

# Discussão da alteração do artigo 14 da Lei nº 8.069



## POTENCIAS CONFLITOS DE INTERESSE

**Fontes Principais de remuneração:** UFRGS, HCPA, consultório privado

**Conferencista & Conselheiro:** Janssen-Cilag, Eli-Lilly, Novartis, Shire.

**Verbas para Pesquisa e Educação:** CNPq, CAPES, FIPE-HCPA, Janssen-Cilag, Eli-Lilly, Novartis, Shire.

**Auxílio para participação em Congressos:** Shire

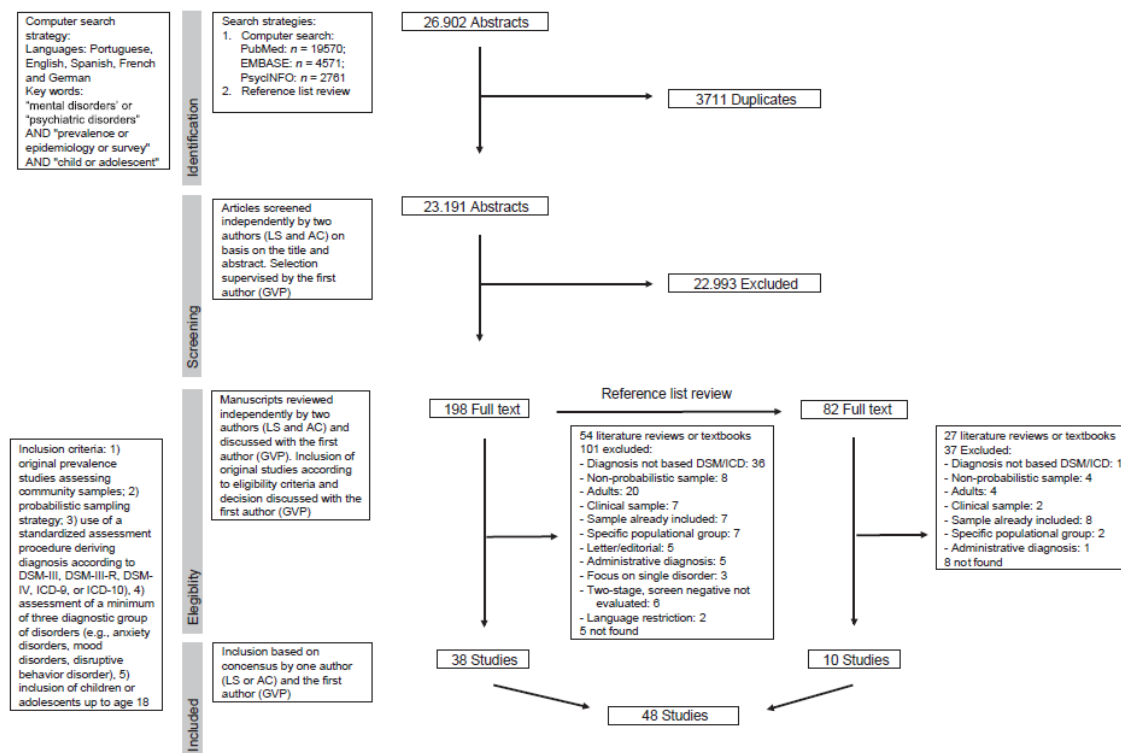
**Livros:** Oxford Press, ArtMed



# Prevalência de Transtornos Mentais na Infância & Adolescência

## Annual Research Review: A meta-analysis of the worldwide prevalence of mental disorders in children and adolescents

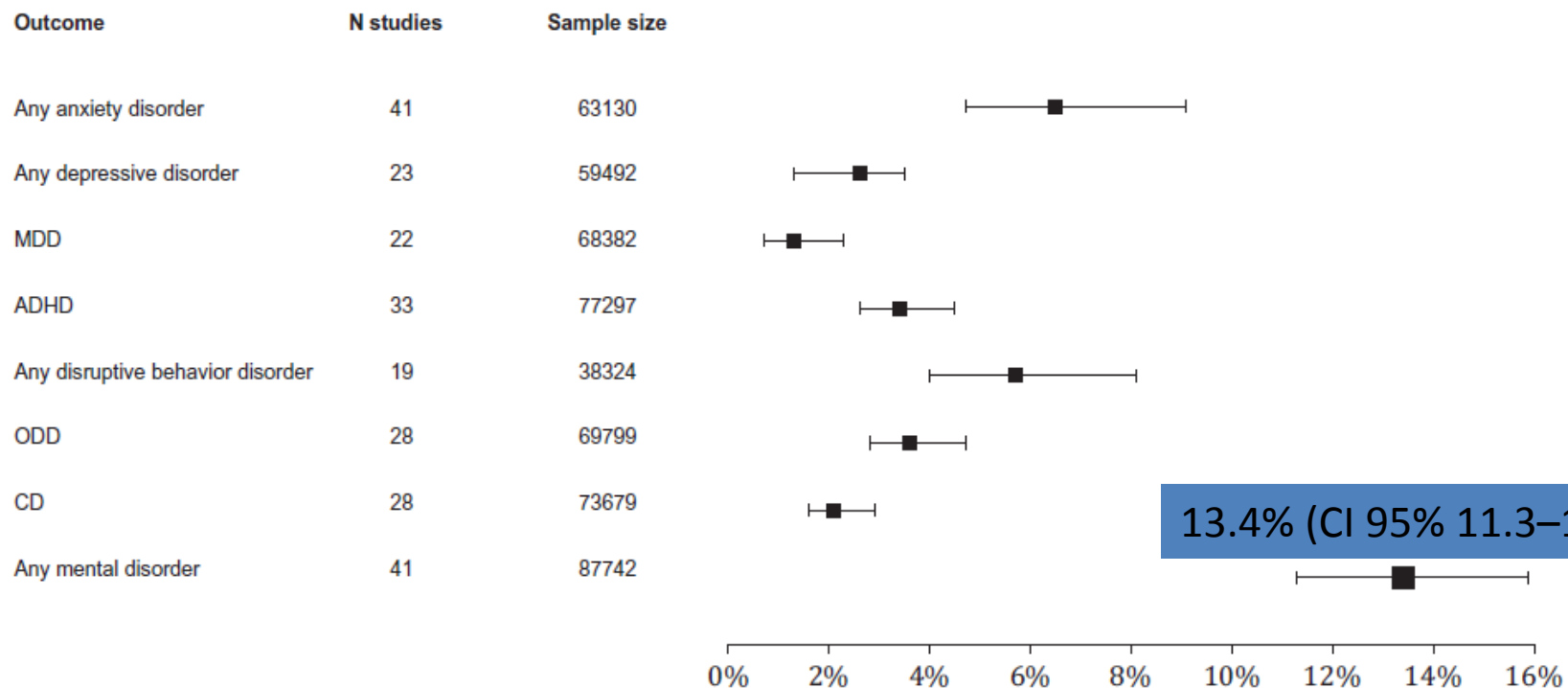
Guilherme V. Polanczyk,<sup>1,2,3</sup> Giovanni A. Salum,<sup>3,4</sup> Luisa S. Sugaya,<sup>1,2</sup> Arthur Caye,<sup>4</sup> and Luis A. Rohde<sup>3,4</sup>



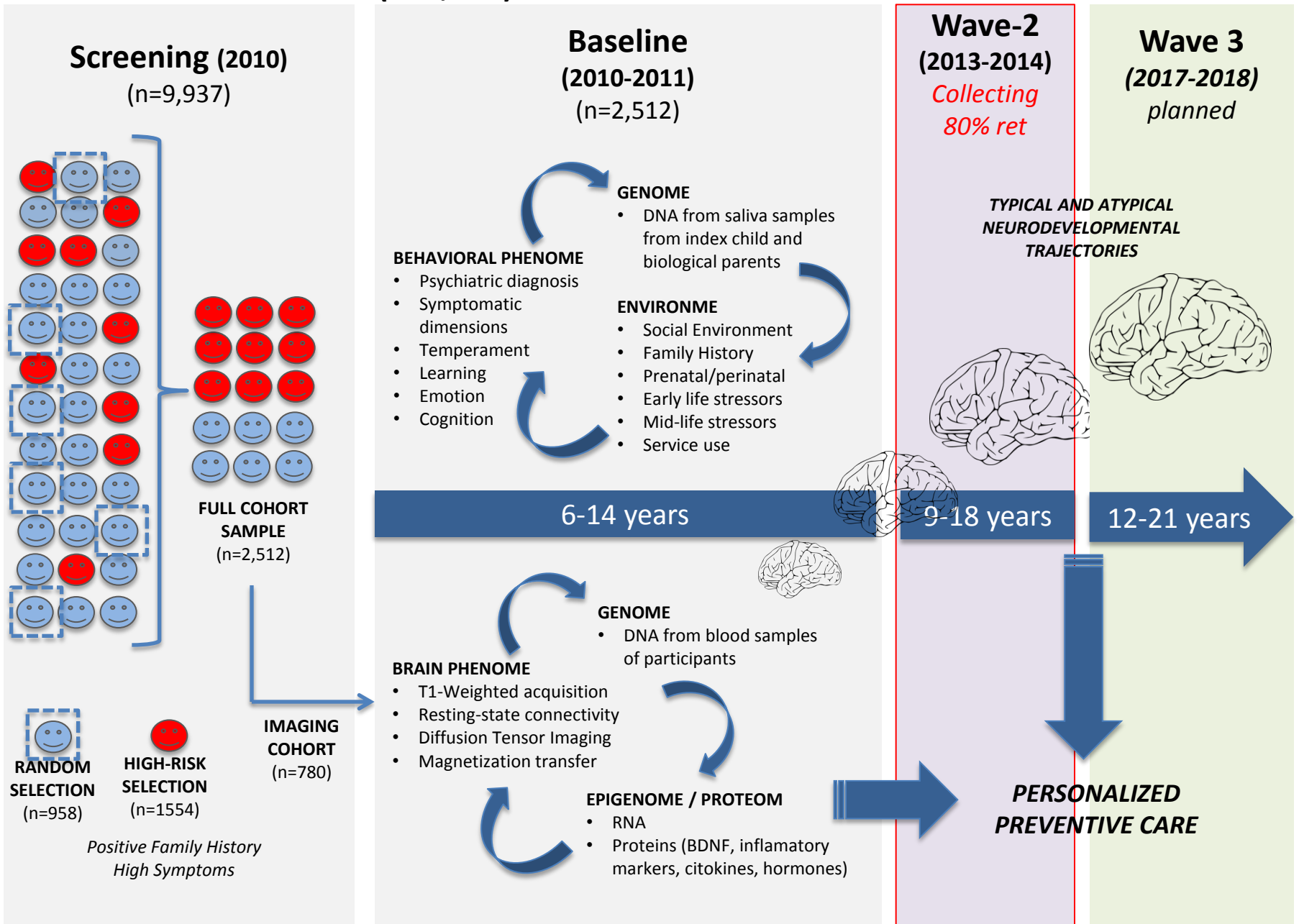
# Prevalência de Transtornos Mentais na Infância & Adolescência

## Annual Research Review: A meta-analysis of the worldwide prevalence of mental disorders in children and adolescents

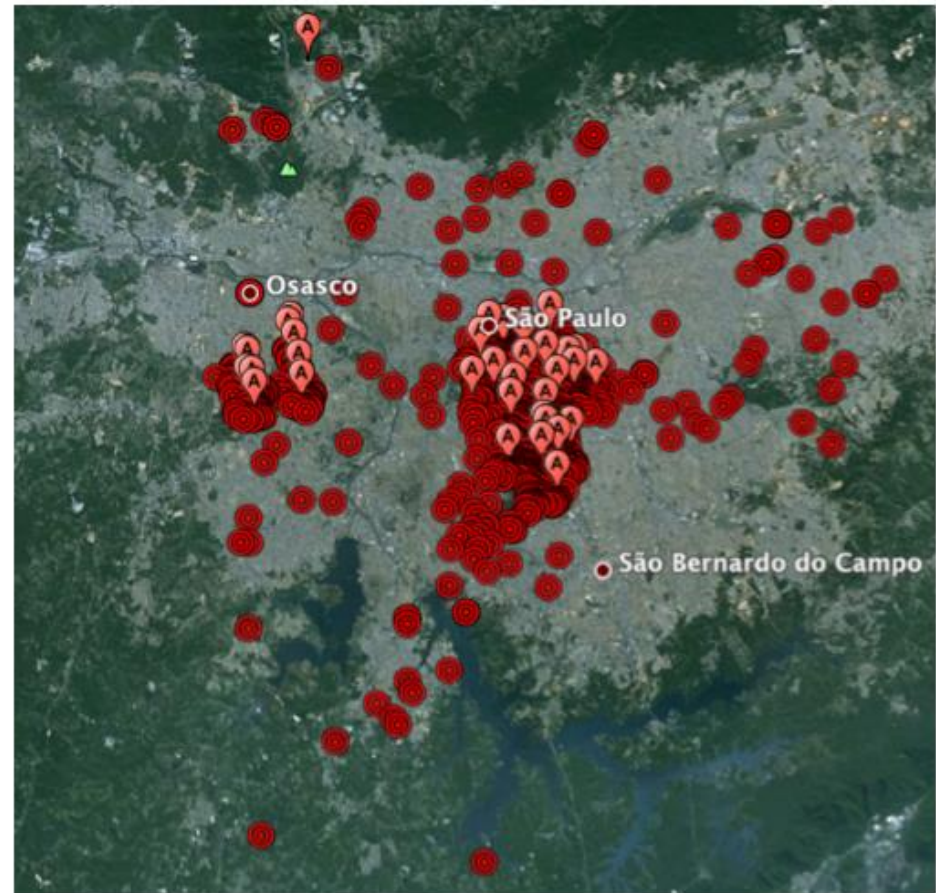
Guilherme V. Polanczyk,<sup>1,2,3</sup> Giovanni A. Salum,<sup>3,4</sup> Luisa S. Sugaya,<sup>1,2</sup> Arthur Caye,<sup>4</sup> and Luis A. Rohde<sup>3,4</sup>



# FULL HIGH RISK COHORT (n=2,512)



# ENRICHED IMAGING COHORT (n=780)



**Figure 1** –Subjects and schools geographic distribution in Porto Alegre and São Paulo

# Prevalência de Transtornos Mentais na Infância & Adolescência

## High risk cohort study for psychiatric disorders in childhood: rationale, design, methods and preliminary results

GIOVANNI ABRAHÃO SALUM,<sup>1,2</sup> ARY GADELHA,<sup>1,3</sup> PEDRO MARIO PAN,<sup>1,3</sup> TAIS SILVEIRA MORIYAMA,<sup>1,3,4</sup>  
 ANA SOLEDADE GRAEFF-MARTINS,<sup>1,4</sup> ANA CARINA TAMANAHA,<sup>1,3</sup> PEDRO ALVARENGA,<sup>1,4</sup>  
 FERNANDA VALLE KRIEGER,<sup>1,4</sup> BACY FLEITLICH-BILYK,<sup>1,4</sup> ANDREA JACKOWSKI,<sup>1,3</sup>  
 JOÃO RICARDO SATO,<sup>1,5</sup> ELISA BRIETZKE,<sup>1,3</sup> GUILHERME VANONI POLANCZYK,<sup>1,4</sup>  
 HELENA BRENTANI,<sup>1,4</sup> JAIR DE JESUS MARI,<sup>1,3</sup> MARIA CONCEIÇÃO DO ROSÁRIO,<sup>1,3</sup>  
 GISELE GUS MANFRO,<sup>1,2</sup> RODRIGO AFFONSECA BRESSAN,<sup>1,3</sup> MARCOS TOMANIK MERCADANTE,<sup>1†</sup>  
 EURÍPEDES CONSTANTINO MIGUEL<sup>1,4</sup> & LUIS AUGUSTO ROHDE<sup>1,2,4</sup>

**Table 2** - Diagnosis compared by selection cluster (random vs. high risk) in those that attended diagnostic interview (n=2,512) according to the Development and Well Being Behavior (DAWBA)

	Total (n=2512)		Randomly selected (n= 958)		Select by high risk (n=1554)		Statistics		
	Q	%	Q	%	Q	%	OR (CI95%)	$\chi^2$ Yates (df=1)	p-value
Any disorder	652	26.0	191	19.9	461	29.7	1.694 (1.397 to 2.053)	28.68	<0.001
Any Emotional	335	13.3	93	9.7	242	15.6	1.716 (1.331 to 2.212)	17.14	<0.001
Separation anxiety	72	2.9	20	2.1	52	3.3	1.624 (0.963 to 2.737)	2.96	0.087
Specific Phobia	89	3.5	28	2.9	61	3.9	1.357 (0.861 to 2.139)	1.46	0.227
Social phobia	26	1.0	3	0.3	23	1.5	4.782 (1.432 to 15.971)	6.78	0.009
Panic disorder	1	0.0	0	0.0	1	0.1	-	-	-
Agoraphobia	4	0.2	0	0.0	4	0.3	-	-	-
PTSD	23	0.9	8	0.8	15	1.0	1.157 (0.489 to 2.740)	0.014	0.907
OCD	7	0.3	2	0.2	5	0.3	1.543 (0.299 to 7.968)	0.017	0.895
GAD	47	1.9	17	1.8	30	1.9	1.090 (0.598 to 1.986)	0.017	0.898
Other anxiety	44	1.8	15	1.6	29	1.9	1.195 (0.638 to 2.242)	0.161	0.689
Major depression	73	2.9	11	1.1	62	4.0	3.578 (1.874 to 6.828)	15.967	<0.001
Other depression	8	0.3	1	0.1	7	0.5	4.330 (0.532 to 35.251)	1.279	0.258
Undiff anx/dep	6	0.2	0	0.0	6	0.4	-	-	-
Mania/bipolar	5	0.2	3	0.3	2	0.1	0.410 (0.068 to 2.459)	0.299	0.585
Any Hyperkinetic	274	10.9	79	8.2	195	12.5	1.597 (1.213 to 2.101)	10.85	<0.001
ADHD combined	105	4.2	29	3.0	76	4.9	1.647 (1.066 to 2.546)	4.683	0.030
ADHD inattentive	95	3.8	24	2.5	71	4.6	1.863 (1.165 to 2.981)	6.380	0.012
ADHD hyp-imp	40	1.6	13	1.4	27	1.7	1.285 (0.660 to 2.503)	0.332	0.565
Other hyperactivity	34	1.4	13	1.4	21	1.4	0.996 (0.496 to 1.998)	<0.001	>0.999
Any CD / ODD	171	6.8	53	5.5	118	7.6	1.403 (1.004 to 1.961)	3.65	0.056
Oppositional defiant	131	5.2	39	4.1	92	5.9	1.483 (1.011 to 2.176)	3.734	0.053
Conduct disorder	40	1.6	11	1.1	29	1.9	1.637 (0.814 to 3.293)	1.518	0.218
Other disruptive	9	0.4	6	0.6	3	0.2	0.307 (0.077 to 1.230)	2.021	0.155

# Prevalência de Transtornos Mentais na Infância & Adolescência

Soc Psychiat Epidemiol (2010) 45:135–142  
DOI 10.1007/s00127-009-0052-2

ORIGINAL PAPER

## Prevalence of psychiatric disorders in a Brazilian birth cohort of 11-year-olds

Luciana Anselmi · Bacy Fleidich-Bilyk ·  
Ana Maria B. Menezes · Cora L. Araújo ·  
Luis A. Rohde

### Abstract

**Objective** To estimate the prevalence of psychiatric disorders in preadolescents aged 11–12 years from a birth cohort in a southern Brazilian city.

**Methods** This is a cross-sectional investigation nested in a cohort study with a two-phase design: screening and diagnosis. In the screening phase, 4,452 preadolescents and their mothers were interviewed with the Strengths and Difficulties Questionnaire (SDQ). In the diagnostic phase, all preadolescents with a positive SDQ ( $n = 122$ ) and their mothers answered the Development and Well-Being Assessment for Children and Adolescents (DAWBA). A sample randomly selected among the cohort participants with a negative SDQ served as a control group (158 subjects and their mothers) and was also assessed using the DAWBA. **Results** After adjustment for the performance of the screening instrument, 10.8% (95% CI 7.1–14.5) of the preadolescents showed at least one psychiatric disorder

according to either the DSM-IV or the ICD-10. The most prevalent disorders were disruptive behavior (prevalence rates were 8.5% according to the DSM-IV and 7.1% according to the ICD-10) and anxiety disorders (prevalence rates were 6.0% according to the DSM-IV and 6.2% according to the ICD-10).

**Conclusion** Both overall and individual prevalence rates of psychiatric disorders found in this study are in the same range of other international studies, although slightly higher than findings from developed countries. The results corroborate previous findings from other epidemiological studies in children and adolescents suggesting the universality of psychiatric disorders across cultures.

**Keywords** Prevalence · Child and adolescent · Mental health problems · Epidemiology · Psychiatric disorders

**Table 1** Prevalence and confidence intervals for psychiatric disorders according to DSM-IV and ICD-10 diagnosis: 1993 cohort sample, follow-up 2004–2005

Disorders	Prevalence (95% CI)	
	DSM-IV	ICD-10
Any diagnosis	10.8 (7.1–14.5)	10.8 (7.1–14.5)
Any anxiety disorder	6.0 (3.2–8.8)	6.2 (3.2–8.8)
Separation anxiety disorder	0.7 (0.3–1.7)	0.8 (0.3–1.9)
Specific phobia	1.4 (0.2–2.2)	1.4 (0.2–2.2)
Social phobia	0.1 (0.3–0.5)	0.1 (0.3–0.5)
Obsessive-compulsive disorder	0.1 (0.3–0.5)	0.1 (0.3–0.5)
Generalized anxiety disorder	1.4 (0.2–2.2)	1.4 (0.2–2.2)
Posttraumatic stress disorder	0.1 (0.3–0.5)	–
Agoraphobia	–	0.1 (0.3–0.5)
Other anxiety disorder	2.2 (0.3–3.7)	2.3 (0.3–3.7)
Any depressive disorders	1.6 (0.4–3.6)	1.6 (0.4–3.6)
Major depression	1.6 (0.4–3.6)	0.9 (0.2–2.0)
Other depressive disorder	0.1 (0.3–0.5)	0.7 (0.3–1.7)
Any ADHD/hyperkinetic disorder	4.1 (1.6–6.4)	2.7 (0.9–5.0)
Any oppositional-conduct disorder	4.4 (1.6–6.4)	4.4 (1.6–6.4)
Oppositional defiant disorder	2.1 (0.3–3.7)	2.1 (0.3–3.7)
Conduct disorder	2.2 (0.3–3.7)	2.2 (0.6–3.4)
Other disruptive disorder	0.1 (0.3–0.5)	0.1 (0.3–0.5)
Less common disorders	1.4 (0.2–2.2)	1.4 (0.2–2.2)
Eating disorders	0.1 (0.3–0.5)	0.1 (0.3–0.5)
Tic disorders and Tourette syndrome	1.3 (0.2–2.2)	1.3 (0.2–2.2)

There were no cases of panic attacks, autistic spectrum disorders, bipolar disorder, attachment disorders, selective mutism, psychotic disorders



# Tratamento dos Transtornos Mentais na Infância & Adolescência no Brasil

OPEN ACCESS Freely available online

PLOS ONE

## The Mental Health Care Gap among Children and Adolescents: Data from an Epidemiological Survey from Four Brazilian Regions

Cristiane S. Paula<sup>1,2\*</sup>, Isabel A. S. Bordin<sup>2</sup>, Jair Jesus Mari<sup>2</sup>, Luciane Velasque<sup>3</sup>, Luis A. Rohde<sup>4</sup>, Evandro S. F. Coutinho<sup>5</sup>

**Table 2.** Use of mental health service according to psychiatric disorders in the whole sample (N=1,721).

K-SADS diagnoses	Mental Health Service Use (past 12 months)		p
	Yes	No	
	N (%)	N (%)	
<b>Any Psychiatric Disorder*</b>			
No (reference)	107 (7.6)	1303 (92.4)	<0.01
Yes	42 (19.8)	170 (80.2)	
<b>Main diagnostic groups**</b>			
None (reference)	107 (7.6)	1303 (92.4)	
Only Affective Disorders	1 (20.0)	4 (80.0)	0.33
Only Anxiety Disorders	15 (17.2)	72 (82.8)	<0.01
Only Disruptive Disorders	13 (20.3)	51 (79.7)	<0.01
Only Eating/Tic/Substance Use Disorders	1 (9.1)	10 (90.9)	0.58
Only Psychotic Disorders	0 (0.0)	1 (100.0)	NA
Comorbidity <sup>‡</sup>	9 (30.0)	21 (70.0)	<0.01

Caete' - MG  
Goianira – GO  
Itaitinga – CE  
Rio Preto da  
Eva – AM

# O caso do TDAH no Brasil

ESTADÃO

Saúde

## Brasil registra aumento de 775% no consumo de Ritalina em dez anos

FABIANA CAMERICOLI - O ESTADO DE S. PAULO  
11 Agosto 2014 | 07h 16

Remédio é usado para tratar o transtorno de déficit de atenção;  
pesquisa pode servir de alerta para uso abusivo do medicamento

A MEDICALIZAÇÃO ESCOLAR – EPIDEMIA DE NOSSO TEMPO: O  
CONCEITO DE TDAH EM DEBATE

A pilula da polêmica 05/03/2013 | 07h03

Diagnósticos errados ajudam a fazer de  
Porto Alegre a capital brasileira líder no  
uso de drogas para hiperatividade

Entre 2009 e 2011, uso de metilfenidato aumentou 75% na faixa dos seis aos 16 anos em todo o país



Original article

# ADHD prevalence estimates across three decades: an updated systematic review and meta-regression analysis

Guilherme V Polanczyk,<sup>1,2,3</sup> Erik G Willcutt,<sup>4</sup> Giovanni A Salum,<sup>3,5</sup> Christian Kieling<sup>5</sup> and Luis A Rohde<sup>3,5\*</sup>

<sup>1</sup>Department of Psychiatry, University of São Paulo Medical School, São Paulo, Brazil; <sup>2</sup>Department of Psychiatry, University of São Paulo Medical School, São Paulo, Brazil; <sup>3</sup>National Institute of Developmental Psychiatry for Children, São Paulo, Brazil; <sup>4</sup>Department of Psychology and Neuroscience, University of Virginia, Charlottesville, VA, USA; <sup>5</sup>ADHD Outpatient Program at the Child and Adolescent Psychiatry Institute of Porto Alegre, Federal University of Rio Grande do Sul, Porto Alegre, Brazil

\*Corresponding author. ADHD Outpatient Program (ProDAH), Hospital de Especialidades, Rua Barcellos Street, 2350, 90035-003, Porto Alegre, RS, Brazil. E-mail: lrohde@ufrgs.br

Accepted 21 November 2013

## Abstract

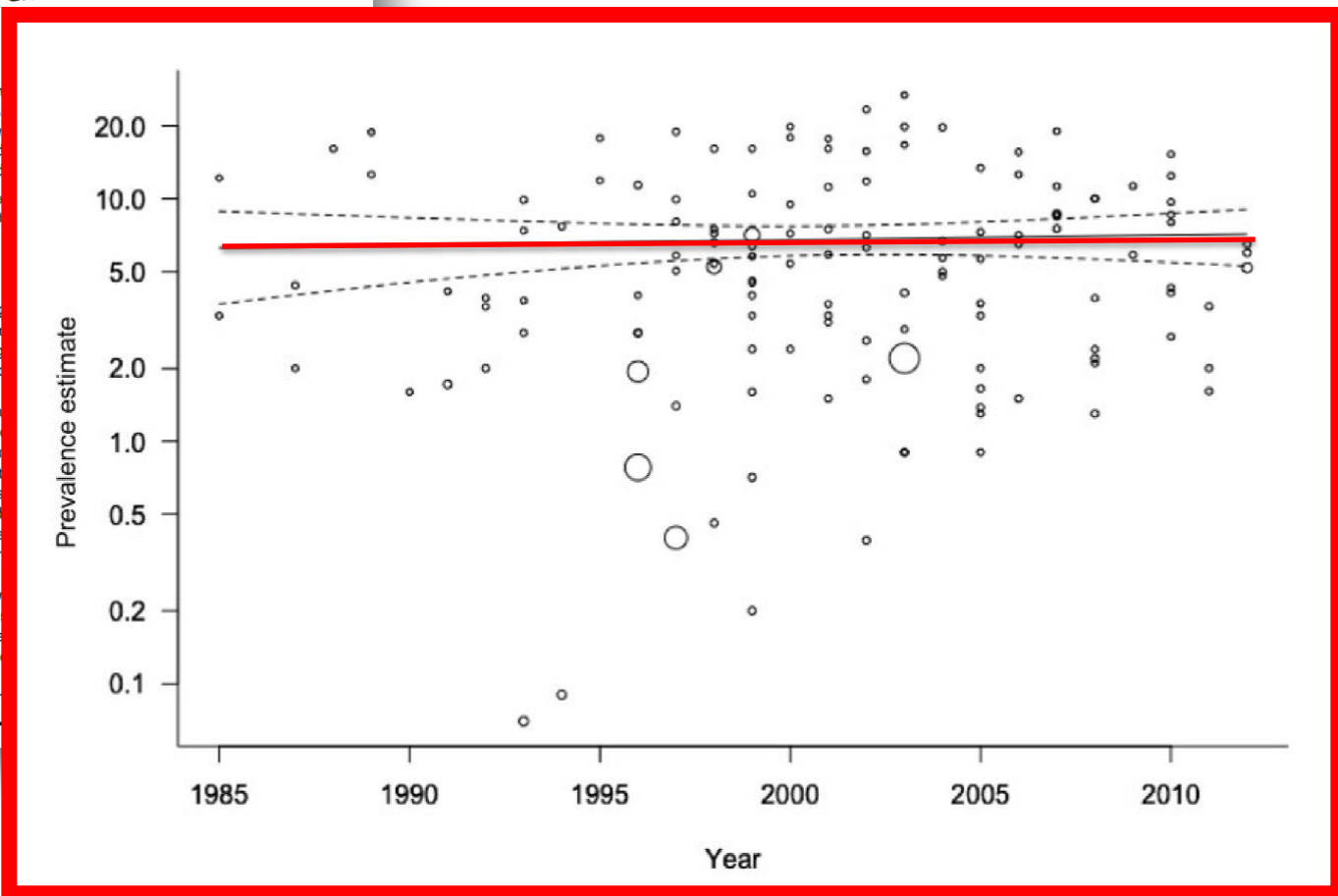
**Background:** Previous studies have identified significant variability in ADHD prevalence estimates across different methodological procedures. However, increasing methodological procedures throughout the past few decades have fuelled the concern that the prevalence of the disorder has increased over time.

**Methods:** We updated the two most comprehensive meta-analyses available in the literature. Meta-regression was used to assess the effect of year of study in the context of both methodological variability in ADHD prevalence (diagnostic criteria and information), and the geographical location of studies.

**Results:** We identified 154 original studies and 154 meta-analyses. Methodological procedures investigated were similar across studies. Geographical location and year of study had no effect on ADHD prevalence estimates.

**Conclusions:** Confirming previous findings, variability in ADHD prevalence estimates is mostly explained by methodological characteristics. There has been no evidence to suggest an increase in ADHD prevalence over time, and the prevalence of the disorder who meet criteria for ADHD when standardized.

**Key words:** ADHD, epidemiology, prevalence, time, cross-sectional



# O caso do TDAH no Brasil

Rev Bras Psiquiatr. 2012;34:513-516



**Revista Brasileira de Psiquiatria**  
RBP Psychiatry  
Official Journal of the Brazilian Psychiatric Association  
Volume 34 • Number 4 • December 2012



Carta aos Editores

## O TDAH é subtratado no Brasil

**Tabela 1** Número máximo de pacientes sob tratamento contínuo em 2009-2010 no Brasil e o número previsto de indivíduos com TDAH baseado na prevalência das estimativas mais conservadoras

Faixa etária	População brasileira *	Prevalência estimada do TDAH	Número estimado dos indivíduos com TDAH no Brasil	Número estimado de pacientes com TDAH sob tratamento em 2009**	Número estimado de pacientes com TDAH sob tratamento em 2010**
5 a 19 anos	49.127.006	0,9%	442.143	-	-
20 a 59 anos	107.242.035	0,45%	482.589	-	-
60 anos ou mais	20.590.599	NA	-	-	-
<b>TOTAL</b>			<b>924.732</b>	<b>149.937</b>	<b>184.481</b>

\*Dados do IBGE ([www.ibge.gov.br](http://www.ibge.gov.br)), 2010. \*\* Os números de comprimidos vendidos no Brasil em 2009-2010 foram 32.986.110 e 40.585.870. É considerado tratamento se o indivíduo ingerir uma pílula por dia (independente da dosagem ou preparação farmacêutica) por 22 dias por mês, 10 meses por ano.

# THE LANCET



## Mortality in children, adolescents, and adults with attention deficit hyperactivity disorder: a nationwide cohort study



*Søren Dalsgaard, Søren Dinesen Østergaard, James F Leckman, Preben Bo Mortensen, Marianne Giørtz Pedersen*

# Tratamento do TDAH



## Mortality in children, adolescents, and adults with attention deficit hyperactivity disorder: a nationwide cohort study

Søren Dalsgaard, Søren Dinesen Østergaard, James F Leckman, Preben Bo Mortensen, Marianne Giørtz Pedersen

	Number of deaths	Person-years	Mortality rate per 10 000 person-years	Crude model MRR (95% CI)*	Partly adjusted model MRR (95% CI)†	Fully adjusted model MRR (95% CI)‡
Age at first ADHD-diagnosis (years)						
1-5	10	29 944	3.34	2.23 (1.11-3.91)	1.97 (0.99-3.46)	1.86 (0.93-3.27)
6-17	59	136 048	4.34	1.83 (1.40-2.35)	1.63 (1.25-2.09)	1.58 (1.21-2.03)
>17	38	17 057	22.28	5.24 (3.73-7.12)	4.46 (3.18-6.07)	4.25 (3.03-5.78)
No ADHD	5473	24 724 510	2.21	1.00 (reference)	1.00 (reference)	1.00 (reference)
p value§	..	..		p<0.0001	p<0.0001	p<0.0001
Overall cohort	5580	24 907 560	2.24	..	..	..

Cohort consisted of 1.92 million children born in 1981-2011. MRR=mortality rate ratio. ADHD=attention deficit hyperactivity disorder. ..=not applicable. \*Crude model adjusted for age, calendar year, and sex. †Partly adjusted model adjusted for age, calendar year, sex, parental history of psychiatric disorders, and maternal and paternal age at time of delivery. ‡Fully adjusted model adjusted for age, calendar year, sex, parental history of psychiatric disorders, maternal and paternal age at time of delivery, parental educational, and parental employment status. §p value measures the overall effect of being diagnosed with ADHD at different ages, compared with individuals without ADHD.

Table 2: MRR according to age at first diagnosis of ADHD, compared with those without ADHD at same age

# Tratamento do TDAH

## Effect of drugs on the risk of injuries in children with attention deficit hyperactivity disorder: a prospective cohort study

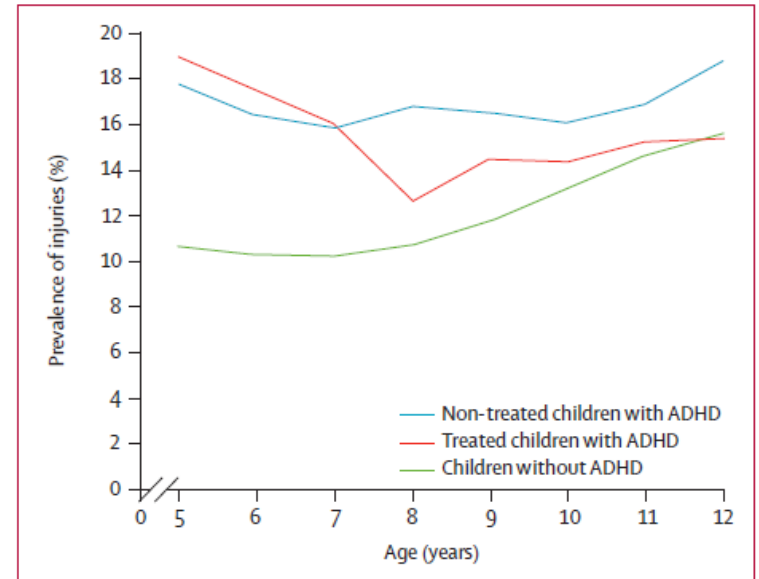


Søren Dalsgaard, James F Leckman, Preben Bo Mortensen, Helena Skyt Nielsen, Marianne Simonsen

	Difference-in-difference			Adjusted linear mixed model*		
	$\beta$ †	p value	DID % change in treated (95% CI)‡	$\beta$ †	OR (95% CI)	p value
<b>Injuries</b>						
Overall estimate§	-0.063	<0.0001	-31.5% (-43.3 to -19.7)	-0.035	0.82 (0.74 to 0.89)	<0.0001
At age 10 years	-0.045	0.008	-31.5% (-54.8 to -8.2)	-0.031	0.84 (0.74 to 0.95)	0.003
At age 11 years	-0.051	0.005	-33.6% (-56.8 to -10.3)	-0.036	0.85 (0.74 to 0.95)	0.005
At age 12 years	-0.067	0.001	-43.5% (-69.0 to -18.1)	-0.053	0.76 (0.65 to 0.88)	<0.0001
<b>Emergency ward visits</b>						
Overall estimate§	-0.052	<0.0001	-28.4% (-40.2 to -16.6)	-0.029	0.86 (0.79 to 0.93)	0.0003
At age 10 years	-0.048	0.012	-28.2% (-50.1 to -6.3)	-0.032	0.87 (0.76 to 0.97)	0.009
At age 11 years	-0.050	0.009	-27.6% (-48.2 to -7.1)	-0.025	0.89 (0.79 to 0.99)	0.030
At age 12 years	-0.081	<0.0001	-45.7% (-65.7 to -25.8)	-0.056	0.76 (0.65 to 0.87)	<0.0001

ADHD=attention deficit hyperactivity disorder. DID=difference-in-difference. OR=odds ratio. \*Model adjusted for sex, birthweight, birth complications, diagnosis of intellectual disability, maternal and paternal education, employment status, and psychiatric history, and maternal smoking during pregnancy. † $\beta$  is the estimated mean difference between treated and non-treated individuals. ‡The % change=( $\beta$ /mean) × 100, where the mean is the mean of the dependent variable (injuries or emergency ward visits) in the treated group at baseline. §One fitted panel data model with a linear age trend and outcomes at age 4, 10, 11, and 12 years.

**Table 3: Effect of pharmacological treatment with stimulant drugs before age 10 years in children with ADHD on the subsequent risk of sustaining an injury and on having an emergency ward visit, after age 10 years**



**Figure: Prevalence of injuries in children without ADHD (n=705 563) and by pharmacological treatment status in children with ADHD (n=4557)** Treatment was defined as pharmacological treatment for at least 6 months during a year after age 5 years and before age 10 years. Children with ADHD who received treatment (n=1457) had a reduction in the prevalence of injuries from 19% at age 5 years to 15% at age 12 years, whereas the prevalence of injuries in children with ADHD without pharmacological treatment (n=3100) increased from 18% to 19%. In children without ADHD, the prevalence of injuries increased from 11% to 16% from age 5 years to 12 years. The figure shows the descriptive change with increasing age. However, in the difference-in-difference analyses of the estimated effect of ADHD drugs on the risk of injuries, only injuries after the age of 10 years were included.

# Tratamento do TDAH

Revista Brasileira de Psiquiatria. 2015;37:67-70

© 2015 Associação Brasileira de Psiquiatria

doi:10.1590/1516-4446-2014-1378

## BRIEF COMMUNICATION

### The Brazilian policy of withholding treatment for ADHD is probably increasing health and social costs

Carlos R. Maia,<sup>1</sup> Steffan F. Stella,<sup>2</sup> Paulo Mattos,<sup>3</sup> Guilherme V. Polanczyk,<sup>4</sup> Carisi A. Polanczyk,<sup>1,2</sup> Luis A. Rohde<sup>1</sup>

<sup>1</sup>Universidade Federal do Rio Grande do Sul (UFRGS), Porto Alegre, RS, Brazil. <sup>2</sup>Instituto de Avaliação de Tecnologia em Saúde (IATS), Porto Alegre, RS, Brazil. <sup>3</sup>Universidade Federal do Rio de Janeiro (UFRJ), Rio de Janeiro, RJ, Brazil. <sup>4</sup>Universidade de São Paulo (USP), São Paulo, SP, Brazil.

**Objective:** To estimate the economic consequences of the current Brazilian government policy for attention-deficit/hyperactivity disorder (ADHD) treatment and how much the country would save if treatment with immediate-release methylphenidate (MPH-IR), as suggested by the World Health Organization (WHO), was offered to patients with ADHD.

**Method:** Based on conservative previous analyses, we assumed that 257,662 patients aged 5 to 19 years are not receiving ADHD treatment in Brazil. We estimated the direct costs and savings of treating and not treating ADHD on the basis of the following data: a) spending on ADHD patients directly attributable to grade retention and emergency department visits; and b) savings due to impact of ADHD treatment on these outcomes.

**Results:** Considering outcomes for which data on the impact of MPH-IR treatment are available, Brazil is probably wasting approximately R\$ 1.841 billion/year on the direct consequences of not treating ADHD in this age range alone. On the other hand, treating ADHD in accordance with WHO recommendations would save approximately R\$ 1.163 billion/year.

**Conclusions:** By increasing investments on MPH-IR treatment for ADHD to around R\$ 377 million/year, the country would save approximately 3.1 times more than is currently spent on the consequences of not treating ADHD in patients aged 5 to 19 years.

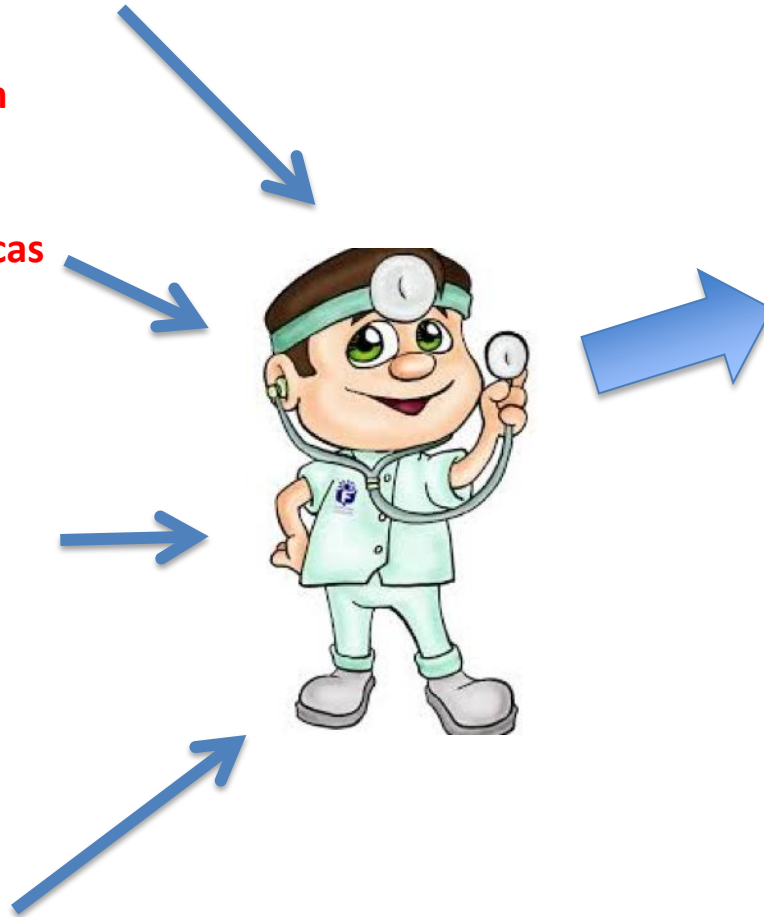
**Keywords:** attention-deficit/hyperactivity disorder; social and political issues; costs and cost analysis; child psychiatry; central nervous system stimulants



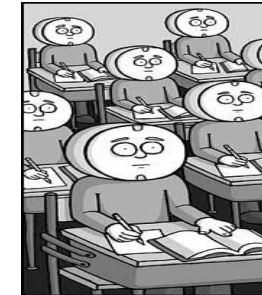
# O TDAH: Um cenário complexo

## Dimensional View of Attention Deficit Hyperactivity Disorder

**Medicações eficazes e com perfil de eventos adversos menores do que a maioria das medicações psiquiátricas**



Famílias de classe media e media alta



Entretanto, em famílias menos favorecidas...

# Association Between Alpha-2a-adrenergic Receptor Gene and ADHD Inattentive Type

Marcelo Schmitz, Daniel Denardin, Tatiana Laufer Silva, Thiago Planca, Tatiana Roman, Mara Helena Hutz, Stephen V. Faraone, and Luis Augusto Rohde

## CASES

486 STUDENTS WERE SELECTED AT THE SCHOOLS BASED ON TEACHERS' SCORES IN THE SNAP-IV

ALL INVITED TO DIAGNOSTIC PHASE:

- 1) K-SADS-E APPLIED BY RESEARCH ASSISTANTS
- 2) ESTIMATED IQ BY TRAINED PSYCHOLOGISTS
- 3) FULL CLINICAL ASSESSMENT BY A CHILD PSYCHIATRIST

13 REFUSES  
331 NEGATIVE FOR ADHD-I  
18 MENTAL RETARDATION  
24 BIOLOGICAL MOTHER NOT AVAILABLE

100 CASES

## CONTROLS

245 STUDENTS WERE SELECTED AT THE SCHOOLS BASED ON TEACHERS' SCORES IN THE SNAP-IV

151 INVITED TO DIAGNOSTIC PHASE:

- 1) K-SADS-E APPLIED BY RESEARCH ASSISTANTS
- 2) ESTIMATED IQ BY TRAINED PSYCHOLOGISTS
- 3) FULL CLINICAL ASSESSMENT BY A CHILD PSYCHIATRIST

37 REFUSES  
12 HAD ADHD  
02 HAD MENTAL RETARDATION

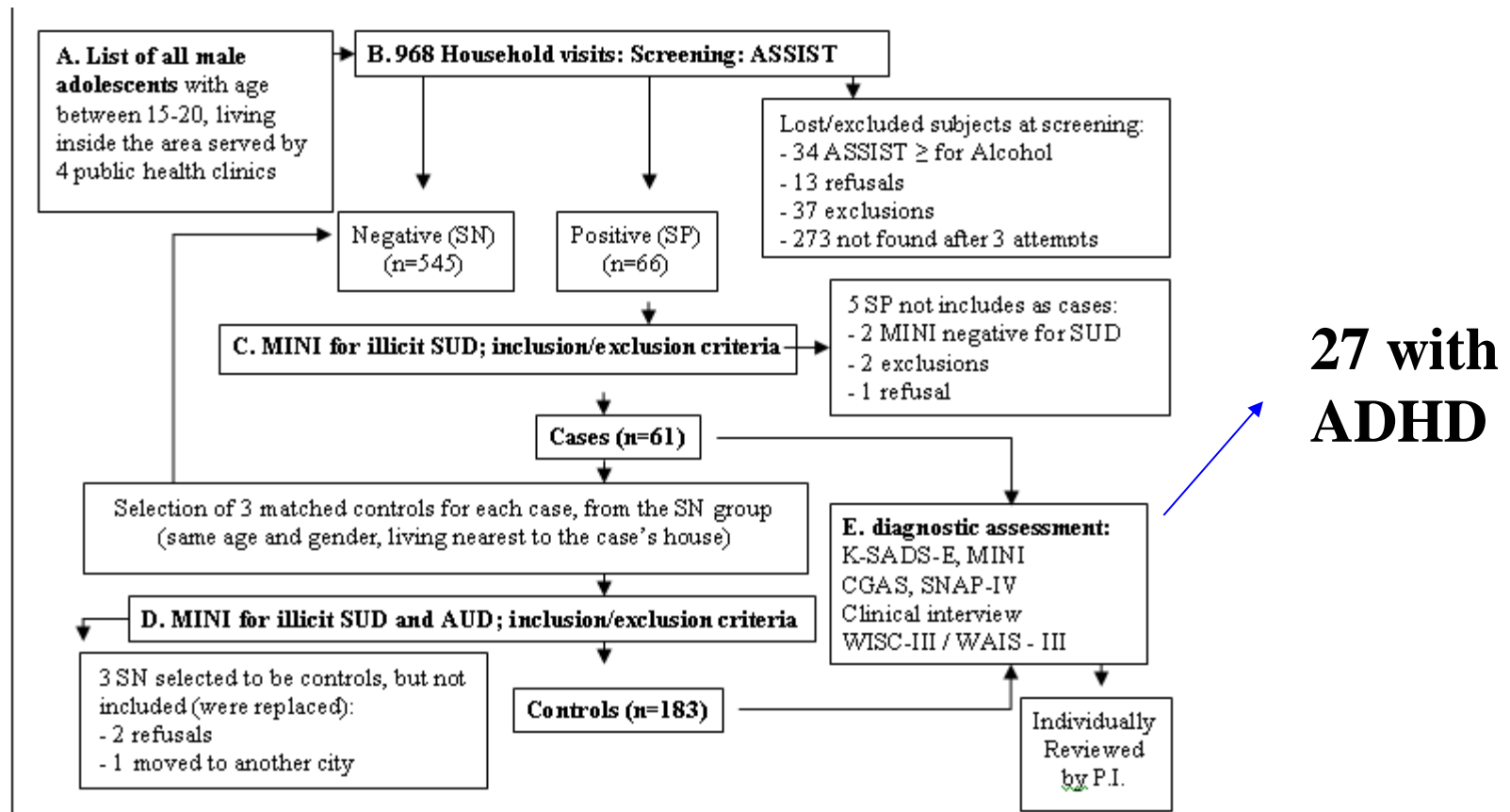
100 CONTROLS

Figure 1. Flow chart of the patients' participation.

# Is attention-deficit/hyperactivity disorder associated with illicit substance use disorders in male adolescents? A community-based case-control study

Claudia M. Szobot,<sup>1,2,4</sup> Luis A. Rohde,<sup>2</sup> Oscar Bukstein,<sup>3</sup> Brooke S. G. Molina,<sup>3</sup> Caroline Martins,<sup>4</sup> Pauline Ruaro<sup>4</sup> & Flávio Pechansky<sup>1</sup>

Center for Drug and Alcohol Research, Hospital de Clínicas de Porto Alegre (HCPA), Federal University of Rio Grande do Sul (UFRGS), Brazil,<sup>1</sup> ADHD Outpatient Clinic, HCPA, UFRGS, Brazil,<sup>2</sup> Lutheran University of Brazil, School of Medicine, Brazil<sup>3</sup> and Western Psychiatric Institute and Clinic, University of Pittsburgh School of Medicine, USA<sup>4</sup>



## A.D.H.D. Rates Rise Around Globe, but Sympathy Often Lags

By KATHERINE ELLISON NOVEMBER 9, 2015 11:58 AM 100 Comments



“We need to be worried about the industry pressures, and we need to be worried about overdiagnosis, for sure,” said Luis Rohde, a professor of child psychiatry at Federal University of Rio Grande do Sul in Brazil, and president of the [World Federation of A.D.H.D.](#)

“But we also need to see the suffering of these families, and of children who are not being able to grow up healthy without the diagnosis.”

# Modificações do artigo 14 da Lei 8069

## Conclusões

- Transtornos mentais na infância e adolescência são prevalentes de forma similar no Brasil e no mundo, mas poucos portadores tem acesso a tratamento no nosso país.
- O TDAH acarreta morbi-mortalidade na população de crianças e o tratamento adequado diminui esses desfechos.
- Há um aumento de prescrições de estimulantes para TDAH no país por diversas razões, incluindo prescrições inadequadas. Entretanto, o maior problema de saúde pública no Brasil em relação ao TDAH é o subdiagnóstico e subtratamento em populações carentes.
- Nesse contexto, os legisladores devem ter muito bom senso para que determinadas ações não acarretem ainda menor acesso a tratamento a quem mais precisa.
- § 2º A prevenção do uso indiscriminado, desnecessário ou excessivo de psicofármacos em crianças e adolescentes inclui-se entre os temas a serem tratados nas campanhas de educação sanitária previstas no caput.” **(Nota do Relator Senador Rodrigo RoleMBERG)**

# Modificações do artigo 14 da Lei 8069

## Conclusões

- § 2º **O diagnóstico e tratamento adequado dos transtornos mentais**, bem como a prevenção do uso indiscriminado, desnecessário ou excessivo de psicofármacos em crianças e adolescentes **incluem-se** entre os temas a serem tratados nas campanhas de educação sanitária previstas no caput.”  
**(Nota do Relator Senador Rodrigo Rolemberg)**

# Caso de menino algemado em escola provoca briga judicial nos EUA

BBC Mundo

🕒 4 agosto 2015

Ele foi algemado pelo policial Kevin Sumner, responsável pela segurança de uma escola do estado americano do Kentucky, que queria que a criança ficasse quieta porque punha os outros alunos em risco, com sua agitação.

