

A Descriptive Review of Nordic Clinical Practice Guidelines for Pediatric ADHD: Evaluating the Evidence Base for Methylphenidate

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Abstract

Background: Pediatric medication use in Attention Deficit Hyperactivity Disorder (ADHD) is rising sharply across the Nordic countries, with Iceland and Finland currently showing the highest prevalence rates. The reasons behind the cross-country differences remain unclear.

Objective: To describe the level of agreement in the graded evidence base for methylphenidate – the first-line ADHD medication for children – as is available in the Nordic Clinical Practice Guidelines (CPGs) on pediatric ADHD.

Method: Relevant Nordic CPGs covering ADHD medication treatment for children over 6 years-of-age were identified using strict search criteria and by visiting the Nordic CPG databases (in Nov 2025). Only the most current version of CPGs was included in the analysis and relevant links from the CPG were visited and reviewed with relevant sections adopted. All english translations were produced with the aid of large linguistic models.

Results: The Icelandic CPG lacked the grading of available evidence for methylphenidate altogether. For benefits, the chosen outcomes varied and the Finnish and Norwegian CPGs graded the quality of evidence as of high quality, the Danish as moderate and the Swedish from moderate to very low. For potential harms associated with methylphenidate use, also the Norwegian CPGs lacked the grading of evidence. The Finnish CPG concluded on high to moderate quality of evidence, the Swedish on moderate to very low and the Danish only on very low quality of evidence.

Conclusions: There is a low level of agreement between Nordic guidelines regarding the quality of evidence for methylphenidate in pediatric ADHD. This could contribute to the observed cross-country differences in prescribing practices. A centralized CPG development process and stronger collaboration among Nordic CPG working groups seem warranted.

Keywords: Child Psychiatry; ADHD; Methylphenidate; Clinical Practice Guideline; Evidence Based Medicine; Adolescent Psychiatry.

Introduction

Pediatric medication use in Attention Deficit Hyperactivity Disorder (ADHD) is rising sharply across the Nordic countries, with Iceland and Finland currently showing the highest prevalence rates (1,2). In 2022, 18% of Icelandic(3) and 8% of Finnish(4) and Swedish(5) adolescent boys were using ADHD medications. In 2024, already 11% of Finnish boys and 4% of girls aged 7–12 were medicated(4). The reasons behind these trends and cross-country differences remain unclear.

The Nordics all have their own established national programmes for developing Clinical Practice Guidelines (CPGs) on the management of ADHD. In general, CPGs aim to guide healthcare professionals and patients towards treatment decisions based on the best available scientific evidence (6). High-quality reporting of the expected health benefits and potential

harms of treatment options form the core of the CPGs (7). However, providing high-quality CPGs necessitates considerable resources and in-depth methodological skills not always available in small countries such as the Nordics.

An earlier study systematically reviewed both national and international CPGs published by 2019 on the management of ADHD and found the CPG's to be generally low in quality (8). However, the Nordic guidelines are typically published in non-English language and were, thus, excluded from the study and have not yet been assessed at any level. Little is therefore known about their content or level of agreement although potential contradictions in the national CPGs could also explain the cross-country trends in pediatric ADHD medication use in the Nordics. Advances in AI translation (9-11) now make the assessment of non-english CPGs possible.

The aim of this analysis was to describe the graded evidence base available within the Nordic CPGs on pharmacological treatment of pediatric ADHD and to identify the level of agreement between them. Focus was set on the evidence base for methylphenidate, since it is typically considered as the first-line ADHD medication for children (12). While providing a balanced Nordic comparison, the study also sought to address Finland's immediate need to explore potential reasons for the recent local increases in pediatric ADHD medication use.

Methods

For identifying all relevant Nordic CPGs the following eligibility criteria were applied: 1) Evidence-based CPGs on ADHD; 2) published in Denmark, Finland, Iceland, Norway or Sweden; 3) original source CPGs; 4) both national or international CPGs; 5) published by the 1st November 2025; 6) published by an organisation or a group in a CPG database; 7) covering psychopharmacological treatments; 8) targeted to physicians (either general practitioners and/or specialists) and 9) covering children aged 6 years and older. For literature searches the following Nordic CPG databases were used: Current Care Guidelines (Finland), Socialstyrelsen (National Board of Health and Welfare, Sweden), Helsedirektoratet (Norwegian Directorate of Health, Norway), Sundhedsstyrelsen (Danish Health Authority, Denmark) and Embætti landlæknis (The Directorate of Health, Iceland). The key-word used to search the CPG database was "ADHD". Only the most current version of CPG from each source was included in the analysis and relevant links from the CPG were visited and reviewed with relevant sections adopted.

All English translations were produced with the Google AI (version available in Oct 2025) and Chat GPT (version available in Nov 2025), using one large linguistic model (LLM) to validate the other. Although LLMs appear not to have been utilised for this purpose previously, there are already implications on their validity and accuracy when translating patient-specific discharge instructions (9), patient education materials (10), and outcome questionnaires (11), provided that translations are subjected to caution and human professional quality control. Accordingly, the translations were all critically appraised to exclude any outliers introduced solely by the LLM.

CPGs were searched for recommendations on methylphenidate with focus on the quality gradings applied for the available evidence on the expected benefits and potential harms either on short-term or long-term basis. To allow comparison, the gradings were harmonised, if lacking, using the Grades of Recommendation, Assessment, Development, and Evaluation (GRADE) (7), by classifying the quality of the linking evidence with a 4-level-scale (A = high;

B = moderate; C = low; and D = very low). All gradings with their linking evidence base were then tabulated.

Results

As expected, all identified full-text Nordic CPGs were in non-English language and thus required translations with the LLMs. The Finnish CPG (13) was the most current and the Danish (14) the least (Table) and all CPGs had been updated during the last five years.

All guidelines emphasized the role of non-pharmacological treatments (i.e. psychological, pedagogical, and social interventions involving parents, school, and daycare) as first-line treatment, before considering medication. Methylphenidate was recommended as the first drug of choice in all but the Norwegian CPG, where all stimulants (i.e. methylphenidate and amphetamines) were recommended as first choice over other medications (data not shown). However, there was variation in the quality of the chosen outcomes and the synthesis of evidence (Table). Additionally, there was heterogeneity in how – if at all – the Nordic CPGs had graded the quality of the supporting evidence for methylphenidate (Table).

Discussion

This descriptive review of Nordic CPGs on pediatric ADHD suggests low level of agreement upon the graded evidence base for methylphenidate. For benefits, the Icelandic CPG (15) lacked the grading of available evidence for methylphenidate. The Finnish (13) and Norwegian CPGs (16) graded the quality of available evidence as of high quality and thus higher than the Danish (14) and Swedish (17) CPGs. There was also variation in the synthesis of evidence but not enough to explain the heterogeneity in the quality gradings. For potential harms associated with methylphenidate, both the Icelandic (15) and Norwegian (16) CPGs lacked the grading of available evidence, the Finnish CPG (13) concluded on high to moderate quality of evidence as the Swedish CPG (17) concluded only on moderate to very low and the Danish (14) on very low quality of evidence.

For addressing the potential reasons for the recent increases in pediatric ADHD medication use in Finland, a more in-depth evaluation of the Finnish CPG was in order. Accordingly, the conclusion on the benefits of methylphenidate in the Finnish CPG was mainly based on the 2023 Cochrane review on methylphenidate for children and adolescents in ADHD (18). The Cochrane systematic reviews are widely known to provide high-quality assessments and synthesis of evidence. However, opposed to the Finnish CPG, the Cochrane collaboration concluded that methylphenidate versus placebo or no intervention may improve teacher-rated ADHD symptoms

TABLE 1. The quality of evidence for methylphenidate as reported in the Nordic clinical practice guidelines (CPGs) on pediatric ADHD (i.e. for children ≥ 6 years-of-age).

CPG by country of origin (year of CPG publication/update)	Benefits	Harms
Denmark ¹⁴ (2021)	Based on the randomized trials reviewed, a good effect was found on both ADHD core symptoms and behavioral difficulties, as reported by teachers, parents, and observers/clinicians. (Quality of evidence: B)	No significantly higher number of serious adverse effects was reported, but this estimate is very uncertain (Quality of evidence: D).
Finland ¹³ (2025)	Methylphenidate significantly reduces inattention, impulsivity, and hyperactivity symptoms of ADHD in children and adolescents, at least in short-term (less than six months) treatment (Quality of evidence: A)	Side effects of methylphenidate are common but usually mild in the short-term treatment of ADHD in children and adolescents (Quality of evidence: A). Treatment of ADHD with methylphenidate does not apparently increase the risk of serious cardiovascular adverse effects (Quality of evidence: B).
Iceland ¹⁵ (2023)	NA	NA
Norway ¹⁶ (2022)	A large number of controlled studies have documented that treatment with methylphenidate containing medications results in a significant reduction of symptoms (such as difficulties with concentration, hyperactivity, and impulsivity) in 70–80% of children and adolescents with ADHD/Hyperkinetic disorder (Quality of evidence: A)	NA
Sweden ¹⁷ (2024)	For up to 1 year methylphenidate reduces core ADHD symptoms in children and adolescents more than placebo (SMD - 0,78; 95% CI -0,93 - 0,62) (Quality of evidence: B). Methylphenidate improves functioning in children and adolescents with ADHD more than placebo, as evaluated with the WFIRS-P (mean difference -0.25; 95% CI -0.35 to -0.15) (Quality of evidence: C). It is unclear whether methylphenidate has an effect on functioning in children and adolescents with ADHD when evaluated using the BSFQ, SCS, PREMB-R AM, or PM tools, as well as academic performance (various domains of reading, spelling, and	It is unclear whether methylphenidate affects treatment discontinuation due to side effects in children and adolescents (Quality of evidence: D). Methylphenidate increases systolic blood pressure more than placebo in children and adolescents (SMD 0.15; 95% CI 0.05 to 0.25) (Quality of evidence: B) Methylphenidate increases diastolic blood pressure more than placebo in children and adolescents (SMD 0.27; 95% CI 0.17 to 0.38) (Quality of evidence: B). It is unclear whether methylphenidate affects the frequency of sudden death/ventricular arrhythmia or

mathematics) (Quality of evidence: D).	mortality (all causes) in children and adolescents (Quality of evidence: D).
It is unclear whether treatment with methylphenidate affects quality of life in children and adolescents with ADHD (Quality of evidence: D).	There are no studies to assess whether methylphenidate affects the frequency of myocardial infarction or stroke in children (≥ 6 years).

Note. Quality of the supporting evidence is graded with a 4-level-scale (A = high; B = moderate; C = low; and D=very low) as recommended by the GRADE working group (7). ADHD=Attention Deficit Hyperactivity Disorder, BSFQ= Before-School Functioning Questionnaire, CI= Confidence Interval, NA=Not available, PREMB-R AM or PM=Parent Rating of Evening and Morning Behavior Scale (morning/evening subscale), Revised, SCS*= School Competence Scale, SMD=Standardized Mean Difference, WFIRS-P*= Weiss Functional Impairment Rating Scale-Parent Report, *The abbreviations in the report were not defined, so these expansions have been provided based on expert knowledge and assumptions.*

and general behaviour in children and adolescents but the certainty of the evidence was considered very low (18). Likewise, the Norwegian CPG (16) referred to “numerous controlled studies” demonstrating the efficacy of stimulants, yet references were available to the NICE 2008 guideline (19), a systematic review published by Prasad et al in 2013 (20) and a randomised controlled trial published by Slama et al in 2015 for osmotic-release oral system methylphenidate (21).

For potential harms, the in-depth analysis of the Finnish CPG indicated that the grading of the evidence base relied again on the Cochrane 2023 review (18) as well as seemingly also on a previous Cochrane review (2018) on the evidence of adverse events of methylphenidate observed in non-randomised studies (22). However, the 2023 Cochrane review concluded that methylphenidate may have no effects on serious adverse events and quality of life and may be associated with an increased risk of adverse events considered non-serious but again, the certainty of the evidence was concluded to be very low (18). Likewise, the Cochrane review in 2018 concluded the evidence to suggest that methylphenidate may be associated with a number of serious adverse events as well as a large number of non-serious adverse events in children and adolescents but the certainty in the evidence was again concluded to be very low (22).

Guideline development demands transparent and rigorous methods for reviewing the included evidence combined with a professional appraisal on the quality of that evidence, and the balance between the expected benefits and harms at the population level. Sometimes the CPG's fail to reach the expected quality in guiding evidence based clinical practice. The findings from this study indicate that the same published evidence base for methylphenidate is interpreted and graded in various ways depending on the Nordic country. This suggests that human factors are perhaps too greatly involved within some of the National CPG developmental processes therefore compromising the quality and equity of ADHD treatment in the Nordics.

The majority of the CPG's on ADHD treatment have previously been deemed of low quality (8). Yet, the CPG on ADHD published in 2018 by the National Institute of Care and Health Excellence (NICE) (23) could serve as a high-quality model for other CPGs (8) but is an extensive achievement with a supporting evidence review of more than 700 pages already on the pharmacological efficacy and sequencing pharmacological treatment. Such efforts are out of reach for the small Nordic countries and therefore other approaches to avoid duplication and misallocation of resources are needed. Given also that scientific literature is evolving at a rapid pace, it seems that a centralized CPG development process with rigorous national adaptation processes (24) could be capable of producing sufficiently high-quality and up-to-date evidence and clinical recommendations to drive rational ADHD prescribing practices across the Nordics. Alongside, the recently developed, continuously updated web platform on the latest evidence base of ADHD interventions could be utilised (25). At the minimum, more communication and collaboration between the Nordic CPG working parties seem mandatory.

This study has several limitations that caution the interpretations of the findings. First, this review did not apply a systematic approach. Therefore it is possible that some other national CPGs potentially impacting national treatment practices at the time of data collection may have been missed. Should this be the case, it would also emphasize the need for a centralized CPG development processes. Second, due to the dynamic nature of guideline updates, some national CPGs may have been updated after the data collection for this review. This occurred at least in the case of Sweden, where an updated CPG on ADHD was released as recently as March 2026. However, this is unlikely to significantly challenge the primary findings of this study. Third, this study focused on the graded evidence base available for methylphenidate and did not address other potentially relevant information on medication efficacy and safety that may have been available within the CPGs. Finally, it cannot be excluded that applying LLMs and/or human

error caused falsed interpretations of the non-english national guidelines. Thus, it is recommendable by others to conduct further systematic appraisals of these Nordic CPGs in the near future.

Clinical Significance

There seems to be low level of agreement between the Nordic guidelines regarding the quality of evidence for methylphenidate in pediatric ADHD. This may contribute to the cross-country differences in prescribing practices for ADHD. To ensure safe ADHD medication treatment for all Nordic children, a centralized CPG development process and stronger collaboration among Nordic CPG working groups are warranted.

Conflicts of Interest

The author declares no conflicts of interest.

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