34.0	34.2	33.8	-	-	-	14.3	14.1	14.6
Spain	41.1	38.5	43.5	-	-	-	21.3	17.9	24.5
Northern MedSPAD average	38.3	38.5	38.0	-	-	-	19.1	18.5	19.7
Egypt	13.6	19.1	4.6	10.9	15.5	3.6	9.7	13.7	3.1
Morocco	8.9	14.5	4.5	4.1	7.3	1.7	3.0	5.0	1.4
Tunisia	19.4	30.3	12.5	10.8	17.3	6.8	6.4	11.2	3.4
Southern MedSPAD average	14.6	21.0	7.6	9.9	14.9	4.5	7.7	12.1	2.9

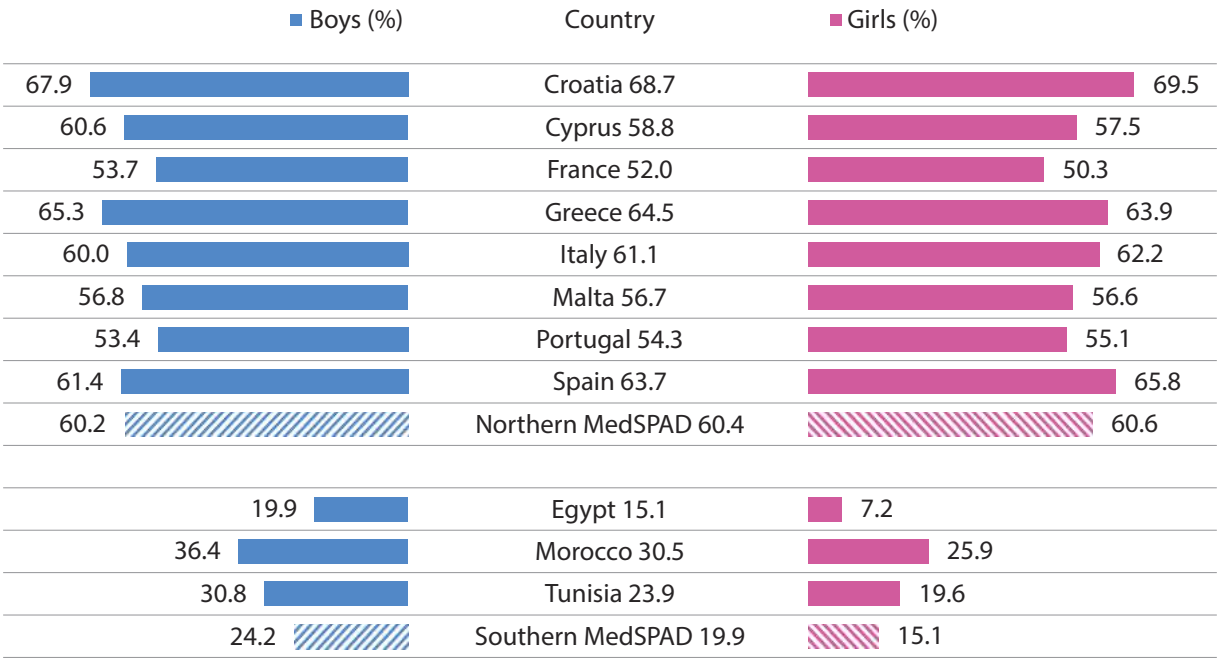
On average, 14.6% of students in southern MedSPAD countries had smoked cigarettes in their lifetime, and 9.9% and 7.7% had smoked in the past year and past 30 days, respectively. Lifetime prevalence was 19.4% in Tunisia, 13.6% in Egypt and 8.9% in Morocco. At country level, the prevalence of smoking cigarettes was higher among boys than girls across their lifetime, the past year and the past 30 days.

Perceived availability and risk perception of cigarette use

On average, 6 in 10 students (60.4%) in northern MedSPAD countries reported that they would find it "fairly easy" or "very easy" to get hold of cigarettes. The perceived availability rate did not vary greatly among countries: the lowest percentage was recorded in France (52%) and Portugal (54.3%), while the highest was in Greece (64.5%) and Croatia (68.7%). Slight gender differences in students' opinions were observed: in France, Cyprus, Greece and Malta, boys found that cigarettes were more readily available, while in Spain, Italy, Portugal and Croatia, more girls were of this opinion (Figure 3.1.3).

In southern MedSPAD countries, on average, 2 in 10 students (19.9%) considered it to be "fairly easy" or "very easy" to get hold of cigarettes. In Morocco, this accounted for 30.5% of students, while in Tunisia and Egypt, the figure was 23.9% and 15.1%, respectively. In these countries, there was a difference of more than 10 percentage points between boys and girls, with boys reporting easy availability of cigarettes more often.

Figure 3.1.3. Cigarettes: perceived availability (prevalence of students responding "fairly easy", "very easy" or "easy" to obtain) (percentage)



On average, 12% of students in the participating northern MedSPAD countries attributed "great risk" to smoking cigarettes occasionally, while 76.6% did so for smoking cigarettes regularly. Where gender differences were found, boys were more likely to perceive "great risk" regarding occasional cigarette use, with the largest gender difference (5.8 percentage points) in Cyprus. The situation was reversed regarding the "great risk" of the regular use of cigarettes, with girls more likely to perceive it as risky.

In southern MedSPAD countries, 31.9% of students attributed "great risk" to smoking cigarettes occasionally, while 53.8% felt there was "great risk" in the regular use of cigarettes. In Morocco, more boys than girls felt there was risk involved in both occasional and frequent cigarette use (Table 3.1.2).

Table 3.1.2. Cigarettes: perceived risk of use (prevalence of students responding "great risk" of harm from use) (percentage)

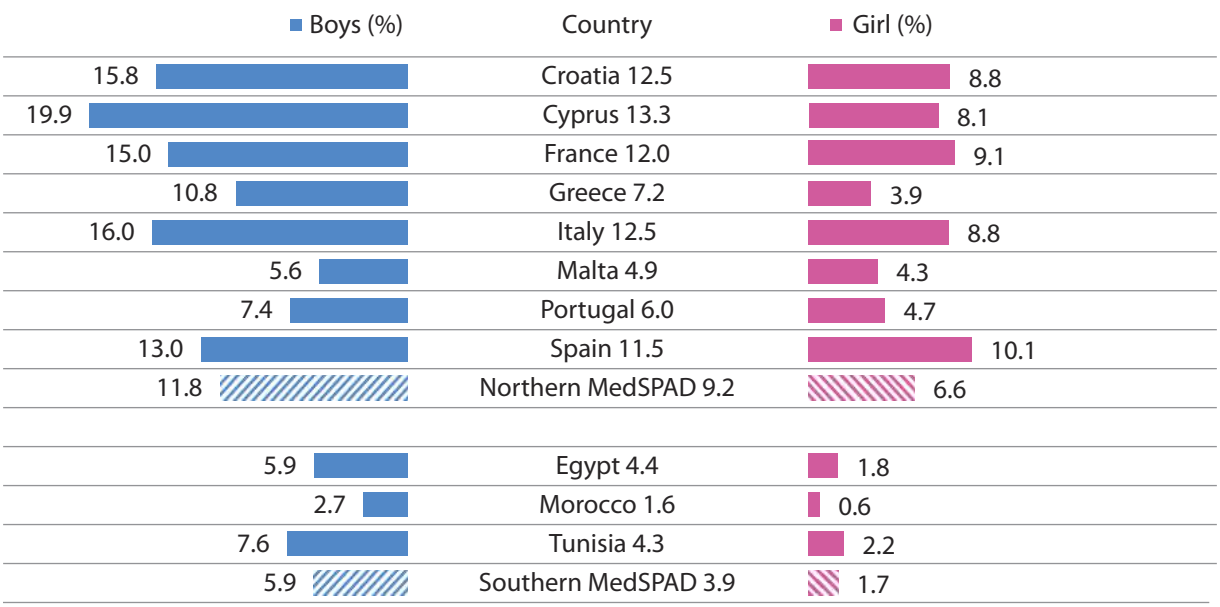
Country	Great risk when used occasionally			Great risk when used regularly		
	Total	Boys	Girls	Total	Boys	Girls
Croatia	12.5	14.3	10.6	62.8	60.8	65.0
Cyprus	10.0	13.3	7.5	87.7	83.7	90.8
France	8.2	10.1	6.3	79.3	77.2	81.4
Greece	7.2	9.2	5.4	94.2	92.2	96.1
Italy	10.1	10.9	9.2	70.4	66.9	74.2
Malta	15.2	16.0	14.3	59.2	57.3	61.1
Portugal	17.8	18.2	17.5	81.2	78.9	83.1
Spain	14.2	14.7	13.8	65.9	62.7	69.0
Northern MedSPAD average	12.0	13.2	10.8	76.6	73.8	79.3
Egypt	32.5	32.2	33.0	42.8	42.8	42.9
Morocco	41.2	36.1	45.2	70.5	63.9	75.7
Tunisia	26.1	26.4	25.9	66.5	63.9	68.0
Southern MedSPAD average	31.9	31.4	32.3	53.8	49.9	58.1

3.2. E-cigarettes

Early onset of e-cigarette use

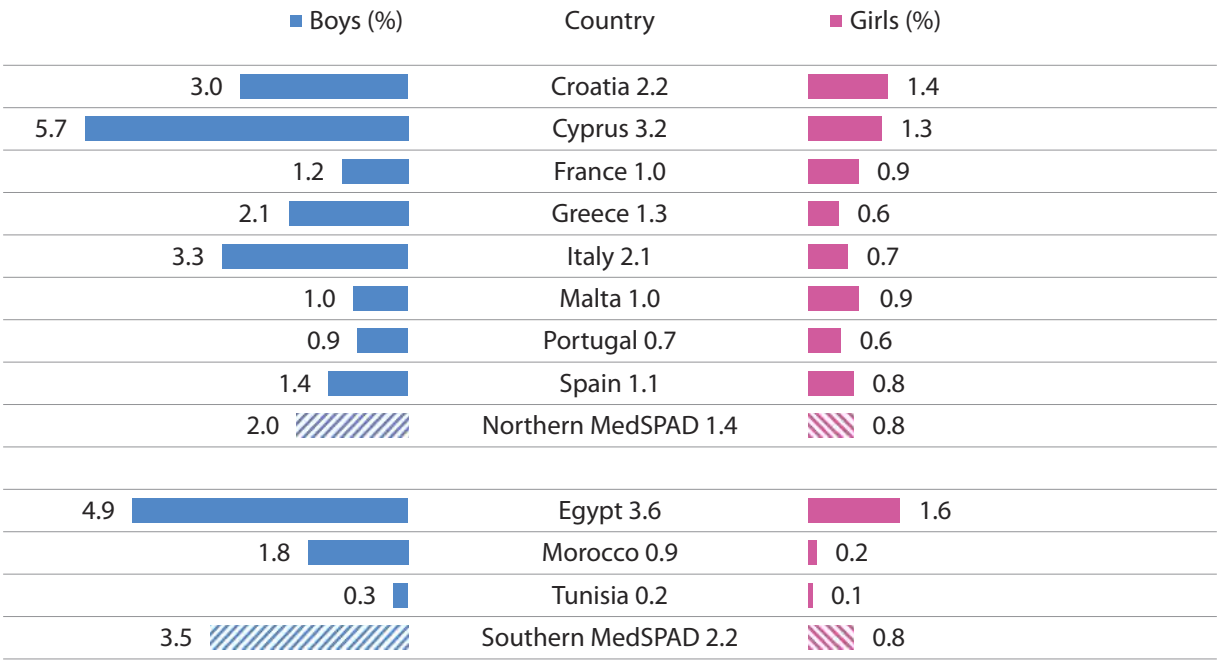
The northern MedSPAD average rate for students who began smoking e-cigarettes at age 13 or younger was 9.2%. The rate of early onset e-cigarette use ranged from 4.9% in Malta and 6% in Portugal to 12.5% in Croatia and Italy and 13.3% in Cyprus. In southern MedSPAD countries, on average, 3.9% of students began using e-cigarettes at age 13 or younger. In Egypt, 4.4% of students reported using e-cigarettes at 13 or earlier, while the rate was 4.3% in Tunisia and 1.6% in Morocco (Figure 3.2.1).

Figure 3.2.1. E-cigarettes: prevalence of students using at age 13 years or younger (percentage)



Among northern MedSPAD students, 1.4% reported using e-cigarettes daily at age 13 or younger (Figure 3.2.2). Cyprus, Croatia and Italy had the highest rates again. In southern MedSPAD countries, early onset of daily e-cigarette use was on average 2.2%, with Egypt at 3.6%, and Morocco and Tunisia at 0.9% and 0.2%, respectively.

Figure 3.2.2. E-cigarettes: prevalence of students using daily at age 13 years or younger (percentage)



E-cigarette use

Table 3.2.1. E-cigarettes: use in lifetime, past 12 months and past 30 days (percentage)

Country	Lifetime use			Past 12 month use			Past 30 day use		
	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls
Croatia	44.1	51.3	36.3	27.5	32.6	22.1	12.5	15.8	8.9
Cyprus	47.1	57.1	39.4	30.0	37.6	24.1	10.4	14.0	7.5
France	45.9	50.7	41.1	34.2	39.0	29.5	16.1	19.5	12.6
Greece	35.1	42.5	28.2	26.5	33.2	20.2	11.0	14.7	7.6
Italy	44.5	52.2	36.0	29.9	34.3	25.1	13.4	15.0	11.7
Malta	20.6	20.6	20.5	15.1	15.7	14.4	7.2	7.7	6.6
Portugal	26.1	32.2	21.0	17.0	21.7	13.0	6.3	8.5	4.5
Spain	41.8	45.9	38.0	27.5	30.6	24.6	9.4	11.1	7.9
Northern MedSPAD average	36.3	42.1	30.7	25.1	29.8	20.6	10.4	13.0	8.0
Egypt	7.8	11.3	2.2	6.6	9.2	2.2	6.2	8.7	2.2
Morocco	10.3	18.1	4.0	6.2	10.7	2.6	3.3	6.0	1.1
Tunisia	21.3	34.1	13.3	13.4	22.8	7.5	6.3	11.6	3.0
Southern MedSPAD average	12.2	17.1	6.8	8.5	12.3	4.3	5.8	9.0	2.3

On average, 36.3% of students in northern MedSPAD countries had used e-cigarettes in their lifetime, 25.1% in the past year, and 10.4% in the past 30 days (Table 3.2.1). The highest prevalence rate of lifetime use was in Cyprus, followed by France and Italy. The highest prevalence rate of current use of e-cigarettes was recorded in France, followed by Italy and Croatia. Boys used e-cigarettes more often: the difference in lifetime prevalence between genders was higher than eight percentage points in all countries except Malta (20.6% for boys v. 20.5% for girls).

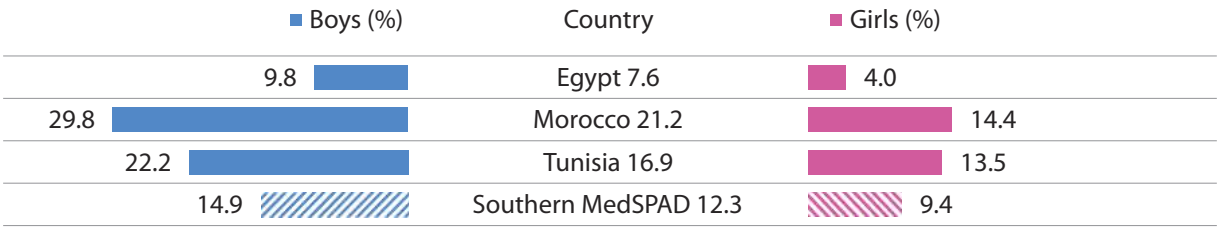
In southern MedSPAD countries, on average, 12.2% of students had used an e-cigarette in their lifetime, 8.5% in the past year, and 5.8% in the past 30 days. Lifetime prevalence was 7.8% in Egypt, 10.3% in Morocco and 21.3% in Tunisia. As with northern MedSPAD countries, e-cigarette use was more common among boys than girls in southern MedSPAD countries, and was so for all timeframes.

Perceived availability and risk perception of e-cigarette use

In southern MedSPAD countries, the perceived availability of e-cigarettes was relatively low. On average, 12.3% of students found it easy to get hold of an e-cigarette. In Morocco, 21.2% of students felt this was the case, while in Tunisia it was 16.9% and in Egypt it was 7.6%. Perceived availability was higher for boys than girls (Figure 3.2.3).

No information was collected on perceived availability related to e-cigarette intake in northern MedSPAD countries.

Figure 3.2.3. E-cigarettes: perceived availability (prevalence of students responding "fairly easy", "very easy" or "easy" to obtain) (percentage)



The average rate for northern MedSPAD students who recognised a "great risk" in smoking e-cigarettes occasionally was 3.8%. Rates were highest in Malta (6.1%), Croatia (5.1%) and Portugal (4.9%), and lowest in Italy (2.7%) and Greece (2.2%). In all countries, gender differences were generally less than 2 percentage points (northern MedSPAD average: 4.5% for boys v. 3.2% for girls).

On average, 28.1% of students in southern MedSPAD countries attributed "great risk" to the occasional use of e-cigarettes, while 37% attributed "great risk" to smoking e-cigarettes regularly. On average, risk perception regarding both occasional and regular consumption of e-cigarettes was higher among girls than boys. This pattern was confirmed in all southern MedSPAD participating countries, with the most noticeable difference found in Morocco (Table 3.2.2).

Table 3.2.2. E-cigarettes: perceived risk of use (prevalence of students responding "great risk" of harm from use) (percentage)

Country	Great risk when used occasionally			Great risk when used regularly		
	Total	Boys	Girls	Total	Boys	Girls
Croatia	5.1	5.6	4.6	-	-	-
Cyprus	3.7	4.6	3.0	-	-	-
France	3.9	4.7	3.1	-	-	-
Greece	2.2	3.1	1.5	-	-	-
Italy	2.7	3.3	2.1	-	-	-
Malta	6.1	6.4	5.7	-	-	-
Portugal	4.9	5.7	4.3	-	-	-

Country	Great risk when used occasionally			Great risk when used regularly		
	Total	Boys	Girls	Total	Boys	Girls
Spain	3.0	3.6	2.4	-	-	-
Northern MedSPAD average	3.8	4.5	3.2	-	-	-
Egypt	30.5	30.0	31.4	36.0	35.7	36.3
Morocco	35.2	30.9	38.5	41.3	35.2	46.1
Tunisia	20.0	19.5	20.4	37.0	33.6	39.1
Southern MedSPAD average	28.1	27.8	28.3	37.0	35.2	39.0

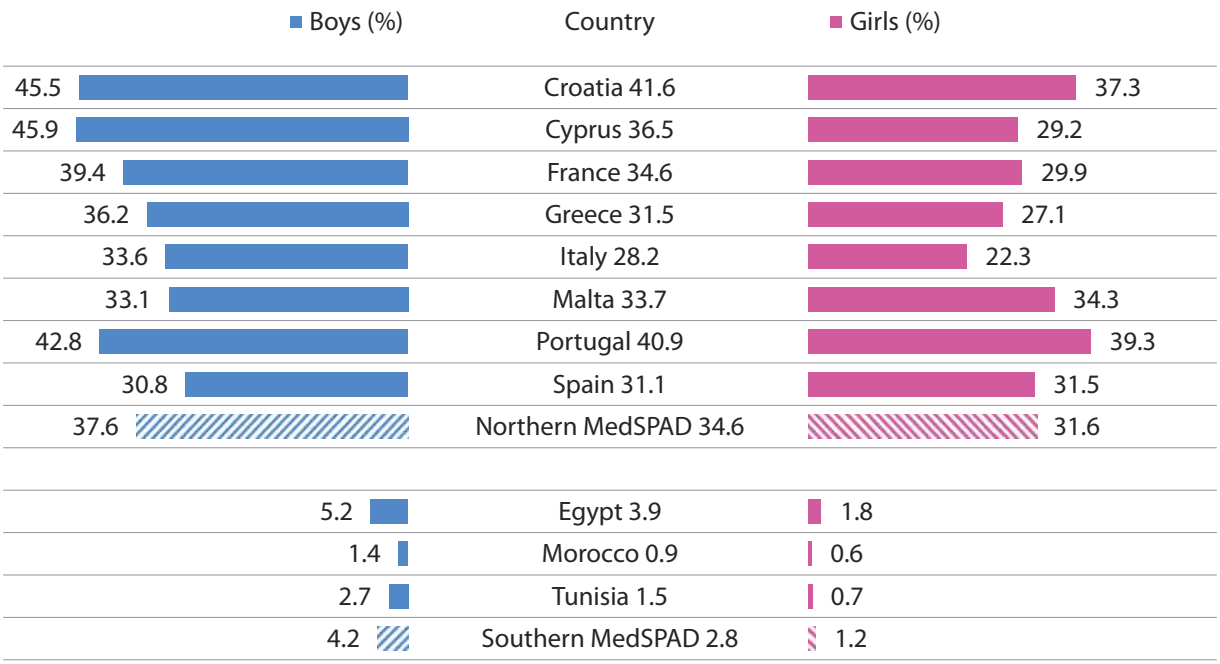
3.3. Alcohol

Early onset of alcohol use

In northern MedSPAD countries, on average, the prevalence of students using alcohol at the age of 13 years or younger (Figure 3.3.1) was 34.6%. The highest average prevalence for early onset of alcohol use was found in Croatia (41.6%), followed by Portugal (40.9%) and Cyprus (36.5%). At country level, the lowest prevalence rates were found in Italy (28.2%), Spain (31.1%) and Greece (31.5%). All northern MedSPAD countries except Spain (30.8% for boys v. 31.5% for girls) and Malta (33.1% for boys v. 34.3% for girls) presented a higher prevalence for male students than female students.

On average, the prevalence rate of southern MedSPAD students who began using alcohol at age 13 or younger was 2.8%. No distinct differences were found between southern countries in terms of gender differences, except for Egypt, where boys presented a rate of early onset of alcohol use 3.4 percentage points higher than girls.

Figure 3.3.1. Alcoholic drinks: prevalence of students using at age 13 years or younger (percentage)



Alcohol use

On average, in northern MedSPAD countries (Table 3.3.1), 83.2% of students consumed alcohol during their lifetime, 75.4% did so in the past 12 months, and 53.3% reported consumption in the past 30 days. Croatia (89.9%), Greece (89.2%) and Italy (84.4%) recorded the highest prevalence rates for both lifetime consumption and consumption in the past year. The highest prevalence for past 30-day alcohol use was observed in Greece (62%), followed by Italy (58.7%), Croatia and Cyprus (both 57.5%). On average, no noticeable gender difference in lifetime consumption prevalence was found (83.1% for boys v. 83.3% for girls), while for past 30-day alcohol use a slight gender difference was observed (54.1% for boys v. 52.7% for girls). At the country level, lifetime prevalence was higher among boys than girls, except for France, Malta and Spain.

In southern MedSPAD countries, on average, 5.7% of students had consumed alcohol in their lifetime, and 4.4% and 3.3% in the past 12 months and past 30 days, respectively. Egypt registered the highest rate (6.4%) of lifetime consumption prevalence, followed by Morocco (4.8%) and Tunisia (4.7%). Noticeable gender differences were observed for consumption across all timeframes. Boys were more likely to consume alcohol than girls, with differences of 5.6 percentage points in lifetime consumption prevalence, 4.1 percentage points for the past year and 3.9 percentage points for the past 30 days.

Table 3.3.1. Alcoholic drinks: use in lifetime, past 12 months and past 30 days (percentage)

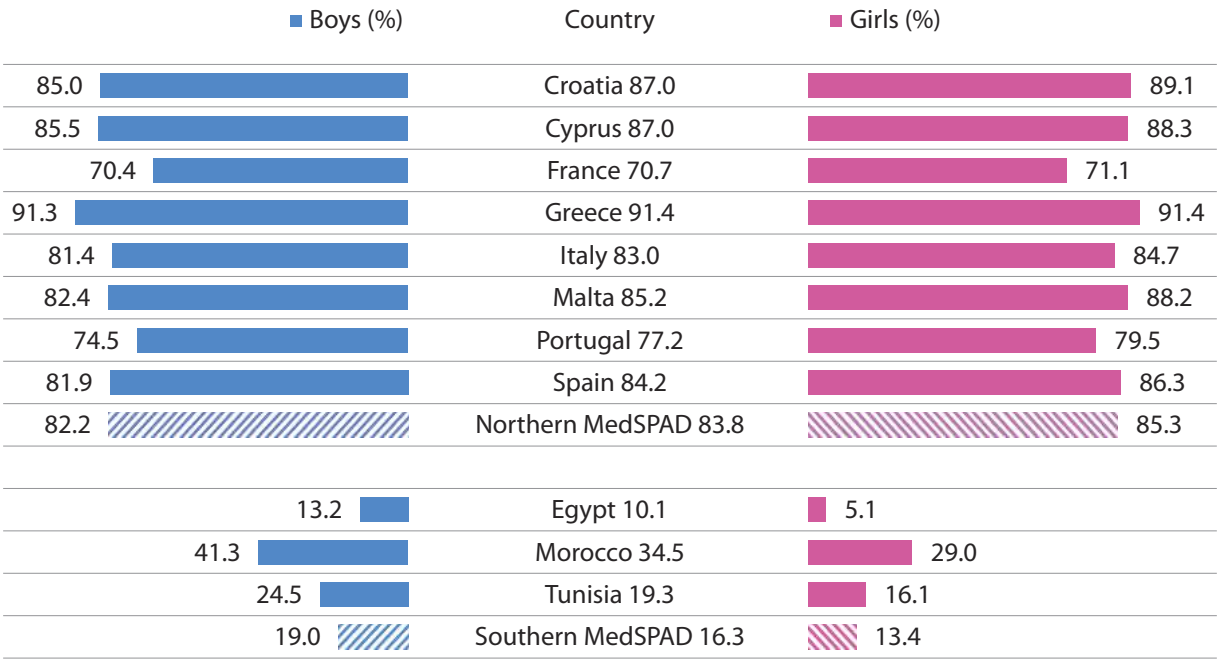
Country	Lifetime use			Past 12 month use			Past 30 day use		
	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls
Croatia	89.9	90.3	89.5	80.1	81.2	79.0	57.5	61.2	53.6
Cyprus	82.9	83.5	82.5	76.2	79.8	73.5	57.5	62.9	53.1
France	80.5	79.8	81.1	71.2	70.6	71.9	53.0	53.8	52.2
Greece	89.2	89.9	88.5	81.8	83.1	80.6	62.0	62.4	61.6
Italy	84.4	85.5	83.2	78.0	79.6	76.3	58.7	60.3	57.0
Malta	81.6	80.7	82.5	73.1	72.0	74.2	48.4	47.3	49.5
Portugal	76.8	76.9	76.7	69.0	68.8	69.2	43.4	44.9	42.1
Spain	78.2	75.2	81.1	71.5	68.2	74.5	47.0	43.5	50.2
Northern	83.2	83.1	83.3	75.4	75.5	75.3	53.3	54.1	52.7
Egypt	6.4	8.6	2.8	5.5	7.1	2.7	4.7	6.4	2.0
Morocco	4.8	7.4	2.8	3.0	4.3	2.0	1.9	3.1	0.9
Tunisia	4.7	8.0	2.6	3.0	5.0	1.8	1.1	2.3	0.4
Southern	5.7	8.3	2.7	4.4	6.3	2.2	3.3	5.1	1.2

Perceived availability and risk perception of alcohol use

On average, more than 8 out of 10 (83.8%) students in northern MedSPAD countries (Figure 3.3.2) reported that they would find it "fairly easy" or "very easy" to get hold of alcohol. This perception did not vary greatly across countries: France (70.7%) and Portugal (77.2%) presented the lowest percentage while the highest prevalence was registered in Greece and Croatia, at 91.4% and 87%, respectively. In all northern MedSPAD countries, without exception, girls were more likely than boys to think they could get hold of alcohol easily.

In southern MedSPAD countries, only 16.3% of students considered it "fairly easy" or "very easy" to get hold of alcohol. Students in Morocco (34.5%) were most likely to think they could get hold of alcohol easily, followed by Tunisia (19.3%) and Egypt (10.1%). In all southern MedSPAD countries, boys were more likely than girls to think they could get hold of alcohol easily.

Figure 3.3.2. Alcoholic drinks: perceived availability (prevalence of students responding "fairly easy", "very easy" or "easy" to obtain) (percentage)



No information was collected in northern MedSPAD countries about the perception of risks related to having alcoholic drinks occasionally, while Cyprus did not register information about the perceived risk of alcoholic drinks. The highest proportion of students considered it likely that there was a risk to themselves in having 3 or more alcoholic drinks (70.5%), followed by those who felt there was a risk in having 5 or more alcoholic drinks (59.6%) and in having 1-2 alcoholic drinks (26.9%) (Table 3.3.2). In most countries, girls were more likely than boys to associate risk with all levels of alcohol consumption.

In southern MedSPAD countries, on average, more than 4 in 10 students (43.3%) believed that alcohol use could be considered a risk if used occasionally. The highest proportion of students considered that having 3 or more alcoholic drinks was risky (53.1%), followed by those who felt there was a risk in having 1-2 alcoholic drinks (49%) and in having 5 or more alcoholic drinks (46.1%). Where gender differences were observed, they were slight (around 1 percentage point) for having alcoholic drinks occasionally, around 8 percentage points for having 1-2 alcoholic drinks, around 11 percentage points for having 3 or more alcoholic drinks, and around 6 percentage points having 5 or more alcoholic drinks. Girls were more likely than boys to associate risk with all levels of alcohol consumption. Results for Tunisia are not shown as the related question in the national questionnaire was not considered to be comparable.

Table 3.3.2. Alcoholic drinks: perceived risk of use (prevalence of students responding "great risk" of harm from use) (percentage)

Country	Great risk when having drinks occasionally			Great risk when having 1-2 drinks every day			Great risk when having 3 or more drinks every day			Great risk when having 5 or more drinks on the same occasion every weekend		
	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls
Croatia	-	-	-	26.8	22.1	31.9	64.2	56.4	72.5	52.0	48.2	56.1
Cyprus	-	-	-	-	-	-	-	-	-	-	-	-
France	-	-	-	17.9	15.4	20.4	71.9	65.4	78.2	48.0	46.7	49.3
Greece	-	-	-	22.2	19.9	24.3	66.9	61.7	71.8	75.4	73.3	77.3
Italy	-	-	-	31.2	26.0	36.9	72.3	66.7	78.5	56.5	54.0	59.3

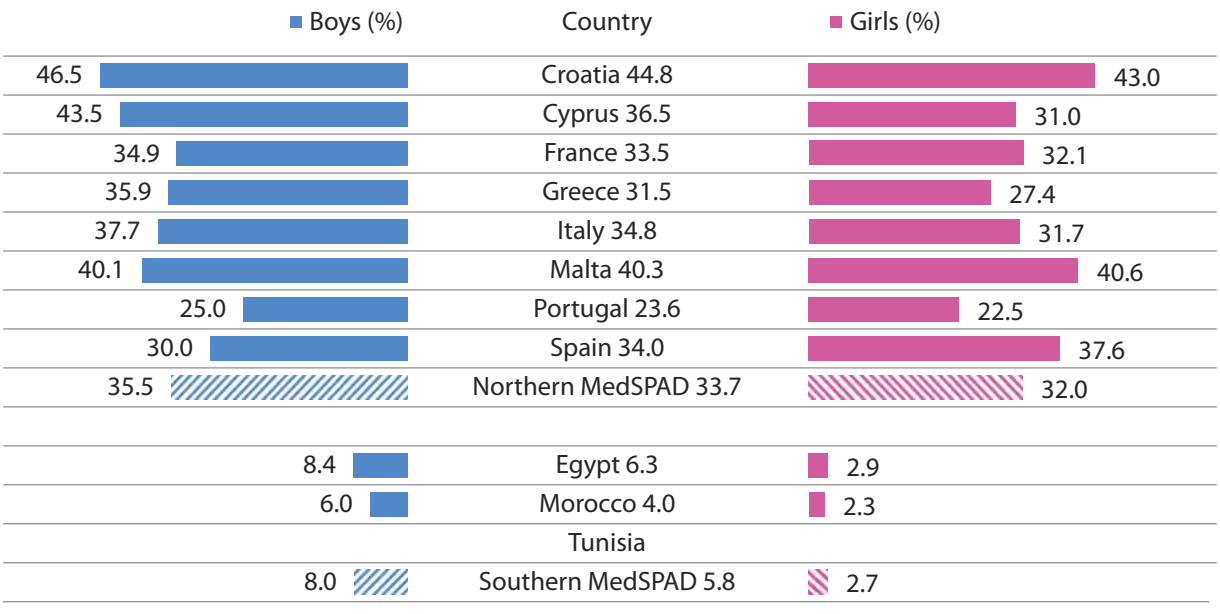
Country	Great risk when having drinks occasionally			Great risk when having 1-2 drinks every day			Great risk when having 3 or more drinks every day			Great risk when having 5 or more drinks on the same occasion every weekend		
	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls
Malta	-	-	-	17.4	14.4	20.4	61.8	56.0	67.7	43.3	39.8	46.8
Portugal	-	-	-	32.3	25.4	38.1	74.9	66.5	81.9	65.8	61.5	69.4
Spain	-	-	-	39.8	33.2	45.8	81.5	77.0	85.6	56.0	53.9	58.0
Northern MedSPAD average	-	-	-	26.9	22.4	31.2	70.5	64.2	76.6	59.6	56.6	62.6
Egypt	40.9	41.3	40.2	36.9	36.6	37.4	39.6	39.4	40.0	40.9	40.5	41.5
Morocco	50.0	45.7	53.4	62.1	57.4	65.8	67.8	60.5	73.6	66.5	59.2	72.1
Tunisia	44.6	46.0	43.7	65.5	61.9	67.8	71.2	67.1	73.8	-	-	-
Southern MedSPAD average	43.3	42.8	43.8	49.0	44.6	53.9	53.1	48.0	58.7	46.1	43.4	50.0

Heavy episodic drinking in the past 30 days

Among all northern MedSPAD students, on average, 33.7% reported heavy episodic drinking in the past 30 days (Figure 3.3.3). The highest prevalence was observed in Croatia (44.8%), followed by Malta (40.3%) and Cyprus (36.5%), while the lowest rate was found in Portugal (23.6%). On average, the gender difference was 3.5 percentage points, with generally higher rates found for boys. Malta and Spain were the only countries where higher rates were observed among girls than boys. The most considerable difference between boys and girls was found in Cyprus (43.5% for boys v. 31% for girls), while the smallest difference was registered in Malta (40.1% for boys v. 40.6% for girls).

On average, 5.8% of southern MedSPAD students reported heavy episodic drinking in the past 30 days. Egypt had the highest prevalence rate (6.3%), followed by Morocco (4%). In both countries, more boys than girls reported heavy episodic drinking in the past 30 days (southern MedSPAD average: 8% for boys v. 2.7% for girls). Results for Tunisia are not shown as the related question in the national questionnaire was not considered to be comparable.

Figure 3.3.3. Alcoholic drinks: prevalence of heavy episodic drinking (5 or more drinks on one occasion) at least once in the past 30 days (percentage)



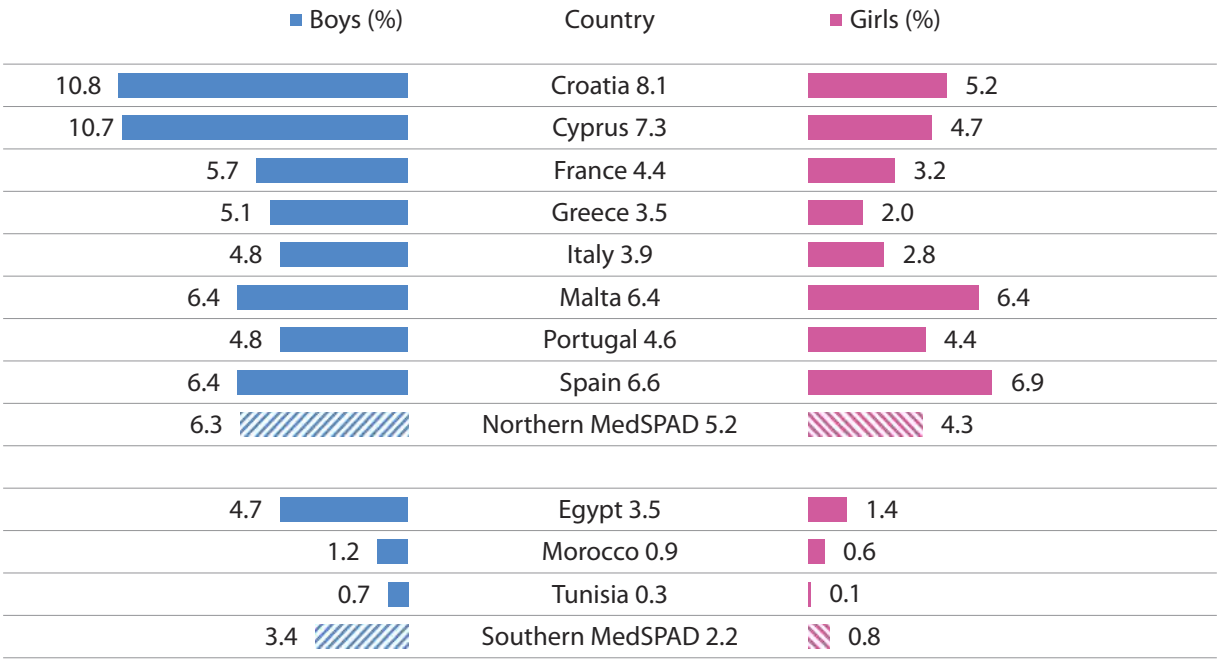
Notes: Results for Tunisia are not available

Early onset of alcohol intoxication

On average, 5.2% of northern MedSPAD students reported alcohol intoxication at age 13 or younger (Figure 3.3.4). The highest prevalence rate was observed in Croatia (8.1%), followed by Cyprus (7.3%), Spain (6.6%) and Malta (6.4%). More boys than girls reported intoxication at an early age (northern MedSPAD average: boys 6.3% v. girls 4.3%). At country level, the highest gender difference was found in Croatia (boys 10.8% v. girls 5.2%), and Spain was the only country where the rate was higher among girls than boys (boys 6.4% v. girls 6.9%).

The southern MedSPAD average prevalence rate for students who reported alcohol intoxication at age 13 or younger was 2.2%. The highest prevalence was observed in Egypt (3.5%), while Morocco and Tunisia reported a prevalence lower than 1%. The highest prevalence rates of boys and girls were both in Egypt (4.7% for boys v. 1.4% for girls), followed by Morocco (1.2% for boys v. 0.6% for girls) and Tunisia (0.7% for boys v. 0.1% for girls).

Figure 3.3.4. Alcoholic drinks: prevalence of students experiencing alcohol intoxication at age 13 years or younger (percentage)



Alcohol intoxication prevalence

An average of 34.2% of northern MedSPAD students reported having been intoxicated during their lifetime, while 27.7% of students were intoxicated in the past year, and 12.4% reported having been intoxicated in the past 30 days (Table 3.3.3). Croatia registered the highest lifetime prevalence (43%), followed by Spain (42.7%) and Italy (35.3%). These three countries maintained a higher prevalence for past 12-month use as well: Spain (36.9%), Croatia (33.9%) and Italy (27.6%). On average, slightly more boys than girls had been intoxicated across all timeframes.

In half of the northern MedSPAD countries (Croatia, Cyprus, France and Greece), alcohol intoxication prevalence was higher in boys than in girls, and the reverse was true in the other half (Italy, Malta, Portugal and Spain). In southern MedSPAD countries, on average, 3.4% of students reported having been intoxicated in their lifetime, 2.4% in the past 12 months and 2.1% in the past 30 days. Egypt registered the highest lifetime prevalence (4.2%), followed by Morocco (3.4%) and Tunisia (1.8%). In each southern MedSPAD country, the prevalence rates of having been intoxicated were higher among boys than girls across all timeframes. For all southern MedSPAD countries, the difference between genders was 2.8% for lifetime use, 2.3% for use in the past 12 months, and 2.2% in the past 30 days.

Table 3.3.3. Alcoholic drinks: experienced alcohol intoxication in lifetime, past 12 months and past 30 days (percentage)

Country	Lifetime use			Past 12 month use			Past 30 day use		
	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls
Croatia	43.0	47.0	38.6	33.9	37.5	30.0	14.5	16.3	12.6
Cyprus	29.5	35.6	24.7	24.1	29.9	19.6	10.8	13.6	8.6
France	33.5	35.9	31.2	27.1	29.5	24.8	14.7	17.0	12.4
Greece	31.0	32.6	29.5	24.6	25.4	24.0	10.1	10.6	9.7
Italy	35.3	33.9	36.8	27.6	27.5	27.8	11.6	11.8	11.3
Malta	32.2	28.8	35.6	25.4	22.9	27.9	12.1	11.4	12.8
Portugal	28.5	27.8	29.0	23.8	23.0	24.4	10.6	10.8	10.5
Spain	42.7	38.2	46.9	36.9	32.1	41.2	16.9	14.3	19.3
Northern MedSPAD average	34.2	34.4	34.0	27.7	27.8	27.7	12.4	12.7	12.2
Egypt	4.2	5.4	2.3	3.5	4.5	1.8	3.3	4.4	1.5
Morocco	3.4	5.4	1.9	1.5	2.1	1.1	1.2	1.6	0.9
Tunisia	1.8	2.2	1.6	0.8	1.1	0.6	0.3	0.3	0.2
Southern MedSPAD average	3.4	4.7	1.9	2.4	3.5	1.2	2.1	3.1	0.9

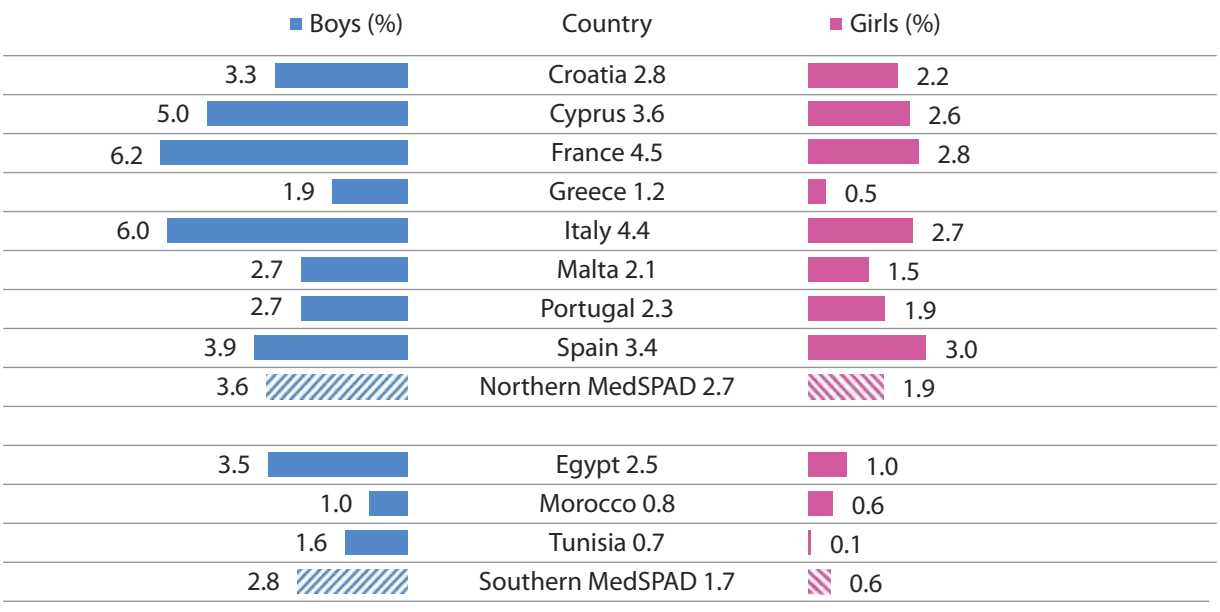
3.4. Cannabis

Early onset of cannabis use

On average, 2.7% of northern MedSPAD students stated that they had first used cannabis at age 13 or younger, and the highest rates were found in France (4.5%), Italy (4.4%) and Cyprus (3.6%) (Figure 3.4.1). In all participating countries, boys were more likely than girls to have used cannabis at age 13 or younger, with differences generally less than 3.5 percentage points (northern MedSPAD average: 3.6% for boys v. 1.9% for girls).

In southern MedSPAD countries, on average, 1.7% of students first used cannabis at age 13 or younger. In Egypt, 2.5% of students reported using cannabis early in life, while the rate was 0.8% in Morocco and 0.7% in Tunisia.

Figure 3.4.1. Cannabis: prevalence of students using at age 13 years or younger (percentage)



Cannabis use

Lifetime cannabis use varied across northern MedSPAD countries (Table 3.4.1). On average, 15.9% of northern MedSPAD students reported using cannabis at least once. The highest prevalence rates of students reporting lifetime use were found in Italy (26.9%), followed by France (22.9%) and Spain (22.7%). On average, 18.3% of boys and 13.7% of girls had used cannabis at least once during their lifetime. Overall, 13.4% of students reported cannabis use in the past 12 months and 8.3% in the 30 days before the survey. Once more, Italy, France and Spain presented the highest prevalence rate for the past 12 months and the past 30 days. At country level, no large gender differences were found, with higher rates for boys than girls registered in France, Italy and Cyprus for cannabis use during the past 12 months and past 30 days.

In southern MedSPAD countries, on average, 4.8% of students had used cannabis in their lifetime, 4.2% in the past year and 2.9% in the past 30 days. The lifetime prevalence was 5.8% in Tunisia, 4.5% in Egypt and 4.1% in Morocco. The prevalence rate among male students was higher for all timeframes: Tunisia registered the highest rate in the past year, while Egypt reported the highest rate in the past 30 days.

Table 3.4.1. Cannabis: use in lifetime, past 12 months and past 30 days (percentage)

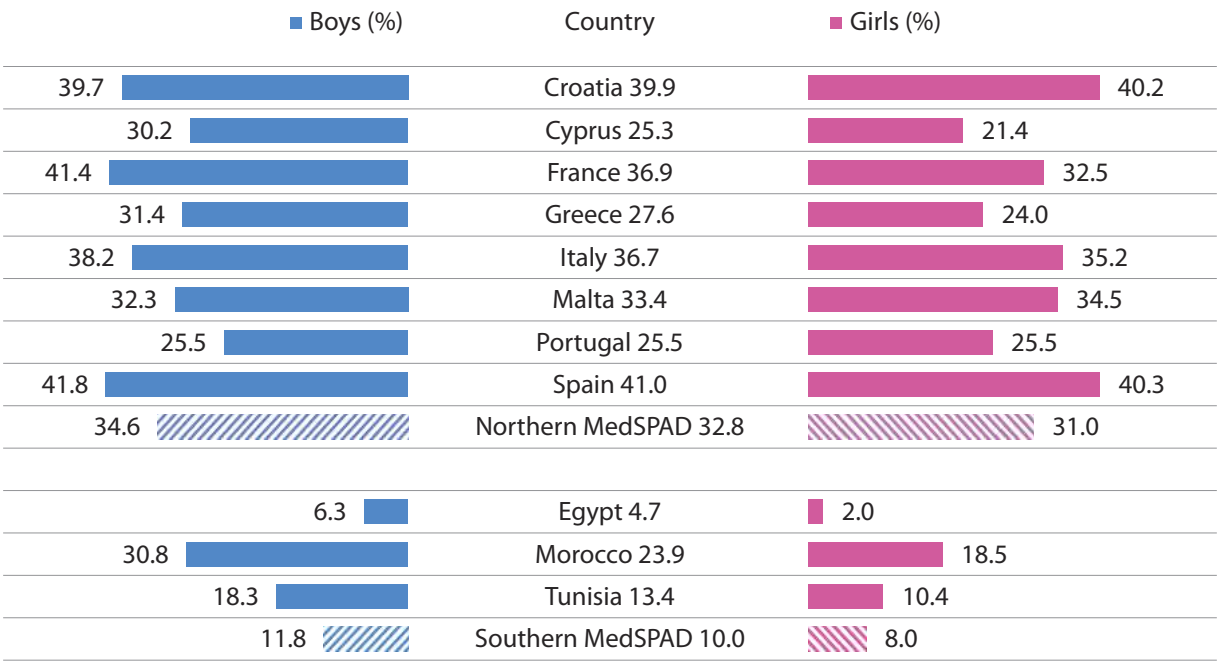
Country	Lifetime use			Past 12 month use			Past 30 day use		
	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls
Croatia	20.5	22.8	18.1	16.6	18.0	15.1	9.2	9.6	8.7
Cyprus	8.4	12.7	5.1	7.7	10.9	5.1	5.5	7.9	3.6
France	22.9	26.3	19.6	19.4	22.4	16.5	13.4	16.1	10.7
Greece	8.2	11.3	5.2	7.2	9.8	4.8	4.7	6.5	2.9
Italy	26.9	29.8	23.8	22.7	25.4	19.9	14.9	17.3	12.2
Malta	11.5	11.3	11.8	9.4	9.3	9.4	4.7	4.7	4.6
Portugal	12.8	14.6	11.4	10.8	12.4	9.4	6.2	7.4	5.3
Spain	22.7	24.0	21.5	19.2	20.0	18.4	11.7	11.7	11.7
Northern MedSPAD average	15.9	18.3	13.7	13.4	15.4	11.6	8.3	9.6	7.0
Egypt	4.5	6.0	2.0	4.4	6.0	1.9	3.7	5.2	1.3
Morocco	4.1	6.1	2.5	2.2	3.9	0.9	1.7	2.9	0.8
Tunisia	5.8	11.6	2.2	4.8	9.4	1.9	1.9	4.1	0.6
Southern MedSPAD average	4.8	7.2	2.2	4.2	6.5	1.7	2.9	4.7	1.0

Perceived availability and risk perception of cannabis use

More than 3 in 10 students (32.8%) of northern MedSPAD countries stated cannabis was easily obtainable (Figure 3.4.2). Students perceived cannabis to be most easily obtainable in Spain (41%), Croatia (39.9%) and France (36.9%), with lower rates in Portugal (25.5%) and Cyprus (25.3%). Boys generally perceived cannabis to be more easily available, except in Croatia and Malta.

On average, 10% of students in southern MedSPAD countries thought cannabis was easily obtainable. Students perceived cannabis to be most easily obtainable in Morocco (23.9%), followed by Tunisia (13.4%) and Egypt (4.7%). There was a noticeable gender difference in Morocco, where the rate was 12.3 percentage points higher for boys than girls.

Figure 3.4.2. Cannabis: perceived availability (prevalence of students responding "fairly easy", "very easy" or "easy" to obtain) (percentage)



On average, 27% of northern MedSPAD students recognised a "great risk" in using cannabis occasionally, while 63.3% of students associated a "great risk" with the regular use of cannabis (Table 3.4.4). Gender differences were negligible at the aggregate level for the risk perception associated with the occasional consumption of cannabis (26.7% for boys v. 27.4% for girls). At the country level, where differences were observed, the rate was slightly higher for girls than boys, except for France and Malta, regarding occasional consumption. Noticeable differences were observed in the risk perception of using cannabis regularly, where girls were more likely to associate a "great risk" with consumption than boys. The highest difference was found in Italy (17 percentage points), followed by Cyprus, France and Croatia.

Table 3.4.2. Cannabis: perceived risk of use (prevalence of students responding "great risk" of harm from use) (percentage)

	Great risk when used occasionally			Great risk when used regularly		
Country	**Total**	**Boys**	**Girls**	**Total**	**Boys**	**Girls**
Croatia	31.8	32.0	31.4	60.9	54.3	68.0
Cyprus	33.8	33.0	34.5	59.6	50.7	66.4
France	20.7	21.5	20.0	71.7	64.9	78.6
Greece	25.6	24.6	26.5	58.5	53.9	62.8
Italy	19.3	18.0	20.6	54.0	45.8	62.8
Malta	25.9	27.7	23.9	56.0	53.3	58.7
Portugal	33.8	33.2	34.2	74.5	68.7	79.4
Spain	26.4	25.7	27.0	67.5	62.4	72.2
Northern MedSPAD average	27.0	26.7	27.4	63.3	57.5	68.8
Egypt	39.5	40.1	38.6	46.8	46.8	46.8
Morocco	45.1	38.6	50.2	56.0	50.6	60.2
Tunisia	47.4	43.7	49.7	67.7	62.1	71.2
Southern MedSPAD average	42.7	40.7	44.8	54.3	50.6	58.4

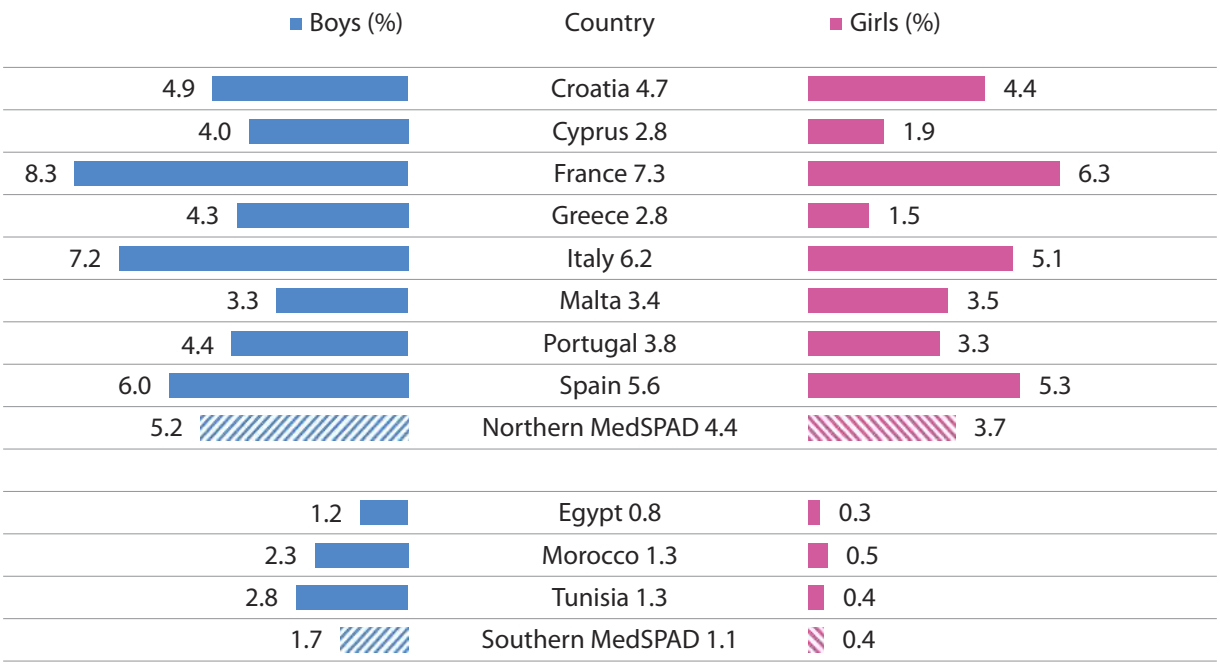
In southern MedSPAD countries, an average of 42.7% of students associated a "great risk" with using cannabis occasionally, while 54.3% believed that using cannabis regularly was very risky. Girls perceived higher risk than boys in regular cannabis use in all southern MedSPAD countries except for Egypt.

High-risk cannabis use

Among the northern MedSPAD sample (both users and non-users of cannabis in the past 12 months), 4.4% of students were classified as high-risk cannabis users based on the Cannabis Abuse Screening Test (CAST), which measures the possible presence and extent of cannabis-related problems (see methodology section). Cyprus (2.8%), Greece (2.8%), Malta (3.4%) and Portugal (3.8%) reported the lowest prevalence rates, while the highest rate was observed in France (7.3%), followed by Italy (6.2%) (Figure 3.4.3). Prevalence was higher among boys than girls, except for Malta (3.3% for boys v. 3.5% for girls). The highest prevalence rates for boys and girls were in France (8.3% for boys and 6.3% for girls), Italy (7.2% for boys and 5.1% for girls) and Spain (6% for boys and 5.3% for girls).

The southern MedSPAD average rate for students classified as high-risk cannabis users was 1.1%. Tunisia and Morocco had a rate of 1.3%, while Egypt had a rate of 0.8%. In all three countries, high-risk cannabis use was more prevalent among boys than girls (1.7% for boys v. 0.4% for girls). The highest difference in terms of percentage points was in Tunisia (2.8% for boys v. 0.4% for girls).

Figure 3.4.3. Cannabis: Prevalence of high-risk users (percentage)



3.5. Cocaine

On average, in northern MedSPAD countries, 2.1% of students had used cocaine during their lifetime, while 1.5% had used it in the past 12 months (Table 3.5.1). No information was collected in these countries for use in the past 30 days. Cyprus, France and Italy recorded the highest lifetime prevalence for cocaine use, with Cyprus maintaining the highest prevalence for use in the past 12 months as well. In all northern MedSPAD countries, lifetime prevalence was higher among boys than girls, with the exception of France and Portugal. In Italy and Spain, lifetime prevalence between genders was equal.

In southern MedSPAD countries, an average of 1.2% of students had used cocaine in their lifetime, and 1.1% and 0.8% had used cocaine in the past 12 months and past 30 days, respectively. Lifetime prevalence of cocaine use 1.7% in Egypt, 0.6% in Tunisia and 0.3% in Morocco. In Egypt, higher prevalence was also recorded for use in the past year and in the past month. In each southern MedSPAD country, prevalence of cocaine use across all timeframes was higher among boys than girls.

Table 3.5.1. Cocaine: use in lifetime, past 12 months and past 30 days (percentage)

	Lifetime use			Past 12 month use			Past 30 day use		
Country	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls
Croatia	2.2	2.4	1.9	1.6	1.8	1.3	-	-	-
Cyprus	3.9	6.6	1.8	3.7	6.6	1.4	-	-	-
France	2.7	2.5	2.8	1.7	2.0	1.4	-	-	-
Greece	1.5	2.3	0.7	1.1	1.8	0.5	-	-	-
Italy	2.3	2.3	2.3	1.5	1.5	1.4	-	-	-
Malta	2.0	2.1	1.8	1.5	1.7	1.3	-	-	-
Portugal	2.1	2.1	2.2	1.4	1.3	1.6	-	-	-
Spain	2.1	2.1	2.1	1.5	1.5	1.4	-	-	-
Northern MedSPAD average	2.1	2.4	1.8	1.5	1.9	1.2	-	-	-
Egypt	1.7	2.2	0.7	1.7	2.2	0.7	1.3	1.8	0.6
Morocco	0.3	0.6	0.2	0.3	0.6	0.2	0.3	0.4	0.2
Tunisia	0.6	1.1	0.3	0.4	0.8	0.2	0.2	0.3	0.1
Southern MedSPAD average	1.2	1.8	0.4	1.1	1.7	0.4	0.8	1.3	0.3

3.6. Ecstasy

In northern MedSPAD countries, on average, 1.7% of students had used ecstasy in their lifetime, while 1.3% had used it in the past year (Table 3.6.1). Cyprus, Portugal and Croatia recorded the highest lifetime prevalence as well as the highest use in the past 12 months. In each northern MedSPAD country, lifetime prevalence was higher among boys, with the exception of Spain, where boys and girls recorded the same lifetime prevalence of use (0.9%). However, for use in the past year, boys recorded higher prevalence of use than girls in all northern MedSPAD countries.

On average, 1.6% of students in southern MedSPAD countries had used ecstasy in their lifetime and 1.4% in the past 12 months, while 1.2% had used the substance in the past 30 days. In all timeframes for which the prevalence of ecstasy use was recorded, on average, boys presented higher rates than girls.

Table 3.6.1. Ecstasy: use in lifetime, past 12 months and past 30 days (percentage)

	Lifetime use			Past 12 month use			Past 30 day use		
Country	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls
Croatia	2.1	2.2	2.0	1.7	1.9	1.4	-	-	-
Cyprus	3.3	5.2	1.8	2.9	5.2	1.0	-	-	-
France	1.7	2.2	1.2	1.4	1.8	1.0	-	-	-
Greece	1.1	1.7	0.6	0.9	1.3	0.6	-	-	-
Italy	1.3	1.7	0.8	0.7	1.1	0.3	-	-	-
Malta	1.1	1.3	0.9	1.0	1.0	0.9	-	-	-
Portugal	3.2	3.9	2.6	2.1	2.6	1.8	-	-	-
Spain	0.9	0.9	0.9	0.8	1.0	0.6	-	-	-
Northern MedSPAD average	1.7	2.2	1.3	1.3	1.7	1.0	-	-	-

	Lifetime use			Past 12 month use			Past 30 day use		
Country	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls
Egypt	2.3	3.0	1.0	2.2	3.0	0.9	2.0	2.7	0.9
Morocco	0.9	1.4	0.5	0.3	0.6	0.2	0.3	0.4	0.2
Tunisia	0.7	1.4	0.3	0.4	0.7	0.2	0.2	0.5	0.1
Southern MedSPAD average	1.6	2.5	0.6	1.4	2.2	0.5	1.2	1.9	0.5

3.7. Heroin

Among northern MedSPAD countries, lifetime heroin use showed a low degree of variability across countries (Table 3.7.1). On average, among these countries, 1.1% of students reported using heroin at least once (1.4% for boys v. 0.8% for girls). The highest prevalence rates of students reporting lifetime use were found in Cyprus (3.2%) and Croatia (1.3%). For the past 12 months, 0.8% of students reported heroin use (1.2% for boys v. 0.5% for girls). No data were obtained in these countries concerning use in the past month.

In southern MedSPAD countries, lifetime use of heroin in the total student population was 1% (Table 3.7.1). Egypt recorded the highest prevalence of lifetime use (1.4%), followed by Morocco (0.5%) and Tunisia (0.3%). Overall, 0.9% of students reported heroin use in the past 12 months and in the 30 days prior to the survey. In general, the prevalence rate among male students was higher than that of female students for all timeframes: Egypt registered the highest rate for all timeframes.

Table 3.7.1. Heroin: use in lifetime, past 12 months and past 30 days (percentage)

	Lifetime use			Past 12 month use			Past 30 day use		
Country	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls
Croatia	1.3	1.5	1.1	0.9	1.2	0.6	-	-	-
Cyprus	3.2	6.2	0.8	3.2	6.2	0.8	-	-	-
France	1.1	1.3	0.9	0.9	1.2	0.7	-	-	-
Greece	1.1	1.5	0.7	1.0	1.5	0.4	-	-	-
Italy	0.8	0.8	0.7	0.4	0.8	0.0	-	-	-
Malta	0.8	1.0	0.7	0.7	0.7	0.7	-	-	-
Portugal	1.1	1.2	1.0	0.7	0.7	0.7	-	-	-
Spain	0.6	0.8	0.5	0.4	0.6	0.3	-	-	-
Northern MedSPAD average	1.1	1.4	0.8	0.8	1.2	0.5	-	-	-
Egypt	1.4	1.9	0.6	1.4	1.9	0.5	1.4	1.9	0.5
Morocco	0.5	0.4	0.6	0.2	0.4	0.0	0.2	0.4	0.0
Tunisia	0.3	0.5	0.3	0.3	0.5	0.2	0.2	0.3	0.2
Southern MedSPAD average	1.0	1.4	0.5	0.9	1.4	0.3	0.9	1.4	0.3

3.8. Amphetamines

The northern MedSPAD average for lifetime amphetamine use was 1.4% (Table 3.8.1). The highest proportion of students who had used amphetamines was in Cyprus (2.4%), followed by Croatia (1.9%), Portugal (1.7%) and France (1.6%). The lowest rates were found in Malta (0.8%), Spain (1%), Greece and Italy (both 1.1%). In all northern

MedSPAD countries except France, boys were more likely to have tried amphetamines at least once during their lifetime. The northern MedSPAD average rate for students who reported using amphetamines in the past year was 1%. Cyprus registered the highest prevalence rate (2.4%), followed by Croatia (1.7%) and France (1.3%). All other countries reported a prevalence lower than 1%.

In southern MedSPAD countries, 1.6% of students reported using amphetamines at least once during their lifetime, while 1.3% reported use in the past 12 months. The highest lifetime prevalence was found in Morocco (3.1%), followed by Egypt (1.9%) and Tunisia (0.3%). Morocco also had the highest prevalence rate (2.3%) for the past year, and for both lifetime prevalence and consumption in the past year boys had higher rates than girls. Conversely, higher lifetime prevalence rates were found among girls in Egypt.

Table 3.8.1. Amphetamines: use in lifetime and past 12 months (percentage)

Country	Lifetime use			Past 12 month use		
	Total	Boys	Girls	Total	Boys	Girls
Croatia	1.9	2.1	1.7	1.7	1.9	1.4
Cyprus	2.4	4.6	0.7	2.4	4.6	0.7
France	1.6	1.5	1.7	1.3	1.5	1.0
Greece	1.1	1.7	0.6	0.8	1.3	0.4
Italy	1.1	1.2	1.0	0.8	0.9	0.6
Malta	0.8	1.1	0.5	0.7	0.8	0.5
Portugal	1.7	1.8	1.6	0.9	1.2	0.7
Spain	1.0	1.0	0.9	0.8	0.9	0.6
Northern MedSPAD average	1.4	1.7	1.1	1.0	1.4	0.7
Egypt	1.9	1.8	2.0	1.7	1.8	1.6
Morocco	3.1	3.3	2.9	2.3	3.1	1.6
Tunisia	0.3	0.2	0.4	0.1	0.0	0.1
Southern MedSPAD average	1.6	1.7	1.5	1.3	1.6	1.0

3.9. Methamphetamines

On average, 1.1% of northern MedSPAD students stated they had used methamphetamines at least once during their lifetime (Table 3.9.1), while 0.9% of students reported using methamphetamines in the past 12 months. The highest lifetime prevalence rate was found in Cyprus (2.7%), followed by France and Croatia (both 1.3%) and Greece and Portugal (both 1.1%). In all countries, except for Croatia, boys were more likely than girls to have used methamphetamines in their lifetime. The highest gender difference was found in Cyprus (5.6% for boys v. 0.5% for girls), followed by Greece (1.2 percentage points). Italy, Spain, Malta, Portugal and France registered gender differences of less than 0.6 percentage points.

The southern MedSPAD average prevalence rate for students who had used methamphetamines at least once during their lifetime was 1.3%. The highest rate was registered in Morocco (2.1%), followed by Egypt (1.7%) and Tunisia (0.2%). In all three countries, boys were more likely to have tried methamphetamines than girls during their lifetime. Overall, 1.1% of students reported methamphetamine use during the past 12 months, and gender differences were generally slight, with an average difference of 0.6%, only Morocco registering a difference of over 1 percentage point.

Table 3.9.1. Methamphetamines: use in lifetime and past 12 months (percentage)

Country	Lifetime use			Past 12 month use		
	Total	Boys	Girls	Total	Boys	Girls
Croatia	1.3	1.3	1.3	0.9	1.1	0.7
Cyprus	2.7	5.6	0.5	2.7	5.6	0.5
France	1.3	1.3	1.2	1.0	1.2	0.8
Greece	1.1	1.7	0.5	0.8	1.3	0.4
Italy	0.8	1.1	0.6	0.7	0.9	0.4
Malta	0.9	1.0	0.7	0.7	0.8	0.5
Portugal	1.1	1.2	1.1	0.8	1.0	0.7
Spain	0.8	1.0	0.6	0.6	0.9	0.4
Northern MedSPAD average	1.1	1.4	0.8	0.9	1.2	0.5
Egypt	1.7	1.9	1.3	1.4	1.5	1.1
Morocco	2.1	2.7	1.5	1.9	2.7	1.3
Tunisia	0.2	0.3	0.2	0.0	0.0	0.1
Southern MedSPAD average	1.3	1.6	0.9	1.1	1.4	0.7

3.10. Crack

Table 3.10.1. Crack: use in lifetime and past 12 months (percentage)

Country	Lifetime use			Past 12 month use		
	Total	Boys	Girls	Total	Boys	Girls
Croatia	1.2	1.5	0.9	0.9	1.5	0.4
Cyprus	3.2	5.9	1.2	3.2	5.9	1.1
France	2.0	2.6	1.5	1.4	1.9	1.0
Greece	0.9	1.6	0.3	0.9	1.6	0.3
Italy	1.4	1.9	0.8	0.9	1.1	0.6
Malta	1.2	1.7	0.7	0.7	0.9	0.5
Portugal	1.5	1.9	1.2	1.0	1.3	0.8
Spain	0.9	1.1	0.7	0.6	0.9	0.4
Northern MedSPAD average	1.3	1.9	0.8	1.0	1.5	0.6
Egypt	1.4	1.8	0.7	1.1	1.4	0.6
Morocco	0.9	1.4	0.5	0.8	1.4	0.3
Tunisia	-	-	-	-	-	-
Southern MedSPAD average	1.3	1.7	0.6	1.0	1.4	0.5

On average, in northern MedSPAD countries, 1.3% of students had used crack during their lifetime while 1% had used crack in the past 12 months (Table 3.10.1). Prevalence for lifetime use fluctuated within a narrow range, between the highest value in Cyprus (3.2%) and the lowest value recorded by Spain and Greece (0.9% for both countries). For prevalence in the past 12 months, rates ranged from 3.2% in Cyprus to 0.6% in Spain. For both lifetime prevalence and use in the past 12 months, the gender gap was around 1 percentage point, with boys

having higher rates than girls. Cyprus had the highest gender gap with a difference of 4.7 percentage points in lifetime prevalence among boys and girls (5.9% for boys v. 1.2% for girls) and of 4.8 percentage points for use in the past 12 months (5.9% for boys v. 1.1% for girls).

In southern MedSPAD countries, on average, 1.3% of students had used crack at least once in their lifetime, while 1% had used crack in the past 12 months. In each country, lifetime prevalence and use in the past 12 months was higher among boys than girls. Egypt had higher rates both for lifetime prevalence and use in the past 12 months. Overall, southern MedSPAD countries had about a difference of a percentage point between genders (1.1 for lifetime use and 0.9 for the past 12 months).

3.11. Hallucinogens

Northern MedSPAD countries only registered lifetime prevalence for hallucinogen use while southern MedSPAD countries also collected prevalence of use in the past 12 months (Table 3.11.1). On average, in northern MedSPAD countries, 1.4% of students used hallucinogens during their lifetime. Prevalence for lifetime use fluctuated in a narrow range, between the highest value in Cyprus (2.4%) and the lowest value recorded by France (1.1%). The gender gap was at 0.8%, with the lifetime prevalence of boys higher than girls.

In southern MedSPAD countries, on average, 1.1% of students used hallucinogens in their lifetime while 1% had used these substances in the past 12 months. In each southern MedSPAD country, the prevalence of hallucinogen use during their lifetime and past 12 months was higher among boys than girls. The difference between genders amounted to 1 percentage point for lifetime prevalence and 0.9 percentage points for the past 12 months.

Table 3.11.1. Hallucinogens: use in lifetime and past 12 months (percentage)

Country	Lifetime use			Past 12 month use		
	Total	Boys	Girls	Total	Boys	Girls
Croatia	1.9	2.2	1.5	-	-	-
Cyprus	2.4	3.1	1.8	-	-	-
France	1.1	1.4	0.7	-	-	-
Greece	1.3	1.9	0.6	-	-	-
Italy	1.2	1.4	0.8	-	-	-
Malta	1.3	1.8	0.8	-	-	-
Portugal	1.8	2.1	1.5	-	-	-
Spain	1.2	1.4	1.0	-	-	-
Northern MedSPAD average	1.4	1.8	1.0	-	-	-
Egypt	1.5	1.9	0.9	1.3	1.6	0.8
Morocco	1.6	2.4	0.9	1.4	2.4	0.6
Tunisia	0.2	0.5	0.0	0.1	0.3	0.0
Southern MedSPAD average	1.1	1.6	0.6	1.0	1.4	0.5

3.12. New psychoactive substances (NPS)

In northern MedSPAD countries, an average of 2.7% students had used new psychoactive substances (NPS) at least once in their lifetime (Table 3.12.1). On average, Croatia had the highest prevalence for lifetime use (5.1%) followed by Cyprus (3.7%). Portugal had the lowest prevalence, at 0.9% of students. Overall, lifetime prevalence amounted to 2.9% for male students and 2.4% for female students, with a gender gap of only 0.5 percentage points. At country level, Greece had the highest gender gap (2.5 percentage points).

Table 3.12.1. NPS: use in lifetime and past 12 months (percentage)

Country	Lifetime use			Past 12 month use		
	Total	Boys	Girls	Total	Boys	Girls
Croatia	5.1	5.1	5.1	-	-	-
Cyprus	3.7	4.6	2.9	-	-	-
France	-	-	-	-	-	-
Greece	2.8	4.1	1.6	-	-	-
Italy	3.1	2.5	3.8	-	-	-
Malta	3.0	2.8	3.2	-	-	-
Portugal	0.9	0.9	0.9	-	-	-
Spain	1.8	1.6	1.9	-	-	-
Northern MedSPAD average	2.7	2.9	2.4	-	-	-
Egypt	4.4	5.1	3.2	4.2	5.1	2.8
Morocco	-	-	-	-	-	-
Tunisia	1.2	1.6	0.9	0.7	1.3	0.4
Southern MedSPAD average	3.3	4.2	2.1	3.0	4.1	1.7

On average, 3.3% of students in southern MedSPAD countries had used NPS at least once during their lifetime; Egypt reported the highest prevalence (4.4%). The use of NPS in the past 12 months was more common among male students than female students for both countries, with a gender gap of 2.3 percentage points in Egypt.

Synthetic cannabinoid use

Table 3.12.2. Synthetic cannabinoids: use in lifetime (percentage)

Country	Lifetime use		
	Total	Boys	Girls
Croatia	2.9	3.0	2.8
Cyprus	4.2	5.2	3.3
France	5.2	5.2	5.1
Greece	3.3	4.6	2.0
Italy	2.8	3.0	2.5
Malta	4.0	3.4	4.5
Portugal	3.9	4.1	3.8
Spain	1.8	1.9	1.6
Northern MedSPAD average	3.4	3.8	3.0
Egypt	1.5	1.8	1.0
Morocco	-	-	-
Tunisia	1.4	2.9	0.5
Southern MedSPAD average	1.5	2.1	0.8

On average, in northern MedSPAD countries, 3.4% of students had used synthetic cannabinoids at least once in their lifetime. Prevalence rates ranged from 1.8% in Spain to 5.2% in France. Besides France, Cyprus, Malta and Portugal also had above-average lifetime prevalence (Table 3.12.2). Overall, male students had a higher lifetime prevalence of use than female students but the gender gap was, on average, not significant: 3.8% of boys reported having used synthetic cannabinoids at least once compared to 3% of girls.

In almost all northern MedSPAD countries, boys indicated a higher use of synthetic cannabinoids than girls, with the exception of Malta (4.5% for girls v. 3.4% for boys). The highest gender gap was recorded in Greece, where lifetime prevalence of boys was more than double that of girls (4.6% for boys v. 2% for girls). Lifetime prevalence of girls was above the average in Cyprus, Portugal, Malta and France, demonstrating notable use of these substances among girls and narrow differences with boys.

The average lifetime prevalence of synthetic cannabinoids in southern MedSPAD countries was 1.5%. Overall, a gender difference of 1.3 percentage points was reported. This difference is significant in Tunisia (2.9% for boys v. 0.5% for girls).

Synthetic cathinones use

In northern MedSPAD countries, on average, 0.8% of students reported having ever used synthetic cathinones, with prevalence rates ranging from 2.4% (Cyprus) to 0.4% (France and Italy). Cyprus had the highest lifetime prevalence, at 1.6 percentage points above the average (Table 3.12.3). In almost all countries, boys reported a higher lifetime prevalence than girls, except for Portugal, where the prevalence of students having ever used synthetic cathinones was slightly higher among girls than boys (1.2% for girls v. 1.1% for boys). Overall, the gender gap was 0.6 percentage points. Cyprus reported the highest difference between boys and girls, with rates 3.2 percentage points higher among boys than girls.

For southern MedSPAD countries, only Tunisia collected prevalence about lifetime use of synthetic cathinones: on average 0.3% of students had used these substances at least once in their lifetime, with higher prevalence rates among boys than girls (0.7% for boys v. 0.1% for girls).

Table 3.12.3. Synthetic cathinones: use in lifetime (percentage)

	Lifetime use		
Country	Total	Boys	Girls
Croatia	-	-	-
Cyprus	2.4	4.2	1.0
France	0.4	0.7	0.2
Greece	0.8	1.4	0.2
Italy	0.4	0.5	0.3
Malta	0.6	0.6	0.5
Portugal	1.2	1.1	1.2
Spain	0.6	0.9	0.4
Northern MedSPAD average	0.8	1.1	0.5
Egypt	-	-	-
Morocco	-	-	-
Tunisia	0.3	0.7	0.1
Southern MedSPAD average	0.3	0.7	0.1

3.13. Pharmaceuticals for non-medical purposes

Use of tranquillisers and sedatives

On average, lifetime use of tranquillisers and sedatives for non-medical purposes in northern MedSPAD countries was 4.3%: the highest prevalence rate was in Cyprus (6.6%) and the lowest rate was in Croatia (2.3%) (Table 3.13.1).

Cyprus reported the highest prevalence rate among boys (7.3%), while Portugal had the highest prevalence among girls (7.4%).

Contrary to trends for other substances, prevalence among girls was higher than boys (4.9% for girls v. 3.7% for boys). In fact, in almost all countries girls used more tranquillisers and sedatives for non-medical purposes, with the exception of Cyprus and Greece, which had a slightly higher prevalence among boys (1.2 percentage points and 0.9 percentage points, respectively). Italy reported the highest gender gap, with a prevalence of girls having used tranquillisers and sedatives at least once in their lifetime that was almost double that of boys (5.6% for girls v. 3% for boys).

In southern MedSPAD countries, on average, the lifetime prevalence of tranquilliser and sedative use among students was 7.9%. Once again, rates were higher among girls than boys. Overall, Egypt reported the highest lifetime prevalence (8.2%), followed by Tunisia (7.9%) and Morocco (6.9%). Egypt had also the highest prevalence for use in the past year and in the past month (7.4% and 6.5%, respectively), followed by Morocco (5.1% and 4.1%, respectively) and Tunisia (4.5% and 3.1%, respectively). Lifetime prevalence was higher among girls than boys (8.2% for girls v. 7.7% for boys), while in the past 12 months (6.8% for boys v. 5.6% for girls) and past 30 days (5.7% for boys v. 4.6% for girls) prevalence was higher among boys. At country level, Egypt had higher prevalence rates among boys than girls across all timeframes, while Tunisia and Morocco had higher prevalence rates among female students. The highest gender gap was recorded in Morocco, where lifetime prevalence among girls was 5.1 percentage points higher than among boys (9.1% for girls v. 4.1% for boys).

Table 3.13.1. Tranquillisers and sedatives: use in lifetime, past 12 months and past 30 days (percentage)

	Lifetime use			Past 12 month use			Past 30 day use		
Country	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls
Croatia	2.3	1.4	3.2	-	-	-	-	-	-
Cyprus	6.6	7.3	6.1	-	-	-	-	-	-
France	6.4	5.9	7.0	-	-	-	-	-	-
Greece	3.5	4.0	3.1	-	-	-	-	-	-
Italy	4.3	3.0	5.6	-	-	-	-	-	-
Malta	3.1	2.5	3.8	-	-	-	-	-	-
Portugal	6.0	4.4	7.4	-	-	-	-	-	-
Spain	4.0	3.5	4.4	-	-	-	-	-	-
Northern MedSPAD average	4.3	3.7	4.9	-	-	-	-	-	-
Egypt	8.2	9.1	6.6	7.4	8.6	5.4	6.5	7.7	4.6
Morocco	6.9	4.1	9.1	5.1	3.5	6.3	4.1	2.9	5.1
Tunisia	7.9	5.4	9.5	4.5	3.0	5.4	3.1	1.2	4.3
Southern MedSPAD average	7.9	7.7	8.2	6.2	6.8	5.6	5.2	5.7	4.6

Use of painkillers

Lifetime prevalence of painkiller use for non-medical purposes in northern MedSPAD countries was on average 3.2%, and ranged from 0.8% in Italy to 6.3% in Cyprus. Besides Cyprus, Croatia (5.7%), Greece (5%) and France (3.3%) had prevalence rates above the average. Overall, lifetime prevalence was higher among girls than boys (3.5% for girls v. 2.9% for boys): in the majority of countries, girls had higher lifetime prevalence of use, with the exception of Spain and Italy, where prevalence among boys was slightly higher. Croatia reported the highest gender gap of 4.2 percentage points (7.9% for girls v. 3.7% for boys).

In southern MedSPAD countries, lifetime prevalence of students having used painkillers for non-medical purposes was 3.7%, while prevalence of use in the past year was 2.6%. Morocco reported the highest prevalence for both timeframes (lifetime prevalence of 6.9% and use in the past 12 months of 6.1%). The gender gap was not so

large, overall. Girls had higher prevalence rates than boys, both for lifetime use and use in the past 12 months, in contrast to trends with most other substances. Tunisia had the highest gender gap for both timeframes: the difference in lifetime prevalence amounted to 3.2 percentage points, while the difference in use in the past year was 2.3 percentage points.

Table 3.13.2. Painkillers: use in lifetime and past 12 months (percentage)

	Lifetime use			Past 12 month use		
Country	Total	Boys	Girls	Total	Boys	Girls
Croatia	5.7	3.7	7.9	-	-	-
Cyprus	6.3	5.9	6.5	-	-	-
France	3.3	2.8	3.8	-	-	-
Greece	5.0	5.0	5.0	-	-	-
Italy	0.8	1.0	0.6	-	-	-
Malta	2.6	2.7	2.5	-	-	-
Portugal	1.8	1.2	2.3	-	-	-
Spain	1.1	1.3	0.9	-	-	-
Northern MedSPAD average	3.2	2.9	3.5	-	-	-
Egypt	3.1	3.2	3.0	2.1	2.5	1.5
Morocco	6.9	6.4	7.3	6.1	5.3	6.7
Tunisia	3.2	1.2	4.4	1.7	0.3	2.6
Southern MedSPAD average	3.7	3.2	4.3	2.6	2.4	2.8

Chapter 4

Other risk behaviours among adolescents

4.1. Gambling

Offline and online gambling activity

As described in the methodology, gambling for money is defined as engagement in at least one of the following gambling activities in the past 12 months: playing on slot machines, playing cards or dice for money, playing the lottery, or betting on sports or animal races.

Table 4.1.1. Gambling: activity in the past 12 months (percentage)

Country	Past 12 month activity		
	Total	Boys	Girls
Croatia	22.0	33.9	9.3
Cyprus	33.3	48.8	21.5
France	-	-	-
Greece	33.3	44.5	22.8
Italy	31.6	40.7	21.6
Malta	14.1	16.4	11.8
Portugal	22.4	32.4	14.0
Spain	16.8	21.7	12.1
Northern MedSPAD average	24.8	33.7	16.4
Egypt	13.9	15.8	10.7
Morocco	16.7	24.2	10.7
Tunisia	21.8	28.8	17.4
Southern MedSPAD average	16.6	19.6	13.3

In northern MedSPAD countries, on average, 24.8% of students reported having gambled for money in the past 12 months (Table 4.1.1). The highest values were found in Cyprus and Greece (both 33.3%) and Italy (31.6%), while Portugal (22.4%), Croatia (22%), Spain (16.8%) and Malta (14.1%) had prevalence rates below the average.

On average, the prevalence of boys reporting having gambled in the past 12 months was almost double that of girls (33.7% for boys v. 16.4% for girls). Cyprus had the highest prevalence among male students (48.8%) while Greece had the highest prevalence among female students (22.8%). In all northern MedSPAD countries, gambling was an activity that involved more boys than girls, with large gender differences. The highest gap between male and female prevalence was found in Croatia, at 24 percentage points (33.9.% for boys v. 9.3% for girls).

In southern MedSPAD countries, on average 16.6% of students reported having gambled in the past 12 months: Tunisia had the highest prevalence (21.8%), followed by Morocco (16.7%) and Egypt (13.9%). The prevalence of boys reporting having gambled was higher than girls, with an average gender gap of 6.6 percentage points (19.6% for boys v. 13.3% for girls). Moreover, in all three countries, prevalence was higher among boys than girls. The highest prevalence among students in southern MedSPAD countries was in Tunisia, both for boys and girls (28.8% for boys v. 17.4% for girls).

For southern MedSPAD countries, it is possible to compare both online and offline behaviour, as gambling activity was assessed in these countries by asking students how often in the past 12 months they had engaged in the four different gambling activities, both offline and online. This distinction was not made in the European

School Survey Project on Alcohol and Other Drugs (ESPAD) , which is carried out in northern MedSPAD countries. Therefore, the remainder of this section will only present results from southern MedSPAD countries.

Table 4.1.2. Gambling offline: prevalence in the past 12 months and proportion of gambling types among those who have gambled

Country	Gambling offline			Slot machines			Cards or dice			Lotteries			Sports or animal betting		
	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls
Egypt	12.1	13.8	9.2	67.4	70.3	60.3	76.3	77.5	73.5	61.0	63.9	54.2	-	-	-
Morocco	13.9	20.4	8.8	34.4	39.6	25.0	55.1	56.0	53.6	40.0	46.5	27.8	70.7	73.3	66.1
Tunisia	18.8	25.6	14.5	19.2	29.0	8.7	76.6	65.2	89.2	16.9	26.2	6.6	37.2	54.6	18.1
Southern MedSPAD average	14.3	17.2	11.2	44.3	52.8	30.1	73.5	70.4	78.6	41.2	49.3	27.5	46.2	60.4	28.4

Table 4.1.3. Gambling online: prevalence in the past 12 months and proportion of gambling types among those who have gambled

Country	Gambling online			Slot machines			Cards or dice			Lotteries			Sports or animal betting		
	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls
Egypt	10.0	11.8	7.1	64.6	66.7	58.8	84.4	86.8	78.0	69.9	70.8	67.2	-	-	-
Morocco	13.3	19.2	8.7	37.2	44.1	25.5	53.1	58.7	43.6	43.0	52.1	27.3	70.0	75.8	60.0
Tunisia	14.4	21.9	9.7	24.4	35.2	9.1	46.5	38.6	57.3	42.5	49.4	33.1	59.8	70.3	44.9
Southern MedSPAD average	11.8	14.9	8.3	45.8	53.3	31.1	65.8	67.4	62.8	55.8	61.3	45.2	63.0	72.1	49.2

On average, the prevalence of students reporting having gambled in physical places (offline) was slightly higher (14.3%) than those reporting having gambled online (11.8%) (Tables 4.1.2. and 4.1.3). Both offline and online, gambling was more frequently reported by male students than female students in all three southern MedSPAD countries.

For offline gambling (Table 4.1.2), Tunisia had the highest rate (18.8%) while Morocco (13.9%) and Egypt (12.1%) were both below the southern MedSPAD average. Egypt had the smallest gender gap (13.8% for boys v. 9.2% for girls), while Morocco and Tunisia both had a gender gap of 11 percentage points. Cards or dice were the predominant activity reported by those gambling offline in the past 12 months (involving on average 73.5% of offline gamblers), followed by betting on sports or animals (46.2%), slot machines (44.3%) and lotteries (41.2%). In Tunisia and Egypt, cards or dice were most common among students who reported having gambled offline in the past 12 months (76.6% and 76.3%, respectively), while in Morocco betting on sports or animals was the activity most frequently reported (70.7%). The proportion of gamblers in the past 12 months was higher among boys than girls for all offline gambling activities with the exception of cards or dice, which was reported by 78.6% of female gamblers compared to 70.4% of male gamblers.

With regard to online gambling (Table 4.1.3), Tunisia had the highest prevalence (14.4%), followed by Morocco (13.3%) and Egypt (10%). For all three countries, the prevalence of online gambling was higher among boys (14.9%) than girls (8.3%). At country level, the highest gender difference was found in Tunisia, at 12 percentage points (21.9% for boys v. 9.7% for girls), followed by Morocco (19.2% for boys v. 8.7% for girls) and Egypt, at 5 percentage points (11.8% for boys v. 7.1% for girls). As with offline gambling, the predominant online gambling activity was card or dice games, involving on average 65.8% of students who gambled online in the past 12 months, followed by betting on sports or animals (63%), lotteries (55.8%) and slot machines (45.8%). For all these gambling activities, the proportion of students who gambled online in the past 12 months was higher among boys than girls: betting on sports and animals had the highest gender gap, at about 23 percentage points (72.1% for boys v. 49.2% for girls), while cards or dice had the lowest gender gap (67.4% for boys v. 62.8% for girls).

Problem gambling

As described in the methodology, the SOGS-RA screening instrument (Poulin 2002; Winters, Stinchfield and Fulkerson 1993) was used in the MedSPAD questionnaire to assess the presence of possible problem gambling behaviour. In Table 4.1.4, estimates of the prevalence of at-risk and problem gamblers among students in southern MedSPAD countries are reported.

Table 4.1.4. Gambling: presence of possible problem gambling behaviour (SOGS-RA screening test) (percentage)

Country	At-risk gambling			Problem gambling		
	Total	Boys	Girls	Total	Boys	Girls
Egypt	0.7	0.8	0.5	2.7	3.4	1.7
Morocco	2.5	3.7	1.5	3.5	6.8	0.9
Tunisia	4.8	8.5	2.6	4.6	9.3	1.6
Southern MedSPAD average	2.2	2.8	1.5	3.4	5.1	1.5

On average, in the southern MedSPAD area, 2.2% of students were classified as being at risk of developing problem gambling behaviour and 3.4% were classed as problem gamblers. At country level, Egypt had the lowest prevalence of gamblers at risk and problem gamblers (0.7% and 2.7%, respectively), followed by Morocco, where 2.5% of students were classified as at-risk gamblers and 3.5% as problem gamblers. Tunisia presented the highest prevalence rate of gamblers at risk and problem gamblers (4.8% and 4.6%, respectively).

Overall, the prevalence of at-risk and problem gamblers was higher among boys than girls, both on average (2.8% for boys v. 1.5% for girls and 5.1% for boys v. 1.5% for girls, respectively) and at country level.

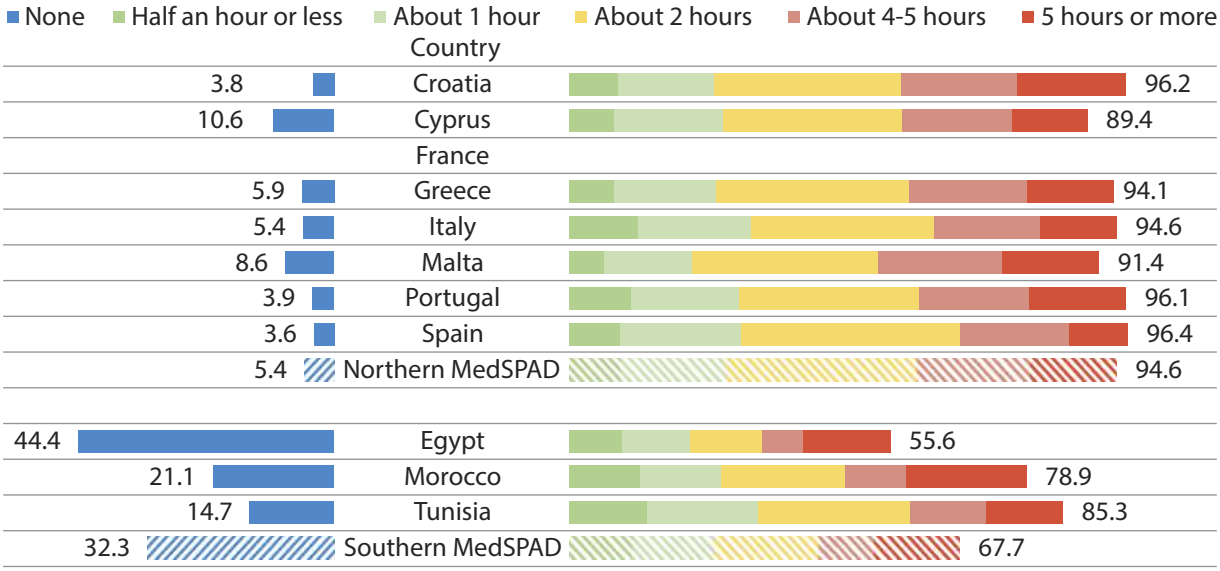
4.2. Social media

Use of social media during school days

In northern MedSPAD countries, more than 3 in 10 students (32.8%) spent around 2 hours using social media on a typical school day, while about 2 in 10 students (19.7%) averaged between 4 and 5 hours, and 1 in 8 students (14.9%) spent more than a full quarter of their day using social media (6 hours or more). The prevalence of this last level of use was higher among girls than boys in northern MedSPAD countries (Figure 4.2.1).

On average, in southern MedSPAD countries, more than 3 in 10 students (32.3%) did not use social media on school days. Conversely, 15.3% of students reported having used social media for more than 6 hours. On average, among boys the prevalence of students reporting a daily use of more than 6 hours was higher than among girls (15.9% v. 14.6%, respectively). Morocco was an exception, with 21% of girls v. 20.4% of boys reporting this frequency of use.

Figure 4.2.1. Social media on a typical school day: average number of hours spent in the past 7 days (percentage)

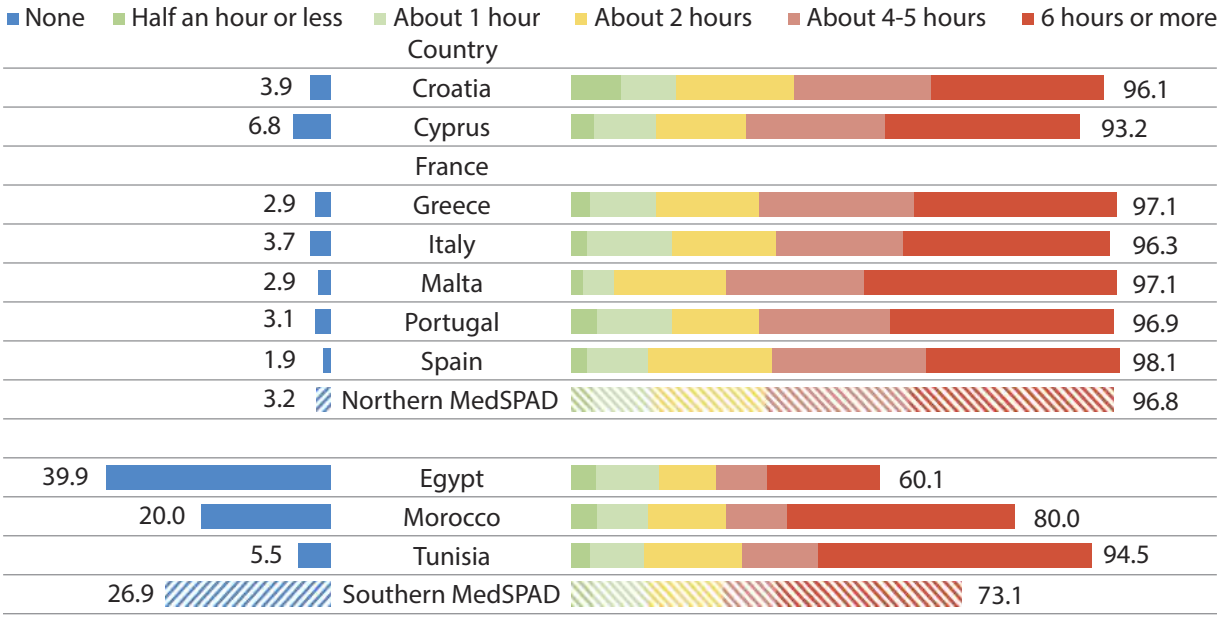


Use of social media during non-school days

In northern MedSPAD countries, more than half of all students (50.9%) spent 2 to 5 hours on social media (Figure 4.2.2). The percentage of average daily use for 6 hours or more reported during non-school days (32.8%) was substantially higher than that reported during school days. During non-school days, the lowest frequencies of social media use (from 30 minutes or less to about 1 hour per day) were, on average, lower (13.1%) than those reported during school days. Among northern MedSPAD countries, Malta (40.6%) and Portugal (36.3%) recorded the highest percentages of prolonged social media use (6 hours or more per day). In northern countries, even during non-school days, girls reported a higher percentage of use exceeding 6 hours (39%) than boys (26.3%).

On average, in southern MedSPAD countries, the percentage of students reporting the lowest frequencies of social media use (from 30 minutes or less to about 1 hour per day) or no use during non-school days was substantially lower than during school days, while the use of social media for more than 6 hours per day involved more than 3 in 10 students (32.4%). Among southern MedSPAD countries, Tunisia (46.2%) recorded the highest percentages of daily use exceeding 6 hours, followed by Morocco (38.1%) and Egypt (23.6%). For social media use exceeding 6 hours per day, on average girls (35%) reported a higher prevalence than boys (30%). Egypt was the only country where this prevalence was slightly higher among boys than girls (23.9% v. 23.2%).

Figure 4.2.2. Social media on a typical non-school day: average number of hours spent in the past 7 days (percentage)



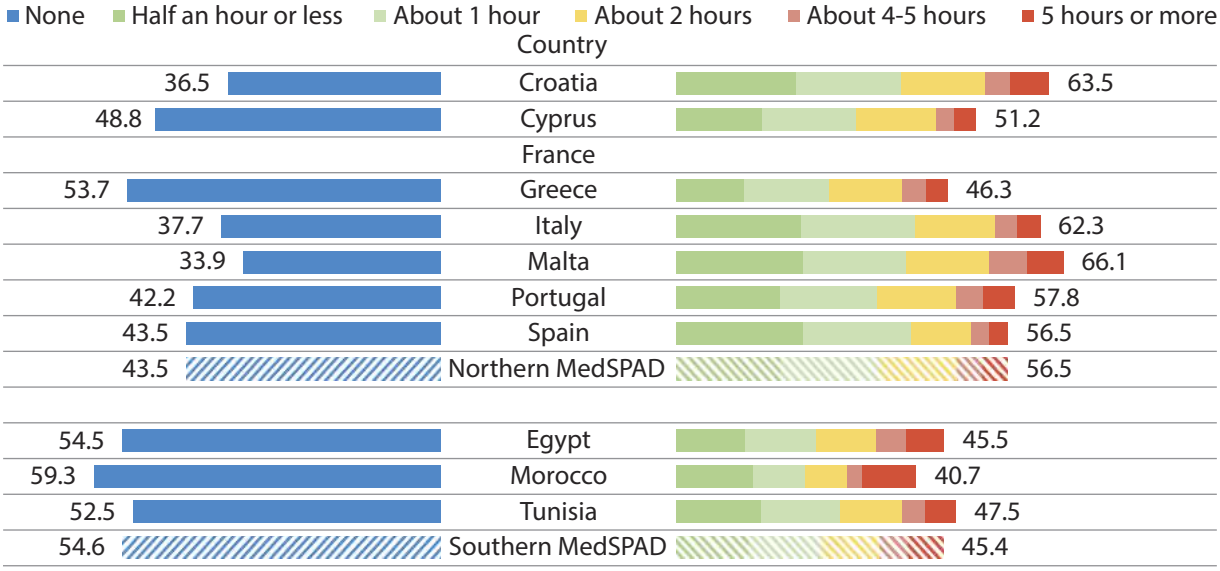
4.3. Gaming

Gaming during school days

On average, in the northern MedSPAD area, more than 4 in 10 students (43.5%) reported no gaming-related activity in the course of a typical school day in the past month (Figure 4.3.1). The percentage of students who played video games during school days for a period of less than 30 minutes to 1 hour (34.7%) exceeded those who engaged in moderate activity of about 2 hours (12.8%), and prolonged use of about 4 to 5 hours (4.4%) and 6 or more hours (4.7%). Male students made greater use of video games, with an average of 8% of male students spending 6 or more hours on gaming compared to 1.6% of female students.

In the southern MedSPAD area, on average, more than half the students (54.6%) reported the absence of any gaming-related activity during school days. Those who reported little use of video games (ranging from less than 30 minutes to about 1 hour) exceeded those who engaged in moderate to prolonged use (24.8% v. 20.6%). Among those with prolonged use, 9.8% reported daily gaming of about 2 hours, 4.4% played about 4 to 5 hours and 6.4% played over 6 hours. Male students made greater use of video games, with an average 8.9% of male students spending 6 or more hours on gaming compared to 3.6% of female students.

Figure 4.3.1. Gaming on a typical school day: average number of hours spent in the past 30 days (percentage)

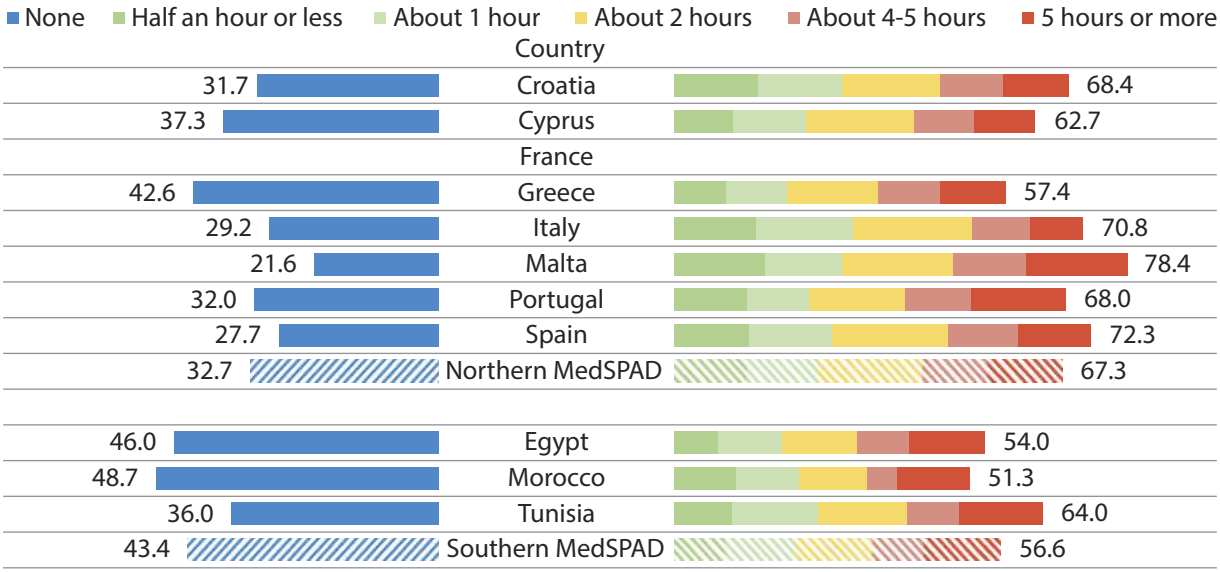


Gaming during non-school days

On average, in northern MedSPAD countries, the percentage of students who reported no gaming activity during typical non-school days (32.7%) was lower compared to school days. The same can be observed for those who reported a little use, ranging from less than 30 minutes to 1 hour per day (25.5%) (Figure 4.3.2). Moderate to prolonged use increased during non-school days. Specifically, students who played video games during the weekends or holidays for moderate or prolonged periods comprised 41.9% of the total, ranging from 2 hours (17.6%), 4-5 hours (11.3%) and 6 hours and over (13%). As on school days, especially on the weekends or during holidays, boys were more likely to play video games for prolonged periods of more than 6 hours (22.6%) compared to girls (3.9%).

In southern MedSPAD countries, the prevalence of students who did not play or made little use of video games (less than 30 minutes to about 1 hour) during the holidays or the weekends was lower compared to school days. The prevalence of students reporting moderate to prolonged use was higher than during school days for all levels of use. Compared with the prevalence reported during school days, the rate of students who used video games from 4-5 hours doubled (8.8%), as was the case with those who gamed for more than 6 hours (13.2%). During weekends and holidays, boys reported more prolonged use of video games (exceeding 6 hours) than girls (18.5% v. 7.4%).

Figure 4.3.2. Gaming on a typical non-school day: average number of hours spent in the past 30 days (percentage)



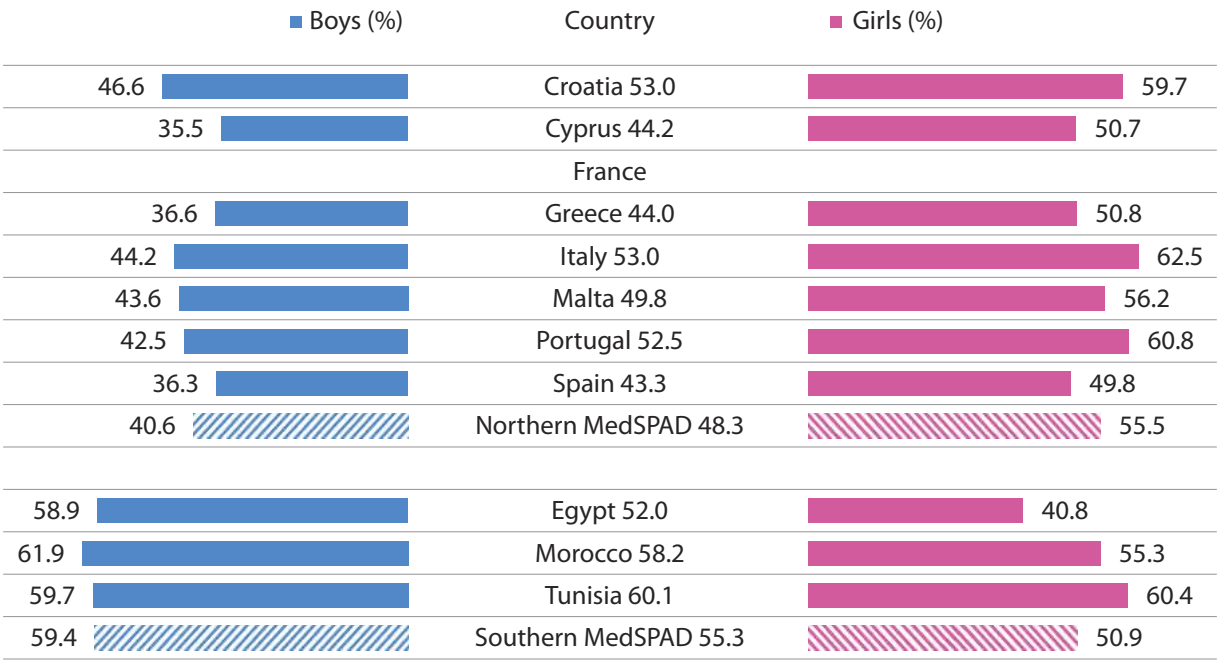
4.4. Self-perceived problems with social media use and gaming

Two summary indexes for the estimation of perceived risks related to social media use and gaming were calculated (range 0-3). These non-clinical screening tools (Holstein et al. 2014) focus on a student's perception of problems related to time spent on these activities, of bad feelings because of restricted access, and of family concerns. Index scores of 0-1 and 2-3 were considered to be indicative of self-perceived low and high risks of problem use, respectively. For more details, see the methodology section.

In the northern MedSPAD area, 48.3% of students scored 2-3 points on the index for self-perceived problems with social media use, suggesting a high risk of problems related to social media use (Figure 4.4.1). At country level, Italy and Croatia (53%) followed by Portugal (52.5%) recorded the highest prevalence of self-perceived high risk. Spain (43.3%) recorded the lowest prevalence. Such perceptions of risk were clearly greater among girls (55.5%) than boys (40.6%).

In southern MedSPAD countries, more than 5 in 10 students (55.3%) reported perceiving a high risk of problematic behaviour in the use of social media. Tunisia (60.1%) reported the highest prevalence rate, while Egypt (52%) had the lowest rate. Perception of risk was higher among boys (59.4%) than girls (50.9%), except for Tunisia (60.4% for girls v. 59.7% for boys).

Figure 4.4.1. Social media: self-perceived high risk of problems with social media use (percentage)

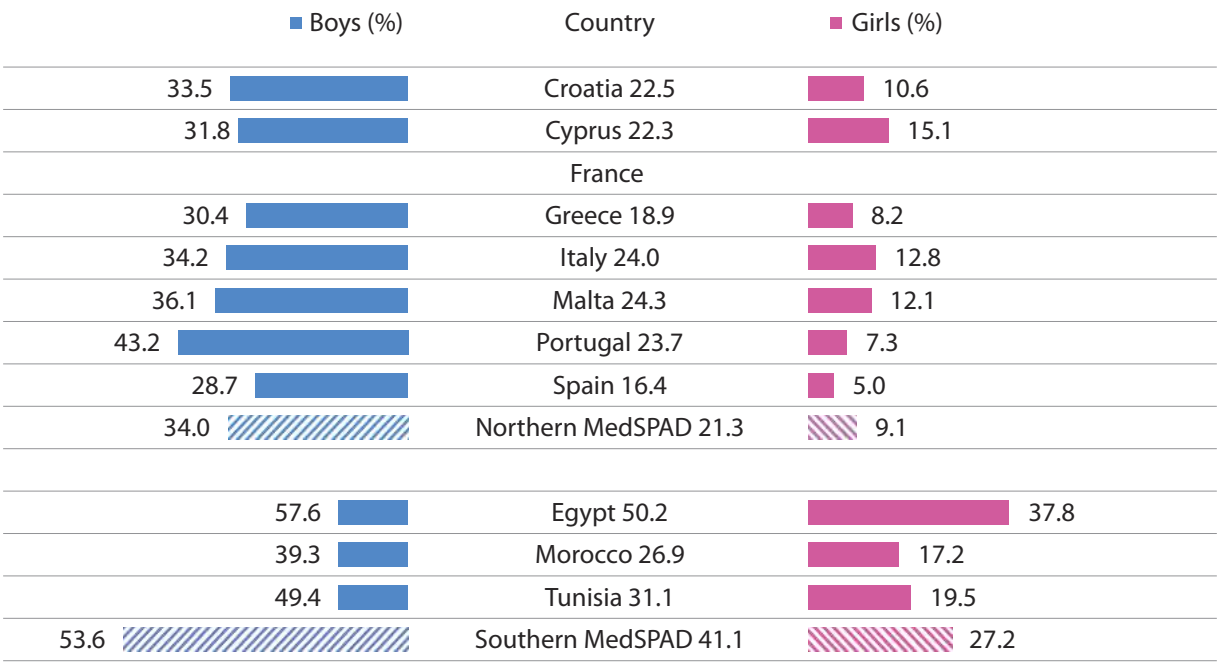


Notes: Results for France are not available

In the northern MedSPAD area, more than 2 in 10 (21.3%) students reported perceiving a high risk of problem behaviour with gaming (Figure 4.4.2). At country level, prevalence ranged between 22% to 24%, except for Spain (16.4%) and Greece (18.9%). Prevalence among boys (34%) was almost four times higher than among girls (9.1%).

In the southern MedSPAD area, on average, more than 4 in 10 students (41.1%) reported a self-perceived high risk of problems with gaming, a prevalence almost double than that estimated in the northern MedSPAD area. Morocco reported the lowest prevalence (26.9%), while Egypt had the highest rate (50.1%). On average, 53.6% of boys reported a self-perceived high risk of problematic gaming, a much higher prevalence than among girls (27.2%).

Figure 4.4.2. Gaming: self-perceived high risk of problems with gaming (percentage)



Notes: Results for France are not available

Chapter 5

Impact of Covid-19 restrictions

5.1. Changes in substance use

Changes in cigarette and e-cigarette use

Between late 2019 and 2020, the world witnessed a new coronavirus infection (Covid-19) that quickly turned into a global pandemic. Every country adopted restrictive measures based on social distancing, which in some countries soon turned into a nationwide lockdown to contain the spread of the pandemic. Therefore, the MedSPAD questionnaire tried to investigate if, during the period of Covid-19 restrictions, students changed their substance use behaviours (i.e. cigarettes, e-cigarettes, alcohol and cannabis) or their habits related to the use of social networks, video games and gambling.

In southern MedSPAD countries, on average, 28.2% of students said they had stopped using cigarettes, 17.7% and 10.2% decreased or increased their use, respectively, and 10.1% started using cigarettes. In comparison, 33.8% of students did not change their habits (Table 5.1.1). On average, a higher percentage of boys than girls reported a change in their use of cigarettes: 17.9% reduced their cigarette use (v. 17% of girls), 11.3% increased their consumption (v. 7% of girls), and 10.3% started using cigarettes (v. 9.7% of girls). Conversely, the proportion of girls who did not change their habits was lower than that of boys. At country level, Egypt presented the highest percentage for "started using" and "increased using" cigarettes, while registering the lowest percentage of students who reported having quit smoking cigarettes (22% in Egypt v. 41.7% in Tunisia and 43.8% in Morocco). Tunisia registered the highest percentage of students who reduced their cigarette use (18.2%).

Regarding changes in e-cigarette use, on average, 34.8% of students in southern MedSPAD countries stated that they stopped using e-cigarettes. Tunisia reported the highest percentage (52.4%), followed by Morocco (46.3%) and Egypt (23.1%) (Table 5.1.2). On average, 36.8% of students did not change their habits, 12.1% reduced their consumption, 9.5% started using e-cigarettes, and 6.9% increased their use. Overall, the percentage of students who increased their consumption of e-cigarettes was lower than the percentages of those who gave up or reduced their use.

Table 5.1.1. Cigarettes: Covid-19 restriction-related changes in substance use (percentage)

Country	Stopped using			Started using			Decreased			Increased			No change		
	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls
Egypt	22.0	23.0	18.4	11.4	12.3	8.1	17.9	17.9	17.6	10.9	12.1	6.6	37.8	34.7	49.3
Morocco	43.8	47.6	36.4	6.3	2.4	13.6	14.1	11.9	18.2	4.7	4.8	4.5	31.3	33.3	27.3
Tunisia	41.7	41.3	42.4	7.5	5.4	11.2	18.2	19.6	15.7	9.7	10.5	8.3	23.0	23.2	22.5
Southern MedSPAD average	28.2	28.2	28.2	10.1	10.3	9.7	17.7	17.9	17.0	10.2	11.3	7.0	33.8	32.3	38.2

Table 5.1.2. E-cigarettes: Covid-19 restriction-related changes in substance use (percentage)

Country	Stopped using			Started using			Decreased			Increased			No change		
	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls
Egypt	23.1	24.6	18.5	12.0	12.6	10.1	10.9	11.2	10.1	8.6	9.8	5.0	45.4	41.7	56.3
Morocco	46.3	45.6	47.8	6.3	7.0	4.3	11.3	10.5	13.0	6.3	5.3	8.7	30.0	31.6	26.1
Tunisia	52.4	51.3	54.1	6.0	7.3	4.0	14.5	16.2	11.9	3.9	3.7	4.1	23.2	21.6	25.9
Southern MedSPAD average	34.8	34.2	36.1	9.5	10.5	7.0	12.1	12.5	11.1	6.9	7.6	5.0	36.8	35.0	40.8

Changes in alcohol habits

On average, 41.3% of southern MedSPAD students reported no change in alcohol consumption, with Egypt having the highest percentage (42.8%). Overall, 26% of students stopped using alcohol, 14.9% decreased their consumption, 10.6% started using alcohol and 7.2% increased their consumption (Table 5.1.3). On average, the percentage of male students that stopped using alcohol was higher than the percentage of female students (28% for boys v. 20.5% for girls), while a slight gender difference could be observed regarding increase in alcohol use: 7.4% of girls increased their consumption v. 7.2% of boys.

Table 5.1.3. Alcohol: Covid-19 restriction-related changes in substance use (percentage)

Country	Stopped using			Started using			Decreased			Increased			No change		
	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls
Egypt	24.4	27.7	14.0	11.9	12.6	9.6	14.4	15.1	12.3	6.5	6.6	6.1	42.8	38.1	57.9
Morocco	39.7	36.6	47.1	10.3	14.6	0.0	13.8	9.8	23.5	3.4	2.4	5.9	32.8	36.6	23.5
Tunisia	25.6	23.8	28.9	4.2	4.7	3.4	17.9	19.7	14.7	13.4	14.0	12.4	38.8	37.7	40.7
Southern MedSPAD average	26.0	28.0	20.5	10.6	11.8	7.4	14.9	15.2	13.9	7.2	7.2	7.4	41.3	37.9	50.8

Changes in cannabis use

Table 5.1.4. Cannabis: Covid-19 restriction-related changes in substance use (percentage)

Country	Stopped using			Started using			Decreased			Increased			No change		
	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls
Egypt	20.0	21.3	16.4	13.3	14.7	9.5	12.2	12.2	12.1	8.3	9.1	6.0	46.2	42.6	56.0
Morocco	34.6	34.3	35.3	15.4	11.4	23.5	11.5	11.4	11.8	3.8	2.9	5.9	34.6	40.0	23.5
Tunisia	28.9	29.0	28.7	5.7	4.6	8.5	13.6	13.8	13.1	19.1	21.4	13.2	32.7	31.2	36.5
Southern MedSPAD average	22.7	23.6	20.3	12.4	12.9	10.8	12.3	12.4	12.2	9.5	10.4	7.1	43.1	40.7	49.5

On average, 43.1% of southern MedSPAD students declared that they did not change their cannabis consumption (Table 5.1.4). On average, 22.7% of students stopped using cannabis, 12.4% started using the substance, 12.3% decreased their consumption, and 9.5% of students increased their use of cannabis. At the country level, Tunisia registered the highest percentage of students who increased their use of

cannabis (19.1%), followed by Egypt (8.3%) and Morocco (3.8%). At the same time, Tunisia reported the lowest proportion of students who started using cannabis (5.7%, v. 13.3% for Egypt and 15.4% for Morocco). Morocco reported a gender difference of 12.1 percentage points among those who started using cannabis, with a prevalence of 23.5% among girls compared to 11.4% for male students. Tunisia registered the highest gender difference (8.2 percentage points) in those increasing their cannabis consumption: 21.4% for boys v. 13.2% for girls.

5.2. Changes in other risk behaviours

Changes in social media use

In southern MedSPAD countries, 45.9% of students increased their use of social media (Table 5.2.1). Tunisia had the highest percentage (50.6%) of students who increased their use of social media, followed by Egypt (43.3%) and Morocco (42.6%). In all three countries, on average, 23.7% of students did not change their habits, 17.5% decreased their use of social media, 7.6% started using social media, and 5.3% stopped using it. Boys were more likely to change their social media habits in Egypt and Tunisia but in Morocco, 45.2% of girls (v. 38.9% of boys) increased their use of social media. On average, 46.4% of girls (v. 45.5% of boys) reported increased use.

Table 5.2.1. Social media: Covid-19 restriction-related changes in use (percentage)

Country	Stopped using			Started using			Decreased			Increased			No change		
	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls
Egypt	7.7	7.5	8.0	11.7	11.4	12.1	17.1	16.4	18.3	43.3	44.1	41.6	20.3	20.5	20.0
Morocco	5.5	8.4	3.4	4.7	5.8	3.8	28.5	30.5	27.0	42.6	38.9	45.2	18.7	16.3	20.5
Tunisia	2.4	2.6	2.2	3.7	3.8	3.7	13.3	13.3	13.3	50.6	51.6	50.0	29.9	28.8	30.7
Southern MedSPAD average	5.3	6.3	4.3	7.6	8.6	6.4	17.5	17.4	17.6	45.9	45.5	46.4	23.7	22.2	25.3

Changes in video games

The use of video games increased, on average, by 36.3 percentage points in southern MedSPAD countries. Tunisia registered the highest percentage (38.5%), followed by Egypt (36.7%) and Morocco (28.8%). On average, 42.2% of male students reported an increase in their use compared to 23.3% of female students (Table 5.2.2). In southern MedSPAD countries, 9.4% of students stopped playing video games and 21.1% played them less, but 10% started playing them. Overall, 23.3% of students reported no changes in their habits. At country level, Morocco reported the highest percentage of students who played less video games (29.8%), compared to 21% in Egypt and 17.6% in Tunisia. Morocco also registered the highest percentage of students who stopped using video games (13.1%), while in Egypt and Tunisia, this percentage was equal to 10.4% and 6.3%, respectively.

Table 5.2.2. Gaming: Covid-19 restriction-related changes in use (percentage)

Country	Stopped using			Started using			Decreased			Increased			No change		
	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls
Egypt	10.4	9.4	12.5	10.1	9.4	11.8	21.0	19.2	25.2	36.7	40.7	27.6	21.8	21.3	22.8
Morocco	13.1	15.1	10.6	8.9	7.1	11.3	29.8	29.0	30.9	28.8	32.1	24.5	19.3	16.8	22.6
Tunisia	6.3	5.1	7.5	10.1	5.0	15.7	17.6	13.3	22.2	38.5	50.1	25.9	27.5	26.5	28.6
Southern MedSPAD average	9.4	8.9	10.1	10.0	7.9	13.4	21.1	18.8	24.8	36.3	42.2	26.5	23.3	22.2	25.2

Changes in online and offline gambling

The southern MedSPAD average for those starting to gamble offline was 11.2%, against 22.5% of students who stopped gambling (Table 5.2.3). Morocco reported the highest percentage (34.8%) of those who had stopped gambling, followed by Tunisia (32.7%) and Egypt (18.5%). On average, 13.3% of students gambled less frequently, while 11.9% increased their gambling. On both these counts, Tunisia registered the highest percentage.

A noticeable gender difference was observed in Tunisia, where 13.9% of female students started gambling compared to 8.8% of male students. This percentage was higher among girls than boys in Egypt, too, but the gender difference was less marked (11.2% of boys v. 12.2% of girls). In general, 41.1% of students did not change their habits.

Table 5.2.3. Gambling offline: Covid-19 restriction-related changes in use (percentage)

Country	Stopped using			Started using			Decreased			Increased			No change		
	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls
Egypt	18.5	20.1	15.1	11.5	11.2	12.2	12.7	11.7	14.7	11.3	11.0	11.8	46.0	45.9	46.2
Morocco	34.8	38.3	27.6	10.1	11.7	6.9	14.6	18.3	6.9	6.7	8.3	3.4	33.7	23.3	55.2
Tunisia	32.7	41.0	15.1	10.4	8.8	13.9	15.0	12.4	20.7	16.3	16.8	15.3	25.5	21.0	35.0
Southern MedSPAD average	22.5	25.6	16.0	11.2	10.8	12.1	13.3	12.4	15.2	11.9	12.0	11.8	41.1	39.3	44.8

On average, 11.4% of southern MedSPAD students began engaging in online gambling during the period of Covid-19 restrictions (Table 5.2.4). The highest percentage was registered in Egypt (12.6%), followed by Morocco (10.8%) and Tunisia (6%). A slight gender difference was registered in Egypt, where girls were more likely to start gambling (13% for girls v. 12.4% for boys). On average, 14% of students in southern MedSPAD countries gambled more frequently, with Egypt registering the highest percentage (15.4%). As shown in Table 5.2.4, 17.9% of girls in Egypt increased gambling compared to 14.2% of boys. In Tunisia, the percentage of students who gambled more frequently was higher among female students than male students (10.3% for boys v. 17.4% for girls). On average, 38.9% of students reported no changes in their gambling habits.

Table 5.2.4. Gambling online: Covid-19 restriction-related changes in use (percentage)

Country	Stopped gambling			Started gambling			Gambled less frequently			Gambled more frequently			No change		
	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls
Egypt	18.7	19.3	17.3	12.6	12.4	13.0	11.6	11.8	11.1	15.4	14.2	17.9	41.8	42.3	40.7
Morocco	33.3	40.3	20.9	10.8	11.7	9.3	19.2	19.5	18.6	5.8	6.5	4.7	30.8	22.1	46.5
Tunisia	33.9	41.7	17.2	6.0	6.9	3.9	17.6	19.0	14.5	12.6	10.3	17.4	30.0	22.0	47.0
Southern MedSPAD average	22.4	24.7	17.6	11.4	11.5	11.3	13.2	13.6	12.4	14.0	12.9	16.5	38.9	37.3	42.3

Chapter 6

Methodology

MedSPAD is a research project initiated in 2003 by the Pompidou Group of the Council of Europe. It is composed of experts nominated by the MedNET committee (MedSPAD members) and aims to, firstly, conduct a school survey within MedSPAD countries based on the MedSPAD methodology, and secondly, share results with other countries. The outcome should be a high quality Mediterranean school survey report on substance use and related behaviours that is comparable with other school surveys.

So far, several MedSPAD surveys have been conducted in different countries based on similar questionnaires and methodologies. The results have been collected in three regional reports (2015, 2017 and 2019).

The primary objective of MedSPAD is to share experiences between countries conducting a MedSPAD survey, those who may wish to do so, and countries already conducting the ESPAD survey. The ambitious long-term objective is to arrive at a common methodology, a goal that MedSPAD countries have been working intensively towards over the past years, in order to produce an evidence-based regional report drawing on a database containing the data of all participating countries.

To this end, despite the difficulties stemming from the Covid-19 pandemic and associated restrictions on mobility and school activity, three countries succeeded in the period 2020-2021 in conducting the MedSPAD survey using, for the first time, a common questionnaire. Egypt conducted the survey in 2020 and Morocco and Tunisia in 2021. The resulting data have been collected and treated centrally to produce a common database. The results presented in this fourth regional report also integrate information from MedSPAD countries that in 2019 conducted the ESPAD survey (Croatia, Cyprus, France, Greece, Italy, Malta, Portugal and Spain). To this end, the data collected through the MedSPAD surveys have been merged with ESPAD data to produce a joint analysis.

Therefore, the results presented in this report are based on data from 11 countries: Croatia, Cyprus, France, Greece, Italy, Malta, Portugal and Spain (termed the northern MedSPAD countries for ease of reference), which carried out the 2019 ESPAD survey, and Egypt, Morocco and Tunisia (termed the southern MedSPAD countries), which carried out the MedSPAD survey in 2020-2021.

Due to the novelty of this experience and the complexity inherent in this ambitious project, and taking account of the work that still needs to be done and of the different survey years, the results of the countries conducting the MedSPAD and ESPAD surveys are presented separately.

6.1. Sample

Following the ESPAD methodology, the target population of the MedSPAD survey included in this report was defined as students who had reached the age of 16 in the calendar year of the survey and who were present in the classroom on the day of the survey. Students enrolled in regular, vocational, general or academic studies were included; those who were enrolled in either special schools or special classes for students with learning disorders or severe physical disabilities were excluded. Table 6.1.1 presents the main sample characteristics. The methods used are largely comparable across all countries, although the time of data collection varies between the ESPAD and MedSPAD surveys and some characteristics, such as sample type or mode of administration, may differ in a limited number of countries.

Table 6.1.1. Sampling characteristics

Country	Survey Name	Survey Year	Target Population birth year	Geographical coverage	Data collection mode	Sample type	Sampling unit(s)	Data weighted	Weight type	Student representativeness (%) (a)	Class participation rate (%) (b)	Student participation rate (%) (c)	no. of records
Croatia	ESPAD	2019	2003	National	Paper and pencil	Stratified random	Class	No	-	98	94	90	2772
Cyprus	ESPAD	2019	2003	National(d)	Paper and pencil	Multistage random	School	Yes	Geographical area and school type	100	75	94	1224
France	ESPAD	2018	2002	National(e)	Web based	Multistage stratified random	Class	No	-	97	100	100	2588
Greece	ESPAD	2019	2003	National	Paper and pencil	Stratified clustered random	Class	Yes	Geographical area	92	89	87	5988
Italy	ESPAD	2019	2003	National	Web based and paper and pencil	Multistage stratified random	Class	No	-	99	89	83	2542
Malta	ESPAD	2019	2003	National	Paper and pencil	Total	No sample	No	-	95	99	78	3043
Portugal	ESPAD	2019	2003	National	Paper and pencil	Stratified random	Class	No	-	100	94	92	4365
Spain	ESPAD	2019	2003	National	Paper and pencil	Multistage stratified random	Class	No	-	100	90	90	3557
Northern MedSPAD average or sum	ESPAD									98	91	89	26079
Egypt	MedSPAD	2020	2004	National(e)	Web based and paper and pencil	Multistage stratified random	Class	No	-	81	99	91	4519
Morocco	MedSPAD	2021	2005	National	Paper and pencil	Stratified random	Class	No	-	92	99	86	1163
Tunisia	MedSPAD	2021	2005	National	Paper and pencil	Clustered multistage stratified random	Class	Yes	Geographical area and school type	90	-	89	2364
Southern MedSPAD average or sum	MedSPAD									88	99	89	8046

(a) Proportion of ESPAD and MedSPAD target students covered by the sampling frame
(b) Proportion of selected classes participating in the survey
(c) Proportion of students of participating classes answering the questionnaire
(d) Only government-controlled areas were covered by the sampling frame
(e) North Sinai Governorate was excluded

The study was carried out on a representative sample of the target population in all participating countries. Data were collected through self-administered questionnaires. All countries used a paper-and-pencil questionnaire except for France, where students answered a web-based questionnaire, and Egypt and Italy, where a mixed administration mode (paper-and-pencil and web based) was employed. Students answered the questionnaires anonymously in the classroom, with teachers or research assistants functioning as survey leaders.

In the majority of ESPAD countries, data collection took place between March and May 2019, with the exception of France, where data collection took place from April to June 2018. In Egypt, data collection took place in December 2020 (student birth cohort of 2004), in Tunisia from April to June 2021 and in Morocco in December 2021 (student birth cohort 2005). In most countries, school classes were the last unit in a multistage stratified random sampling process.

In total, data were collected from 34 115 students in 11 countries: 26 069 students in the countries conducting the ESPAD survey and 8 046 in the countries conducting the MedSPAD survey. Sample sizes ranged from 1 214 in Cyprus to 5 988 in Greece. All samples had national geographical coverage, except for those from Cyprus (only government-controlled areas were included) and Egypt (the North Sinai Governorate was not included). The class participation rate (share of selected classes participating) was generally high: it was 91% on average in northern MedSPAD countries, ranging from 75% in Cyprus to 100% in France, and 99 % on average in both Egypt and Morocco. The proportion of students in the selected classes who were present on the day of the survey and who answered the questionnaire was high both in the northern and in the southern MedSPAD area (89% on average). The student representativeness was very high across the MedSPAD area, with all countries except Egypt reaching 90% or more. The lowest rates were reported in Egypt (81%) and the highest in Cyprus, Portugal and Spain (100%).

Data were weighted in three countries to adjust the sample to the socio-demographic composition of the target population. Details about the weighting applied to the samples of the countries of the northern MedSPAD area are reported in the 2019 ESPAD report (The ESPAD Group 2020). Among the countries of the southern MedSPAD area, sample weights were applied to the sample of Tunisia to account for the geographical distribution of the target population and the type and size of schools.

6.2. MedSPAD questionnaire

Design

In the previous waves of the MedSPAD survey, each country used its own questionnaire and this challenged the comparability of results. To run the MedSPAD survey in 2020-2021, for the first time a new common MedSPAD questionnaire was elaborated by the Italian National Research Council in consultation with the MedSPAD Committee. The MedSPAD questionnaire shares common questions not only with the countries who performed the data collection in 2020-2021, but also with the 2019 ESPAD questionnaire.

The first aim of the MedSPAD questionnaire was to investigate young people's awareness of and experience with different psychoactive substances. New topics were added, such as NPS, gambling, gaming and social media use, as well as new screening tests for problem behaviours related to cannabis use, gambling, gaming and social media use. The new questionnaire was elaborated with the long-term objective of reaching a sufficient level of comparability not only among the countries running the MedSPAD survey, but also with countries running the ESPAD survey.

Topics

In the 2020-2021 MedSPAD questionnaire, the following topics were investigated:

- tobacco and nicotine-based products: patterns of use of cigarettes, electronic cigarettes, water pipes and chewing tobacco;
- alcohol: the consumption of different alcoholic beverages (beer, wine, premixed drinks, spirits, etc.), as well as specific drinking patterns such as binge drinking (five or more drinks on a single occasion) and alcohol intoxication;
- tranquillisers, sedatives and painkillers used for non-medical purposes without a doctor's prescription;
- cannabis and other psychoactive substances: the use of cannabis, cocaine, ecstasy, heroin and inhalants; the use of amphetamines, anabolic steroids, crack, GHB (gamma hydroxybutyrate), hallucinogens (LSD, magic mushrooms, etc.), methamphetamines and NPS;
- social media use, gaming and gambling (both offline and online).

Indicators

The questionnaire modules were designed to collect uniform information across the topics covered. The following indicators were included: age of first substance use; patterns of substance use and engagement in risk behaviours; high-risk use; perceived availability of substances; presence of family members and friends who use substances; risk perception; changes in habits due to the Covid-19 pandemic.

6.3. Creation of the southern MedSPAD dataset

The national datasets from southern MedSPAD countries were centrally collected and validated using standardised procedures adapted from ESPAD in order to maximise the comparability of results. The validation of datasets included verification of data quality and data cleaning. For verification, possible inconsistencies were detected (values out of range, missing variables, incorrect coding, etc.) and relevant actions to be applied to the data were shared with the national teams.

For data cleaning, first, all missing values were examined and the possibility of recoding them was assessed. The logical substitution of missing values was performed in a rather conservative way. In cases where students indicated that they had never used a specific substance and did not respond to other questions about such use, any missing values were substituted with no use for that particular substance. However, no substitutions were made if any contradictory indications of use were reported. Second, records to be excluded from the subsequent analyses were identified in agreement with the national teams and deleted. This included those missing information on gender or birth year, and those with poor data quality: all cases with responses to less than half of the core items were discarded, as were all cases where the respondent appeared to have followed patterns involving repetitive marking of extreme values. Cases labelled as invalid by the national teams due to poor data quality were also excluded. Finally, those countries that used sampling weights were asked to recalculate them on the final sample.

After the completion of all these processes, the southern MedSPAD datasets were merged. The last step included the extraction from the merged dataset of records corresponding to the MedSPAD target population, namely all students who reached the age of 16 in the calendar year of the survey.

6.4. Creation of the northern MedSPAD dataset

The datasets of the northern MedSPAD countries that participated in the 2019 ESPAD survey were extracted from the 2019 ESPAD dataset to form the northern MedSPAD dataset. ESPAD 2019 variables were included at this stage, and no selection, transformation or recoding was applied.

6.5. Development of the international MedSPAD dataset

The southern and northern MedSPAD datasets were merged with the support of a data schema developed for the purpose. This document is an exhaustive collection of all the questions/variables that belong to the two datasets to be merged. On this basis, a harmonisation process was performed to identify the largest number of comparable variables from the MedSPAD and ESPAD surveys. The comparability of each variable was assessed on a three-level scale of matching quality: "complete", "partial" or "impossible". This procedure identified the variables that could be combined and provided indications on any transformation or recoding necessary for the data analysis.

6.6. Statistical analysis

The purpose of this report was to describe southern MedSPAD results and where possible include those from northern MedSPAD countries in order to compare them. For this purpose, a complex statistical analysis plan was developed drawing on the one created for the 2019 ESPAD study to guarantee that the results produced for northern MedSPAD countries were comparable to those published in the 2019 ESPAD report, and that the results for the southern MedSPAD countries were produced with the same algorithms used for ESPAD.

The main indicators presented in this report were calculated as follows.

Availability of substances

Students were asked how difficult they thought it would be to obtain a particular substance if they wanted to. In the MedSPAD questionnaire, the response categories were "impossible", "difficult", "easy" and "don't know". In the ESPAD questionnaire the response categories were "impossible", "very difficult", "fairly difficult", "fairly easy", "very easy" and "don't know". The responses "fairly easy" and "very easy" were merged to indicate perceived easy availability in the case of northern MedSPAD countries, while in the case of southern MedSPAD countries the response "easy" was used.

The availability of each type of alcoholic beverage (beer, premixed drinks, wine and spirits) was investigated separately. If considered relevant, countries included other alcoholic beverages as optional questions in the questionnaire. Alcohol was considered to be available if at least one of each five types of beverage was marked as "easy" to obtain.

Age at first use of substance

Students were asked how old they were when they used a particular substance for the first time, started to use it on a daily basis (cigarettes, e-cigarettes, water pipes and chewing tobacco) and consumed it excessively (alcohol intoxication), where applicable. The response categories ranged from "9 years old or less" to "16 years or older", in increments of 1 year, and included the category "never". First use at 13 years or younger was defined as an indicator of early onset.

Use in lifetime, past 12 months and past 30 days

Students were asked how many times they had consumed a particular substance or engaged in a specific risk behaviour in their lifetime, in the past 12 months and in the past 30 days. The response categories were "0", "1-2", "3-5", "6-9", "10-19", "20-39" and "40 or more". The prevalence of any use (lifetime, past 12 months and past 30 days) and prevalence of intoxication were also calculated.

In the case of gambling, gambling activity was assessed by asking students how often in the past 12 months they had engaged in four different gambling activities: playing on slot machines, playing cards or dice for money, playing the lottery, and betting on sports or animal races. In the MedSPAD survey, the question was asked both in relation to offline and online gambling, while in the ESPAD survey this distinction was not made. For each type, the response options were: "I have not gambled", "monthly or less", "2-4 times a month" and "2-3 times or more a week". As response options provide a frequency interval and not exact values, an overall index of gambling activity was created using dichotomising response options (yes/no). Any response other than "I have not played" was coded as "yes" for each of the questions. Then, in the case of the MedSPAD survey, any "yes" for each of the four online and offline types was coded as "yes" for online/offline gambling. Lastly, overall prevalence was defined as any "yes" for either online or offline gambling. Therefore, as in the 2019 ESPAD report, in this report gambling prevalence was calculated as the rate of those who had gambled for money on at least one of the four games of chance (playing on slot machines, playing cards or dice for money, playing the lottery, betting on sports or animal races) either offline or online in the past 12 months. Caution must be used when comparing the results of the MedSPAD and ESPAD surveys here as, in the latter, gambling activity was surveyed only in relation to the offline mode.

Risk perception on substance use

Students were asked for their opinion on the possible risks associated with substance use. In the MedSPAD questionnaire, the response categories were "no risk", "slight risk", "moderate risk", "great risk" and "don't know". In the ESPAD questionnaire, the response categories were "no risk", "slight risk", "moderate risk", "great risk" and "don't know". The response "great risk" was defined as an indicator of perceived risk.

High-risk cannabis use

The CAST was used to screen for possible cannabis-related problems (Legleye et al. 2007, 2011). The six items of the CAST are worded as follows: (1) "Have you smoked cannabis before midday?"; (2) "Have you smoked cannabis when you were alone?"; (3) "Have you had memory problems when you smoke cannabis?"; (4) "Have friends or members of your family told you that you ought to reduce your cannabis use?"; (5) "Have you tried to reduce or

stop your cannabis use without succeeding?"; and (6) "Have you had problems because of your use of cannabis (arguments, fights, accidents, bad results at school, etc.)?" All of these questions refer to the past 12 months. The response categories for the CAST are "never", "rarely", "from time to time", "fairly often" and "very often". The possible scores for each item are 0 or 1, with the threshold for scoring 1 point being "from time to time" for the first two items and "rarely" for the remaining items (which refer to more serious problems). A total score of 2 or more points (range 0-6) is considered to indicate high-risk use. This cut-off score has been shown to best distinguish individuals at high risk of cannabis-related problems from individuals at low risk of such problems in community samples (Legleye et al. 2007, 2011). It should be noted that there is an ongoing debate about the validity of screening tests, including the CAST. With regard to the CAST specifically, over time, different coding systems and cut-off scores have been validated on representative samples (Bastiani et al. 2013; Legleye et al. 2007, 2011, 2013, 2017) and there is no definitive agreement about the best system or scores to use. Clearly, different computation methods will generate different prevalence results.

In this report, we adopted a binary computation of scores with a cut-off of 2 or more points used to indicate "high-risk use", which has been proposed in adolescent samples (Gyepesi et al. 2014; Legleye et al. 2011) and that allows comparability with the CAST results published in the 2019 ESPAD report (ESPAD Group 2020).

When used in the context of self-reported surveys, the CAST may allow the early identification of adolescents who are liable to present with problem cannabis use or dependence. It should be noted, however, that this test is a screening tool – it can be used to make comparisons and perform epidemiological analyses, but cannot provide a clinical diagnosis.

This report provides prevalence estimates of high-risk users in the total sample based on the CAST instrument. The additional tables available provide three statistics: estimates of the proportion of high-risk users among those students who answered positively to the introductory question of the CAST (i.e. claimed to have used cannabis in the year prior to the survey); the frequency of responses for each of the six CAST items among 12-month users; and the CAST item averages presented separately for each country using a continuous five-point scale from 1, "never", to 5, "very often".

Problem gambling

In the MedSPAD questionnaire, two specific screening tools were used to assess the presence of possible problem gambling behaviour: the SOGS-RA and the Lie/Bet questionnaires. In the ESPAD survey, only the Lie/Bet questionnaire was used.

The SOGS-RA scale consists of 12 items, and each is scored either 1 (affirmative) or 0 (non-affirmative). The first item ("How often have you gone back another day to try and win back money you lost gambling?") is scored 1 if the respondent indicates "every time" or "most of the time" and is scored 0 otherwise. Although there are some variations between studies in the interpretation of scores, generally a score of 4 or greater is considered to indicate "problem gambling", a score between 2-3 is "at-risk gambling", and a score of 0-1 is "no problem" (Poulin 2002; Winters, Stinchfield and Fulkerson 1993).

The Lie/Bet Questionnaire (Johnson et al. 1997), a two-question screening tool, was used to assess the proportion of gamblers with problem gambling behaviour. The two questions used in the tool are "Have you ever lied to family and friends about how much money you have spent on gambling?" and "Have you ever felt that you needed to gamble for more and more money?"; both questions have the response categories "yes" = 1 and "no" = 0 and the Lie/Bet sum score therefore ranges from 0 to 2. A score of 2 points was considered to indicate problem gambling.

Self-perceived problems with social media use and gaming

A specific screening tool (Holstein et al. 2014) was adapted to assess for the presence of self-perceived problems related to two distinct behaviours: social media use and gaming. This tool is a non-clinical instrument focusing on a student's perception of problems related to three items: too much time spent on these activities, bad feelings because of restricted access, and parents' concerns related to the time spent on these activities. Students were asked to what extent they agreed with the above three statements, with the response categories being "strongly agree", "partly agree", "neither agree nor disagree", "partly disagree" and "strongly disagree". Positive answers ("strongly agree" and "partly agree") were summed to produce an index score. An index score of 0-1 points was considered to indicate a low level of self-perceived problems, and a score of 2-3 points was considered to indicate a high level of self-perceived problems related to social media use and gaming.

6.7. Results tables and figures

Prevalence estimates and means were calculated for each participating country, taking sample weights into account for the countries that used them. In the majority of tables presented in this report, totals and gender-specific estimates for boys and girls are presented by country. As noted, in each table the results of the countries conducting the MedSPAD and ESPAD surveys are presented separately. Two averages are also presented with an equal weight assigned to each country: a northern MedSPAD average that is based on the ESPAD countries (Croatia, Cyprus, France, Greece, Italy, Malta, Portugal and Spain) and a southern MedSPAD average that is based on southern MedSPAD countries (Egypt, Morocco and Tunisia). All percentages in the report were calculated on the basis of valid responses and are shown for the total samples, and in separate tables for boys and girls. All estimates are based on the total sample and represent population estimates.

Concluding remarks

Mediterranean countries are heterogeneous not only in terms of socio-demographic and cultural aspects, but also in the different dimensions of the drug phenomenon and the level of implementation of effective instruments to monitor and tackle this problem.

The MedSPAD project was set up, designed and funded by the Pompidou Group of the Council of Europe. It was created to evaluate the problem of drug use among young people and provide countries in the Mediterranean region the opportunity to mutually learn from their experiences and draft appropriate recommendations for evidence-based prevention policies.

The efforts made over recent years have been aimed at building capacity and developing effective tools for monitoring youth substance use and risk behaviours in countries of the southern Mediterranean region, including Egypt, Morocco and Tunisia, where no such information had been collected before. This has been, and will continue to be, done through close co-operation with neighbouring countries of the northern rim of the Mediterranean, which have been participating in the ESPAD project for several years and which have relevant expertise in monitoring substance use.

The objective is to reach a sufficient level of comparability not only among the countries running the MedSPAD survey, but also with countries performing the ESPAD survey.

To this end, and in contrast to the previous waves of the MedSPAD survey where each country used its own methodology resulting in a limited level of comparability of results, the MedSPAD survey 2020-2022 used for the first time a new common MedSPAD questionnaire and harmonised methodology. The MedSPAD questionnaire consists of questions that are common to not only the three countries that carried out the data collection from 2020 to 2022, but also to the 2019 ESPAD questionnaire.

This has allowed the fourth MedSPAD regional report to provide a detailed presentation of young people's awareness of and experience with different psychoactive substances. Furthermore, new topics have been investigated, such as NPS, gambling, gaming and social media use, as well as new screening tests for problem behaviour related to cannabis use, gambling, gaming and social media use.

From a public health perspective, youth substance use needs to be handled as a community and social issue, addressing the individual, environmental and socio-economic determinants. In this light, and taking into consideration the very different demographic, socio-economic and cultural context of the countries included in MedSPAD, this report provides a wide range of information pertaining to these aspects in order to better contextualise and interpret the MedSPAD results. Furthermore, very detailed first-hand, comparative information concerning the national alcohol, tobacco, drug and gambling policies in the MedSPAD region is presented thanks to the efforts of the members of the MedSPAD Committee. This is not an easy task because very often this information is not publicly available or is recorded differently in the various countries.

The results presented in this report show very interesting and different patterns of substance use and risk behaviours. These will provide important implications for future treatment and prevention strategies in the area, increasing the capacity to forecast and tackle emerging phenomena in the Mediterranean region.

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To be found on PG MedNET website: www.coe.int/en/web/pompidou/mednet/MedSPAD.

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Then, in a fresh analysis, this book presents new data from 11 Mediterranean countries on school-age youths' interactions with selected substances and behaviours. It features an examination of early-onset behaviours, perceived substance availability and the prevalence of alcohol, tobacco, high-risk cannabis and other drug use, along with – as a newly added highlight of the survey methodology developed for this study – gambling, gaming and social media habits.

Conducting the survey itself constituted an innovative step in the collection of these data, requiring training of local personnel to implement valid and reliable survey methods in schools and further analysis. This is the first time such a dataset from different countries has been compiled and analysed in this way, providing unprecedented insight into the drugs and addiction situation among youths at a regional scale.

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