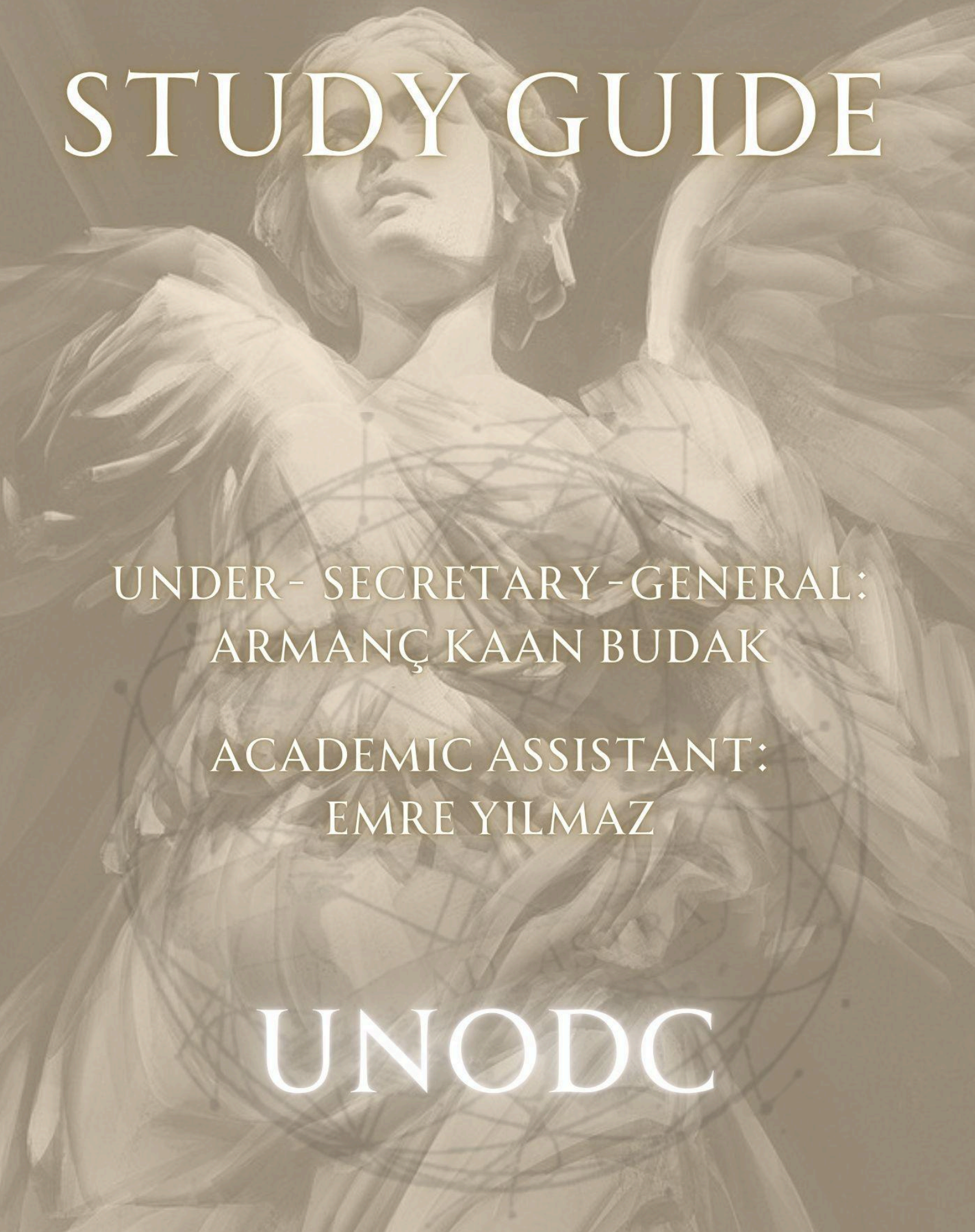
MBMUN'25

STUDY GUIDE



UNDER- SECRETARY-GENERAL:
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UNODC

LETTER FROM THE SECRETARY-GENERAL

Honourable Delegates, Esteemed Advisors, and Distinguished Guests,

My name is Bersun Akkaya. As the Secretary-General, it is with great pride, immense joy, and a privilege that I welcome you to the long-anticipated revival of MBMUN, now with its new iteration. This conference is the revival of a conference rooted in tradition and now reconstructed for a new generation of thinkers and changemakers.

The preparation of this conference has been an odyssey. Alongside an exceptional team of organizational and academic teams, we have devoted countless hours fueled by passion and purpose to ensure that MBMUN'25 embodies not only excellence in diplomacy, but with a genuine commitment to dialogue, cooperation, and meaningful progress to be a platform for meaningful discourse, a forum where today's youth can engage with the complexities of a rapidly changing world.

It is our utmost pleasure to bring together young minds in a time defined by uncertainty, environmental collapse, contested sovereignties, technological upheaval, and a shifting global order nor only to discuss but also to share and develop their ideas with the critical tools of diplomacy, ethics, and global citizenship in a collaborative atmosphere.

This year's theme draws inspiration from one of history's most noble civilizations: the Roman Empire. It invites participants to examine the durability of power and the fragility of institutions. Under the motto Per Aspera Ad Astra "Through Hardships to the Stars" we call upon you to rise above challenges and to reach intellectually and morally, toward something greater.

Each of our ten deliberately selected committees has been formed to combine academic depth with contemporary relevance ranging from historical reenactments to futuristic policy dilemmas, public health to international security, and from post-Soviet sovereignty to the legal dilemmas in orbital militarization. From historical simulation in the Roman Senate to the timeless ethical conflict of the 12 Angry Men, we aim to reflect the diversity of the United Nations and the multidisciplinary challenges that confront our period. Each agenda item was chosen not only to echo global urgency but also to foster intellectual relevance creating a space where rhetoric meets responsibility.

Model United Nations is not merely a conference, it is a living classroom, a training ground for leadership, a crucible where global awareness is tested, and a stage where youth

diplomacy is celebrated. In this regard, whether your voice resonates through heated debate or takes shape in silent diplomacy, never forget that your presence here has meaning. I invite and encourage all my delegates to research boldly, question fearlessly, and above all, remain deeply committed to the principles of respect, empathy, and curiosity for the rest of their lives.. Aim to reach the moon even if you could not reach the moon, you will find your place among the stars, may the light of the stars be your beacon that enlightens your path to knowledge. On behalf of the entire MBMUN'25 Secretariat, I look forward to welcoming you to leave a mark far beyond its closing ceremony.

Cordially,

Bersun AKKAYA

The Secretary General of MBMUN'25

LETTER FROM THE UNDER-SECRETARY-GENERAL & ACADEMIC ASSISTANT

Dear esteemed attendees,

It's a source of pride for me to see everyone gathered here at MBMUN'25 as the Under-Secretary General after all these years. The growth of knowledge and actions among us as human beings has been remarkable; from my involvement as a delegate at MMBALMUN'19 six years ago to now, we have experienced an extraordinary expansion in both the quantity and quality of MUN conferences. This year, in our committee, my prior purpose is to focus on my efforts to share the practices of the Istanbul MUN Society with the Antalya Society as effectively as possible, and we will explore how we can adapt to this rapidly changing environment that engages our minds while maintaining our focus. In particular, we will discuss the potential outcomes of the rapidly increasing use of stimulant medications for therapeutic purposes that I continue to witness firsthand in our country, and how this uncontrolled structure can be brought under control. I wish you all a productive discussion and idea-generation process. In the Guide, we have tried to include the basic ideas and data that need to be mastered in order to identify problems and generate solutions. I kindly request that you read it and come prepared. If you have any questions, please do not

hesitate to ask. You can reach me and the committee's academic assistant, Emre Yılmaz, via email.

Best regards and respect to all of you.

Armanç Kaan Budak

armanckaan@gmail.com

Respected Academic Team and Dear Participants,

I welcome all of you as the Academic Assistant of UNODC committee and MBMUN25. The complexity and cruciality of the ADHD-caused-topics brought me and my fellow Under-Secretary-General here. As a result, the committee should attempt to approach the situation with a little more empathy and try to comprehend why these problems arise and what needs to be done. Please read this guide fully and try to understand the topic at its best, making sure you get solutions for all the Questions to Be Addressed. I hope that this conference will show its academic and social benefits to you and if you have any questions or concerns, feel free to get in touch with me.

Emre YILMAZ

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I. INTRODUCTION

A. Introduction to the Committee

The United Nations Office on Drugs and Crime (UNODC) was established in 1997 as a United Nations organization to combat drug trafficking, crime, corruption, and terrorism. It covers various aspects of drug control, crime prevention, criminal justice reform, and anti-corruption measures. UNODC provides technical assistance, training programs, research, and military activities tailored to specific needs of countries and regions. It also monitors the implementation of international norms and standards related to drug control, crime prevention, and counter-terrorism.

UNODC carries out programs to address global problems related to drugs, crime, corruption, and terrorism. Project CRIMJUST focuses on strengthening the criminal law response to drug trafficking and organized crime, while the Container Control Program

(CCP) works to prevent illegal drug trafficking through shipping containers at ports and transit offices.

UNODC's Education for Justice (E4J) program promotes education and awareness about law, crime prevention, and criminal justice among young people and educators. The Alternative Development Program works with communities affected by drug cultivation to provide sustainable livelihoods as alternatives to drug production. Through these activities and partnerships with governments and civil society, UNODC plays an important role in advancing the international agenda for peace, security, and justice.

B. Introduction to the Topic

The scope of pharmacotherapy in contemporary medicine is virtually limitless. Numerous authorities have constrained or curtailed the utilization of these medications based on their distinct property profiles. Although certain medications are accessible over-the-counter without a prescription, prescription drugs are categorized into various classifications across different countries. Medicines should align with the efficacy profile according to the severity and prevalence of the diagnosed medical problems. Nonetheless, several illnesses exhibit a high incidence in the general population yet are governed by stringent prescribing rules due to the significant hazards associated with pharmacological treatment.

ADHD is arguably the most prevalent of these diseases. The pharmacodynamics of the stimulant medications employed in its treatment resemble those of substances recognized as illicit and potentially fatal. Consequently, psychiatrists prescribing these drugs must exercise meticulousness in the diagnostic and treatment planning processes. Nevertheless, the inherent nature of ADHD necessitates symptomatic diagnosis under current conditions, leading to unwarranted pharmacological interventions, particularly in developing countries, characterized by inaccurate and excessive diagnoses, thereby artificially inflating the already elevated prevalence rate of ADHD.

Medications prescribed due to these misdiagnoses may induce adverse consequences in individuals and exacerbate issues related to drug-related problems, particularly the crime rate, by undermining public order. UNODC possesses the infrastructure and human resources necessary to thoroughly address this issue, given its prior accomplishments.

II. THEORETICAL FRAMEWORK

A. Ethics of Psychiatry & Psychology

Medicine, a compassionate profession, has always held physicians to high ethical standards. The earliest known code of medical ethics is the fifth-century Formula Comitis Archiatrorum, created by Thomas Percival in 1803. This code serves as the foundation for modern medical ethics, emphasizing professionalism, human rights, dignity, medical knowledge, privacy, and equal access to healthcare. The American Medical Association (AMA) code, derived from medical ethics, emphasizes these values. Guidelines for psychiatric and psychological practice are established by organizations like the American Psychological Association and the American Psychiatric Association (APA). A psychiatrist or therapist should strive to respect the highest standards of their profession and honour the patient's faith in them.

Privacy and Confidentiality

Doctors must maintain patient confidentiality to ensure a successful therapeutic alliance and avoid revealing sensitive information without their consent. In psychiatry, patients often share their desires, fears, and concerns about societal stigma. Maintaining anonymity is crucial for effective treatment and the therapeutic relationship, as it prevents societal stigma exposure and hinders the therapeutic relationship.

Pursuing Boundaries

Gutheil and Simon define boundaries as the line that separates therapists from their roles, often arising from the principles of beneficence and non-maleficence. It's crucial for patients and psychiatrists to be aware of boundaries in therapeutic interactions. Gutheil and Gabbard categorize boundary issues into crossings and violations, which pose risks to patients in any situation.

Table 1.1: Boundary Types

Term	*Definition and Example*	*Characteristics*
Boundary	The physical, psychological, and social space occupied by the patient in the clinical relationship	Not hard or fast, movable. context dependent
Boundary crossing	A departure from the usual norms of therapy, that is, the verbal and physical distances normally maintained in a therapeutic interaction (e.g. the physical contact involved in extending a hand to help a patient who has stumbled or fallen)	Frequently occurs. benign deviation from standard practice, harmless, nonexploitative, may even support or advance therapy, may be initiated by either the patient or the therapist

Boundary violation	A boundary crossing of which the intent involves extra therapeutic gratification for the therapist; there is no benefit to the patient but significant risk of harming the patient (eg. a therapist engaging in a sexual relationship with a patient)	Takes the therapist out of the professional role, benefits the therapist more than the patient, transgresses an ethical standard responsibility lies only with the therapist

These could include the role, timing, location, and setting of therapy; finances; presents, services, commercial dealings, and associated issues; language; attire; disclosure of oneself; and bodily interaction.

Individual and Cultural Sensitivity

A psychiatrist must understand each patient's unique challenges and goals to effectively manage their condition. In the US, mental health professionals must assess a patient's ability to provide informed consent, even if legal guidelines require patients to know about their treatment. This highlights the importance of a deeper understanding of a patient than just adhering to DSM or ICD criteria.

Professionalism

Wynia et al. and the American Board of Medical Specialties define professionalism as a morally protective force in society, involving commitment to ethical principles and sensitivity to diverse patient populations. Medical professionalism involves lifelong learning, personal growth, and demonstrating knowledge and compassion in work. Candilis and Martinez suggest adopting a robust professionalism with compassion at its center.

B. Pharmachology & Statistics

According to the Anatomical Therapeutic Chemical Classification System, which is based on the mechanisms of action of neuropsychologically mood-affecting drugs at the physiological and anatomical level, these drugs, which are defined with the code N, are listed in subgroups according to this classification as follows:

Table 2.1: Drugs and Medical Products that effect Nervous System

Drug Name	Drug Name
General anesthetics (N01A)	Anxiolytics (N05B)
Local anesthetics (primarily sodium channel blockers) (N01B)	Hypnotics/sedatives (N05C)
Analgesics (N02A, N02B)	Antidepressants (N06A)

Antimigraine preparations (N02C)	Psychostimulants, agents used for ADHD, and nootropics (N06B)
Anticonvulsants (NO3)	Acetylcholine receptor modulators
Antiparkinson agents (N04)	Treatment of drug dependence (N07B)
Dopamine receptor modulators	Drugs used for vertigo (N07C)
Antipsychotics (N05A)	Other nervous system drugs (N07X)

Among these drugs, the drugs that fall within the scope of Recreational drugs are as follows:

Table 2.2: Major Recreational Drugs

Category	Sub-Category	Drug Name
Depressants		Barbiturates (Nitrous oxide Nonbenzodiazepines Benzodiazepines Carbamates Ethanol (alcohol) (Alcoholic beverage Beer Wine) Gabapentinoids GHB Inhalants (Medical (recreational use)) Hazardous solvents (contact adhesives Gasoline nail polish remover Paint thinner) Other (Freon)) Kaya Quinazolinones
Opioids		Buprenorphine (Heroin) Hydrocodone Tramadol (Suboxone Subutex) Codeine (Lean) Desomorphine (Krokodil) Dextropropoxyphene (Darvocet Darvon) Fentanyl Diamorphine Hydromorphone (Dilaudid) Methadone Mitragyna speciosa (Kratom) Morphine (Opium) Oxycodone (/paracetamol)
Stimulants		Amphetamine MDPV Mephedrone Arecoline (Areca) Betel Caffeine (Coffee Energy drinks Tea) Cathinone (Khat) Cocaine (Coca Crack) Ephedrine (Ephedra) Methamphetamine Methylone Methylphenidate Modafini Nicotine (Tobacco) Theobromine (Cocoa Chocolate)
Entactogens		2C series 6-APB (Benzofury) AMT MDA MDMA (Ecstasy Molly)
Hallucinogens	Psychedelics	Bufotenin (Psychoactive toads Vika Yopo) DMT (Ayahuasca) LSA LSD-25 Mescaline (Peruvian torch Peyote . San Pedro) Psilocybin Psilocin (Psilocybin mushrooms)
	Dissociatives	DXM (recreational use) Glaucine Inhalants (Nitrous oxide (recreational use) alkyl nitrites poppers amyl nitrite) Ketamine MXE Muscimol (Amanita muscaria) PCP Salvinorin A (Salvia divinorum)
	Defiriants	Atropine and Scopolamine (Atropa belladonna Datura Hyoscyamus niger Mandragora officinarum) Dimenhydrinate Diphenhydramine
	Cannabinoids	THC (Cannabis (Marijuana) Hashish Hash oil) Neocannabinoid / synthetic cannabinoids (JWH-018 APICA APINACA Spice)
	Oneirogens	Calea zacatechichi Silene capensis
Club drugs		Cocaine Quaaludes MDMA (Ecstasy Molly) Nitrous oxide (recreational use) Poppers

Psychiatric disorders are among the most prevalent and impactful health conditions globally, affecting individuals across all age groups. Four major categories that stand out due to their frequency and clinical importance are Attention-Deficit/Hyperactivity Disorder (ADHD), mood disorders, anxiety disorders, and personality disorders. Each of these conditions shows distinct prevalence patterns across populations, with variations influenced by age, gender, and diagnostic criteria.

ADHD is one of the most common neurodevelopmental disorders, particularly in childhood. It affects approximately 5 to 7% of children and adolescents worldwide. While it was once believed to be limited to youth, we now know that ADHD often persists into adulthood. About 60% of children diagnosed with ADHD continue to experience symptoms

later in life, and adult ADHD affects roughly 2.5 to 3.5% of the global population. The condition is more commonly diagnosed in males during childhood, with a male-to-female ratio of about 2:1 to 3:1, though this gap narrows significantly in adulthood.

Mood disorders, including major depressive disorder (MDD) and bipolar disorder, are also highly prevalent. Major depression is one of the leading causes of disability worldwide, with an estimated 12-month prevalence of around 6 to 7% and a lifetime prevalence reaching up to 15–20%. Women are about twice as likely as men to experience depression. Bipolar disorder, which includes both Bipolar I and II, is less common but still significant, with a lifetime prevalence estimated between 2.4 and 4%, and a roughly equal distribution between genders.

According to a 2023 nationwide study made in US, over three out of ten persons (29%) have had a diagnosis of depression at some point in their lives, and roughly 18% are actively dealing with depression. Depression is more common in women than in men, and it is more common in younger adults than in older adults. Although depression can strike anyone at any age or moment, it typically first manifests in the late teens to mid-20s.

Anxiety disorders represent the most widespread category of mental health disorders globally. These include generalized anxiety disorder (GAD), panic disorder, social anxiety disorder, phobias, and others. In any given year, around 12 to 18% of adults suffer from an anxiety disorder, and the lifetime prevalence is approximately 30%. These conditions are more prevalent in females, with a female-to-male ratio of roughly 2:1. Despite often being underdiagnosed, anxiety disorders contribute to significant distress, impairment, and comorbidity with other psychiatric conditions.

Personality disorders (PDs) are enduring patterns of inner experience and behavior that deviate markedly from cultural expectations and cause significant functional impairment. These disorders are estimated to affect approximately 9 to 13% of the general adult population. They are commonly grouped into three clusters: Cluster A (odd/eccentric), Cluster B (dramatic/emotional), and Cluster C (anxious/fearful). Among the specific disorders, borderline personality disorder (BPD) has a prevalence of about 1.4 to 1.6%. Personality disorders are notable not only for their chronic nature but also for their high comorbidity with mood and anxiety disorders, often complicating diagnosis and treatment.

In summary, psychiatric disorders are widespread and diverse in their presentation. ADHD affects roughly 2.5 to 3.5% of adults, mood disorders like depression

and bipolar disorder range between 6% and 20% across different time spans, anxiety disorders affect up to 30% of individuals over a lifetime, and personality disorders impact roughly 1 in 10 adults. Understanding these prevalence patterns is crucial for informing public health strategies, guiding early intervention efforts, and improving mental health outcomes across the globe.

C. Most Commonly Misdiagnosed Disorders: Mood, Anxiety and Personality Disorders

ADHD is a common experience that requires a consistent pattern of hyperactivity-impulsivity and/or inattention that impairs functioning or development. It is highly curable, and some individuals with ADHD may experience both inattentional and hyperactivity-impulsivity symptoms. Inattentional symptoms include difficulty maintaining organization, focus, and staying on task, while hyperactivity may involve excessive movement or excessive talking. Impulsivity involves the inability to consider things before acting or exercise self control, and can lead to interruptions or judgments without considering long-term effects.

Depression symptoms vary in severity and include feelings of depression, agitation, hopelessness, loss of interest, weight or appetite changes, excessive or too little sleep, reduced vitality, aimless motions, remorse or worthlessness, forgetfulness, difficulty focusing, and suicidal thoughts. These symptoms can be triggered by a shift in weight, appetite, sleep, reduced vitality, aimless motions, heightened exhaustion, remorse, forgetfulness, and difficulty making small judgments.

Anxiety disorders, such as panic disorder, social anxiety disorder, generalized anxiety disorder, and other phobias, can also be present. Persistent anxiety that interferes with day-to-day functioning is typically associated with generalized anxiety disorder (GAD), which can last months or even years. These disorders can manifest in various forms, such as panic disorder, social anxiety disorder, generalized anxiety disorder, and other phobias. It is important to note that these symptoms are not the same as periodically feeling anxious or worried about unpleasant situations, and they are highly curable.

OCD sufferers may invest more than one hour per day in their compulsive or obsessional behaviors, experience momentary anxiety relief, or face serious issues in their daily life due to these attitudes or actions. Some OCD sufferers also have a tic disorder, which involves repeated motions or sounds. Motor tics include abrupt, fleeting movements of the eyes and body parts, while vocal tics involve sniffing, grunting, and frequent throat clearing.

In some cases, individuals diagnosed with anxiety disorders or mood disorders are often co-occurring with OCD. Treatment options exist to help patients control their symptoms and enhance their quality of life.

Personality is the unique thoughts, emotions, and behaviors that set an individual apart from others. It is influenced by factors like environment, experiences, and genetic traits. A personality disorder, typically starting in late adolescence or early adulthood, is persistent over time, creating distress or functional issues and differing from societal norms. The DSM-5-TR categorizes personality disorders into ten types, including antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, dependent, histrionic, paranoid, schizophrenia, and schizophreniatypal.

Antisocial personality disorder involves disobedience to social standards and impulsive behavior. Its important to remark that asociality and antisocial behaviour is not the same. Asociality is a willingness for not getting into social relationships antisocial behaviour is a disability in getting to social relationships. Avoidant disorder involves high shyness, feelings of inadequacy, and sensitivity to criticism. Borderline disorder is characterized by strong emotional patterns, impulsivity, low self-esteem, and unstable interpersonal connections. Narcissistic disorder requires approval and lacks empathy, while OCD is obsessed with control, perfection, and orderliness. Dependent disorder involves clingy and subservient conduct, histrionic disorder is attention-seeking and overly emotional, paranoid disorder involves suspicion, schizophrenia lacks emotional expression and social detachment, and schizophreniatypal disorder is characterized by warped thinking, unusual behavior, and extreme discomfort in intimate relationships.

D. Attribution Methods of Law

In law, citation procedures vary from country to country in the context of national legal systems, and although some countries have standardized these procedures and made them a commonly accepted guideline, some countries do not have commonly accepted attribution procedures.

In order to refer to your own country's legislation and jurisprudence, you will confirm and research the existence of a commonly accepted citation procedure in the country you represent. if your country does not have a commonly accepted procedure, it is appropriate to research and use the citation procedures of countries that are similar to your country's legal structure (both legislation and jurisprudence).

In the context of international law, using the summarized and simplified acceptances on the following web page as citation procedures will be sufficient for completing your tasks within the committee.

https://guides.library.ubc.ca/legalcitation/intlaw

https://www.scribd.com/document/547963424/Bluebook-21-Ed-2020 (USA)

III. HISTORICAL BACKGROUND AND MAJOR RISKS

A. History of ADHD

The conceptualization of what we now call Attention-Deficit/Hyperactivity Disorder (ADHD) has evolved significantly over the past two centuries. Initial descriptions of behavior consistent with ADHD date back to the late 18th century. In 1798, Scottish physician Alexander Crichton documented observations of children who had difficulty maintaining attention, noting that their minds were “incapable of attending with constancy to any one object of attention.” A few decades later, in 1845, German psychiatrist Heinrich Hoffmann published a children's book featuring a character named “Fidgety Phil,” who displayed exaggerated hyperactivity and impulsive behavior—traits strikingly similar to what would later become central to the ADHD diagnosis.

Medical recognition of such behavior as part of a diagnosable disorder began in earnest in the early 20th century. In 1902, British pediatrician Sir George Still presented a landmark series of lectures describing a group of children who, despite normal intelligence, exhibited serious difficulties with self-regulation. He referred to this as a deficit of “moral control,” implicitly linking these traits with impaired volition and early notions of executive dysfunction. A few decades later, the 1917–1920 encephalitis epidemics gave rise to a clinical picture of children who developed hyperactivity and attentional difficulties following infection. This led to the use of the term “post-encephalitic behavior disorder,” and strengthened the theory that such behaviors might have biological underpinnings.

From the 1930s to the 1960s, terminology and theories regarding the disorder continued to shift. The concepts of “minimal brain damage” and later “minimal brain dysfunction (MBD)” gained popularity, reflecting an assumption that neurological injury or immaturity—though often not identifiable on imaging—was responsible for the observed symptoms. During this time, pharmaceutical interest in these behaviors began to grow. In 1937, Dr. Charles Bradley discovered that Benzedrine, an amphetamine, unexpectedly improved academic performance and behavior in children with conduct problems. This serendipitous finding marked the beginning of stimulant use in child psychiatry. By the 1950s, Dexedrine (dextroamphetamine) became the standard pharmacological option for managing hyperactive behaviors, long before the term ADHD existed.

The formal classification of ADHD began to crystallize between the 1960s and 1980s. The term “Hyperkinetic Reaction of Childhood” was introduced in the second edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-II) in 1968. This label emphasized hyperactivity as the defining feature of the disorder. However, as clinical understanding grew, attention-related symptoms were also acknowledged. In the 1980 DSM-III, the name changed to Attention-Deficit Disorder (ADD), which could be diagnosed with or without hyperactivity. Just seven years later, the revised DSM-III-R combined these into the now-familiar term ADHD, mandating the presence of hyperactivity in all diagnostic subtypes. This change reflected a growing consensus that inattention and impulsivity could not be easily separated from motor hyperactivity.

In the 1990s and beyond, understanding of ADHD underwent significant refinement. The 1994 DSM-IV formally split ADHD into three subtypes—inattentive, hyperactive-impulsive, and combined—allowing for more nuanced categorization. The next two decades saw a surge in research into the neurobiology and genetics of ADHD. Brain imaging studies identified structural and functional differences in regions involved in attention and self-regulation. Executive dysfunction, once an intuitive idea, became a measurable neuropsychological deficit. Longitudinal research confirmed that ADHD often persists into adulthood, contradicting earlier views that it was a childhood-limited condition.

The DSM-5-TR, released in 2022, updated the nomenclature, replacing "subtypes" with "presentations" to reflect the fluctuating nature of symptom expression over time. ADHD is now recognized as a neurodevelopmental disorder characterized by impairments in attention regulation, impulse control, and executive functioning. Its causes are

multifactorial, involving heritable genetic influences, deviations in brain structure and neurotransmitter activity, and environmental contributors such as early trauma or toxins.

B. History of ADHD Drugs

Pharmacological treatments evolved in parallel with diagnostic understanding. The 1955 introduction of methylphenidate (Ritalin), developed by CIBA Pharmaceuticals (now Novartis), marked the beginning of modern stimulant therapy. Initially prescribed for hyperkinetic children, Ritalin acts by inhibiting the reuptake of norepinephrine and dopamine—two key neurotransmitters implicated in ADHD. By the 1960s and 1970s, Ritalin use became widespread, but concerns emerged in 1975 about overdiagnosis, misuse, and long-term safety, particularly in children.

The 1980s and 1990s brought further innovation and popularization of stimulant medications. Extended-release formulations were developed to improve convenience and adherence, reducing the need for multiple daily doses. In 1996, Adderall, a mixed amphetamine salt with longer-lasting effects than earlier medications, was approved and quickly gained popularity as an alternative to Ritalin.

In the early 2000s, non-stimulant treatments began to emerge. Atomoxetine (Strattera), a selective norepinephrine reuptake inhibitor, became the first non-stimulant medication approved for ADHD. Unlike stimulants, it carries no abuse potential and is not a controlled substance. This era also saw the release of newer long-acting stimulant formulations like Concerta (extended-release methylphenidate) and Vyvanse (a prodrug of dextroamphetamine that is metabolized in the body, reducing potential for misuse).

The 2010s and 2020s brought even more diversification in treatment approaches. Medications like guanfacine extended-release (Intuniv) and clonidine extended-release (Kapvay), initially used to treat hypertension, found new utility in addressing ADHD symptoms—especially in cases involving tics or sleep difficulties—due to their action as alpha-2 adrenergic agonists. Pharmacogenetic research also gained traction, aiming to understand how genetic factors such as CYP2D6 polymorphisms or dopamine receptor variants influence individual responses to medication. Meanwhile, digital therapeutics—such as video game-based interventions—gained approval as adjunct treatments, particularly for pediatric ADHD.

C. Global and National Restrictions of ADHD Drugs

Global regulatory frameworks for ADHD medications are deeply influenced by international treaties such as the 1961 Single Convention on Narcotic Drugs and the 1971 Convention on Psychotropic Substances. These conventions place methylphenidate and amphetamines in Schedule II, on par with opioids under U.S. law, requiring strict prescription controls, close medical oversight, and limited international trade. In the United States, the DEA classifies these medications as Schedule II controlled substances. They cannot be refilled over the phone, require handwritten prescriptions, and are monitored through Prescription Drug Monitoring Programs (PDMPs). In contrast, atomoxetine remains outside the scheduling system due to its lack of euphoric effects.

In Europe, stimulant medications are heavily regulated. In Germany, they are governed by the Betäubungsmittelgesetz (Narcotics Law), which mandates special prescription forms. In France, only qualified specialists can prescribe methylphenidate, and meticulous records must be kept. The UK classifies such drugs as Class B controlled substances, with strict timelines for dispensing and documentation. Some European countries, such as Sweden and the Netherlands, impose particularly tight limits on amphetamine-containing products, often banning Adderall altogether.

Canada regulates methylphenidate and amphetamines as Schedule I drugs under the Controlled Drugs and Substances Act, mirroring U.S. regulations. Australia categorizes ADHD medications under Schedule 8 (S8), requiring special authority from regional health departments. Prescriptions are usually limited to pediatricians and psychiatrists. In Japan, the landscape is even stricter. Amphetamines are banned outright except in very rare, regulated cases. Methylphenidate is legal in specific formulations (e.g., Concerta), but Ritalin was withdrawn from the market due to widespread abuse. Only designated hospitals are allowed to issue prescriptions.

Turkey permits ADHD medications like Ritalin and Concerta through "kırmızı reçete" (red prescription), which is a special controlled format. Only neurologists, psychiatrists, or child psychiatrists can prescribe them, and pharmacies must meticulously log each dispensation for regulatory review.

In Gulf countries such as Saudi Arabia and the UAE, laws are extremely strict. Individuals traveling with stimulant medications must present medical documentation or risk

imprisonment. In Russia, most amphetamines and even methylphenidate are banned or nearly impossible to obtain legally.

D. Moral Devastation and Criminal Tendency

The misuse of ADHD medications—particularly stimulants—can have complex implications for individual behavior and societal crime rates. Stimulants stimulate the dopamine reward pathways in the brain, similar to how drugs like cocaine operate. When these drugs are crushed and snorted or injected, they can induce euphoria and dependency. Addiction may lead individuals to steal, forge prescriptions, or sell pills illegally, particularly among adolescents and young adults in academic environments.

Long-term misuse can result in severe neuropsychiatric effects including paranoia, aggression, and impaired impulse control. These symptoms can exacerbate existing behavioral issues and may contribute to violent or antisocial behavior, especially when combined with other substances like alcohol. The existence of a black market for diverted prescription drugs can fuel organized crime and normalize the idea of drug-related lawbreaking among youth. Some individuals with legitimate prescriptions may be pressured to share or sell their medications.

Chronic misuse also promotes risky behavior such as reckless driving or financial impulsivity. When stimulant abuse becomes normalized, prescription laws are undermined, and societal attitudes may become more tolerant toward broader forms of drug crime. This has the secondary effect of stigmatizing those who legitimately need ADHD medication, reducing access and trust in proper treatment pathways.

While therapeutic use of ADHD medication, particularly under medical supervision, has been shown to reduce criminal behavior and improve long-term outcomes, non-medical use can have the opposite effect—fueling aggression, impulsivity, and criminality. The same medication that improves executive function when used properly can deteriorate behavioral control when abused.

On a broader moral level, misuse of ADHD medication can contribute to a form of personal and cultural degradation. Taking prescription stimulants without a medical need—particularly to gain an academic or professional edge—challenges core values of integrity, fairness, and discipline. It implies that outcomes matter more than the process, fostering a mentality that justifies unethical means for desirable ends. Over time, such

attitudes can erode one's sense of self-respect and diminish empathy, particularly as chronic misuse heightens irritability and emotional detachment.

In this way, stimulant misuse reflects and reinforces late-capitalist ideologies that treat the brain as a performance machine rather than a part of the human experience worthy of care. Productivity becomes the primary virtue, and moral standards are sacrificed for efficiency and results. This trajectory—from therapeutic aid to social and moral corrosion—underscores the need for strict oversight, responsible prescribing, and greater public awareness of both the benefits and dangers of ADHD pharmacotherapy.

As stimulant medications became more widely used among students and professionals, the boundary between medical necessity and enhancement gradually began to erode. In societies where competitive performance is highly valued, stimulant overuse has increasingly been normalized. What was once a treatment for a specific neurodevelopmental disorder has, in some circles, morphed into a culturally tolerated practice of self-optimization. In this context, ethically ambiguous behaviors—such as exaggerating symptoms, sharing medications among peers, or pressuring physicians for prescriptions—have become increasingly accepted. The result is a growing cultural tolerance for manipulation, where obtaining an advantage through pharmaceutical means is seen not as deceit, but as strategic adaptation.

This shift mirrors deeper philosophical concerns. The use of stimulants without medical indication reflects an instrumental view of human existence—where people, including oneself, are seen primarily as tools for productivity rather than ends in themselves. In such a mindset, the individual is valued not for their character or humanity, but for their capacity to produce results. Over time, this can lead to a profound form of alienation, where the individual becomes disconnected from their intrinsic motivations and moral framework. The brain, once a symbol of identity and autonomy, becomes commodified—a vessel to be optimized, hacked, and leveraged in pursuit of performance.

E. Economic Impact

Beyond the moral and philosophical implications, the misuse of ADHD medications has significant economic consequences across multiple sectors. When prescribed appropriately, these drugs are highly cost-effective. However, widespread misuse and

diversion result in hidden costs that ripple through healthcare, education, productivity, and the criminal justice system.

Healthcare systems, for instance, face mounting burdens. Emergency room visits due to stimulant-related complications—such as cardiovascular events, overdoses, or stimulant-induced psychosis—have surged. Between 2004 and 2011 in the United States, ER visits related to non-medical stimulant use increased by over 300%. Misuse also exacerbates mental health issues such as anxiety, depression, and psychosis, increasing the demand for psychiatric interventions and long-term therapy. As more adolescents and young adults enter rehabilitation for prescription stimulant misuse, publicly funded addiction treatment programs face greater strain.

Insurance fraud represents another substantial cost. “Doctor shopping,” the practice of seeking prescriptions from multiple providers, as well as the proliferation of counterfeit diagnoses, contribute to waste and abuse. Insurers, including public programs like Medicaid, may unknowingly reimburse for medications that were inappropriately prescribed. These false claims not only inflate healthcare costs but also erode trust in the medical system.

In the workplace, stimulant use may yield short-term cognitive enhancement in high-pressure environments, but the long-term effects can be counterproductive. Chronic use may lead to burnout, emotional dysregulation, and chemical dependence, ultimately reducing productivity and increasing absenteeism. Furthermore, if drug-enhanced performance becomes the norm, workplaces may lose a sense of fairness and integrity, leading to declining morale and trust among employees.

Educational institutions are particularly vulnerable to the corrosive effects of stimulant misuse. On many campuses, non-medical use is widespread, creating an environment of “academic doping” where performance is pharmacologically enhanced. This undermines meritocratic ideals, pressures non-using students, and contributes to cheating scandals that can tarnish institutional reputations. Schools and universities also incur administrative costs associated with investigating such behavior and maintaining compliance with controlled substance regulations.

The criminal justice system likewise bears the burden of stimulant misuse. Illicit possession, prescription forgery, and the sale of stimulants result in arrests, prosecutions, and incarceration—all of which consume public resources. Moreover, drug-related offenses often

co-occur with other crimes, amplifying the demands placed on law enforcement and correctional systems.

F. Lack of Differable and Comprehensive Monitoring Tools

Globally, patterns of stimulant use and misuse vary depending on a country's regulatory framework. In nations with stringent drug laws, such as Japan or the United Arab Emirates, overall stimulant consumption is lower. However, this rigidity may inadvertently reduce access for individuals who genuinely need treatment, thereby contributing to under-treatment and decreased national productivity. Conversely, in lower- and middle-income countries, ADHD is frequently misdiagnosed or underdiagnosed, while the illegal market for stimulants continues to expand. These challenges often overwhelm fragile regulatory infrastructures and exacerbate disparities in care.

Compounding these issues is the absence of robust monitoring tools. The diagnosis of ADHD remains largely clinical, relying on subjective interviews, questionnaires, and behavioral observations. There are no definitive laboratory tests, imaging findings, or cognitive biomarkers to confirm the diagnosis objectively. As a result, clinicians must rely on judgment, which is vulnerable to patient deception, overinterpretation of normal behavior, or bias—particularly in environments where academic or occupational pressures are high. What is needed are validated biomarkers—genetic, neuroimaging, or neuropsychological—that can reliably distinguish ADHD from other conditions.

Even in countries with prescription drug monitoring programs (PDMPs), significant gaps remain. Some nations lack centralized systems altogether, while others have fragmented or underutilized infrastructures. In the U.S., while PDMPs are widely implemented, data access is often delayed, inter-state coordination is inconsistent, and few systems generate automated alerts for suspicious prescribing patterns. Real-time, nationally integrated databases capable of flagging early refills, high dosages, or poly-provider prescriptions would dramatically improve surveillance and reduce misuse.

Another systemic weakness lies in the lack of follow-up. Once an ADHD diagnosis is made, patients are often continued on stimulants for years without reassessment. This neglect allows for unnecessary long-term use, unmonitored side effects, and the improper involvement of family members in medication access. Regular evaluations—ideally

every 6 to 12 months—should be mandated, with prescriptions linked to evidence of ongoing need and benefit.

Comorbidities and differential diagnoses are also insufficiently screened. Many conditions—sleep disorders, anxiety, depression, thyroid dysfunction, substance misuse—can mimic ADHD symptoms. In fast-paced environments such as telemedicine or general practice, such possibilities are often not ruled out. Standardized diagnostic protocols and comorbidity checklists embedded in electronic health records would significantly improve diagnostic accuracy and patient safety.

In academic settings, the lack of oversight for accommodation requests further complicates matters. Some students receive stimulant prescriptions or testing modifications based on vague or unverifiable claims. The absence of rigorous psychoeducational testing allows self-report alone to dictate high-stakes educational decisions. Institutions should require independent diagnostic verification and maintain standards for eligibility, ensuring that special accommodations are grounded in objective evidence.

Public awareness and professional education also lag behind the rapid expansion of ADHD pharmacotherapy. Many physicians and patients underestimate the addictive potential of stimulants or rationalize their misuse when framed as academic enhancement. Such misconceptions facilitate casual sharing of medications, pressure on clinicians, and a culture of informal drug circulation. To counteract this, ongoing continuing medical education (CME) should be required for prescribers, alongside public campaigns that clearly articulate the risks—medical, ethical, and legal—of stimulant misuse.

The rise of telehealth and online pharmacies further complicates the picture. Many jurisdictions lack systems to monitor digital prescribing practices. Some platforms issue prescriptions based solely on online checklists, without any face-to-face evaluation or long-term oversight. Regulatory bodies must establish licensing standards, data reporting requirements, and AI-driven detection tools capable of identifying irregular prescribing behavior in digital contexts.

These concerns point to a broader societal conversation about how ADHD medications are diagnosed, distributed, and used. Should clinical interviews continue to be the gold standard for diagnosis, or should objective testing be mandated? Is stimulant use in school and work environments a legitimate form of cognitive enhancement, or does it constitute a form of cheating? Should governments implement stricter real-time monitoring

systems at the expense of patient privacy? Is the misuse of ADHD medication contributing to long-term moral decay by normalizing utilitarian reasoning over ethical behavior? These questions underscore the need for nuanced public debate that weighs medical utility against social risk.

IV. POSITIONS OF THE RELEVANT STATES

A. Developed States

Globally, the landscape varies. In the United States, ADHD diagnosis rates are among the highest in the world. Access to medication is relatively easy through general practitioners and psychiatrists. However, the same environment fosters widespread misuse—particularly among students—where approximately 30% report using stimulants non-medically. Although the DEA's Schedule II classification and state PDMPs offer some control, overprescription and fraud remain rampant.

In Canada, diagnosis rates are similarly high among children and increasingly so among adults. Prescription access is widespread, and public insurance helps cover treatment in some provinces. Yet misuse, especially among youth, is on the rise. Despite national drug schedules, Canada lacks a unified monitoring system that can track trends across provinces.

The United Kingdom enforces tighter controls. Diagnosis is mostly limited to specialists, and stimulant prescriptions fall under Schedule II with strict dispensing rules. Misuse is less common than in North America, but growing concerns on university campuses are prompting policy reviews. A major obstacle remains the long waiting lists under the NHS, which delay access to legitimate care.

Australia applies one of the strictest regimes. While ADHD is commonly diagnosed in children and increasingly among adults, medication access requires state-level authorization and close regulation under Schedule 8 controls. Despite these safeguards, black market activity is emerging, particularly in educational settings, highlighting the need for uniform regulation across states.

B. Developing and Non-Developed States

In developing and non-developed countries, the landscape of ADHD diagnosis and treatment reflects systemic gaps in healthcare access, regulation, and public awareness.

Across these regions, ADHD is often misunderstood, underdiagnosed, or misinterpreted as a behavioral or moral failing. In many public school systems, symptoms of inattention or hyperactivity are seen as disobedience rather than indicators of a neurodevelopmental disorder. While awareness is slowly growing in private institutions and urban centers, it remains very limited in rural and low-resource settings.

Access to medication is another major barrier. Methylphenidate and atomoxetine, the most common ADHD medications, are typically available only in major cities and private clinics. Amphetamines, such as Adderall, are usually not approved or available due to regulatory concerns. In some areas, stimulants can be obtained without proper prescriptions, particularly through informal or unregulated sources. Prescription rules, even when legally required, are often vague, poorly enforced, or nonexistent.

In middle-income countries such as Turkey, diagnosis is becoming more common, especially among children. Access is restricted to red prescriptions, which only certain specialists can issue. Although national pharmacy tracking systems are in place, reports of stimulant misuse and academic doping—particularly in urban areas—are growing. The primary challenge is ensuring access to care without reinforcing stigma or encouraging inappropriate use.

In India, for example, methylphenidate is classified as a Schedule H drug, requiring a prescription, but enforcement is inconsistent, and over-the-counter access is still possible in rural areas. In Pakistan, enforcement is similarly weak, and reports suggest that stimulants can be purchased without formal authorization.

Even where prescription systems exist, the lack of national electronic monitoring allows for diversion, overprescription, and emerging black-market distribution, particularly among urban students seeking academic enhancement. This creates an uneven pattern: undertreatment in poorer or rural populations and potential overtreatment or misuse in affluent, high-pressure educational settings.

In Brazil, for instance, stimulant use is growing in cities, and prescription records are logged, but enforcement in rural areas remains weak. Egypt and Nigeria present different challenges, where ADHD symptoms are often attributed to cultural or spiritual causes, and medications are scarcely available or prohibitively expensive. These countries also suffer from a severe shortage of psychiatrists and a near-complete absence of structured national mental health policies for ADHD.

In Indonesia, access to medications like methylphenidate and atomoxetine exists but is largely restricted to wealthier populations due to cost and urban concentration. Diagnosis in private schools is increasing, yet public understanding and policy frameworks lag behind. Across all these countries, common themes emerge: low levels of awareness, significant disparities between public and private healthcare sectors, urban-rural gaps in treatment access, and a near-total absence of electronic prescription tracking systems.

In countries like Bangladesh and Nepal, ADHD remains largely invisible in the public health narrative. Mental health services are minimal, especially for children, and the concept of neurodevelopmental disorders is often overshadowed by more immediate concerns such as infectious disease and malnutrition. Where psychiatric services do exist, they are concentrated in urban tertiary hospitals, and stimulant medications like methylphenidate are either unavailable or unaffordable for most families. Without regulatory structures or awareness campaigns, misdiagnosis is common, and both under- and overtreatment occur informally.

In the Philippines, awareness of ADHD is gradually improving, particularly in private schools and among English-speaking medical professionals. Medications like atomoxetine and methylphenidate are available in urban centers but remain expensive. Prescription rules exist but enforcement varies, and access in rural areas is very limited. There is a growing middle-class demand for diagnosis and medication, driven partly by exposure to Western norms, but without a national registry or monitoring system, stimulant misuse could rise as access increases.

In Kenya and South Africa, the situation reflects stark socioeconomic divides. In South Africa, ADHD is better recognized in the private healthcare sector, where medications and specialized services are accessible to wealthier populations. In the public system, however, long wait times, misdiagnosis, and limited drug availability remain significant barriers. In Kenya, mental health infrastructure is severely limited, and most children with ADHD symptoms go undiagnosed or are mislabeled as disruptive. There are few psychiatrists, and stimulant medications are scarce or restricted to private import channels.

In Latin America, beyond Brazil, countries like Argentina, Colombia, and Chile show mixed progress. In Argentina, ADHD is increasingly diagnosed in private schools, and methylphenidate is available by prescription. However, rural populations have limited access to both diagnosis and medication, and concerns about overprescription in urban centers have

begun to surface. In Colombia and Chile, diagnosis is growing in urban settings, and medications are moderately available, but healthcare inequality and poor prescription tracking systems raise concerns about both accessibility and the potential for misuse.

In the Middle East, wealthier Gulf countries like the United Arab Emirates and Saudi Arabia offer a different model. These nations have relatively advanced healthcare systems, and ADHD diagnosis is more widely accepted in private clinics. However, stimulant medications are classified as controlled substances, and importing them without formal medical documentation can result in legal penalties. Prescriptions require strict justification, and patients often need approval from national health authorities. While this tight control limits misuse, it also creates barriers for those genuinely in need of long-term treatment, especially expatriates and lower-income citizens.

In contrast, in war-affected or politically unstable countries such as Syria, Yemen, and Sudan, ADHD is virtually unaddressed. Health systems are focused on emergency care, and psychiatric services are either unavailable or inaccessible. Children with developmental disorders are usually undiagnosed, marginalized, or excluded from formal education. The concept of ADHD, let alone access to stimulant treatment, is a luxury far beyond reach.

These systemic gaps carry ethical and public health consequences. Children with genuine ADHD often go untreated, disciplined, or stigmatized, while stimulant overuse may quietly proliferate among elite or urban populations under academic pressure. Without national treatment guidelines or clear regulatory frameworks, misuse and neglect can both coexist, reinforcing inequality in access to care.

Addressing this imbalance requires coordinated national policies. Countries need to develop clinical guidelines for ADHD that reflect local realities, train primary care physicians in neurodevelopmental disorders, and integrate ADHD medications into essential drug lists with proper safeguards. Public education campaigns are equally crucial—not only to reduce stigma, but also to inform communities about the risks of misuse and the benefits of legitimate treatment. Without these measures, both underdiagnosis and unethical overuse will continue to grow, deepening healthcare inequity and undermining trust in medical institutions.

Taken together, these national profiles illustrate the tension between access and control. Striking the right balance remains one of the most pressing challenges in modern psychiatric and public health policy.

V. INTERNATIONAL COOPERATION AND THE NGO'S ROLE

The problem of overdiagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and the resulting prescribing of stimulant drugs requires a coordinated global response, especially in the context of emerging crime trends that endanger public order. International cooperation and the active participation of Non-Governmental Organizations (NGOs) are cruciaş in addressing this multifaceted problem. These organizations aim to standardize diagnostic protocols, ensure equal access to mental health services and give support for policies that balance effective treatment with public safety. Their efforts span research, policy development and education but they face significant obstacles due to global injustice in health systems, cultural perceptions of ADHD, and regulatory inconsistencies.

Because there are large differences in diagnostic criteria for ADHD and access to care between countries, international collaboration is necessary to harmonize approaches to ADHD diagnosis and treatment. The World Health Organization (WHO) plays a central role in this effort, particularly by developing standardized instruments such as the Adult ADHD Self-Rating scale. This screening tool, validated in multiple languages and cultural contexts, aims to increase consistency in defining ADHD globally, particularly in low and middleincome countries where diagnostic resources are limited. WHO aims to reduce both underdiagnosis, which can lead to individuals remaining untreated and subject to impulsive behavior leading to risk of offending, and overdiagnosis, which can lead to unnecessary stimulant recipes and subsequent misuse. However, WHO's efforts are constrained by limited funds and shifting national priorities, especially in regions where mental health service is limited or under-resourced.

International collaboration also extends to addressing systemic problems such as drug shortages that disrupt treatment continuity and increase the risk of negative outcomes, including criminal behavior. NGOs complement international efforts by filling gaps in advocacy, education, and service delivery, especially in regions with limited mental health infrastructure. Organizations such as Children and Adults with Attention-Deficit/Hyperactivity Disorder (CHADD) in the United States play an important role in supporting patients, families, and clinicians. CHADD provides resources, such as the Adult ADHD Toolkit, that guide individuals through the diagnosis and treatment process, and maintains a directory of ADHD specialists to improve access to quality care. By advocating for policy changes, CHADD aims to reduce stigma and ensure equal access to treatment. This

is crucial to prevent untreated ADHD from contributing to impulsive or antisocial behavior. In the context of public policy, CHADD's efforts to educate communities about appropriate ADHD management help reduce the risks of overdiagnosis and misuse of stimulants that can encourage diversion and illicit use. Similarly, the UK Adult ADHD Network (UKAAN), founded by National Health Service mental health professionals, promotes evidence-based assessment and treatment protocols for adult ADHD. UKAAN aims to reduce impulsive crime by integrating ADHD screening and treatment into criminal justice systems, demonstrating a direct link between effective ADHD management and public safety.

Other NGOs, such as the American Academy of Pediatrics (AAP), are addressing broader mental health issues by collaborating with organizations such as the American Academy of Child and Adolescent Psychiatry and the Children's Hospital Association. In emerging markets such as South Africa, local NGOs are focusing on psychoeducation and mental behavioral therapy as a complement to pharmacological interventions to address treatment gaps where access to specialists and medications is limited.These organizations also advocate safer prescribing practices, such as the use of extended-release stimulant formulations, which are less prone to abuse and diversion than immediate-release versions. By providing community-based support and education to healthcare providers, NGOs help reduce the risks of overdiagnosis and inappropriate prescribing, which can exacerbate substance abuse and criminal tendencies.

Despite these efforts, international cooperation and NGOs face significant challenges that limit their impact. Diagnostic variability remains a critical issue as differences between the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD) lead to inconsistency in ADHD prevalence estimates and treatment approaches. Cultural perceptions of ADHD as a “Western” or “childhood” disorder further complicate global efforts, delaying diagnosis and contributing to stigma in adults and underrepresented groups. In low or middle incomed countries , access disparities become apparent, with limited availability of trained clinicians and medications hindering effective ADHD management.

Regulatory challenges also hinder international efforts to address stimulant abuse. While organizations such as World Health Organization or European Medicines Agency advocate for tighter controls on the prescribing of stimulants, diverted stimulants could contribute to drug-related-crimes by fueling substance abuse networks. NGO’s try to address

this problem by advocating for policies that encourage safer distribution practices, but these initiatives require global cooperation, coordination and funding. Lack of consensus on terminology for nonmedical stimulant use complicates research and policy development.

VI. QUESTIONS TO BE COVERED

1. Should the diagnosis of ADHD rely solely on clinical interviews, or is there a need for mandatory objective testing (e.g., neuropsychological or biomarker-based)?

2. Does the widespread prescription of stimulant medication represent medical progress or an overmedicalization of normal childhood and adult behavior?

3. Is the non-medical use of ADHD drugs in academic or professional settings a form of cheating, or a legitimate tool for cognitive enhancement?

4. Should governments implement stricter real-time prescription monitoring systems to prevent stimulant diversion and misuse, even at the cost of patient privacy?

5. Does the misuse of ADHD drugs contribute to long-term moral decay in society by promoting utilitarian values over ethical integrity?

6. Can stimulant misuse meaningfully increase criminal behavior, or are underlying socioeconomic and psychological factors more decisive in that link?

7. Should the economic burden caused by ADHD drug misuse be considered a public health crisis, and if so, who should bear the responsibility: doctors, patients, or regulators?

8. Is it ethically defensible to prescribe ADHD medications to individuals with only mild or ambiguous symptoms, especially in high-pressure educational environments?

9. Should schools and universities have the right to verify or challenge students' ADHD diagnoses when accommodations or stimulant prescriptions are involved?

10. Given the potential harms of both under-treatment and over-treatment, how should societies balance access to ADHD medications with the need for tight control?

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