Principles of drug education for schools

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NSW GOVERNMENT

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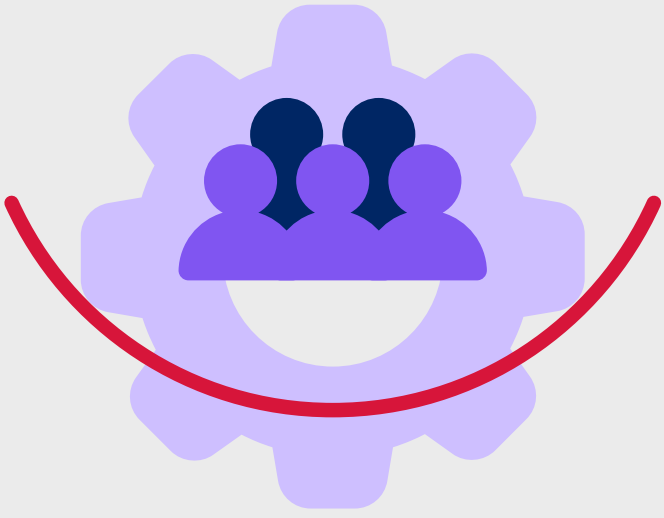
Introduction

Drug education matters

Every day, young Australians navigate a world where decisions about legal and illegal drugs are a part of life. Alcohol remains the most commonly used drug among young people and is a major contributor to harm in Australia, with nearly 60% of secondary school students reporting alcohol use before age 16. Many will also encounter smoking or vaping, and around one in six will experiment with an illicit drug during adolescence, most commonly cannabis.[1]

In this context, alcohol and other drug education is not optional, but rather a core component of the school curriculum. When delivered well, it equips students with the skills, confidence and judgement needed to make safer, more informed decisions. It strengthens resilience, supports wellbeing and contributes to healthier futures for young people and their communities.



About the Principles

The ‘Principles of drug education for schools’ (the Principles) provide a practical, evidence-informed framework to guide Australian schools in delivering effective alcohol and other drug education. Grounded in Australia’s harm-minimisation approach of demand reduction, supply reduction and harm reduction, and aligned with international best practice, the Principles reflect what works in real classrooms across diverse communities and settings.

The updated Principles build on earlier work. First established in 1994 and last updated in 2004, the ‘National Principles for School Drug Education’ were designed to strengthen consistent, high-quality education across the country.[2,3] In 2024, Turning Point and Monash University were commissioned by the NSW Government to lead a national review, ensuring the Principles reflect contemporary evidence, respond to emerging challenges and remain grounded in the realities of Australian schools.

Developed through extensive national consultation with young people, teachers, school leaders, researchers, health professionals and community stakeholders, the revised Principles are closely aligned with Australian education contexts and curricula. Each of the 5 principles is evidence-based, practical and actionable. Together, they support consistent, inclusive and responsive drug education that promotes wellbeing and aligns with whole-school and community priorities.

The Principles can be embedded in classroom teaching, integrated within wellbeing initiatives or implemented through whole-school strategies.

Why the Principles are needed

Misconceptions about how to deliver drug education remain widespread. Approaches that rely on one-off sessions, scare tactics or simplistic messaging ignore the complexity of young people’s experiences and often fail to influence behaviour. Such methods can inadvertently increase curiosity, reinforce myths, undermine credibility or escalate risk taking.

The updated Principles directly address these challenges. They provide teachers, schools and parents with a clear, evidence-based guide that shifts practice towards approaches that are student-centred, relevant, effective and impactful. The accompanying implementation guide offers practical tools to support the translation of the Principles at classroom, leadership and community levels.

The purpose of drug education

Drug education provides structured learning experiences that build students’ knowledge, skills and confidence to make safer decisions about alcohol and other drugs. It helps young people understand the different ways they may encounter alcohol or other drugs, whether through peers, families, communities or online, and how to respond safely, ethically and thoughtfully.

Drug education addresses both illegal and legal substances, including alcohol, tobacco, prescription medications and over-the-counter products. It also creates space to explore broader public issues such as:

- regulation
- harm reduction and policy debates
- supporting students to engage critically and confidently with complex topics.

Effective drug education must also address current and emerging substances and trends. Its goals extend beyond raising awareness. It strengthens health literacy, builds emotional and social skills, and provides practical strategies to support students’ wellbeing. When done well, drug education supports resilience, promotes mental health and wellbeing and contributes to safer school communities.

Building lifelong skills

Drug education plays a vital role in developing young people's health literacy. This includes the ability to find, understand, critically evaluate and use health information in real-life situations. Students learn to:

- navigate health services
- analyse online content
- seek help when neededparticipate actively in decisions affecting their own and others' wellbeing.

Drug education in schools aims to:

1. **build health literacy.** Students evaluate information, understand short- and long-term effects and identify credible sources of help, skills that underpin lifelong decision-making.
2. **reduce harm.** Evidence-informed approaches can prevent or delay the onset of drug use, reduce risk and strengthen protective factors such as:
   - emotional regulation
   - social connectedness
   - the confidence to make informed choices, set boundaries and seek help when needed.
3. **improve life outcomes.** Preventing, delaying or reducing substance use is associated with better educational engagement, improved mental health and stronger long-term social and economic wellbeing. Drug education supports both individual development and broader community resilience.

Embedding drug education across the learning environment

Drug education is most effective when delivered through a coordinated, whole-school approach by aligning:

- curriculum content and delivery
- wellbeing initiatives
- staff capabilities
- parent engagement
- community partnerships
- consistent school policies

This creates a safe and inclusive environment that supports prevention and promotes wellbeing.

A whole-school approach includes:

- integrating developmentally appropriate and evidence-based approaches across year levels
- creating safe, inclusive school environments grounded in trust and respect
- providing professional learning and high-quality teaching resources
- engaging with parents, families and carers in open, informed conversations
- connecting with local health and community services
- offering stigma-free, non-judgemental supports for students affected by drug use
- ensuring school policies reflect the health-promoting values taught in the curriculum, including policies regarding the availability or promotion of alcohol at school events involving parents, staff or external visitors

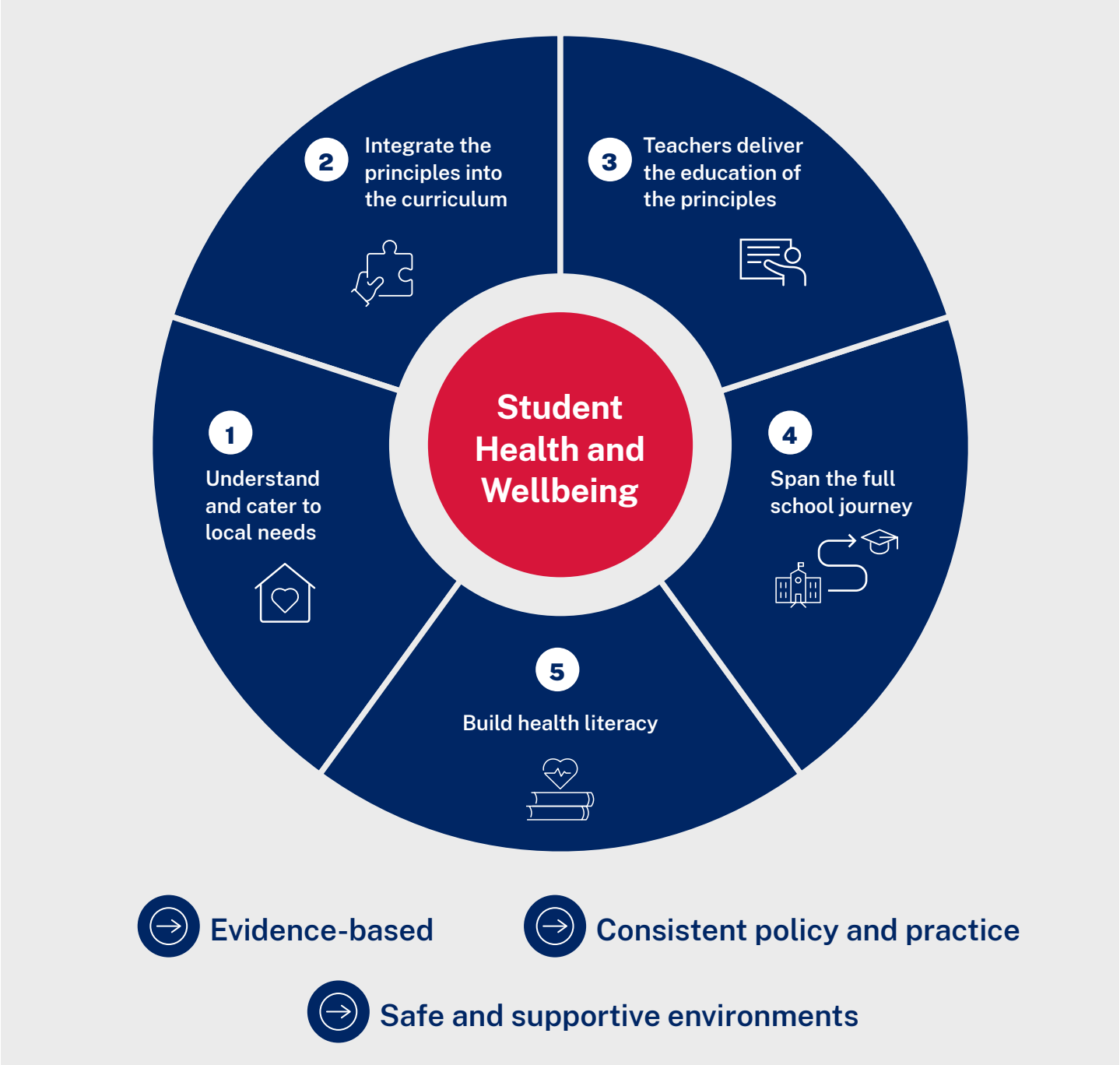
Families play a central role. When parents and carers are engaged through accessible resources, open communication and school-based activities, prevention messages are reinforced at home and drug education becomes more consistent and impactful.

At the core of effective practice is a coherent, well-structured curriculum plan: a series of developmentally appropriate lessons and experiences delivered consistently across the school years. These may be embedded in key learning area programs, including health education classes, within wellbeing programs or taught separately.

Drug education is most effectively delivered by teachers and strengthened through contributions from external specialists. High-quality approaches are inclusive and culturally responsive, building on learning over time to enhance health literacy and support long-term wellbeing.

A whole-school approach ensures learning is reinforced across different contexts and relationships. It considers not only classroom teaching but also how schools model wellbeing, engage families and reflect health-promoting values in everyday practice. This alignment of policy, practice and pedagogy ensures drug education is relevant, respectful and tailored to the social and cultural context of each school.

The 5 principles of effective drug education



The graphic above illustrates the 5 key principles of effective drug education, all centred around student health and wellbeing:

- understand and cater to local needs
- integrate the principles into the curriculum
- teachers deliver the education of the principles
- span the full school journey
- build health literacy.

These principles are underpinned by 3 core enablers: a clear evidence base, consistent policy and practice, and safe and supportive environments. Together, they reflect the foundations of quality teaching and align with the state education wellbeing frameworks and initiatives.

Principle 1

Understand your school community and deliver evidence-based approaches that meet local needs

Effective drug education begins with understanding your school's unique context

Every school has its own social, cultural and economic setting, and drug education should be tailored to reflect the strengths, needs and priorities of that community.[4–6] Listening to your school community provides valuable insights, while publicly available data can deepen the understanding of local alcohol and drug use patterns and related issues.

A strengths-based approach values ongoing dialogue with students, teachers, families, health workers and community leaders.[7] These conversations help schools:

- identify shared goals
- respond to emerging challenges, including evolving drug trends[8,9]
- ensure that approaches are inclusive, culturally responsive and grounded in community priorities.[10]

Drug education is a long-term effort built on trust

Drug education is not a one-off lesson or isolated activity. It is a shared, long-term responsibility built on collaboration, mutual trust and a collective commitment to student wellbeing.[11,12] Curriculum planning and resource selection should begin with a clear understanding of what matters most to the school community.[6,13]

Select quality, evidence-informed resources

Choose well-tested, developmentally appropriate resources to ensure drug education is both safe and impactful.[14] Schools should select evidence-based materials that align with the needs, values and aspirations of their students.[13,15-17] Interventions without rigorous evaluation should be used cautiously, as poorly designed approaches may be ineffective or unintentionally harmful.[18,19] Avoid scare tactics, moralistic messages or anecdotal approaches.[20] Research shows these strategies are ineffective for learning or lasting behavioural change, and can increase experimentation or risky behaviour.[15,21]

Deliver high-quality education that builds students' capability

High-quality drug education is developmentally appropriate, delivered by trained teachers and integrated within a whole-school approach to wellbeing. It goes beyond teaching about the harms of alcohol and other drugs. It actively builds students' health literacy and equips them with the skills to make healthy, informed and safer choices.[22] This includes fostering capabilities that support students to navigate complex situations within and beyond the classroom:[23]

- social and emotional awareness
- interpersonal skills
- critical thinking
- personal development.

Ensure drug education is inclusive and culturally responsive

Schools should prioritise approaches that reflect the diversity of their student population.[24] This includes accounting for socio-economic, cultural and linguistic backgrounds,[12,25] and ensuring that priority populations can access drug education in ways that meet their needs. Drug education should:

- use accessible language
- be adaptable to different settings
- foster an environment where all students feel seen, respected and valued.[26]

For Aboriginal and /or Torres Strait Islander communities, this means recognising Country, kinship, community, cultural continuity and self-determination. Approaches should be grounded in Aboriginal and/or Torres Strait Islander ways of knowing, being and doing, and be aligned with the NSW Social and Emotional Wellbeing (SEWB) framework.

For culturally and linguistically diverse (CALD) communities, this may include providing materials in multiple languages, particularly to support family engagement, and ensuring content is culturally relevant and appropriate.

Principle 2

Adapt the school curriculum and incorporate identified evidence-based resources

Embed drug and alcohol education across the curriculum

Drug education is most effective when delivered as part of a school's broader approach to wellbeing and learning rather than as a standalone topic or in response to isolated incidents.[27,28] One-off events or ad hoc presentations are unlikely to produce a lasting impact.[26] A coordinated, whole-school approach, where learning is integrated across subjects and underpinned by a shared commitment to student wellbeing, supports meaningful, sustained outcomes.[29]

Ensure strong coordination across year levels

Teachers and school staff should work together to set shared goals, agree on clear learning outcomes and develop a consistent understanding of effective practice when planning curriculum, teaching and learning sequences.[30] This collaboration ensures key messages are developmentally appropriate, build progressively over time and are reinforced across learning areas and year levels.[5] It also ensures that values, such as respect, inclusion, self-awareness and personal responsibility, are reflected in the way students are taught and supported across the whole school.[31]

Lay strong foundations by beginning early

The early years provide an opportunity to develop the social and emotional capabilities that underpin healthy decision-making later in life.[22,26] Teaching children to recognise and manage emotions, resolve conflicts constructively and stay safe around medications builds skills that support self-regulation, resilience and interpersonal competence. Focusing on early childhood and developmental prevention equips children with the resources they need to navigate risk and make responsible choices as they grow.[32]

Foster connection, safety and positive behaviours

A strengths-based, whole-school approach requires creating environments that promote belonging, safety and positive behaviour. Except when there is an immediate and serious risk of harm, students found in possession of alcohol or other drugs should not be automatically suspended. High-risk students should also not be isolated or grouped separately, as this can increase stigma, reinforce negative peer influence and escalate risky behaviours.[33]

Instead, these students benefit most from support within the broader school community through individualised interventions, trusted relationships and targeted mentoring.[17] Punitive or surveillance-based strategies, including random drug testing or entrapment-style tactics, can undermine trust, damage relationships and discourage students from seeking help when they most need it.[34] Effective drug education prioritises creating safe, respectful spaces where students can engage in open dialogue, explore challenges and develop the skills to make informed, thoughtful decisions.[6,27]

Principle 3

Empower teachers to lead drug education

Teachers are best placed to lead effective drug education

Drug education is most impactful when delivered by people students know and trust (such as teachers, school counsellors and trained peer leaders), who can provide age-appropriate guidance within a safe and supportive learning environment.[35,36] Teachers expertise in pedagogy, curriculum design and classroom management positions them uniquely to deliver developmentally appropriate, engaging education that aligns with broader learning and wellbeing goals.[36–38]

Strong, consistent relationships support meaningful learning

Teachers interact with students every day, allowing them to build trusted relationships that support sensitive conversations about alcohol and other drugs.[6,37] Their ongoing presence enables them to scaffold complex health concepts, reinforce key messages over time and adjust teaching to reflect students' diverse needs, backgrounds and lived experiences.[39] This consistency creates a learning environment where students feel safe to ask questions, explore different perspectives and make connections between lessons and their own lives.[6,37]

External contributors should complement, not replace, teacher-led learning

Peer educators, community organisations and other external contributors can enrich drug education by offering specialised perspectives and real-world insights.[17,40] Their impact is greatest when they are thoughtfully integrated into a teacher-led, curriculum-aligned sequence of learning.[17,33] Evidence-based external initiatives with demonstrated relevance to school settings can broaden perspectives and enhance student engagement,[5,14,41] but these contributions should support, not substitute, the central role of the teacher.[5]

Parent programs that actively involve both parents and young people and build practical skills and knowledge can further strengthen drug education by reinforcing key messages beyond the classroom and supporting consistent learning across school and home environments.[42]

Avoid simplistic, moralising or fear-based messages

Drug education must be grounded in an evidence-based understanding of human behaviour.[43] Young people's experiences with alcohol and other drugs are shaped by a complex interplay of commercial, political, economic, social, psychological and biological factors. Effective approaches recognise this complexity and avoid simplistic, moralising or fear-based messages, which research shows are ineffective and can increase risk or stigmatisation.

Instead, high-quality drug education:

- provides accurate, age-appropriate information
- develops critical thinking and emotional literacy
- equips students with practical strategies to manage peer influence, stress and everyday decision-making.[19]

Principle 4

Deliver drug education from Kindergarten through Year 12, building understanding and skills progressively

Drug education is most effective when it follows a sequential, age-appropriate learning pathway

Effective drug education spans the entire school journey from the early years of primary school through to the end of secondary school.[44] It should not be delayed until students are already making decisions about alcohol or other drug use. Learning that is scaffolded, developmentally appropriate and aligned with students' cognitive, emotional and social growth allows key messages to be

- introduced gradually
- reinforced over time
- and built upon in meaningful ways as students mature.[27,45]

Ongoing education recognises that drug use exists on a continuum, and that long-term, consistent learning is essential to reducing drug-related harms.

Early childhood sets the foundation for lifelong decision-making

Early childhood is a critical period for brain development and learning. Drug education in these years should focus on building core social and emotional skills, such as:

- recognising and managing emotions
- resolving conflicts respectfully
- developing patience, self-regulation and simple decision-making skills.[46,47]

These foundational capabilities are linked to healthier choices later in life and act as protective factors that reduce the risk of future harm across a range of health and social outcomes.[48]

In the primary years, build basic health and safety literacy

Primary-aged students should develop an understanding of the safe use and potential risks of over-the-counter and prescription medications, alongside age-appropriate introductions to smoking, vaping and alcohol.[23,36,49]

Early learning should include opportunities for critical inquiry and media literacy, helping children think about health information in simple, meaningful ways. These lessons should avoid fear-based messaging and instead focus on building confidence, curiosity and foundational health knowledge.

In secondary school, broaden learning to reflect emerging challenges

As students transition to secondary school, the curriculum should expand to address a wider range of substances, including:

- ongoing education about alcohol, tobacco and vaping
- the introduction of cannabis, emerging drug trends and illicit drugs.

Learning should continue to build skills such as resilience, refusal and help-seeking strategies, harm reduction approaches and critical thinking skills to support informed and confident decision-making.[27,35]

Drug education should support whole-student wellbeing

At every stage of schooling, drug education should be delivered through a holistic lens that supports the full spectrum of student wellbeing.[50] This includes:

- physical health (understanding risk and safety)
- emotional wellbeing (resilience, self-regulation and self-worth)
- social health (relationships, connection and support networks)
- spiritual health (meaning, purpose and identity)
- health literacy.

Embedding drug education within this broader wellbeing framework helps students understand the relevance of what they learn and apply it confidently to their everyday lives.

Principle 5

Use interactive, engaging methods to build health literacy

Drug education must be engaging, relevant and connected to the everyday lives of young people

Students do not simply absorb information. They actively interpret it while navigating influences from friends, family, various media, including the internet, and broader cultural norms.[41,51] Drug education must therefore extend beyond facts and figures[16,35] and provide opportunities for authentic learning, practical life skills and critical reflection on societal values and choices.[16,52]

The way we talk to young people about alcohol and other drugs matters

A common barrier to effective drug education is the misconception that drinking, smoking, vaping and other drug use are more common than they actually are.[1,53] These perceptions, often driven by peers, media portrayals and social narratives, can normalise substance use.[19]

In reality, while adolescents may be exposed to alcohol or other drugs, most either abstain or use infrequently.[1,53] Normative education that corrects these misperceptions can reduce peer pressure and validate the healthy decisions many students already make. Using credible, locally relevant data and facilitating open discussion about risk, motivation and choice helps students build an accurate understanding of peer behaviour and strengthens confidence in their own decisions.[7]

Behaviour is influenced by far more than knowledge

Emotional states, stress, the need for social belonging and personal and cultural values all shape young people's decisions about alcohol and other drug use.[17,54] Effective drug education acknowledges these complexities and creates space for students to explore real-life pressures and influences, including peer dynamics, loneliness and the role of social media.[54] Highlighting immediate, personally relevant consequences, such as the effects on relationships, school engagement and mental health, helps make risks more tangible and meaningful.[22]

Students learn best through participatory, hands-on experiences

Interactive, participatory teaching methods are central to effective drug education.[35,55] Learning should include:

- role-plays
- group discussions
- media analysis
- peer-led activities
- opportunities for students to locate and evaluate information through critical inquiry.

It should also provide structured practice of key practical skills, such as:

- saying no
- resisting peer influence
- setting boundaries
- seeking help
- making values-aligned choices[35,56,57]

These hands-on experiences build social competence, assertiveness and decision-making skills, all of which enhance resilience and reduce the risk of harm.[7,58] Online and digital learning programs can also play an important role by increasing student engagement and improving the school's capacity to deliver drug education consistently and reliably over time.[59,60]

Media literacy should be a central focus

Young people are exposed to conflicting, highly curated disinformation. This includes glamorised messages about alcohol and other drug use across advertising, entertainment and digital platforms.[17,52] Supporting students to critically analyse the commercial determinants of health, and recognise how messages shape attitudes, norms and behaviour, empowers them to navigate media influence and make safer, more thoughtful choices, even under peer or cultural pressure.[6,23]

Assessment of learning is essential

Teachers should use a range of assessment approaches to monitor student knowledge, skill development and attitudes over time. This helps ensure that key health literacies are being effectively strengthened and that learning is progressing as intended.

References

1. Scully M, Bain E, Koh I, Wakefield M and Durkin S (2023) 'ASSAD 2022–2023: Australian secondary school students' use of tobacco and e-cigarettes' Cancer Council Victoria, accessed 24 February 2026.
2. Ballard R, Gillespie A and Irwin R (1994) *Principles for drug education in schools*, 1st edn, University of Canberra, Canberra.
3. Meyer L and Cahil H (2004) 'Principles of school drug education' Australian Government Department of Education, Science and Training, accessed 24 February 2026.
4. Baum F (2016) *The new public health*, 4th edn, Oxford University Press, Oxford.
5. United Nations Office on Drug and Crime (UNODC) (2018) 'International standards on drug use prevention: second updated edition' UNODC, accessed 24 February 2026.
6. Ponsford R, Melendez-Torres GJ, Miners A, Falconer J and Bonell C (2024) 'Whole-school interventions promoting student commitment to school to prevent substance use and violence, and improve educational attainment: a systematic review', *Public Health Research*, 12(2):1–290, doi: 10.3310/DWTR3299, accessed 24 February 2026.
7. Faggiano F, Minozzi S, Versino E and Buscemi D (2014) 'Universal school-based prevention for illicit drug use', *The Cochrane Database of Systematic Reviews*, 12:CD003020, doi: 10.1002/14651858.CD003020.pub3, accessed 24 February 2026.
8. Tinner L, Palmer JC, Lloyd EC, Caldwell DM, MacArthur GJ, Dias K, Langford R, Redmore J, Wittkop L, Watkins SH, Hickman M and Campbell R (2022) 'Individual-, family- and school-based interventions to prevent multiple risk behaviours relating to alcohol, tobacco and drug use in young people aged 8–25 years: a systematic review and meta-analysis', *BMC Public Health*, 22(1):1–17, doi: 10.1186/s12889-022-13072-5, accessed 24 February 2026.
9. Barnes C, Turon H, McCrabb S, Hodder RK, Yoong SL, Stockings E, Hall AE, Bialek C, Morrison JL and Wolfenden L (2023) 'Interventions to prevent or cease electronic cigarette use in children and adolescents', *The Cochrane Database of Systematic Reviews*, 11(11):CD015511, doi: 10.1002/14651858.CD015511.pub2, accessed 24 February 2026.
10. Smith DT, Kelly AB, Chan GCK, Toumbourou JW, Patton GC and Williams JW (2013) 'Beyond the primary influences of parents and peers on very young adolescent alcohol use:evidence of independent community associations', *The Journal of Early Adolescence*, 34(5):569–584, doi.org/10.1177/0272431613498647, accessed 24 February 2026
11. Toumbourou JW, Westrupp EM, Benstead M, Klettke B, Clancy EM, Kelly AB, Reavley N and Rowland B (2024) 'Using effective community coalitions to prevent mental and behavioral disorders on a national scale', *Mental Health & Prevention*, 33:200322, doi.org/10.1016/j.mhp.2024.200322, accessed 24 February 2026.
12. Sadeghi S, Sabzi Khoshnami M, Imani A and Noruzi S (2025) 'Preventing adolescent substance use disorder: a systematic review of community-based practices and social work implications', *Journal of Substance Use*, 30(3):361–372, doi.org/10.1080/14659891.2024.2332776, accessed 24 February 2026.
13. Medina-Martínez J and Villanueva-Blasco VJ (2023) 'Prevention versus pseudo-prevention: a systematic review of school drug prevention and its indexing in best practice portals', *International Journal of Mental Health and Addiction*, 23:443–473, accessed 24 February 2026.
14. Teesson M, Newton NC and Barrett EL (2012) 'Australian school-based prevention programs for alcohol and other drugs: a systematic review', *Drug and Alcohol Review*, 31(6):731–736, doi: 10.1111/j.1465-3362.2012.00420.x, accessed 24 February 2026.
15. Lee NK, Cameron J, Battams S and Roche A (2016) 'What works in school-based alcohol education: a systematic review', *Health Education Journal*, 75(7):780–798, doi.org/10.1177/0017896915612227, accessed 24 February 2026.
16. Cuijpers P (2002) 'Effective ingredients of school-based drug prevention programs: a systematic review', *Addictive Behaviors*, 27(6):1009–1023, doi: 10.1016/s0306-4603(02)00295-2, accessed 24 February 2026.
17. Widnall E, Dodd S, Russell AE, Curtin E, Simmonds R, Limmer M and Kidger J (2024) 'Mechanisms of school-based peer education interventions to improve young people's health literacy or health behaviours: a realist-informed systematic review', *PLoS One*, 19(5): e0302431, doi:10.1371/journal.pone.0302431, accessed 24 February 2026.
18. MacArthur G, Caldwell DM, Redmore J, Watkins SH, Kipping R, White J, Chittleborough C, Langford R, Er V, Lingam R, Pasch K, Gunnell D, Hickman M and Campbell R (2018) 'Individual-, family-, and school-level interventions targeting multiple risk behaviours in young people', *The Cochrane Database of Systematic Reviews*, 10(10):CD009927, doi: 10.1002/14651858.CD009927.pub2, accessed 24 February 2026.

References

19. Biallas RL, Rehfuess E and Stratil JM (2022) 'Adverse and other unintended consequences of setting-based interventions to prevent illicit drug use: a systematic review of reviews', *Journal of Public Health Research*, 11(2), doi.org/10.1177/22799036221103362, accessed 24 February 2026.
20. MacCoun RJ and Reuter P (2010) *Drug war heresies: learning from other vices, times, and places*, Cambridge University Press, Cambridge.
21. Skara S and Sussman S (2003) 'A review of 25 long-term adolescent tobacco and other drug use prevention program evaluations', *Preventive medicine*, 37(5):451–474, doi: 10.1016/s0091-7435(03)00166-x, accessed 24 February 2026.
22. Melendez-Torres GJ, Tancred T, Fletcher A, Thomas J, Campbell R and Bonell C (2018) 'Does integrated academic and health education prevent substance use? Systematic review and meta-analyses', *Child: Care, Health and Development*, 44(4):516–530, doi: 10.1111/cch.12558, accessed 24 February 2026.
23. Mylocopos G, Wennberg E, Reiter A, Hébert-Losier A, Filion KB, Windle SB, Gore G, O'Loughlin JL, Grad R and Eisenberg MJ (2024) 'Interventions for preventing e-cigarette use among children and youth: a systematic review', *American Journal of Preventive Medicine*, 66(2):351–370, doi: 10.1016/j.amepre.2023.09.028, accessed 24 February 2026.
24. Snijder M, Stapinski L, Lees B, Ward J, Conrod P, Mushquash C, Belone L, Champion K, Chapman C, Teesson M and Newton N (2020) 'Preventing substance use among indigenous adolescents in the USA, Canada, Australia and New Zealand: a systematic review of the literature', *Prevention Science*, 21(1):65–85, doi: 10.1007/s11121-019-01038-w, accessed 24 February 2026.
25. Moore GF, Littlecott HJ, Turley R, Waters E and Murphy S (2015) 'Socioeconomic gradients in the effects of universal school-based health behaviour interventions: a systematic review of intervention studies', *BMC Public Health*, 15 15:907, doi: 10.1186/s12889-015-2244-x , accessed 24 February 2026.
26. McBride N (2003) 'A systematic review of school drug education', *Health Education Research*, 18(6):729–742, doi: 10.1093/her/cyf050, accessed 24 February 2026.
27. Kirchhoff E and Keller R (2021) 'Age-specific life skills education in school: a systematic review', *Frontiers in Education*, 6:660878. doi: 10.3389/feduc.2021.660878, accessed 24 February 2026.
28. Singh A, Bassi S, Nazar GP, Saluja K, Park M, Kinra S and Arora M (2017) 'Impact of school policies on non-communicable disease risk factors – a systematic review', *BMC Public Health*, 17(1):292, doi: 10.1186/s12889-017-4201-3, accessed 24 February 2026.
29. Peters LWH, Kok G, Ten Dam GT, Buijs GJ and Paulussen TGWM (2009) 'Effective elements of school health promotion across behavioral domains: a systematic review of reviews', *BMC Public Health*, 9:182, doi: 10.1186/1471-2458-9-182, accessed 24 February 2026.
30. Fletcher A, Bonell C and Hargreaves J (2008) 'School effects on young people's drug use: a systematic review of intervention and observational studies', *Journal of Adolescent Health*, 42(3):209–220, doi: 10.1016/j.jadohealth.2007.09.020, accessed 24 February 2026.
31. Shackleton N, Jamal F, Viner RM, Dickson K, Patton G and Bonell C (2016) 'School-based interventions going beyond health education to promote adolescent health: systematic review of reviews', *Journal of Adolescent Health*, 58(4):382–396, doi: 10.1016/j.jadohealth.2015.12.017, accessed 24 February 2026.
32. Gardner LA, Rowe AL, Newton NC, Egan L, Hunter E, Devine EK, Aitken T, Thornton L, Teesson M, Stockings E and Champion KE (2024) 'A systematic review and meta-analysis of school-based preventive interventions targeting e-cigarette use among adolescents', *Prevention Science*, 25(7):1104–1121, doi: 10.1007/s11121-024-01730-6, accessed 24 February 2026.
33. Jobehdar MM, Razaghi E, Haghdoost AA, Baleshzar A, Khoshnood K, Ghasemzadeh and Motevalian SA (2021) 'Factors that influence the effectiveness of primary prevention of substance use: a review of reviews', *Iranian Journal of Psychiatry and Behavioral Sciences*, 15(4):e116288, accessed 24 February 2026.
34. Galanti MR, Coppo A, Jonsson E, Bremberg S and Faggiano F (2014) 'Anti-tobacco policy in schools: upcoming preventive strategy or prevention myth? A review of 31 studies', *Tobacco Control*, 23(4):295–301, doi: 10.1136/tobaccocontrol-2012-050846, accessed 24 February 2026.

References

35. Lize SE, Iachini AL, Tang W, Tucker J, Seay KD, Clone S, DeHart D and Browne T (2017) 'A meta-analysis of the effectiveness of interactive middle school cannabis prevention programs', *Prevention Science*, 18(1):50–60, doi: 10.1007/s11121-016-0723-7, accessed 24 February 2026.
36. Rhayun S and Moonkyoung P (2021) 'Meta-analysis of the effects of smoking prevention programs for young adolescents', *Child Health Nursing Research*, 27(2):95–110, doi: 10.4094/chnr.2021.27.2.95, accessed 24 February 2026.
37. Buckley EJ and White DG (2007) 'Systematic review of the role of external contributors in school substance use education', *Health Education*, 107(1):42–62, accessed 24 February 2026.
38. Singh RD, Jimerson SR, Renshaw T, Saeki E, Hart SR, Earhart J and Stewart K (2011) 'A summary and synthesis of contemporary empirical evidence regarding the effects of the Drug Abuse Resistance Education Program (D.A.R.E.)', *Contemporary School Psychology*, 15:93–102, doi.org/10.1007/BF03340966, accessed 24 February 2026.
39. Tancred T, Paparini S, Melendez-Torres GJ, Fletcher A, Thomas J, Campbell R and Bonell C (2018) 'Interventions integrating health and academic interventions to prevent substance use and violence: a systematic review and synthesis of process evaluations', *Systematic Reviews*, 7(1):227, doi: 10.1186/s13643-018-0886-3, accessed 24 February 2026.
40. MacArthur GJ, Harrison S, Caldwell DM, Hickman M and Campbell R (2016) 'Peer-led interventions to prevent tobacco, alcohol and/or drug use among young people aged 11–21 years: a systematic review and meta-analysis', *Addiction*, 111(3):391–407, doi: 10.1111/add.13224, accessed 24 February 2026.
41. Snijder M, Stapinski L, Lees B, Ward J, Conrod P, Mushquash C, Belone L, Champion K, Chapman C, Teesson M and Newton N (2020) 'Preventing substance use among indigenous adolescents in the USA, Canada, Australia and New Zealand: a systematic review of the literature', *Prevention Science*, 21(1):65–85, doi: 10.1007/s11121-019-01038-w, accessed 24 February 2026.
42. Allen ML, Garcia-Huidobro D, Porta C, Curran D, Patel R, Miller J and Borowsky I (2016) 'Effective parenting interventions to reduce youth substance use: a systematic review', *Pediatrics*, 138(2): e20154425, doi: 10.1542/peds.2015-4425, accessed 24 February 2026.
43. Sameroff A (2010) 'A unified theory of development: a dialectic integration of nature and nurture', *Child Development*, 81(1):6–22, doi: 10.1111/j.1467-8624.2009.01378.x, accessed 24 February 2026.
44. Onrust SA, Otten R, Lammers J and Smit F (2016) 'School-based programmes to reduce and prevent substance use in different age groups: what works for whom? Systematic review and meta-regression analysis', *Clinical Psychology Review*, 44:45–59, doi: 10.1016/j.cpr.2015.11.002, accessed 24 February 2026.
45. Catalano RF, Fagan AA, Gavin LE, Greenberg MT, Irwin CE Jr, Ross DA and Shek DTL (2012) 'Worldwide application of prevention science in adolescent health', *The Lancet*, 379(9826):1653–1664, doi: 10.1016/S0140-6736(12)60238-4, accessed 24 February 2026.
46. Sawyer SM, Afifi RA, Bearinger LH, Blakemore S-J, Dick B, Ezeh AC and Patton GC (2012) 'Adolescence: a foundation for future health', *The Lancet*, 379(9826):1630–1640, doi: 10.1016/S0140-6736(12)60072-5, accessed 24 February 2026.
47. Ciocanel O, Power K, Eriksen A and Gillings K (2017) 'Effectiveness of positive youth development interventions: a meta-analysis of randomized controlled trials', *Journal of Youth and Adolescence*, 46(3):483–504, doi: 10.1007/s10964-016-0555-6, accessed 24 February 2026.
48. Durlak JA, Weissberg RP, Dymnicki AB, Taylor RD and Schellinger KB (2011) 'The impact of enhancing students' social and emotional learning: a meta-analysis of school-based universal interventions', *Child Development*, 82(1):405–432, doi: 10.1111/j.1467-8624.2010.01564.x, accessed 24 February 2026.
49. Khayyati F, Allahverdipour H, Shaghaghi A and Fathifar Z (2015) 'Tobacco use prevention by integrating inside and outside of school based programs: a systematic review article', *Health Promotion Perspectives*, 5(2):81–91, doi: 10.15171/hpp.2015.010, accessed 24 February 2026.
50. Langford R, Bonell CP, Jones HE, Pouliou T, Murphy SM, Waters E, Komro KA, Gibbs LF, Magnus D and Campbell R' (2014) 'The WHO Health Promoting School framework for improving the health and well-being of students and their academic achievement', *Cochrane Database of Systematic Reviews*, (4):CD008958, doi: 10.1002/14651858.CD008958.pub2, accessed 24 February 2026.

References

51. Park E and Drake E (2015) 'Systematic review: internet-based program for youth smoking prevention and cessation', *Journal of Nursing Scholarship*, 47(1):43–50, doi: 10.1111/jnu.12104, accessed 24 February 2026.
52. Hindmarsh CS, Jones SC and Kervin L (2015) 'Effectiveness of alcohol media literacy programmes: a systematic literature review', *Health Education Research*, 30(3):449–465, accessed 24 February 2026.
53. Australian Government Australian Institute of Health and Welfare (AIHW) (n.d.) *Alcohol, tobacco & other drugs in Australia*, AIHW website, accessed 24 February 2026
54. Jackson C, Geddes R, Haw S and Frank J (2012) 'Interventions to prevent substance use and risky sexual behaviour in young people: a systematic review', *Addiction*, 107(4):733–747, doi: 10.1111/j.1360-0443.2011.03751.x, accessed 24 February 2026.
55. Rodriguez DM, Teesson M and Newton NC (2014) 'A systematic review of computerised serious educational games about alcohol and other drugs for adolescents', *Drug and Alcohol Review*, 33(2):129–135, doi: 10.1111/dar.12102, accessed 24 February 2026.
56. Lemstra M, Bennett N, Nannapaneni U, Neudorf C, Warren L, Kershaw T and Scott C (2010) 'A systematic review of school-based marijuana and alcohol prevention programs targeting adolescents aged 10–15', *Addiction Research & Theory*, 18(1):84–96, doi.org/10.3109/16066350802673224, accessed 24 February 2026.
57. Tomokawa S, Miyake K, Akiyama T, Makino Y, Nishio A, Kobayashi J, Jimba M, Ayi I, Njenga SM and Asakura T (2020) 'Effective school-based preventive interventions for alcohol use in Africa: a systematic review', *African Health Sciences*, 20(3):1397–1406, doi: 10.4314/ahs.v20i3.45, accessed 24 February 2026.
58. Hodder RK, Freund M, Wolfenden L, Bowman J, Nepal S, Dray J, Kingsland M, Yoong SL and Wiggers J (2017) 'Systematic review of universal school-based 'resilience' interventions targeting adolescent tobacco, alcohol or illicit substance use: a meta-analysis', *Preventive Medicine*, 100:248–268, doi: 10.1016/j.ypmed.2017.04.003, accessed 24 February 2026.
59. Champion KE, Newton NC, Barrett EL and Teesson M (2013) 'A systematic review of school-based alcohol and other drug prevention programs facilitated by computers or the internet', *Drug and Alcohol Review*, 32(2):115–123, doi: 10.1111/j.1465-3362.2012.00517.x, accessed 24 February 2026.
60. Champion KE, Newton NC and Teesson M (2016) 'Prevention of alcohol and other drug use and related harm in the digital age: what does the evidence tell us?', *Current Opinion in Psychiatry*, 29(4):242–249, doi: 10.1097/YCO.0000000000000258, accessed 24 February 2026.

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