

# Psychiatric Diagnoses Among Children and Young People in the Nordic Countries

With focus on statistics from Denmark, Faroe Islands,  
Finland, Åland, Iceland, Norway and Sweden.

Nordic Medico-Statistical Committee (NOMESCO)

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# Introduction

In recent years, concerns about the mental health of children and young people have grown across many countries. Responding to this issue, the Nordic Committee for Children and Young People (NORDBUK) requested the Nordic Medico-Statistical Committee (NOMESCO) to collect and present statistics on this topic within the Nordic region. This article highlights selected statistics on psychiatric diagnoses trends among children and young people, with specific sections dedicated to each country.

## Objectives

The report had two main objectives: the first was to investigate time trends in the prevalence of psychiatric diagnoses in the child and adolescent population. The second was to assess the comparability of the statistical measures across several Nordic countries.

The countries and regions covered in this report are Iceland, Finland, Åland, Norway, Sweden, Denmark, and the Faroe Islands.

Each country has collected information on the prevalence of psychiatric diagnoses among children and young people (see the list of relevant psychiatric diagnoses in Table 1). The report describes healthcare contacts with primary care services and psychiatric healthcare centres, as well as patterns of medication use.

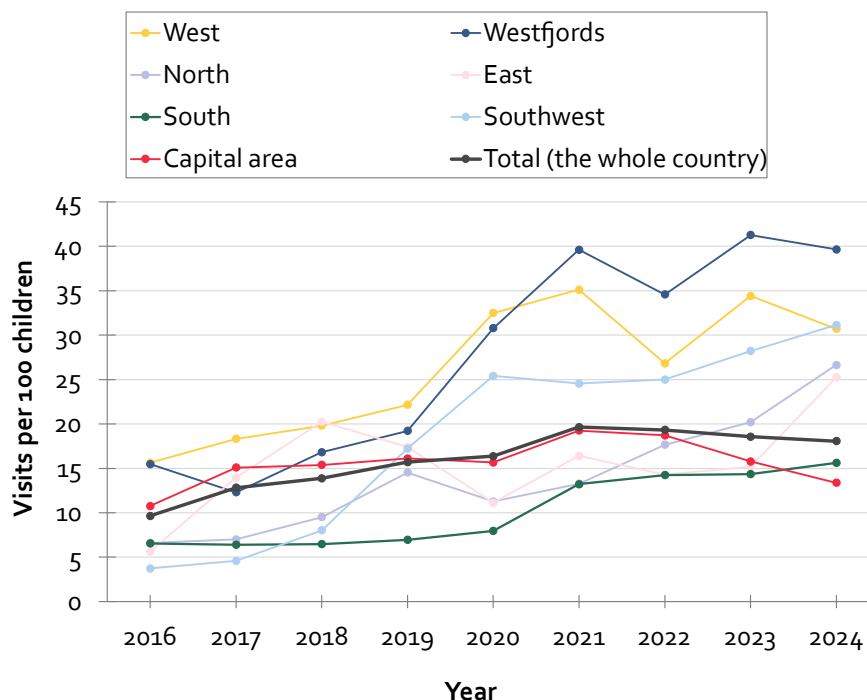
The statistical measures analysed were healthcare visits, one-year prevalence of psychiatric diagnoses among children and young people and one-year prevalence of drug use. The data were obtained from national registers covering primary care, outpatient and inpatient care and prescription drug registers (drugs dispensed in pharmacies).

# Iceland

## Visits to primary care for mental or behavioural disorders

The Directorate of Health in Iceland recently published a Public Health Indicator on mental and behavioural disorders among 6–17-year-olds. The indicator presents the number of visits by 6–17-year-olds to primary health care or secondary mental health care centres within primary care where the main (first) diagnosis was a mental or behavioural disorder (ICD-10: F10-F69, F90-F99), per 100 population of the same age. Figures are presented for each of the seven health districts and are separated by sex.

Judging by the number of primary care consultations where the first diagnosis was a mental or behavioural disorder, there are clear signs that primary care has expanded its services for children and adolescents with mental health issues. This development coincides with the introduction of psychological services at primary healthcare centres in 2017. Since then, many mental health teams have started operating within primary care. The number of children's visits to primary care for mental and behavioural disorders has increased since 2017, particularly in rural districts.



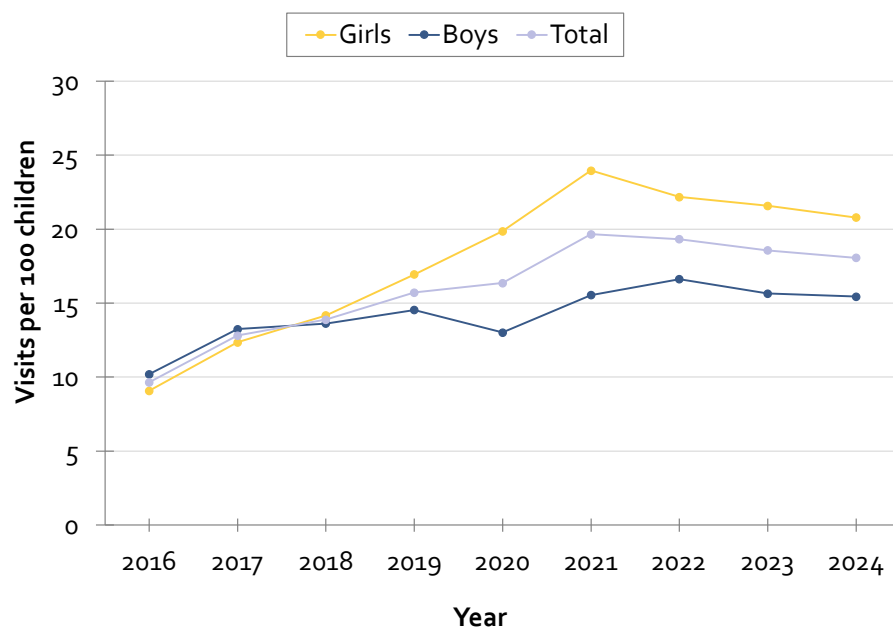
**Figure 1.** Rate of healthcare visits for mental and behavioural disorders among children and adolescents (ages 6–17 years), per 100 population, by health district, Iceland

Source: The Directorate of Health, Iceland. Register of Primary Health Care Contacts.

**Note.** Included ICD-10 codes: F10-F69, F90-F99.

There is a considerable difference in the number of visits per 100 inhabitants across residential areas (Figure 1). The rate is generally higher in regions outside the capital area and lowest in the capital area. One possible explanation is that the availability of secondary mental health services, provided by private practice psychiatrists and psychologists, varies greatly by region in Iceland. A large majority of child and adolescent psychiatrists and psychologists are located in the capital area, resulting in reduced access to these services in other parts of the country. Children outside the capital area thus have access to mental health services provided by primary care in their home community, while children in the capital area also have access to services from private practice psychiatrists in their home community. The geographic distribution of services affects regional utilisation.

In recent years, girls have recorded higher rates of visits associated with mental or behavioural disorder diagnoses than boys. While boys had marginally higher rates in 2016 and 2017, rates among girls have exceeded those of boys since 2018, with the gender gap widening steadily through 2021 (Figure 2).



**Figure 2.** Rate of healthcare visits for mental and behavioural disorders among children and adolescents (ages 6–17 years), per 100 population, by sex, Iceland

Source: The Directorate of Health, Iceland. Register of Primary Health Care Contacts.

**Note.** Included ICD-10 codes: F10-F69, F90-F99.

## Selected psychiatric diagnoses within primary care

Table 1 presents the annual prevalence of selected psychiatric diagnoses among children and adolescents aged 0–18 years in Iceland. Prevalence is defined as the number of individuals with relevant ICD-10 codes recorded in primary healthcare or secondary mental health services within primary care during the specified year, based on data from the Register of Primary Health Care Contacts.

The earlier measure on mental and behavioural disorders (Figures 1 and 2) considers only visits and counts the number of such encounters, with analyses restricted to primary diagnoses. In contrast, the measure used for the diagnostic groups presented in Table 1 counts individuals rather than visits, includes other types of healthcare contacts beyond visits, and imposes no restrictions on diagnostic order.

As shown in Table 1, it is difficult to obtain the prevalence of certain psychiatric diagnosis groups among children and adolescents from primary healthcare data alone. Figure 3 displays the prevalence trends for the groups in Table 1, for which there is sufficient data for both boys and girls.

**Table 1.** Annual prevalence of psychiatric diagnoses among children and adolescents (ages 0–18 years), per 1,000 population, 2010–2024, Iceland

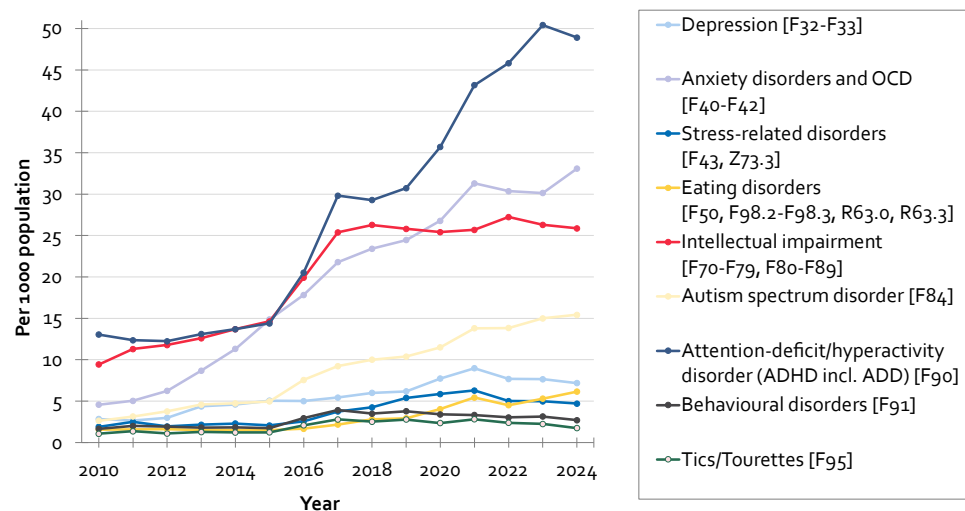
Group [ICD-10 codes]		2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Psychotic disorders [F1x.5, F1x.7, F23, F25, F28, F29]	Boys	*	*	*	*	*	*	*	-	*	*	*	*	*	*	*
	Girls	-	*	-	*	*	-	*	*	*	*	*	*	*	*	*
	Total	*	*	*	*	0,1	*	*	*	*	*	0,1	*	*	0,1	0,1
Manic episode [F30]	Boys	-	-	-	*	-	-	-	-	*	-	-	-	-	-	-
	Girls	-	-	-	*	*	*	-	*	*	*	-	-	-	-	*
	Total	-	-	-	*	*	*	-	*	*	*	-	-	-	-	*
Bipolar disorder [F31]	Boys	*	-	*	*	*	-	*	*	*	*	*	*	-	0,1	*
	Girls	*	-	*	*	*	-	*	*	*	*	*	*	0,1	0,1	*
	Total	*	-	*	*	*	-	*	*	*	*	*	0,1	0,1	0,1	*
Depression [F32-F33]	Boys	2,4	2,0	2,2	2,9	3,0	3,3	3,7	4,0	4,8	4,4	4,8	5,7	5,7	5,1	4,7
	Girls	3,3	3,3	3,8	5,9	6,3	6,8	6,3	6,9	7,3	8,1	10,8	12,4	9,8	10,4	9,8
	Total	2,8	2,7	3,0	4,4	4,6	5,1	5,0	5,4	6,0	6,2	7,7	9,0	7,7	7,7	7,2
Anxiety disorders and OCD [F40-F42]	Boys	3,7	4,1	4,9	6,2	7,7	9,2	12,0	15,3	16,7	18,1	18,2	20,7	20,3	20,4	22,4
	Girls	5,5	6,0	7,6	11,3	15,1	20,7	23,9	28,5	30,4	31,1	35,8	42,5	40,9	40,5	44,4
	Total	4,6	5,0	6,2	8,7	11,3	14,9	17,8	21,8	23,4	24,5	26,8	31,3	30,4	30,1	33,1
Stress-related disorders [F43, Z73.3]	Boys	1,5	2,0	1,5	1,7	1,7	1,2	1,9	2,5	3,3	4,1	4,3	4,5	3,5	3,4	3,5
	Girls	2,4	3,0	2,4	2,6	3,0	3,0	3,2	5,0	5,3	6,8	7,5	8,2	6,6	6,7	6,0
	Total	1,9	2,5	2,0	2,2	2,3	2,1	2,6	3,7	4,3	5,4	5,9	6,3	5,0	5,0	4,7
Eating disorders [F50, F98.2-F98.3, R63.0, R63.3]	Boys	1,3	1,2	1,2	1,0	1,3	1,3	1,2	1,9	2,4	2,6	3,8	4,3	4,2	4,4	5,3
	Girls	1,9	2,1	2,1	2,0	1,7	1,7	2,2	2,5	3,2	3,2	4,4	6,6	4,8	6,3	7,0
	Total	1,6	1,6	1,6	1,5	1,5	1,5	1,7	2,2	2,8	2,9	4,0	5,4	4,5	5,3	6,2
Intellectual impairments [F70-F79, F80-F89]	Boys	12,9	15,6	16,7	18,1	19,0	20,8	27,8	35,1	36,0	34,9	34,4	34,9	35,5	35,1	34,1
	Girls	5,8	6,8	6,6	6,8	8,2	8,2	11,8	15,3	16,1	16,2	15,9	16,0	18,5	16,9	17,1
	Total	9,4	11,3	11,8	12,6	13,7	14,6	19,9	25,4	26,3	25,8	25,4	25,7	27,2	26,3	25,9
Autism spectrum disorder [F84]	Boys	3,9	5,1	5,8	7,2	7,4	7,9	11,9	13,9	14,9	15,1	16,5	19,2	18,5	20,7	20,6
	Girls	1,3	1,1	1,7	1,8	2,0	1,9	3,1	4,3	4,9	5,4	6,2	8,1	8,8	8,8	9,8
	Total	2,6	3,1	3,8	4,6	4,7	5,0	7,6	9,2	10,0	10,4	11,5	13,8	13,8	15,0	15,4
Attention- deficit/hyperactivity disorder (ADHD incl. ADD) [F90]	Boys	18,9	18,0	17,9	19,4	20,1	20,5	29,4	40,7	39,0	40,3	45,9	53,8	56,1	61,0	57,3
	Girls	6,9	6,5	6,3	6,6	7,1	8,0	11,3	18,5	19,1	20,7	24,9	31,9	34,9	39,1	39,9
	Total	13,0	12,4	12,2	13,1	13,7	14,4	20,5	29,8	29,3	30,7	35,7	43,2	45,8	50,4	48,9
Behavioural disorders [F91]	Boys	2,3	2,9	2,7	2,6	2,6	2,5	4,3	5,5	5,3	5,1	5,2	4,9	4,4	4,4	3,7
	Girls	1,0	1,0	1,1	1,0	1,1	1,0	1,6	2,3	1,6	2,5	1,5	1,6	1,6	1,8	1,6
	Total	1,7	2,0	1,9	1,8	1,8	1,8	2,9	3,9	3,5	3,8	3,4	3,3	3,0	3,1	2,7
Attachment disorders [F94.1-F94.2]	Boys	*	*	*	*	-	*	*	*	*	*	*	*	*	*	*
	Girls	-	-	-	-	-	*	*	*	*	*	*	*	*	*	*
	Total	*	*	*	*	-	*	*	*	0,1	0,1	0,1	0,1	0,1	0,1	0,1
Tics/Tourette [F95]	Boys	1,6	2,1	1,5	1,8	1,9	1,8	3,2	4,3	3,7	3,9	3,5	3,7	3,2	2,8	2,5
	Girls	0,6	0,6	0,6	0,7	0,6	0,6	0,9	1,3	1,3	1,6	1,2	1,8	1,5	1,6	0,9
	Total	1,1	1,4	1,1	1,3	1,2	1,2	2,1	2,8	2,5	2,8	2,4	2,8	2,4	2,2	1,7

Source: The Directorate of Health, Iceland. Register of Primary Health Care Contacts. **Note.** \* Masked values where case numbers for either boys or girls are between 1 and 4

The highest and most rapidly increasing prevalence is observed for attention-deficit/hyperactivity disorder (ADHD), which rises steadily throughout the period, with a pronounced acceleration after 2016 and again after 2020. Anxiety disorders and obsessive–compulsive disorder (OCD) also show a substantial upward trend, increasing consistently from 2010, with some fluctuation in recent years but remaining at a clearly elevated level by 2024.

Autism spectrum disorder (ASD) prevalence increases gradually but persistently across the entire period. Depression and stress-related disorders show more moderate increases, with a noticeable rise around 2019–2021 and some stabilisation thereafter. Eating disorders increase slowly over time, particularly from around 2018 onward.

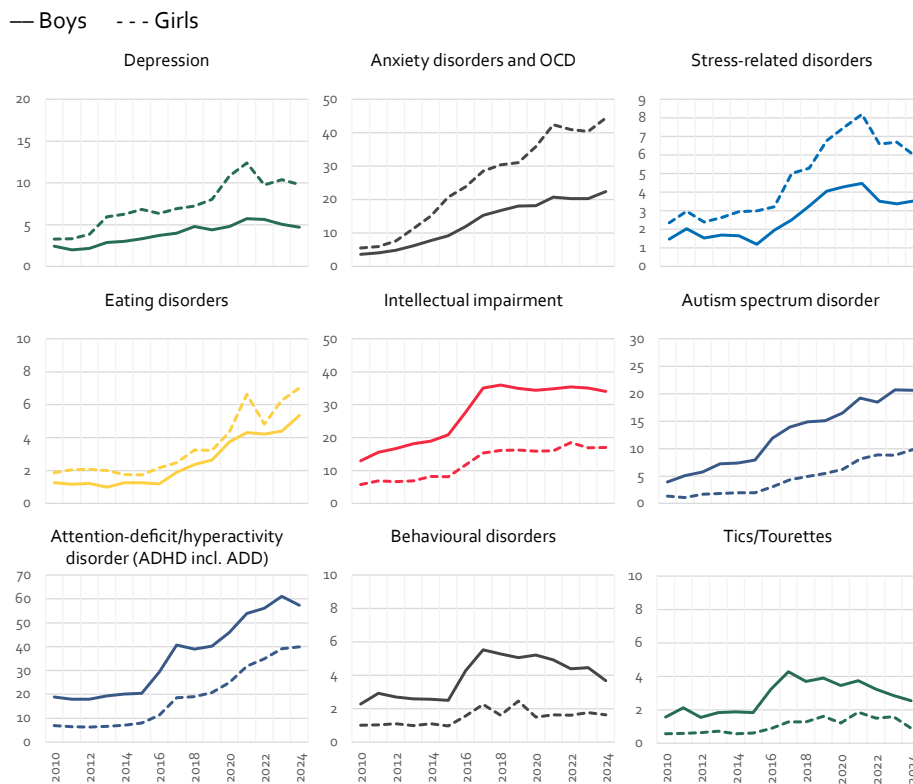
In contrast, tics/Tourette’s syndrome and behavioural disorders remain comparatively rare and show relatively stable prevalence over time. Intellectual impairment increases during the early and mid-2010s, followed by stabilisation and a slight decline in the later years of the period.



**Figure 3.** Annual prevalence of psychiatric diagnoses in primary care among children and adolescents (ages 0–18 years), per 1,000 population, Iceland

Figure 4 shows clear gender differences across most diagnostic groups, noting that the y-axis scales vary between groups. Depression, anxiety disorders and OCD, stress-related disorders, and eating disorders are consistently more prevalent among girls than boys, with differences increasing from the mid-to-late 2010s onward as prevalence rises in both genders.

In contrast, intellectual impairment, autism spectrum disorder (ASD), attention-deficit/hyperactivity disorder (ADHD), behavioural disorders, and tics/Tourette’s syndrome show higher prevalence among boys throughout the period. For ASD and ADHD, prevalence increases in parallel for both genders, while behavioural disorders and tics/Tourette’s syndrome remain at lower and relatively stable levels over time.



**Figure 4.** Annual prevalence of psychiatric diagnoses in primary care among children and adolescents (ages 0–18 years), per 1,000 population, by sex, Iceland

In summary, the figures demonstrate a general increase in the recorded prevalence of several psychiatric diagnosis groups among children and adolescents over the past decade, with particularly strong growth in ADHD and anxiety-related disorders. Clear and persistent gender differences are observed, with boys more frequently diagnosed with neurodevelopmental and behavioural disorders, and girls showing higher prevalence of internalizing disorders such as anxiety, depression, stress-related disorders, and eating disorders.

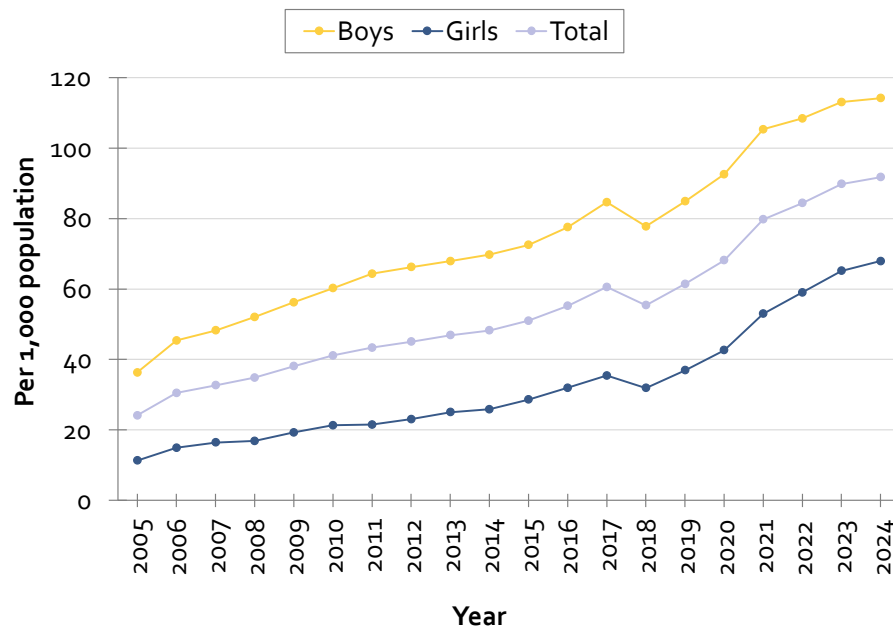
When interpreting these trends, it is important to note that the prevalence estimates reflect only children and adolescents who have had contact with primary healthcare or secondary mental healthcare services provided within primary care. Individuals who seek care exclusively from private practices and hospitals may not be captured in these data. Furthermore, in line with legislation and national health policy objectives, Icelandic health authorities have placed increasing emphasis in recent years on strengthening mental health services within primary care. Consequently, while the observed trends indicate growing mental health challenges among children and adolescents, they may also partly reflect improved access to, availability of, and detection within mental health services in primary care settings.

## Use of ADHD medication

The use of ADHD medication among children aged 6–17 years in Iceland has increased steadily over the past two decades. In 2024, the dispensed amount for this age group reached 91.8 defined daily doses (DDD) per 1,000 inhabitants per day, reflecting a substantial rise compared with earlier years. This upward trend has been consistent since 2005, with a particularly sharp increase observed after 2015.

Gender differences are clear, with boys receiving significantly more medication than girls. In 2024, the rate for boys was 114.2 DDD per 1,000 inhabitants per day, while for the rate girls it was 67.9 DDD per 1,000 inhabitants per day.

Overall, the data show a sustained and marked increase in ADHD medication use among children and adolescents in Iceland. Since 2005, usage in this age group has more than tripled, highlighting a significant shift in treatment patterns over time.



**Figure 5.** Use of attention-deficit/hyperactivity disorder (ADHD) medication among children and adolescents (ages 6–17 years), defined daily doses per 1,000 population per day, Iceland

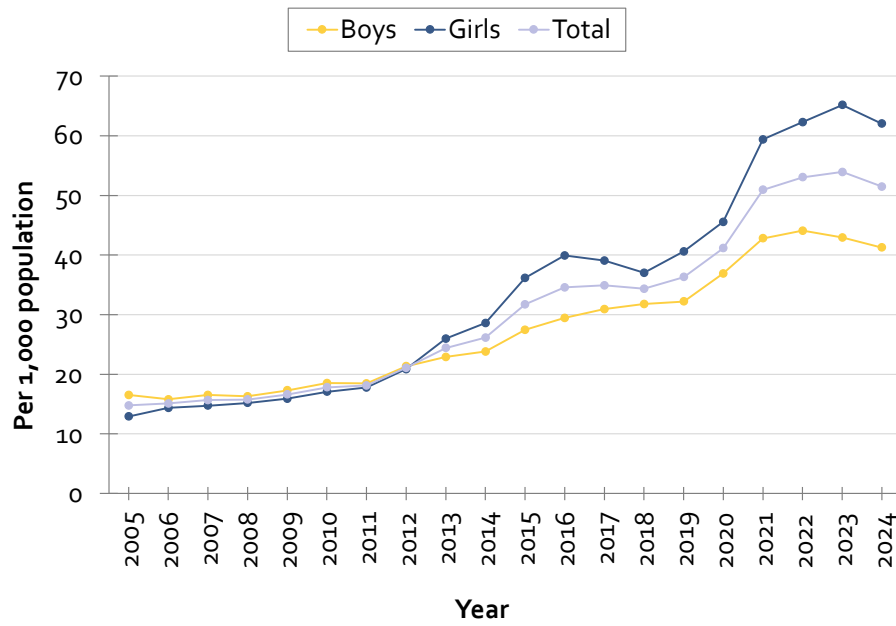
Source: The Directorate of Health, Iceland. Prescription Medicines Register

**Note.** Included ATC-codes: C02AC02, N0BA02, N06BA04, N06BA09, N06BA12.

## Use of antidepressants

Antidepressants are classified under ATC group N06A according to the Anatomical Therapeutic Chemical (ATC) system. While these medications are primarily indicated for depression, many are also widely prescribed for anxiety disorders, both in Iceland and internationally, as anxiety is a registered indication for several drugs in this group. Additionally, some medications within the N06AX subgroup are commonly used to treat sleep disturbances and anxiety among older adults.

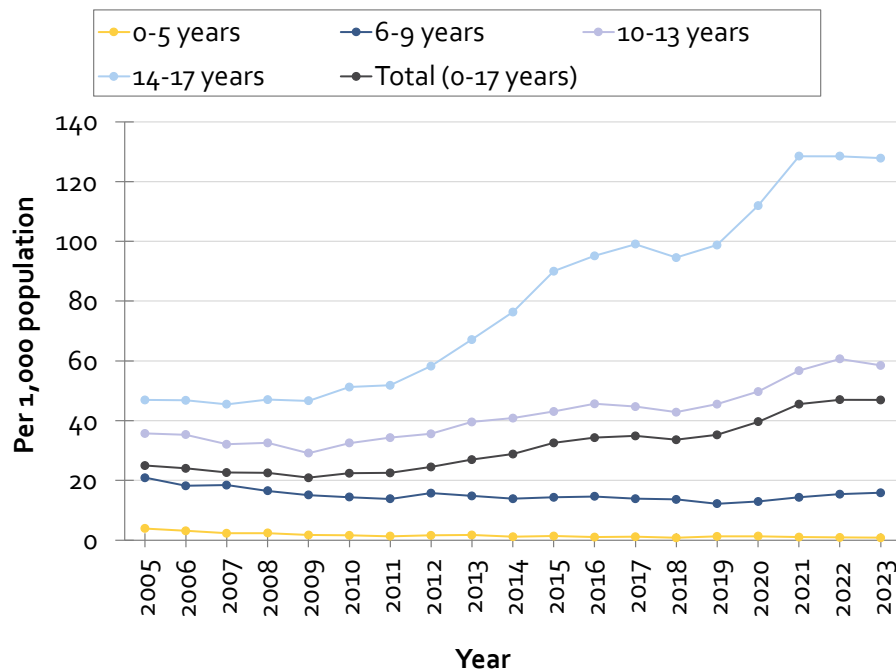
However, the use of antidepressants among children has increased significantly in recent years, particularly among adolescents. Data from the Icelandic Medicines Database show that nearly twice as many children under 18 were prescribed antidepressants in 2023 as in 2005. This rise is largely driven by increased use among the oldest age group (14–17 years): in 2023, 128 per 1,000 children in this age group received antidepressants, compared to 47 per 1,000 in 2005. Use has also grown among children aged 10–13, although to a lesser extent than among older adolescents. These trends align with findings from various surveys indicating rising symptoms of anxiety, depression, and distress in these age groups.



**Figure 6.** Use of antidepressant medication among children and adolescents (ages 6–17 years), defined daily doses per 1,000 population per day, Iceland

Source: The Directorate of Health, Iceland. Prescription Medicines Register.

**Note.** Included ATC-codes: N06AA04, N06AA09, N06AB03, N06AB04, N06AB05, N06AB06, N06AB10, N06AX05, N06AX11, N06AX12, N06AX16, N06AX21, N06AX26.



**Figure 7.** Number of children and adolescents receiving at least one antidepressant prescription annually (ages 0–18 years), by age group, Iceland

**Note.** Included ATC group: N06A

## Finland

The Finnish data are taken from the Care Register for Health Care, which includes inpatient care and outpatient visits in specialised care. Since 2019, the private sector has increasingly been reporting its activities in this register.

For the period prevalence in year 2024, the most common diagnoses are intellectual impairments, ADHD, and anxiety disorders. Boys have more ADHD, autism spectrum disorders, behavioural disorders, intellectual impairments, and tics/Tourette's syndrome, while girls have more anxiety disorders, stress-related disorders, eating disorders, and manic episodes. The prevalence of bipolar disorders, attachment disorders, and psychotic disorders are low, under 1 per 1,000, and the pattern is similar for both sexes.

The table presents the prevalence of various psychiatric diagnoses among children and adolescents (ages 0–18) in 2024, with figures provided per 1,000 population.

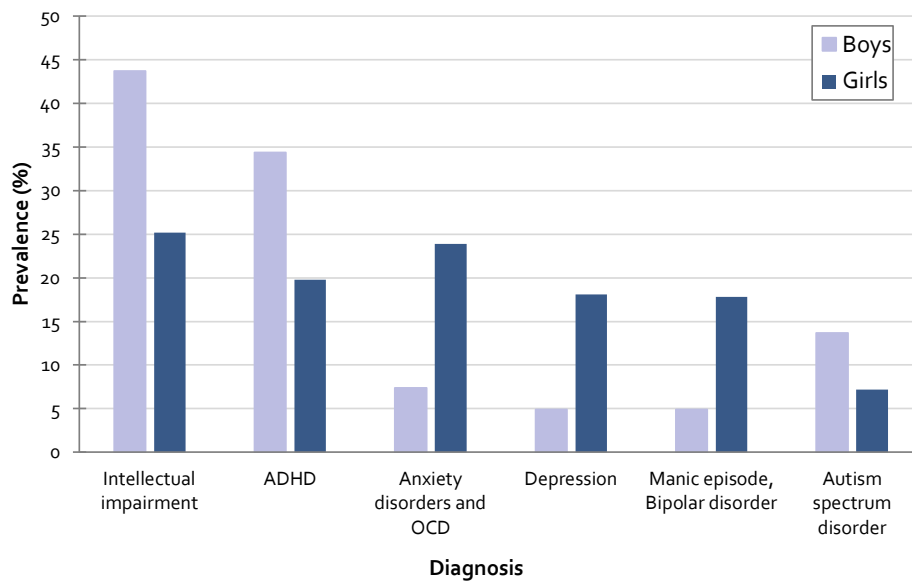
**Table 2.** Prevalence of psychiatric diagnoses among children and adolescents (ages 0–18 years), per 1,000 population, 2024, Finland

Group [ICD-10 codes]	Boys	Girls	Total
Attention-deficit hyperactivity disorders. ADHD [F90]	34.4	19.8	27.3
Autism spectrum disorder [F84]	13.7	7.2	10.5
Anxiety disorders and OCD [F40-F42]	7.4	23.9	15.5
Stress-related disorders [F43]	2	3.9	2.9
Stress-related disorders [F43+Z73.3]	2	4	3
Behavioural disorders (like oppositional defiant disorder) [F91]	3.2	1.2	2.2
Oppositional defiant disorder [F91.3]	1.5	0.6	1
Depression [F32-F33]	4.9	18.1	11.4
Eating disorders [F50. F98.2-F98.3. R63.0]	1.5	6.6	4
Eating disorders [F50. F98.2-F98.3. R63.0. R63.3]	1.5	6.6	4
Tics/Tourette [F95]	3.7	1.4	2.6
Bipolar disorder [F31]	0.2	0.5	0.3
Manic episode. Bipolar disorder [F30-F31]	4.9	17.8	11.2
Intellectual impairments [F70-F79. F80-F89]	43.7	25.2	34.6
Attachment disorders [F94.1-F94.2]	0.5	0.4	0.5
Psychotic disorders [F1x.5. F1x.7. F23. F25. F28. F29]	0.7	0.9	0.8

Source: THL Finnish Institute for Health and Welfare (Care Register for Health Care)

**Note.** Hospital inpatient and outpatient diagnoses for 2024.

Figure 8 illustrates the six most prevalent diagnoses from Table 2, separated by sex.



**Figure 8.** Prevalence of psychiatric diagnoses among children and adolescents (ages 0–18 years), per 1,000 population, by sex, 2024, Finland

Source: THL Finnish Institute for Health and Welfare (Care Register for Health Care)

**Note.** Hospital inpatient and outpatient diagnoses for 2024.

The trends from 2010 to 2024 show increasing annual prevalence for all diagnoses for men and women, excluding psychotic disorders, for which the prevalence for men declined by 6 percent. The largest increase was observed for attention-deficit hyperactivity disorders with a five-fold increase in 2024 compared to 2010. The increase in prevalence was between two- and three-fold for autism spectrum disorder (2.9-fold), tics/Tourette’s syndrome (2.7-fold), anxiety disorders and OCD (2.5-fold) and oppositional defiant disorder (2.3-fold). The prevalence of intellectual impairment also increased by 50 percent; however, the prevalence of intellectual disabilities (F70-F79) did not increase, and the entire increase was in disorders of psychological development (F80-F89).

The factors behind the increase include better recognition of psychiatric and neurodevelopmental disorders, improved access to care, and increased mental health services in child and adolescent psychiatry. In general, the Finnish ward guarantee ensures that treatment must be completed within three months. However, those under 23 years of age must be able to access treatment within two weeks if the matter concerns the examination or treatment of an illness or injury. Furthermore, in the psychiatric specialised healthcare of children and adolescents (under 23 years of age), examinations and a specialist’s assessment must be carried out within six weeks of the referral. Treatment must be arranged within three months of the need for treatment being determined.

## Åland

No figures for Åland are shown in this article. The Åland extract from Finland's Care Register for Health Care currently has known limitations: (1) very small population numbers with substantial year-to-year volatility; (2) incomplete coverage because care provided outside of Åland is not captured; and (3) registration and quality issues. Åland reports data to the Finnish Institute for Health and Welfare and this reporting is currently under review. The goal is to publish robust and comparable Åland statistics in the future. The figures for Åland are, however, included in the Finnish statistics.

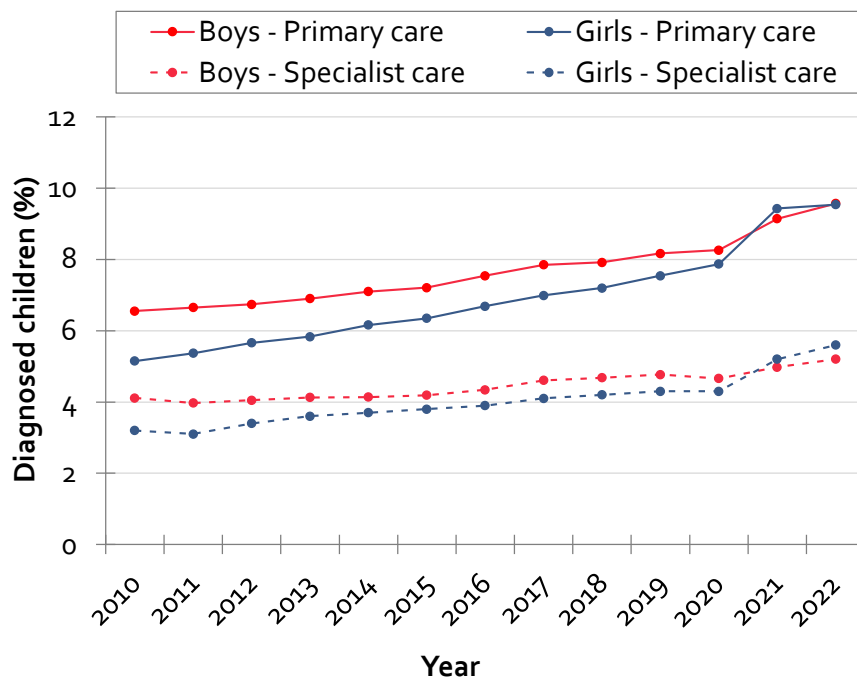
# Norway

## Mental health trends among children and youth

The observed increase in consultations within primary and specialist health services due to psychiatric challenges among children and young people is widely reported in Norway and across the Nordic region.

Several factors contribute to this trend. Awareness of mental health conditions among parents, teachers, and health professionals has increased substantially. Furthermore, the reduced stigma associated with seeking help has lowered the threshold for accessing psychiatric health services. More consistent diagnostic registration during consultations may also contribute to the longitudinal increase in recorded diagnoses.

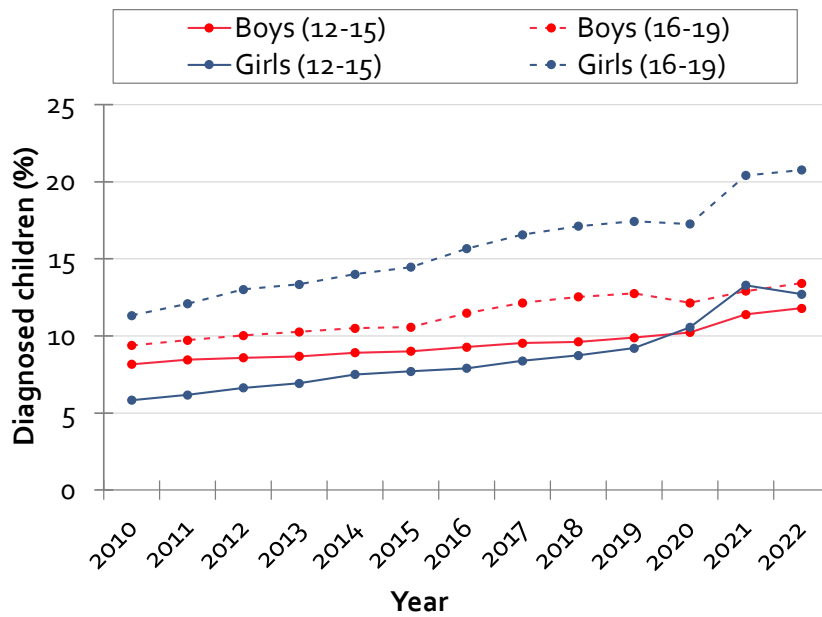
For young people, high performance expectations, extensive social media use, and reduced opportunities for unstructured play are significant factors. The COVID-19 pandemic in 2019-2021, and associated restrictions, led to social isolation, disrupted routines, school closures, and reduced access to support services for young people. These factors might have exacerbated stress, anxiety, and emotional difficulties during this period.



**Figure 9.** Percentage of children and adolescents (ages 0–19 years) diagnosed with psychiatric disorders in primary or specialist healthcare services, 2010–2022, Norway

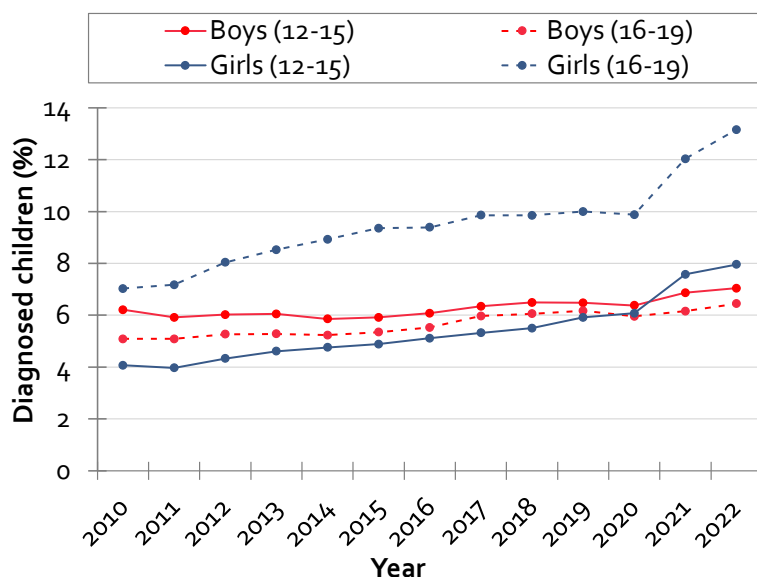
Source: For primary health services; The Norwegian Health Economics Administration (HELFO) and for specialist health services; Norwegian Patient Registry (NPR)

As observed in Iceland, the frequency of consultations has increased in Norway. Notably, consultation rates among girls now match or exceed those of boys. Data indicates that this increase is most pronounced in older age groups. While there has been steady rise in consultations for psychiatric diagnoses (ICPC codes P01-P99) in primary care across all age groups and a moderate increase in specialist care (ICD-10 codes F00-99) leading up to 2020, the period from 2020 to 2022 saw a significant spike. This surge coincided with the pandemic, particularly affecting girls aged 12–15 in primary care and girls aged 16–19 in specialist health services.



**Figure 10.** Percentage of adolescents (ages 12–19 years) with contact in primary healthcare services and a registered psychiatric diagnosis, by age group, 2010–2022, Norway

Source: Primary care; The Norwegian Health Economics Administration (HELFO)



**Figure 11.** Percentage of adolescents (ages 12–19 years) with contact in specialist healthcare services and a registered psychiatric diagnosis, by age group, 2010–2022, Norway

Source: Norwegian Patient Registry (NPR)

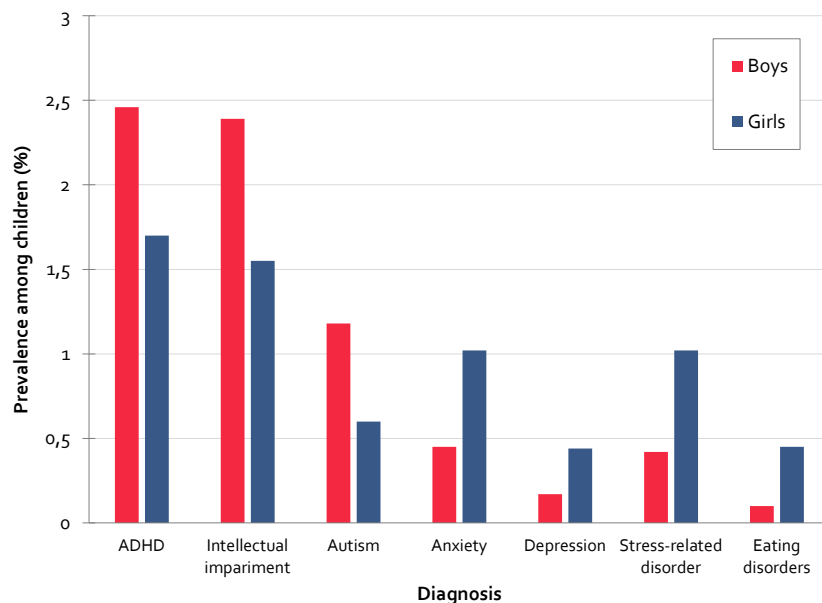
**Table 3.** Consultation rates in specialist healthcare services among children and adolescents (ages 0–18 years), per 1,000 population, by sex, 2024, Norway

Group [ICD-10 code]	Boys	Girls	Total
Attention-deficit hyperactivity disorders. ADHD [F90]	21	14.1	17.6
Autism spectrum disorder [F84]	9.3	4.4	6.9
Anxiety disorders and OCD [F40-F42]	4.5	12.3	8.3
Stress-related disorders [F43]	4.1	9.3	6.6
Stress-related disorders [F43+Z73.3]	4.1	9.4	6.7
Behavioural disorders [like oppositional defiant disorder] [F91]	0.9	0.5	0.7
Oppositional defiant disorder [F91.3]	0.5	0.2	0.4
Depression [F32-F33]	4.5	6.9	4.5
Eating disorders [F50. F98.2-F98.3. R63.0]	0.9	4.7	2.8
Eating disorders [F50. F98.2-F98.3. R63.0. R63.3]	0.9	4.7	2.8
Tics/Tourette [F95]	4	1.8	2.9
Bipolar disorder [F31]	0.1	0.3	0.2
Manic episode. bipolar disorder [F30-F31]	0.2	0.3	0.2
Intellectual impairments [F70-F79. F80-F89]	19.5	12.2	15.9
Attachment disorders [F94.1-F94.2]	0.5	0.5	0.5
Psychotic disorders [F1x.5. F1x.7. F23. F25. F28. F29]	0.3	0.4	0.4

Source: Norwegian Patient Registry (NPR)

**Note.** All consultations in the specialist healthcare services are included in the figures; somatic, psychiatric, drug addiction treatment, psychiatric wards for children and young people, and contract specialists.

The figure below shows the prevalence of a selection of diagnoses for girls and boys aged 0-18 years. For girls, there has been a significant increase in ADHD since 2010. For other diagnoses, there have been minor changes during the period. The most prevalent diagnoses for girls are ADHD, depression, stress-related disorders, and anxiety. Eating disorders have a low prevalence among young girls. However, among older girls, the prevalence is higher. For boys aged 0-18 years there is a high prevalence of ADHD, and there has been an increasing trend since 2016. There has also been a minor increase in consultations for autism among boys during the period.

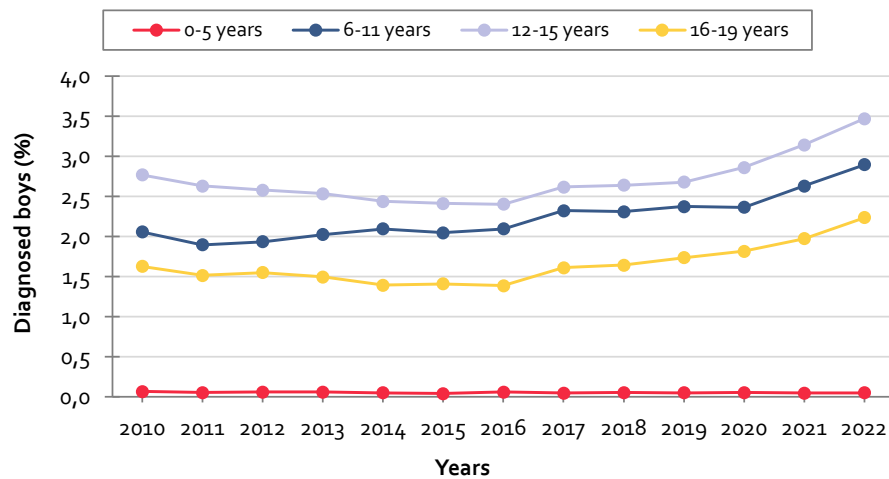


**Figure 12.** Prevalence of attention-deficit/hyperactivity disorder, intellectual impairments, autism spectrum disorders, anxiety, depression, stress-related disorder, eating disorders, and depression among children and adolescents (ages 0–18 years), percent by sex, 2024, Norway

Source: Norwegian Patient Registry (NPR)

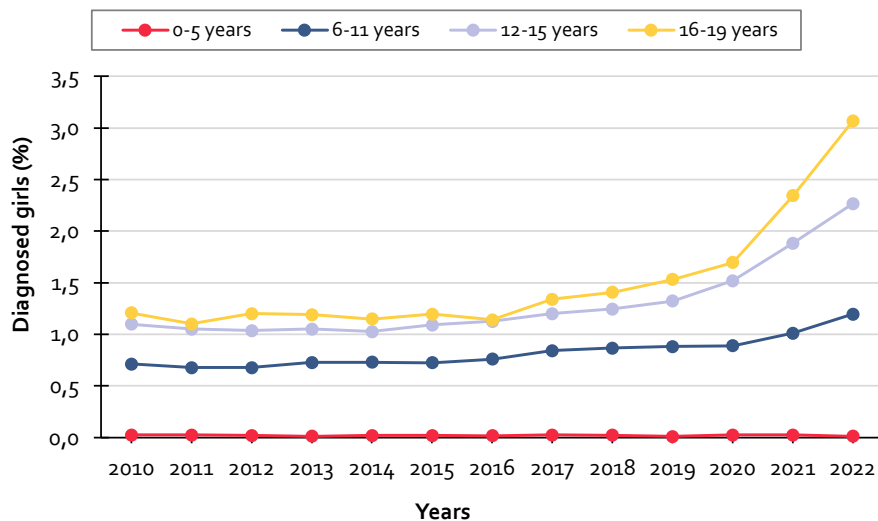
## ADHD, ADD – Attention-deficit hyperactivity disorder

Prevalence remained stable at 3 to 5 percent until 2018. Since then, a sharp increase has occurred, particularly among girls. Prescription data for ADHD medication shows a similar trend. In 2022, 5.4 percent of boys aged 12–15 years and 3.3 percent of girls aged 16–19 years received medication for ADHD. Boys are more likely than girls to receive ADHD medication in younger age groups.



**Figure 13.** Percentage of boys (ages 0–19 years) diagnosed with attention-deficit/hyperactivity disorder in specialist healthcare services, by age group, 2010–2022, Norway

Source: Norwegian Patient Registry (NPR)



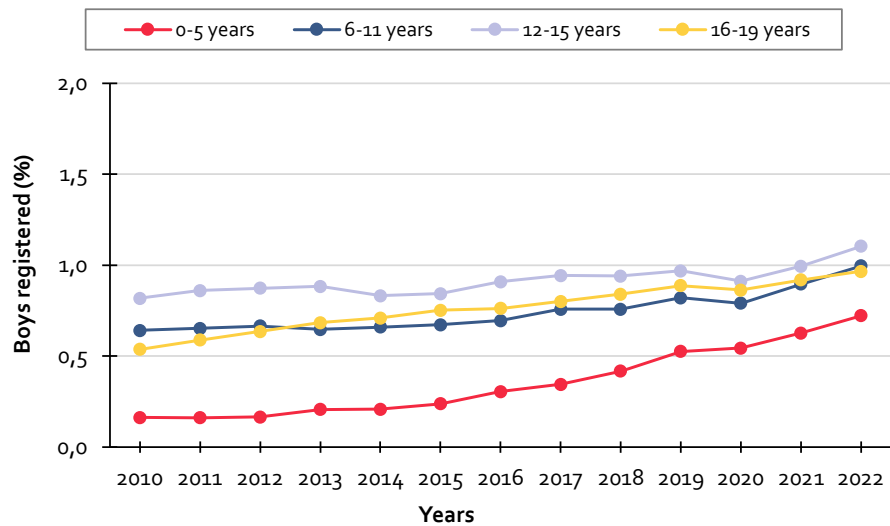
**Figure 14.** Percentage of girls (ages 0–19 years) diagnosed with attention-deficit/hyperactivity disorder in specialist healthcare services, by age group, 2010–2022, Norway

Source: Norwegian Patient Registry (NPR)

Medication used in the treatment of ADHD includes central stimulant drugs. From 2010 to 2022, the use of ADHD medication increased for both girls and boys. In younger age groups (below 16 years) boys are more likely than girls to receive this medication. In 2022, 5.4 percent of boys aged 12–15 years and 3.3 percent of girls aged 16–19 years were treated with ADHD medication.

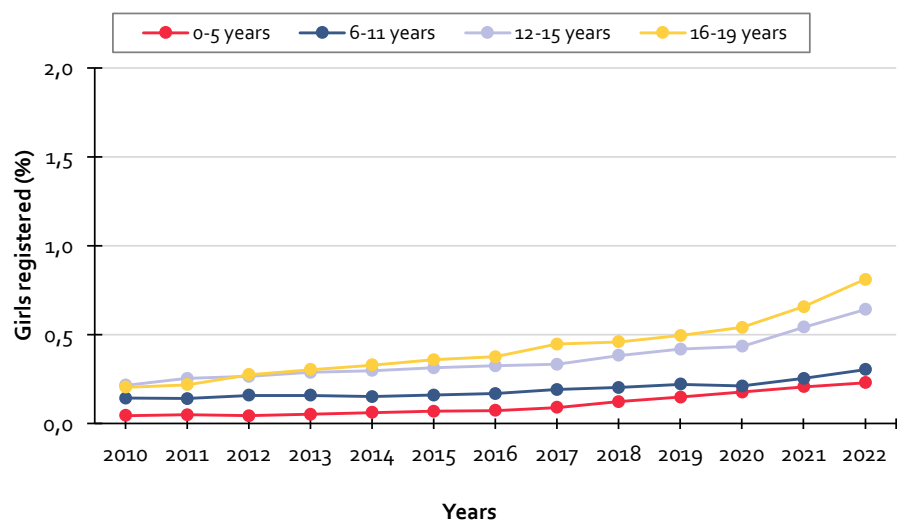
## Autism spectrum disorder

Diagnoses have increased markedly over the past decade across all demographics, with the steepest rise occurring in the last three years, especially among girls and preschool children.



**Figure 15.** Percentage of boys (ages 0–19 years) diagnosed with autism spectrum disorders in specialist healthcare services, by age group, 2010–2022, Norway

Source: Norwegian Patient Registry (NPR)

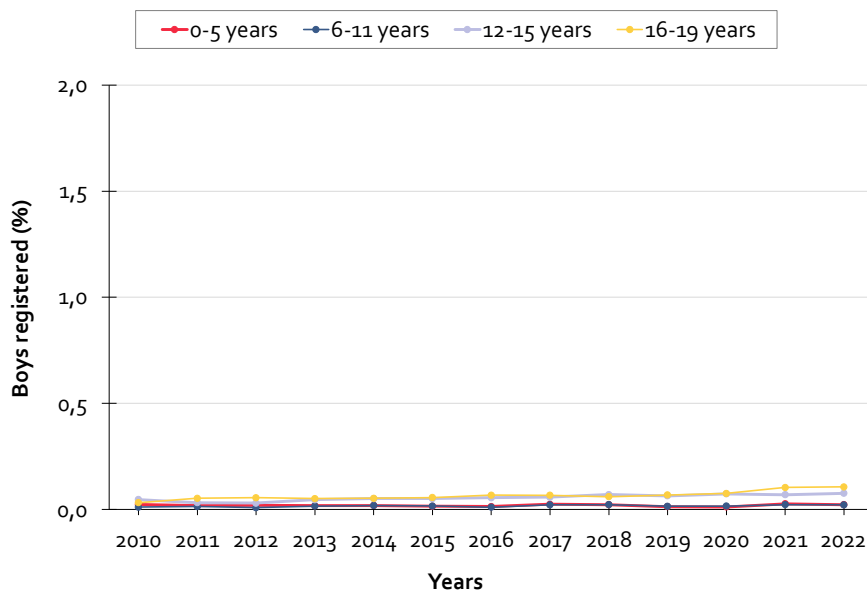


**Figure 16.** Percentage of girls (ages 0–19 years) diagnosed with autism spectrum disorders in specialist healthcare services, by age group, 2010–2022, Norway

Source: Norwegian Patient Registry (NPR)

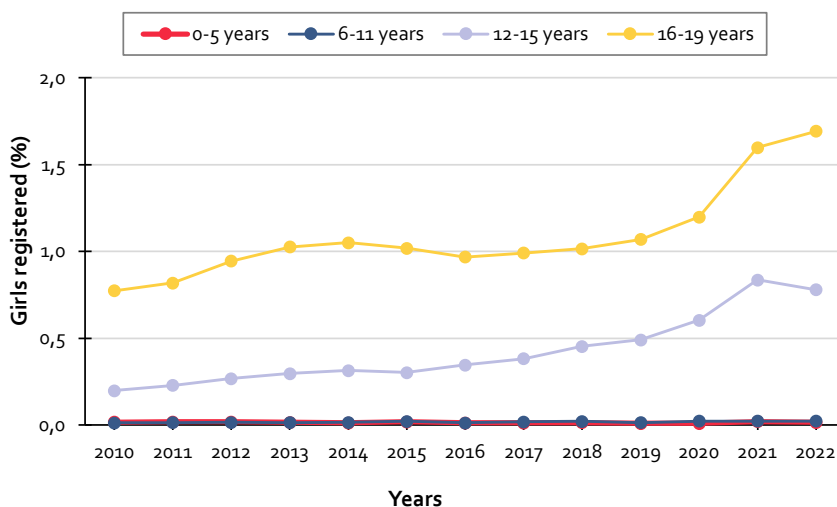
## Eating disorders

While uncommon in early childhood, prevalence rises during adolescence. Among girls (12–16 years), diagnoses increased from 0.2 percent in 2010 to 0.8 percent in 2022, primarily driven by cases of anorexia and unspecified eating disorders. Rates among boys remain below 0.1 percent.



**Figure 17.** Percentage of boys (ages 0–19 years) diagnosed with eating disorders in specialist healthcare services, by age group, 2010–2022, Norway

Source: Norwegian Patient Registry (NPR)

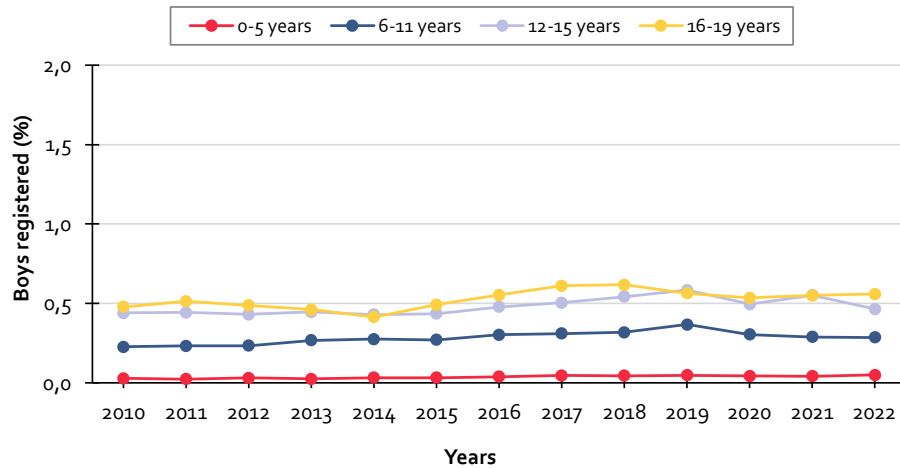


**Figure 18.** Percentage of girls (ages 0–19 years) diagnosed with eating disorders in specialist healthcare services, 2010–2022, Norway

Source: Norwegian Patient Registry (NPR)

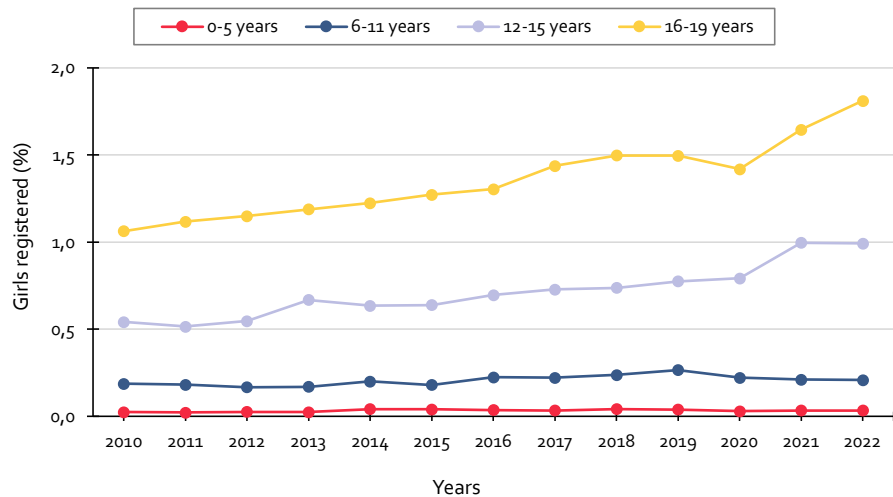
The increase among adolescent girls is primarily attributable to anorexia (F50.0/F50.1) and other unspecified eating disorders (F50.8/F50.9). In contrast to anorexia, diagnoses of bulimia (F50.2/F50.3) have declined or remained stable during the same period.

## Stress-related disorders



**Figure 19.** Percentage of boys (ages 0–19 years) diagnosed with stress-related disorders in specialist healthcare services, by age group, 2010–2022, Norway

Source: Norwegian Patient Registry (NPR)

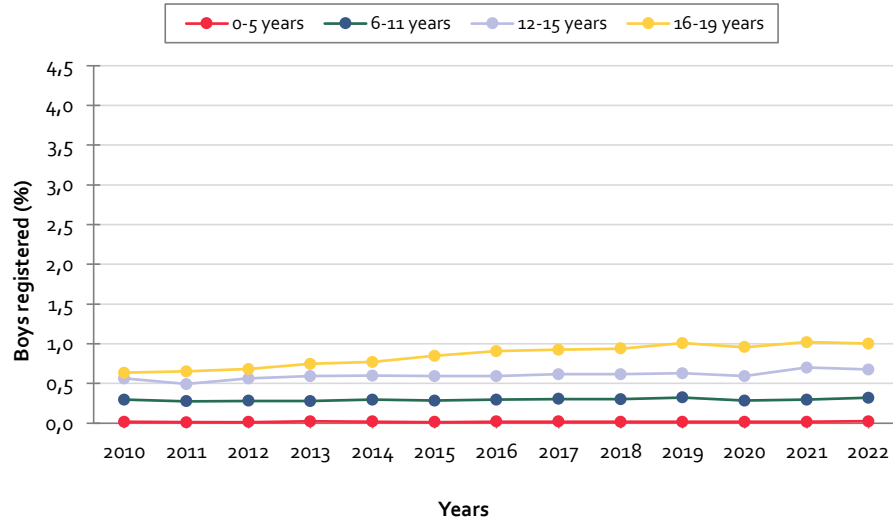


**Figure 20.** Percentage of girls (ages 0–19 years) diagnosed with stress-related disorders in specialist healthcare services, by age group, 2010–2022, Norway

Source: Norwegian Patient Registry (NPR)

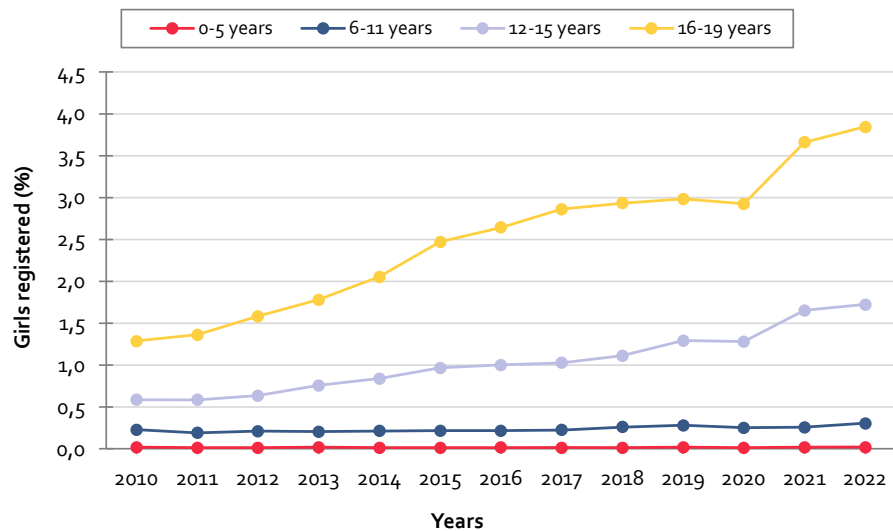
## Anxiety

Anxiety and depression remain among the most prevalent diagnoses for girls, alongside ADHD and stress-related disorders.



**Figure 21.** Percentage of boys (ages 0–19 years) diagnosed with anxiety disorders in specialist healthcare services, by age group, 2010–2022, Norway

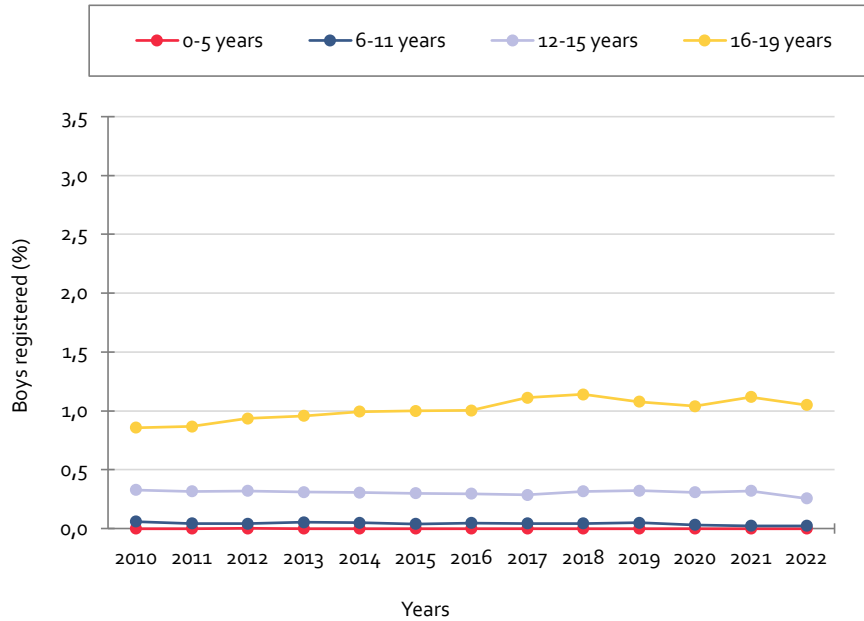
Source: Norwegian Patient Registry (NPR)



**Figure 22.** Percentage of girls (ages 0–19 years) diagnosed with anxiety disorders in specialist healthcare services, by age group, 2010–2022, Norway

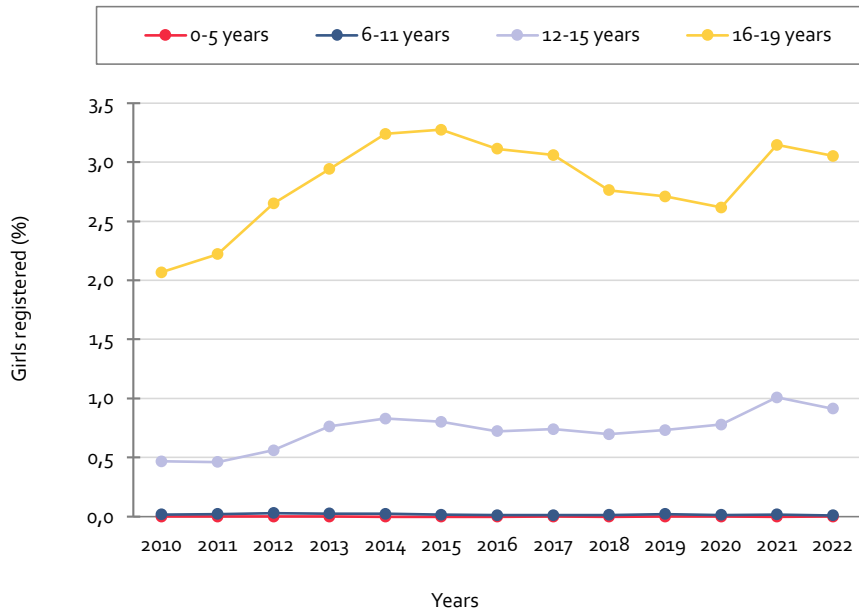
Source: Norwegian Patient Registry (NPR)

## Depression



**Figure 23.** Percentage of boys (ages 0–19 years) diagnosed with depressive disorders in specialist healthcare services, by age group, 2010–2022, Norway

Source Norwegian Patient Registry (NPR)



**Figure 24.** Percentage of girls (ages 0–19 years) diagnosed with depressive disorders in specialist healthcare services, by age group, 2010–2022, Norway

Source Norwegian Patient Registry (NPR)

## Sweden

The information below describes the use of psychiatric healthcare services among children and young patients up to 17 years of age in Sweden during the period 2010-2024. Only healthcare services provided in psychiatric outpatient and inpatient care clinics are included. The main diagnosis and possible multiple diagnoses within the group of relevant psychiatric diagnoses were included (Table 4). The current Swedish national patient register does not cover healthcare contacts in the primary care, which is considered the first line of psychiatric care in Sweden<sup>1</sup>. A consequence for this report is a significant underestimation of the number of patients in need of psychiatric care among the children and youth. In addition, only healthcare contacts with a physician are registered in the Swedish national patient register. Information on when the diagnoses were established is not recorded. A more complete analysis of psychiatric care for children and adolescents would require access to healthcare services in primary care and additional information on services provided by other professional categories in addition to physicians in specialised outpatient care clinics.

### Recent reform in Swedish psychiatric care

Starting in 2024, Swedish outpatient psychiatric clinics have started to report to the national patient register services performed by healthcare personnel other than physicians (Socialstyrelsen 2026). Five regions (out of 21) were exempted from the new registration procedure because they changed their patient record system. In the new data collection, about 40 percent of all psychiatric healthcare services were provided by physicians for ADHD, depression, and autism diagnoses. This means that most psychiatric services for children were provided by other professional categories, such as nurses and psychologists.

As in the other Nordic countries, the psychiatric diagnoses with high one-year prevalences in the child and adolescent population were ADHD/ADD, anxiety (including OCD), autism, and depression. There were large differences between boys and girls in the prevalence of certain psychiatric diagnoses. More boys than girls had healthcare contacts for ADHD or autism diagnoses. Children had more healthcare consultations for ADHD and

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<sup>1</sup> An extended data collection is planned for the national patient register to include primary care services and the requisition of medicines in healthcare. This will take several years. In April 2026, Socialstyrelsen will report to the government a proposal for new regulations on reporting primary care data to the national patient register (Socialdepartementet S2025/00940). The governmental mission is to prepare for future changes in the Swedish Health and Medical Services Act.

autism in Sweden compared to Norway. In previous decades, girls were underdiagnosed with neurodevelopmental conditions (such as ADHD and autism) to a greater extent than boys.

The prevalence for autism spectrum disorders was estimated at 1 to 1.5 percent in the population (SKR 2022). For adolescents between 10 and 17 years, the estimated prevalences were 4.7 percent among boys and 2.5 percent among girls with a diagnosis date between 1998 and 2023 (Socialstyrelsen 2024).

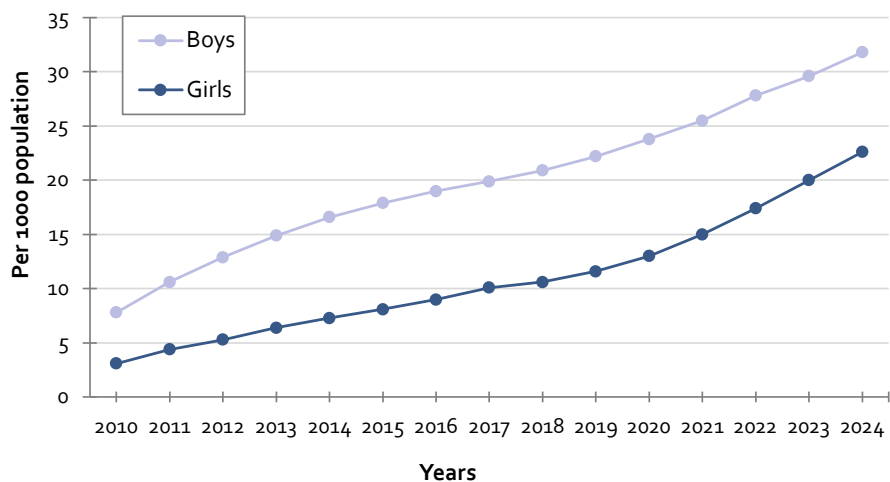
Girls had more healthcare contacts than boys in the following conditions: anxiety, stress, depression, and eating disorders. Similarly to findings in the other Nordic countries, boys had more healthcare contacts than girls for ADHD and autism.

**Table 4.** Proportion of children and adolescents (ages 0–17 years) with at least one physician healthcare contact for psychiatric diagnoses, per 1,000 population, 2024, Sweden

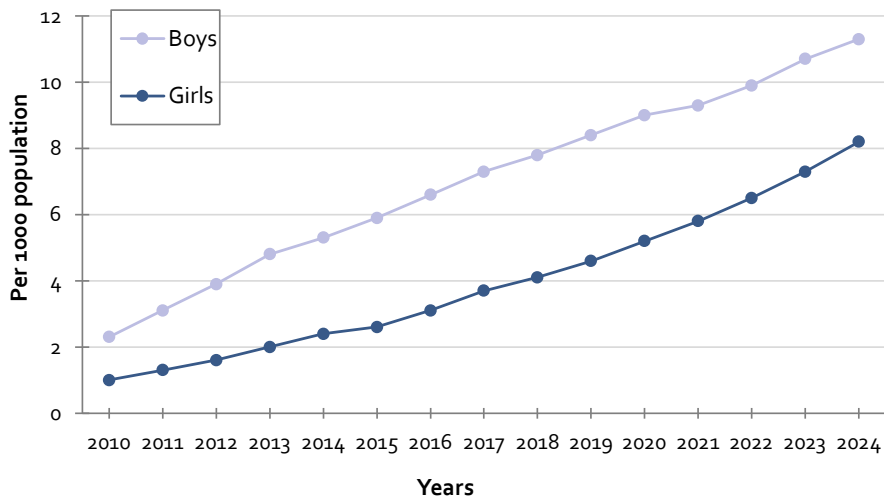
Diagnosis group [ICD 10-SE]	Boys	Girls	Total
ADHD. ADD [F98.8]	31.8	22.6	27.4
Attention-deficit hyperactivity disorders [F90]	32.3	22.8	27.7
Autism spectrum disorder [F84]	11.3	8.2	9.8
Anxiety disorders and OCD [F40-F42]	6.6	17.6	12
Stress-related disorders [F43+Z73.3]	1	3	2
Behavioural disorders [F91]	2.3	1.1	1.8
Oppositional Defiant Disorder [F91.3]	1.9	0.9	1.4
Depression [F32-F33]	3.2	9.1	6
Eating disorders [F50. F98.2-F98.3. R63.0.R63.3]	0.4	4.5	2.4
Tics [F95]	1.1	0.4	0.8
Bipolar. incl. manic behavior [F30-31]	0.1	0.3	0.2
Intellectual impairments [F70-79]	1.5	0.8	1.2
Intellectual impairments [F70-79.F80-89]	13.5	9.6	11.6
Attachment disorders [F941-F942]	0.2	0.4	0.3
Psychotic disorders [F1x.5.F1x.6. F23.F25.F28.F29]	0.1	0.1	0.1

Source: National patient register, Sweden.

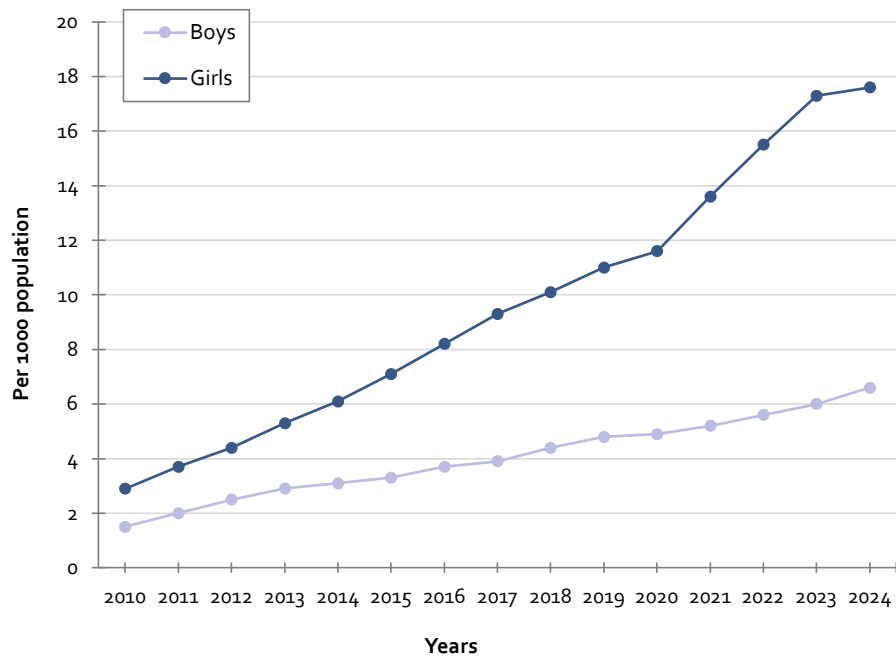
**Note.** Young patients belong to the adult category when they are 18 years old. Only services in psychiatric specialised clinics for children (Child and Adolescent Mental Health Services) were included.



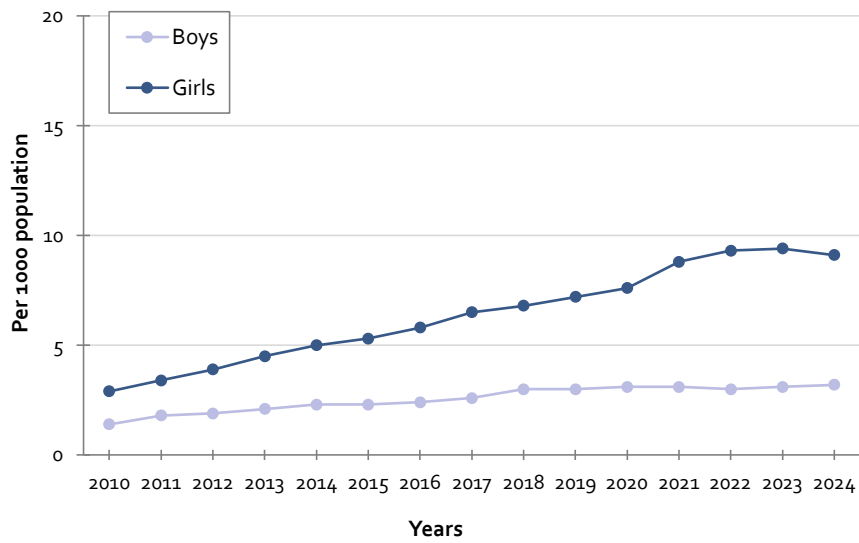
**Figure 25.** Proportion of boys and girls (ages 0–17 years) with healthcare contact for attention-deficit/hyperactivity disorder, per 1,000 population, Sweden



**Figure 26.** Proportion of boys and girls (ages 0–17 years) with healthcare contact for autism spectrum disorders, per 1,000 population, Sweden



**Figure 27.** Proportion of boys and girls (ages 0–17 years) with healthcare contact for anxiety disorders, per 1,000 population, Sweden



**Figure 28.** Proportion of boys and girls (ages 0–17 years) with healthcare contact for depressive disorders, per 1,000 population, Sweden

## The use of prescription medicines in the treatment of psychiatric diagnoses in children and adolescents

The use of diagnosis-specific drugs for treating children and youth with psychiatric diagnoses is presented below. The source for the data is the Swedish national prescribed drug register, which covers prescribed medication dispensed in pharmacies.

The drugs for the treatment of three diagnoses are identified with the following ATC codes: 1) for the treatment of ADHD: ATC group N06BA, centrally acting sympathomimetics (excl. N06BA07 Modafinil and C02AC02 Guanfacine); 2) for the treatment of depression, anxiety, and pain: antidepressants (N06A); 3) for the treatment of sleep disturbances/deprivation- N05CH melatonin receptor agonists.

The measures presented in the figures below are the proportion of children and young patients who receive a certain type of drug, per 1,000 in the population, by age (0 to 17 years) and sex. The prescribers are healthcare professionals in the primary care or specialised outpatient and inpatient clinics.

Adding information about individual users of ADHD drugs provides a more accurate estimate of patients diagnosed with ADHD. The Swedish prescribed drug register has fewer dropouts (compared to detection of ADHD diagnoses in the national patient register) and the drugs have a clear indication for the treatment of ADHD.

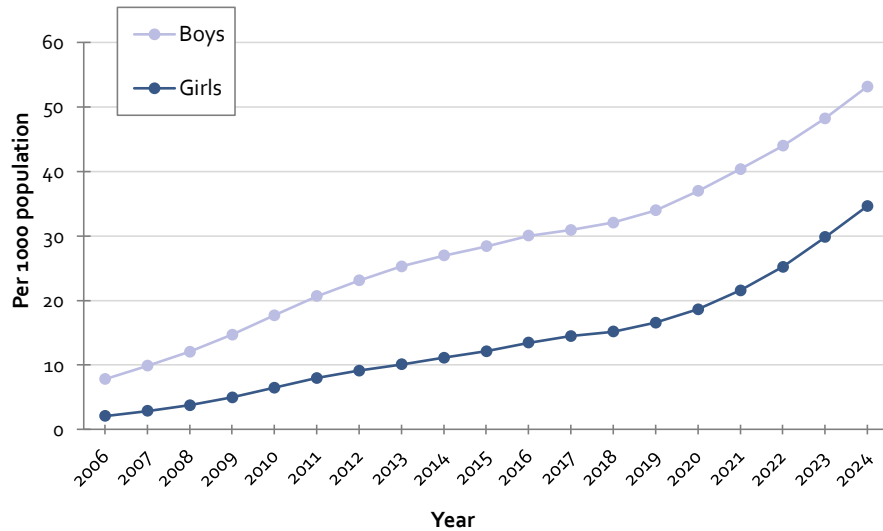
A Swedish study of the prevalence of ADHD in schoolchildren aged 0-17 years, based on drug use, estimated a prevalence of 10.5 percent for boys and 6 percent among girls as of 2022 (Socialstyrelsen 2023). The sex differences in ADHD drug use have been explained by the fact that girls were diagnosed several years later than boys and that girls historically have been underdiagnosed.

Figure 29 shows a steady increase in the consumption of ADHD drugs over the period 2006-2024. Both boys and girls aged 0-17 years show an increase in the use of ADHD drugs. Boys receive ADHD treatment to a greater extent than girls, which is in line with the information on healthcare use of psychiatric services for ADHD diagnoses.

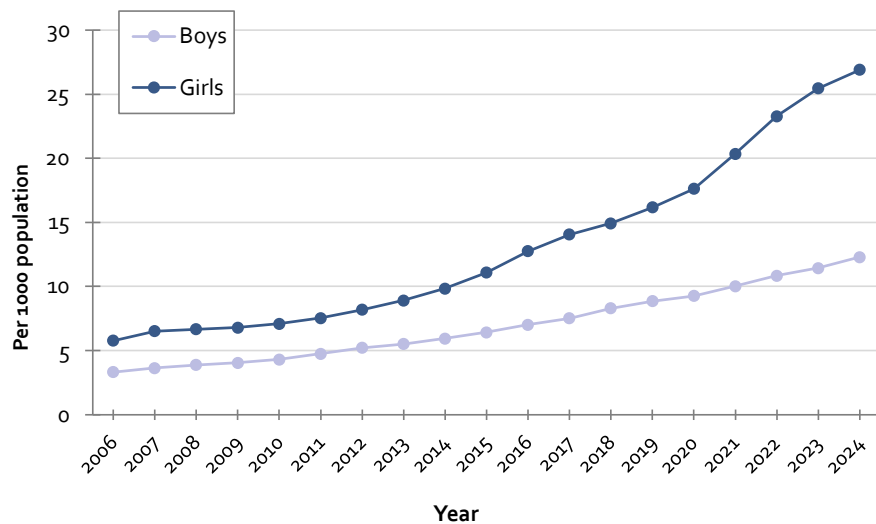
Sex differences are reversed in Figure 30: more girls than boys had at least one antidepressant prescription. This is also in line with the psychiatric care for the treatment of anxiety and depression, which is more frequent among girls.

The strong increase in time in the use of melatonin among children and adolescents suggests an increase in sleep deprivation (Figure 31). A Swedish

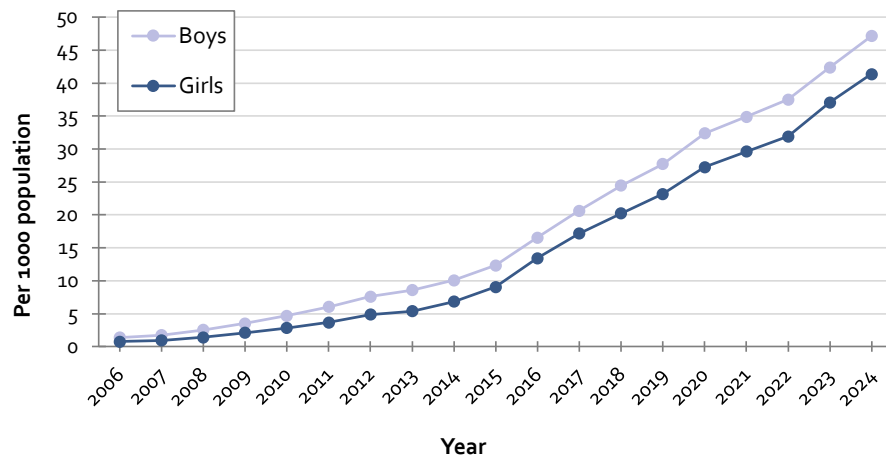
report has suggested that the use of melatonin dispensed in pharmacies for children’s sleep disorders was one of the highest in Europe (SKR 2022). It is also possible that in other countries, sleeping pills are more frequently purchased over the counter.



**Figure 29.** Use of attention-deficit/hyperactivity disorder medication among boys and girls (ages 0–17 years), per 1,000 population, Sweden



**Figure 30.** Use of antidepressant medication among boys and girls (ages 0–17 years), per 1,000 population, Sweden



**Figure 31.** Use of melatonin among boys and girls (ages 0–17 years), per 1,000 population, Sweden

## Discussion

The number of children and adolescents who use psychiatric healthcare services has increased since 2010 in Sweden.

The information in this report cannot be used to uncover the causes of this development in the use of psychiatric care. However, there are a number of possible explanations for the increase in mental health problems among children and adolescents in Sweden. At the societal level, the following factors are important. Teachers, parents, and patients have increased knowledge and awareness of mental health diagnoses. This has been contributed to by the growth in reports on mental health in the official Swedish media. The active debate on mental health problems in society has meant that patients experience decreased stigma when seeking help for mental health problems. At the individual level, children and young people face increased mental health challenges related to high expectations to perform well, screen time, social media, and sleep deprivation. All these factors have contributed to an increase in the demand for psychiatric services. On the supply side, the recent increase in services provided by private psychiatric care providers might also put pressure on the health system.

# Denmark

## Method

The following table and figures describe the situation for children and adolescents diagnosed with a psychiatric condition in the secondary sector between the ages of 0-17 in Denmark. Both primary and secondary diagnoses within the following ICD-10 codes are included: F20-F43, F50, F70-F84, F90-F95, F98.2, F98.8 and R41.8.

The population in the table and figures below is limited to individuals who have been in contact with the hospital sector with either a primary or secondary diagnosis within the relevant disease group during the period 2019-2024. For all reporting years, the reference date is January 1. The population is limited to individuals who are alive and have a registered residence in Denmark as of January 1 in the reporting year. Age is determined as of January 1. A contact with the hospital sector includes all public and private inpatient and outpatient care as well as health clinic visits. The Danish national patient register does not record healthcare visits in the primary sector, which can result in an underestimation of the total number of children and adolescents aged 0-17 with a psychiatric diagnosis in Denmark.

## Results

Table 5 shows the prevalence of selected psychiatric diagnoses among children and adolescents in Denmark in 2019 and 2024.

Across all the selected psychiatric diagnoses, the most prominent developments occur within the neurodevelopmental disorders, in particular ADHD/ADD and autism spectrum disorders. ADHD/ADD shows the biggest increase, rising from 19.8 per 1,000 in 2019 to 25.7 per 1,000 in 2024. This trend corresponds to an increase of 5.9 per 1,000, or approximately 30 percent. The prevalence of autism spectrum disorders increases from 13.9 to 18.8 per 1,000 (35 percent.), representing the second largest increase. These patterns may reflect an increase in the recognition of these psychiatric diagnoses as well as increased diagnostic activity within the clinical system.

In comparison, several other selected psychiatric diagnoses remain stable or show slight declines. Stress-related disorders remain unchanged at 10.1 per 1,000 people between 2019 and 2024 and developmental disorders and tics/Tourette's syndrome show no change. Affective disorders decline from 2.5 to 2.2 per 1,000 (12 percent.) while attachment disorders show the largest decrease of 20 percent. from 2.5 to 2.0. Anxiety/OCD shows a small overall decline although girls' prevalence has increased.

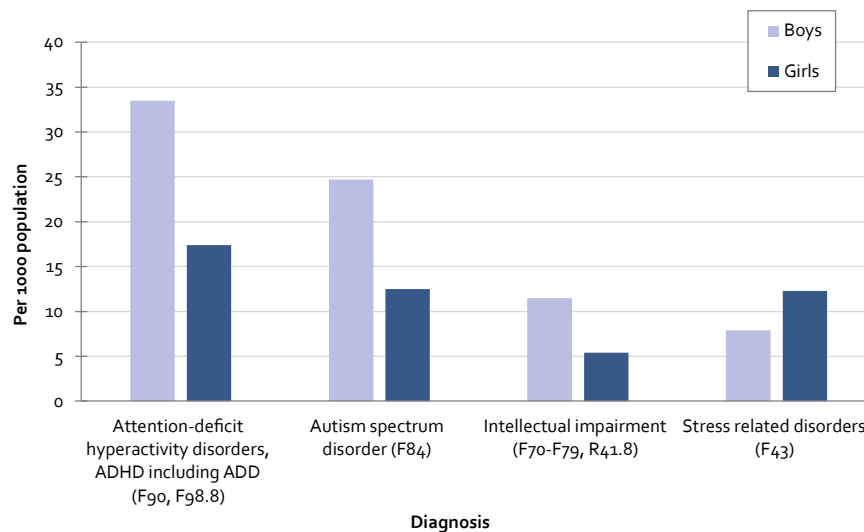
Overall, Table 5 indicates that increases in overall prevalence of psychiatric diagnoses are mainly driven by the neurodevelopmental disorders, while emotional and behavioural conditions remain stable or slightly declining.

**Table 5.** Prevalence of selected psychiatric diagnoses among children and adolescents (ages 0–17 years), per 1,000 population, by sex, 2019 and 2024, Denmark

Diagnosis (ICD-10 code)	2019			2024		
	Boys	Girls	Total	Boys	Girls	Total
Affective disorders [F30-F39]	1.7	3.3	2.5	1.1	3.4	2.2
Anxiety disorders and OCD [F40, F41, F42, F93]	7.0	8.6	7.8	5.6	9.7	7.6
Attachment disorders [F94]	3.0	1.9	2.5	2.4	1.6	2.0
Attention-deficit hyperactivity disorders, ADHD including ADD [F90, F98.8]	27.8	11.3	19.8	33.5	17.4	25.7
Autism spectrum disorder [F84]	19.8	7.7	13.9	24.7	12.5	18.8
Behavioural disorders [F91, F92]	3.9	1.7	2.8	3.7	1.7	2.7
Developmental disorders [F80, F81, F82, F83]	10.7	4.7	7.8	10.0	5.5	7.8
Eating disorders [F50, F98.2]	0.9	3.4	2.1	0.8	4.0	2.3
Intellectual impairments [F70-F79, R41.8]	10.2	4.8	7.6	11.5	5.4	8.5
Psychotic disorders [F20-F29]	0.9	1.4	1.2	0.7	1.5	1.1
Stress related disorders [F43]	8.7	11.5	10.1	7.9	12.3	10.1
Tics/Tourette [F95]	6.0	1.9	4.0	5.5	2.3	4.0

Source: The Danish National Patient Register, 6 February 2026

**Note.** The population in the table is limited to unique individuals who have been in contact with the hospital sector with either a primary or secondary diagnosis within the relevant disease group during the period 2019-2024.



**Figure 32.** Prevalence of attention-deficit/hyperactivity disorder, autism spectrum disorders, intellectual impairments, and stress-related disorders among children and adolescents (ages 0–17 years), per 1,000 population, by sex, 2024, Denmark

Source: The Danish National Patient Register, 6 February 2026

Figure 32 shows the sex-specific prevalence for the four most common psychiatric diagnoses: ADHD/ADD, autism spectrum disorder, stress-related disorders, and intellectual impairments.

Boys have a substantially higher prevalence in the three neurodevelopmental categories, whereas girls have a higher prevalence of stress-related disorders. Specifically, the prevalence of ADHD/ADD in boys (33.5 per 1,000) is almost double that of girls (17,4 per 1,000). Autism spectrum disorder follows a similar pattern, with boys (24.7 per 1,000) showing almost twice the prevalence observed among girls (12.5 per 1,000). The prevalence of intellectual impairments shows an even larger difference with the prevalence among boys being more than double that among girls.

In contrast, stress-related disorders show the reverse pattern, with girls having a higher prevalence (12.3 per 1,000) compared to boys (7.9 per 1,000).

These trends align with the general findings that neurodevelopmental disorders are more common among boys, and stress-related disorders are more common among girls.

## ADHD/ADD – Attention-deficit hyperactivity disorder

Figure 33 shows the ADHD/ADD-specific prevalence across four age groups from 2019 to 2024. The figure shows that older age groups have both higher baseline prevalence and a steeper increase over the period 2019-2024.

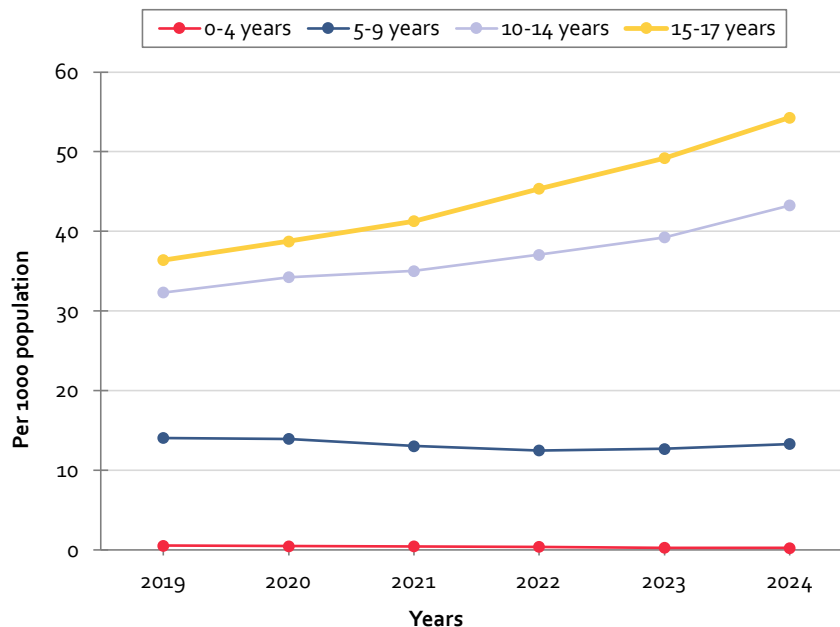


Figure 33. Prevalence of attention-deficit/hyperactivity disorder, including attention-deficit

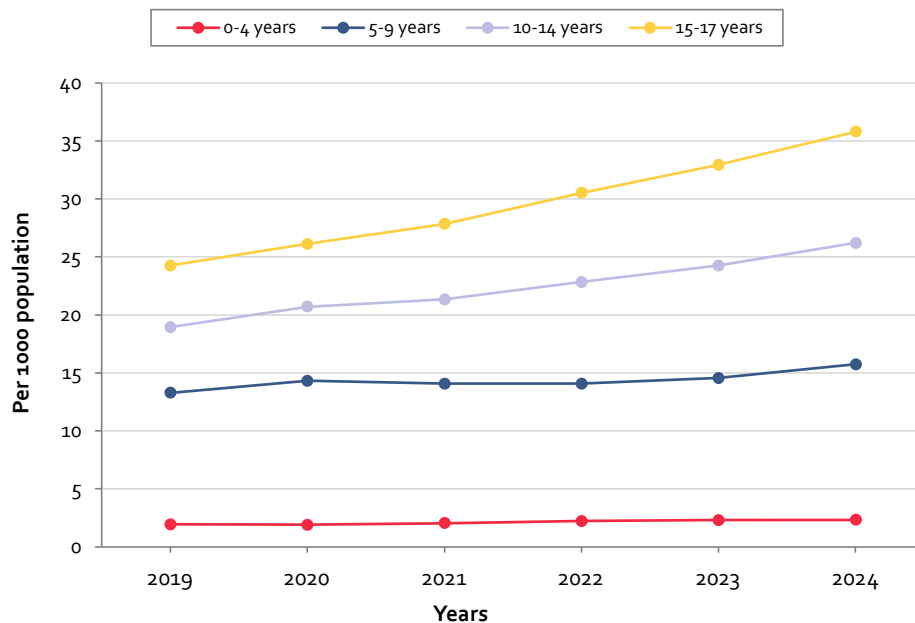
disorder, among children and adolescents (ages 0–17 years), per 1,000 population, by age group, 2019–2024, Denmark

Source: The Danish National Patient Register, 6 February 2026

The 0-4-year-olds show a decline from 0.5 to 0,3 per 1,000 and the 5-9-year-olds also show a slight decline from 14.1 to 13.3 per 1,000.

In contrast, the two oldest age groups show a strong increase. The prevalence for 10-14-year-old rises from 32.2 to 43.3 per 1,000 while the 15-17-year-olds shows the most significant increase from 36.4 to 54.3 per 1,000. These increases likely reflect cumulative diagnoses with age, increased awareness of ADHD, as well as increased rates of assessment and referral over time.

## Autism spectrum disorder

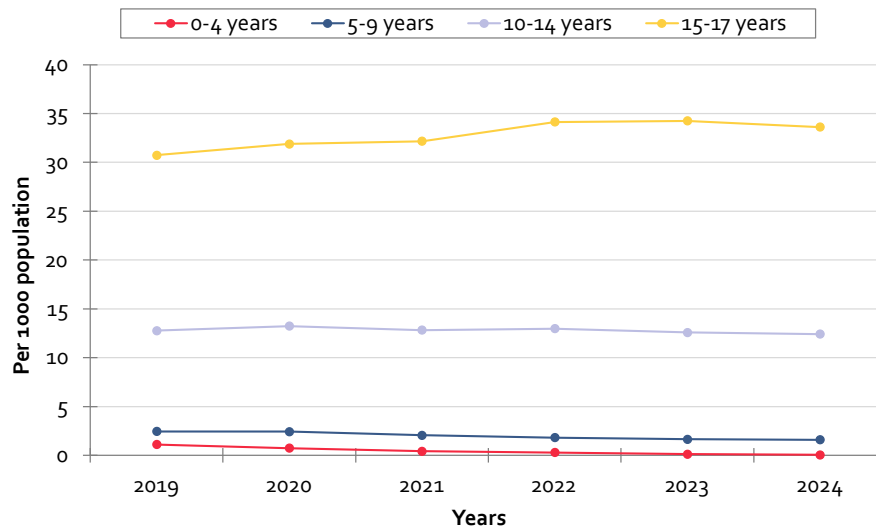


**Figure 34.** Prevalence of autism spectrum disorders among children and adolescents (ages 0–17 years), per 1,000 population, by age group, 2019–2024, Denmark

Source: The Danish National Patient Register, 6 February 2026

All four age groups show increases from 2019 to 2024. The 0-4-year-olds and 5-9-year-olds increases slightly, while the two oldest age groups show the steepest increases, with approximately 38 percent (10–14-year-olds) and 48 percent (15–17-year-olds) from 2019 to 2024. This trend indicates that older children and adolescents account for most of the growth between 2019 and 2024.

## Stress-related disorders



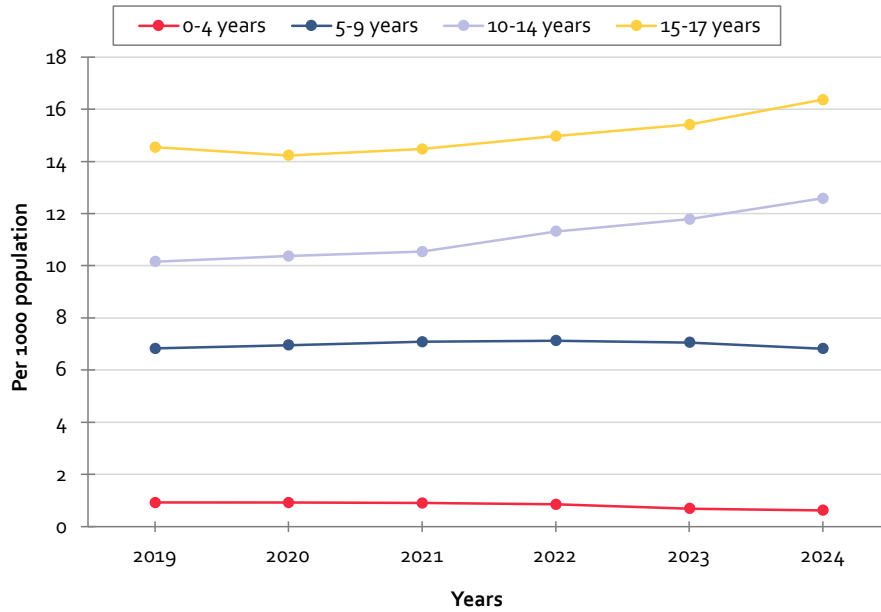
**Figure 35.** Prevalence of stress-related disorders among children and adolescents (ages 0–17 years), per 1,000 population, by age group, 2019–2024, Denmark

Source: The Danish National Patient Register, 6 February 2026

Stress-related disorders display a contrasting pattern compared to the rising neurodevelopmental trends. The two youngest age groups show a clear decline in prevalence, while rates among the 10-14-year-olds remain almost unchanged. The only group showing an increase is the 15-17-year-olds, where the rate increases from 30.7 to 33.6 per 1,000, with a peak in 2022 at 34.1 per 1,000.

This divergence indicates that stress-related diagnoses are increasingly common/concentrated among older adolescents while becoming less common/concentrated among younger children.

## Intellectual impairments



**Figure 36.** Prevalence of intellectual impairments among children and adolescents (ages 0–17 years), per 1,000 population, by age group, 2019–2024, Denmark

Source: The Danish National Patient Register, 6 February 2026

The prevalence of intellectual impairments shows modest declines in the 0-4-year-olds but increases in the two oldest groups. Prevalence among 10-14-year-olds increases from 10.2 to 12.6 per 1,000 (24 percent), while prevalence among 15-17-year-olds rises from 14.5 to 16.4 per 1,000 (13 percent.).

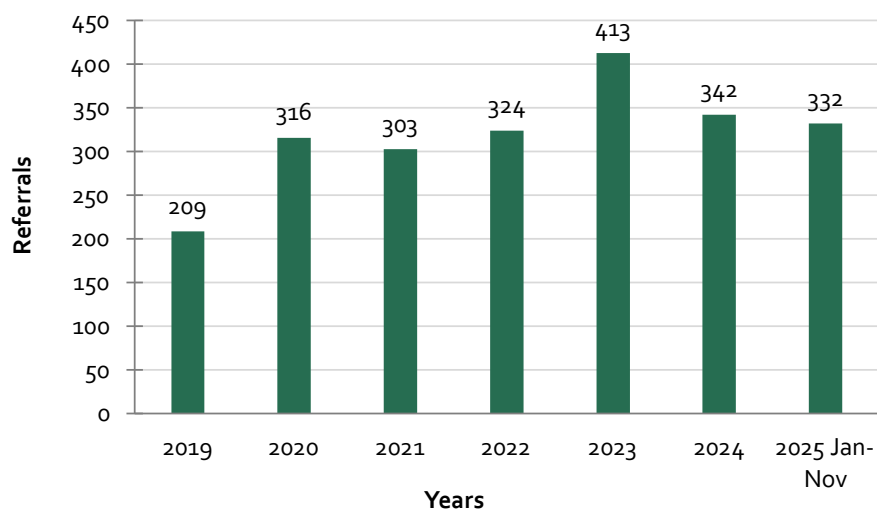
These increases might reflect cumulative identification patterns and later assessment timing for intellectual functioning, particularly when educational demands intensify in the early- to middle-school years.

# Faroe Islands

## ASD and ADHD prevalence

Statistics for children's and adolescents' psychiatric health are not easily accessible in the Faroe Islands. However, the section below attempts to provide an indication of the situation, mainly based on an article published in January this year. The article is limited to ASD and ADHD.

There are three hospitals in the Faroe Islands, and only the National Hospital has a Child and Adolescent Psychiatry Department (CAPD). All children with suspected ASD and ADHD are referred to this department.



**Figure 37.** Number of referrals to psychiatric hospital services among children and adolescents, Faroe Islands

Source: The National Hospital, Landssjúkrahúsið

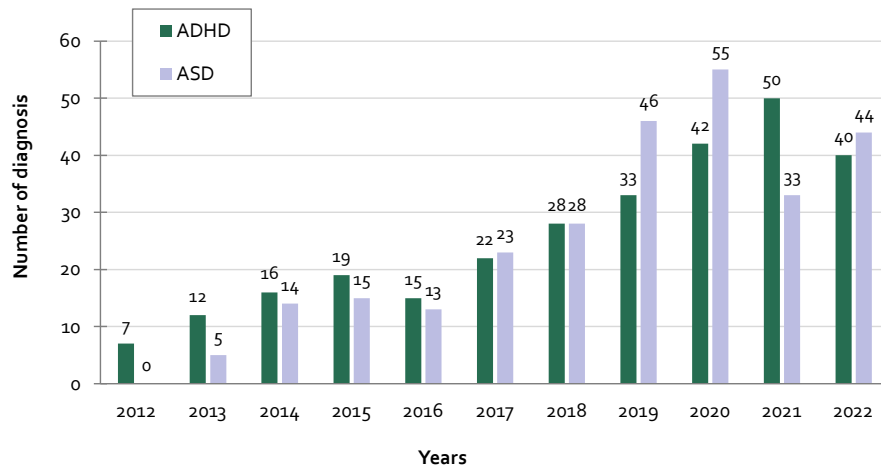
The number of children and adolescents referred to the psychiatric hospital has been more than 300 in total per year in recent years. In 2019, the number was 209 and in 2023 it was 413. The total number of people aged 6-18 years was approximately 9,000 in 2025.

Due to a lack of psychiatrists, young people have to wait for the first consultation. The waiting time is approximately 16 months, as there are almost 300 people on the waiting list.

The study on which the article is based on included all children born from January 1, 2004, to December 1, 2022, who were diagnosed with ASD or ADHD in the hospital records.

The numbers of ASD and ADHD diagnoses has increased significantly from 2012 to 2022, as the numbers were below 10 at the beginning of the period, but increased to more than 40 at the end. One explanation of this increase

might be that additional resources have been allocated to the hospital during the period.



**Figure 38.** Annual number of autism spectrum disorder (ASD) and attention-deficit/hyperactivity disorder (ADHD) diagnoses among children and adolescents, Faroe Islands

Source: Osa T., Mohr M., Halling J. et al. Prevalence of ASD, ADHD and co-occurring conditions among children and adolescents in the Faroe Islands, 2004-2022: a nationwide register-based study. *BMC Pediatr* (2026). <https://doi.org/10.1186/s12887-026-06521-2>

The study found that the prevalence of ASD and ADHD was 2.7 percent and 2.9 percent in total, with higher prevalence among boys in both cases.

**Table 6.** Prevalence of autism spectrum disorder (ASD) and attention-deficit/hyperactivity disorder (ADHD), and age at diagnosis, among children and adolescents, by sex, 2004–2022, Faroe Islands

Sex/Diagnosis	ASD	ADHD
Boys	3.4%	3.8%
Girls	2.0%	2.0%
Total	2.7%	2.9%

Age/Diagnosis	ASD	ADHD
Boys	9.5	10.8
Girls	12.7	11.9

Source: Osa T., Mohr M., Halling J. et al. Prevalence of ASD, ADHD and co-occurring conditions among children and adolescents in the Faroe Islands, 2004-2022: a nationwide register-based study. *BMC Pediatr* (2026). <https://doi.org/10.1186/s12887-026-06521-2>

The study also found that boys received their diagnosis earlier than girls and, in general, the diagnosis was given at a higher age than in several other European countries. This is relevant, as earlier identification may facilitate timelier intervention and reduce subsequent mental health risks.

## Summary

This report had two main objectives: the first was to investigate time trends in the prevalence of psychiatric diagnoses in the child and adolescent population. The second aim was to investigate which measures are comparable across several Nordic countries.

### Time trends in the prevalence of psychiatric diagnoses in the child and adolescent population

The proportion of children and adolescents with psychiatric diagnoses has increased significantly during the period 2010-2024 in all Nordic countries. This is also confirmed in this report, based on registered diagnoses and the use of medication to treat the diagnoses.

For ADHD diagnosis, the one-year prevalences for the latest year available were: 25.7 in Denmark, 29 in Faroe Islands, 27.3 in Finland, 48.9 in Iceland, 17.6 in Norway and 27.4 in Sweden per 1000 in the population of children and young persons aged 0 to 17/18 years (based on national patient register data). Ten years ago, the proportions of the population 15-19 years having at least one ADHD drug used in the treatment were between 13 and 41 per 1,000 in the Nordic countries (Nomesco report 2017, p.168).

Some explanations for the growth observed in the prevalence of psychiatric diagnoses in the child population were put forward in this report:

At the societal level, the following factors are considered important. Teachers, parents and patients have increased knowledge and awareness of mental health diagnoses; patients experience a decreased stigma when seeking help for mental health problems. Children and young people face health problems related to screen time, social media, and sleep deprivation. In school, children experience high stress levels related to expectations to perform well.

All these factors have contributed to an increase in the demand for psychiatric services. On the supply side, the recent increase in services provided by private psychiatric care providers might also put a pressure on the health system.

Some explanations could be more specific to certain countries. The presence of a COVID-19 pandemic effect on the mental health of adolescents is widely recognised. In this report, a spike for healthcare services for several psychiatric diagnoses was observed for the adolescent age group in Norway during the COVID-19 pandemic period of 2020-2024. The spike was stronger for girls aged 12 to 17 years. However, such a spike could not be observed in

the case of Sweden, where the increase is more smoothly distributed over the period 2010-2024.

The following factors have been emphasized: better recognition of psychiatric and neurodevelopmental disorders, improved access to care, and increased mental health services in child and adolescent psychiatry. For Finland, the Finnish ward guarantee ensures that treatment must be completed within three months. Another driving factor was the increase in the private psychiatric services. It remained unclear how well the used Nordic data sources cover the use of private services.

## Comparability of the statistics of psychiatric healthcare for children and adolescents in the Nordic countries

We expect to find similarities in the healthcare services provided to children and adolescents in the Nordic countries. The welfare system present in the countries provides free healthcare, generous public funding for medication to the whole population, and free medication for children.

The basis for the statistics in the healthcare system of the Nordic countries is the individual, personal-number-based register. Every citizen and permanent resident, also those using the healthcare services has a personal ID number, which makes it possible to link information at the individual level from several registers: patient register, prescribed drug register, causes of death register, etc. This provides unique possibilities for comparative analyses of the public health in the Nordic countries.

Similar sources of information in the Nordic countries were the services for children and adolescents in specialised psychiatric outpatient care and inpatient care. Only healthcare provided by physicians was included. This could be developed in the future by adding healthcare services provided by other professionals, such as psychologists, specialised nurses, psychotherapists, dieticians, and speech therapists.

Also available in all the Nordic countries was the information on drug use in the treatment of psychiatric disorders. The national drug registers covered individual prescriptions dispensed at pharmacies.

A significant difference in the availability of data between the countries was that Iceland and Norway had access to statistics on psychiatric healthcare provided in the primary care. The national patient registers in Finland and Sweden did not include primary care. Finland does have a specific register on all primary health care visits since 2011. However, it could not be used in this report. The register includes diagnoses only, if given by a physician. The data providers can choose if they give these diagnoses with ICD-10 or ICPC2-codes. The bridge coding between these two classifications was unavailable.

It was not possible to analyse some of the selected psychiatric diagnoses. In Iceland, information was sparse or not available for psychotic disorders, manic episodes, bipolar disease and attachment disorder.

The measures described in this report were one-year prevalences: number of users of healthcare services per 1,000 in the population, by diagnosis, country, age and sex. In addition to number of patients, Iceland also analysed number of healthcare contacts. One-year prevalences were presented for drug use, defined as number of users per 1,000 in the population, by drug class, country, age and sex.

In the future analyses, the role of the psychiatric healthcare in the whole healthcare system of the countries might be worth investigating further. Changes in the share of private/public provision of healthcare services could be another topic of analysis. Other measures may be needed: number of healthcare contacts, digital healthcare contacts, hospitalisations, the cost of healthcare per patient, and category of professionals meeting the patients.

Any data collection requires that NOMESCO agrees on the indicators and data sources as well as on the statistical harmonisation of all indicators to ensure the best possible comparison between the Nordic countries.

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