not explicitly rely on behavioral science to validate this aim. Unfortunately, the prevalence of drug use in the country has declined very little. The long-term efficacy of different treatment programs for illicit drugs is also debatable but smoking cessation efforts have been quite successful both on a national level and in individual programs. This paper will consider what psychologists and other behavioral investigators might contribute to the drug policy debate.

SUPPLY REDUCTION, DEMAND REDUCTION, AND HARM REDUCTION: POLICY RESPONSES. Dr. Robert MacCoun, Graduate School of Public Policy, University of California at Berkeley, Berkeley, CA.

While the supply reduction emphasis of the Reagan-Bush years has left many of our most serious drug problems intact, it is difficult to frame a "slam-dunk" argument that a shift in emphasis to demand reduction will dramatically change the picture—prevention and treatment effects are significant and probably cost-effective, but modest in size. Thus, many have concluded that we should be debating legalization vs. prohibition. After spending several years examining the content of this debate (via a content analysis of 20 years of op-ed essays) and the relevant empirical data (the criminological literature on deterrence, historical data, and cross-national data on European experiences), I believe that there is simply no compelling basis for predicting whether potential increases in use would be small enough to be compensated for by the reduction in drug-related crime. Moreover, public reaction to the Surgeon General's recent comments underscores the political resistance to legalization in mainstream America. However, the legalization debate is not the only alternative to the supply demand debate. A more profitable debate might incorporate the harm reduction perspective that is rapidly evolving in Western Europe and Australia. I will contrast this approach to traditional American supply and demand reduction, and offer an integrative framework that shows the conditions under which European-style harm reduction complements or conflicts with American-style use reduction.

SYMPOSIUM

Assessment and Medications for Treating Attention Deficit Disorders and Comorbidities.

Chair: *Thomas E. Brown*, Department of Psychology, Yale University, New Haven, CT.

ASSESSMENT OF ADDs: DSM IV AND BEYOND. Thomas E. Brown, Department of Psychology, Yale University, New Haven, CT.

Revised diagnostic criteria for ADDs have just been published in DSM IV. These criteria, intended to apply to children, adolescents and adults, recognize ADDs with and without hyperactivity and incorporate some symptoms not previously included in ADD diagnoses. Recent research has proposed an expanded model of core symptoms in ADDs and has documented high levels of comorbidity between ADDs and other disorders of learning, language, mood, anxiety and substance abuse (Biederman, et al., 1991, 1993, Brown & Gammon, 1993).

Although many of the diagnostic instruments available for assessment of ADDs were designed primarily to measure disruptive behavior disorders in hyperactive children, some measures useful for assessment of cognitive and behavioral impairments in ADDs have been developed. This presentation will review assessment tools and techniques for ADD symptoms in children, adolescents and adults; it will also address problems of differential diagnosis and measurement of effects of medications.

MEDICATIONS FOR UNCOMPLICATED ADDs IN CHILDREN, ADOLESCENTS & ADULTS. Walid Shekim, Department of Psychiatry, UCLA Neuropsychiatric Hospital, Los Angeles, CA.

Medications for children with ADDs have been extensively studied; there has been less research on pharmacological treatments of ADDs in adolescents and adults. Available research offers some guidelines for use of psychostimulants as first-line interventions for ADDs at all age levels, but there appears to be wide variation among patients as to what dose and timing of doses is most effective. Published mg/kg guidelines seem to overmedicate some patients while undermedicating others; many specialists now use absolute dose methods to titrate maximally effective doses. This presentation will discuss choice of stimulants and effective dosing strategies for patients of all ages whose ADDs are not complicated by comorbid disorders.

About 20–25% of ADD patients do not respond fully to stimulant treatment; some get no response, some get only partial response, and others experience intolerable side effects. For these patients alternative medications, e.g. tricyclic antidepressants or selective serotonin reuptake inhibitors, may be helpful in alleviating behavioral symptoms and associated mood problems, but these tend to be less effective for sharpening focus and improving concentration or other cognitive ADD symptoms. Recent research has demonstrated that some ADD patients who do not respond fully to stimulants or these antidepressants sometimes benefit from using stimulants and an antidepressant in combination. This presentation will review research on these alternative and combined medication treatments for uncomplicated ADDs.

MEDICATIONS FOR ADDs WITH COMORBID AGGRESSION. Robert D. Hunt, Department of Psychiatry, Vanderbilt University, Nashville, TN.

Epidemiologic studies indicate that at least 50% of children diagnosed with ADHD also have comorbid oppositional defiant disorder and/or conduct disorder, both of which include significant problems with aggression. High rates of conduct disorder are also reported in longitudinal studies of ADHD adolescents (40%) while anti-social personality disorder is reported (40%) in some studies of ADHD adults. Clinical studies indicate that children with ADHD and comorbid aggression often have very poor outcome.

Stimulant medications have been reported effective for ADHD patients with aggression, though the "roller coaster" effects resultant from the relatively short half-life of stimulants may cause other problems. Tricyclic antidepressants have been used successfully with some aggressive ADHD patients. Selective serotonin reuptake inhibitors (SSRIs) have been found useful for some with this comorbid combination, but clinical reports suggest that some very aggressive ADHD patients initially respond well to SSRIs and then