popular in some geographic areas, especially among female adolescents. A conflictual message about the hazards of drinking and driving is clearly present with the emergence of the “mini-market,” where beer, recreational items, and gasoline are sold at the same site. The media message to youth is clear: alcoholic beverages are essential to social acceptance, of minimal harm to health, and a reward at the end of a normal day’s work, a school exam, a sports victory, or for any relaxing moment.\textsuperscript{30,31} The risk for excessive alcohol use is never stated or even implied.

Adolescent Development

Drinking by youth is perceived by society as normal experimental behavior. Teenagers report that they drink for enjoyment, for peer acceptance, to forget problems, or to reduce stress and anxiety in their lives. Not all drinking by adolescents is hazardous, and a significant number of individuals do not continue to use alcohol after their initial experience. Adolescents, however, may be at increased risk of becoming intoxicated while drinking less than adults because of their limited experience with alcohol and smaller body size. In addition, in susceptible adolescents the time frame of progression to alcohol dependence is much shorter compared with adults.\textsuperscript{15} They are less able to recognize and compensate for the neuropsychiatric effects of alcohol use due to biologic, cognitive, and psychological immaturity, and may experience psychological arrest of development with continued abuse.\textsuperscript{32} Those with early antisocial behavior, poor self-esteem, school failure, attention deficit disorder, learning disabilities, drug-using friends, and who are alienated from their peers or families are at increased risk. Depressed adolescents or those who have been physically or sexually abused may use alcohol in an attempt to cope with their psychological distress and have a higher incidence of alcohol or other drug addiction.\textsuperscript{33,34}

RECOMMENDATIONS

1. Pediatricians should condemn the nontherapeutic use of all psychoactive drugs, including alcohol and nicotine by children and adolescents.
2. The AAP encourages all providers of adolescent health care to discuss the hazards of alcohol and other drug use with their patients as a routine part of risk behavior assessment, to take the opportunity to reinforce nonuse behaviors and assess current use with a nonjudgmental approach. Special attention should be paid to the discussion of this issue when risk factors for problem drinking, such as a family history of alcoholism, are present.
3. Pediatric residency training programs should develop and implement substance abuse education curricula for medical students and residents.
4. Prenatal visits and preventive child health care provide an opportunity to inquire about a family history of alcoholism and parental attitudes about alcohol use. Parents can be urged to use alcohol safely and in moderation, to restrict children from family alcohol supplies (or remove them), and recognize the influence their own drinking patterns can have on their children and their parenting. The practice of giving alcohol to young children should be discouraged, though appropriately supervised use in a religious ceremony is acceptable to many.
5. Pediatricians should encourage their patients to avoid attending parties where alcohol is served, at least until the adolescent is mature enough and is able to use appropriate refusal techniques to avoid the pressure to drink. Pediatricians should discourage parents from allowing their children to attend such parties and should not allow alcohol to be served to minors at parties in their own homes.
6. Pediatricians are encouraged to assist families, churches, community agencies, and school personnel in developing alcohol education programs and alcohol-free activities. The medical complications and physiologic effects of alcohol use can be taught and information shared about the developmental aspects of childhood and adolescence that increase the risk of problem drinking and adverse consequences from alcohol use.
7. Pediatricians are encouraged to support a “zero tolerance” policy in local schools against alcohol, tobacco, and other drug use not only at school, but also at all school-sponsored and sanctioned activities that applies equally to students and staff. Penalties for noncompliance should be clear and enforced.
8. The Academy supports a ban on the advertising of alcohol similar to that of cigarettes. As an initial alternative, there should be equal time from television networks for public service announcements about the hazards of alcohol use. Pediatricians should work with other professionals and concerned parents to persuade the media to eliminate or substantially modify the current glamorous portrayal of alcohol use, both in regular programming and commercials. Controlled, responsible alcohol use by adults should be conveyed by the media, including the option of not drinking alcohol in social settings, especially when children are present.
9. Continued legal efforts should be supported in states where “zero tolerance” laws have not yet been enacted. The AAP recommends a standard blood alcohol level of no more than 0.02% for those under the legal drinking age who are operating a motor vehicle and supports the automatic suspension or delay of conferral of drivers’ licenses for minors convicted of alcohol or drug law violations. Research is encouraged on the effects of these laws in reducing the number of fatal traffic crashes and on the overall downward trend in motor vehicle fatalities in the under-21 age group.
10. Pediatricians need to be able to recognize early signs of alcohol and other drug abuse or dependency so that patients can be properly managed and/or referred for assessment and initiation of treatment. In addition, parents need guidance and support in assessing their children’s use of alcohol and in setting appropriate limits and con-