

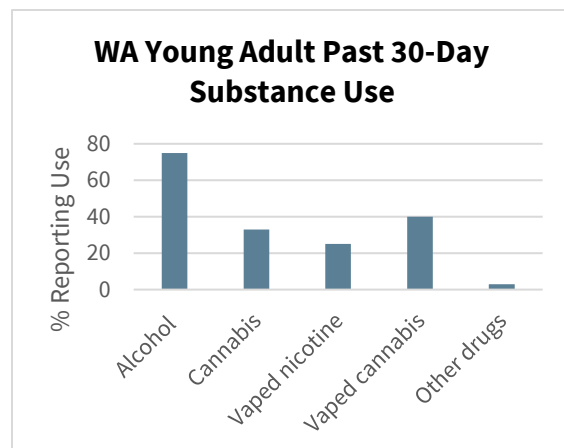
Preventing and reducing young adult substance use: Risks and protections

A critical window for prevention

Young adulthood (ages 18–26¹) is a unique life stage marked by possibilities, instability, and identity exploration.² Many young adults experience major changes in living arrangements, educational pursuits, career development, and social networks. These changes bring new opportunities, but also new risks. Substance use and related harms tend to peak during young adulthood,^{3,4} making this a critical window for prevention and intervention.

Young adult substance use

Recent data suggest that among young adults in Washington State, approximately 75% used alcohol in the past 30 days, 33% used cannabis, 25% vaped nicotine, 40% vaped cannabis, and 3% used other drugs.⁵



There are **serious public health consequences** for young adult substance use. For example, in the U.S., thousands of young adults are hospitalized each year due to alcohol use,⁶ cannabis use has been linked to increased mental health problems,^{7,8} and opioid-related deaths have reached record highs.⁹ The combined economic, social, and health costs of

young adult substance use affect individuals, families, communities, and healthcare systems.

Risk and protective factors

Identifying factors that increase risk (risk factors) or reduce risk (protective factors)^{1,10} for young adult substance use is essential to develop and implement effective prevention policies and programs. Risk and protective factors are organized into individual, social, family, school/work, and community domains similar to the social-ecological model.^{11,12}

Some risk factors linked to school and/or work may initially appear counterintuitive. For example, several studies have found that working full-time is associated with greater alcohol use among young adults. This may be due to greater disposable income or more exposure to drinking peers. Relatedly, participation in high school and college athletics tends to be associated with greater alcohol use (but not other substances). This may be due to increased pressure or peer norms around alcohol use. More research is needed to understand what may be driving these patterns.

Table 1 further summarizes a list of risk and protective factors identified in research in the past decade.

The list of **protective factors** in Table 1 is short, as it focuses on factors found in at least two long-term studies in the past decade. There is some promise, as more protective factors have been identified in individual long-term studies in the past decade. For example:

- protective behavioral strategies for alcohol (behaviors that reduce harm such as setting drink limits)¹³
- perceiving greater risk from substance use¹⁴
- having friends who are engaged in school¹⁵
- perceiving family support and care¹⁶
- regularly eating dinner with family¹⁵

- participating in community activities like volunteering¹⁷
- neighborhood connections¹⁸
- smoke-free laws¹⁹
- tobacco taxes at the state and local (community) levels¹⁹

Protective factors can also **buffer the effects of risk factors**. For example, one study found that when parents were warm, involved, and provided practical help during young adulthood, racial discrimination had less of an impact on binge drinking for Black males.²⁰ Another study showed that resilience and social support lessened the effects of adverse childhood experiences (e.g., childhood abuse, neglect, household dysfunction) on substance use.^{21,22}



Why context matters

Risk and protective factors are not evenly distributed; young adults in marginalized communities are often exposed to more risk factors and fewer protective factors. It's critical to address broader systemic issues like racism, discriminatory policies, and neighborhood conditions to reduce these disparities.^{23,24} Additionally, certain factors have a stronger impact on substance use for specific populations, highlighting the need for targeted prevention strategies. For example:

- Racial discrimination is linked to greater use, particularly for Black men.^{23,25}
- Adverse childhood experiences influence substance use more for Latine young adults compared to White young adults.²⁶
- Sexual minorities report higher levels of substance use than their heterosexual peers, especially in states with discriminatory policies towards LGBTQ+ individuals.²⁷

Implications for policy and practice



Expanding and tailoring prevention for young adults

Most prevention research and programs focus on childhood and adolescence.²⁸ Further research can distinguish which factors are relevant for young adult programming versus those that are best addressed earlier in development. Adaptations of effective prevention programming for young adults, particularly those not attending 4-year colleges, should be prioritized.

A key challenge is reaching young adults outside of college settings. Much of the existing research has focused on young adults attending college because they are both more accessible to researchers and a high-risk population, leaving gaps in our understanding of the broader young adult population. **Screening, brief intervention, and referral to treatment (SBIRT)** is one effective approach that can be used to reach young adults in and out of college settings (e.g., primary care, community settings, universities)²⁹.

Personalized normative feedback interventions that aim to correct misperceptions about peer use and peer approval of use are also effective strategies for reducing substance use³⁰.



Strengthen supportive relationships and environments

Programming for young adults should focus on strengthening bonds to prosocial peers, family, and community. Parents and caregivers play an important role in their young adults lives; several studies show promising results for parent-based interventions with college students.³¹ Further, investing in trauma-informed prevention research and programs for young adults is also needed,

particularly for those exposed to adverse childhood experiences.



Strengths-based approaches

Additional research can better understand protection for young adult use. Prioritizing protective factors already identified in research is one way to direct limited funding towards the most promising prevention strategies. Further, strengthening assets can lead to more effective, empowering, and equitable prevention strategies that build on the resilience and resources already present in communities.



Harm Reduction

Given that abstinence is not a realistic or desired goal for many young adults, prevention efforts should also prioritize harm reduction strategies, such as getting to lower blood alcohol levels and using more protective behavioral strategies, alongside efforts to delay initiation and reduce overall substance use risk.^{32,33}



Implement policies that reduce access and regulate marketing

Expanding public health policies like smoke-free laws and tobacco taxes show promise for reducing substance use among young adults. Regulating the marketing and advertising of substance products, which often target young people, is another important strategy.³⁴ This may include strategies such as improving social media age restrictions, counter-marketing campaigns, and limiting promotion of substances at events targeting young adults.^{34–36}



Prioritize equity and tailored approaches

Prevention efforts should be designed to be culturally responsive and accessible to young adults across diverse identities and backgrounds. For example, across race, socioeconomic status, college attendance, gender identity, and sexual



orientation. Continued support for research can identify populations most at risk for substance use and to develop effective, tailored prevention strategies.

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Table 1. Risk and protective factors for young adult substance use

	Alcohol	Tobacco	Cannabis	Other Drugs
Individual	• Adverse childhood experiences³⁷ • Racial discrimination²⁰ • Sexual assault and victimization³⁸ • Anxiety³⁹ • ADHD⁴⁰ • Antisocial behavior⁴¹ • Impulsivity^{42,43} • Early onset of alcohol use⁴⁴ • Prior alcohol use^{16,45} • Cannabis use⁴⁶ • Positive alcohol expectancies^{47,48} • Coping drinking motives^{49,50} • Enhancement drinking motives⁵¹	• Adverse childhood experiences^{37,52} • Physical violence victimization⁵³ • Mental health symptoms^{54,55} • Externalizing symptoms⁵⁶ • ADHD⁵⁷ • Impulsivity^{58,59} • Adolescent tobacco use^{60,61} • Adolescent substance use⁶² • Tobacco use^{63,64} • Substance use^{65,66} • Susceptibility to tobacco use⁶⁷ • Intentions to use⁶⁸ • Higher conscientiousness⁶⁹ • Negative views about tobacco⁷⁰	• Adverse childhood experiences^{71,72} • Racial discrimination²⁵ • Perceived stress⁷³ • Depressive symptoms¹⁵ • Externalizing symptoms⁷⁴ • ADHD symptoms^{71,75} • Antisocial behavior⁵³ • Impulsivity⁴⁸ • Early onset of substance use^{71,74} • Substance use^{14,65} • Higher agreeableness⁷⁶ • Self-regulation¹⁵	• Adverse childhood experiences^{25,77} • Racial discrimination⁷⁸ • Sexual victimization⁷⁹ • Depression⁸⁰ • Anxiety³⁹ • Antisocial behavior^{81,82} • Impulsivity⁸¹ • Early onset and adolescent substance use⁷⁸ • Cigarette Smoking⁸³ • Alcohol use⁸⁴ • Tendency to consider long-term consequences⁸⁵
Social	• Peer alcohol use^{86,87} • Affiliation with deviant peers⁸⁸ • Perceived peer drinking^{89,90} • Peer approval of drinking⁸⁴ • Being in a committed relationship⁹¹	• Peer tobacco use^{66,92} • Exposure to positive tobacco messages from friends, family, social media³⁴	• Peer substance use^{48,93} • Affiliation with deviant peers⁹⁴	• Peer substance use⁹⁵ • Affiliation with deviant peers⁸¹ • Peer approval of substance use⁹⁶
School Work	• Participating in athletics¹⁷ • Working full-time⁹⁷	• Enrollment in a technical or public university vs. private university^{40,60}		
Family	• Family history of substance use problems^{98,99} • Parental alcohol use¹⁰⁰ • Parental approval of drinking¹⁰¹ • Parental monitoring⁴⁶	• Family history of substance use problems¹⁰² • Family and household tobacco use^{103,104} • Prenatal tobacco exposure¹⁰⁵	• Family history of substance use problems³⁹ • Parental substance use¹⁰²	• Family substance use⁸⁰
Community			• Exposure to tobacco advertising¹⁴ • Neighborhood disorder/violence²⁴ • Religious attendance¹⁶	

Note: Includes factors identified in 2 or more longitudinal (2 or more timepoints) studies published in the past decade. Risk factors, **Protective Factors**.

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