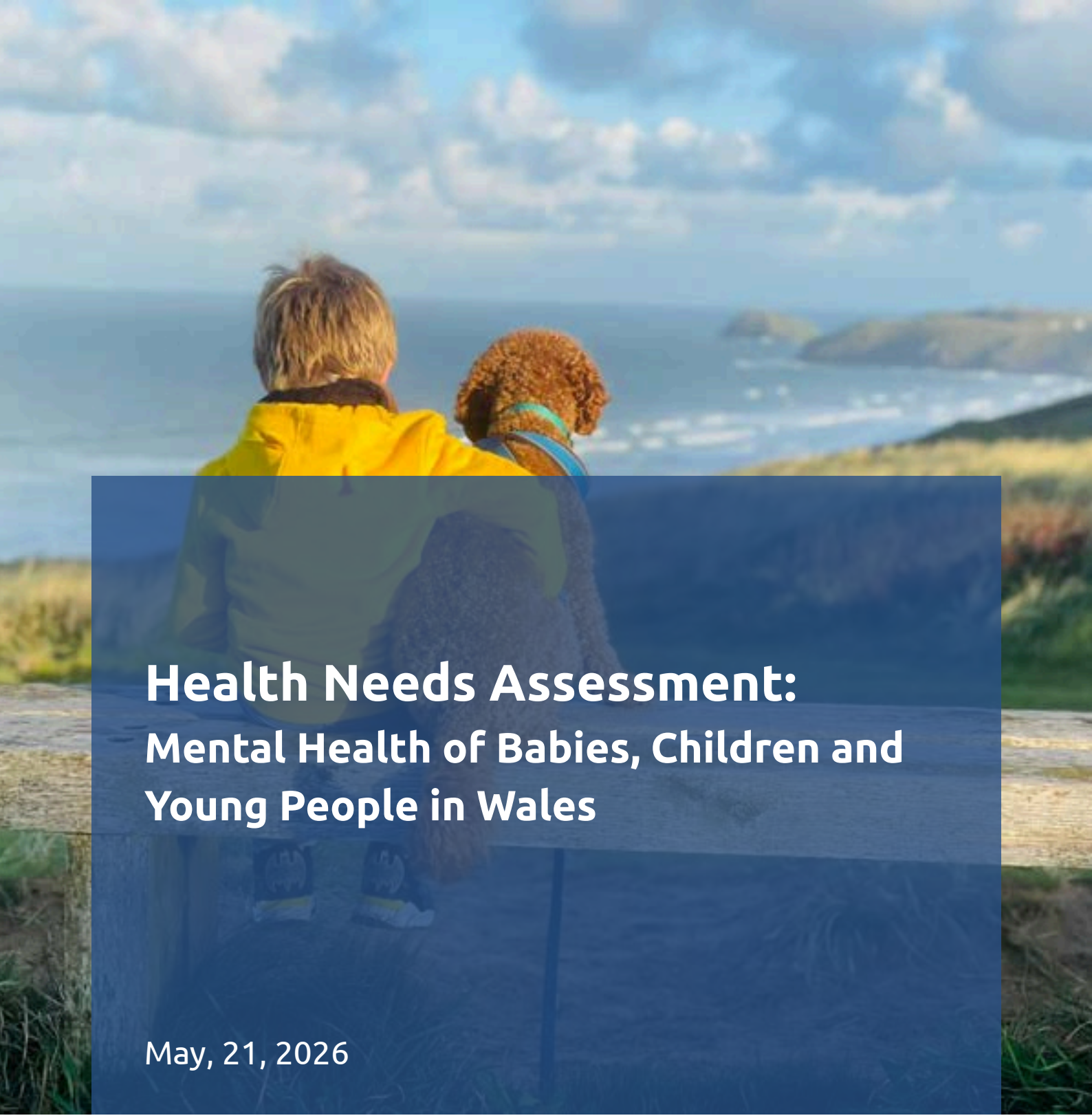

Health Needs Assessment:
Mental Health of Babies, Children and Young People in Wales

May, 21, 2026

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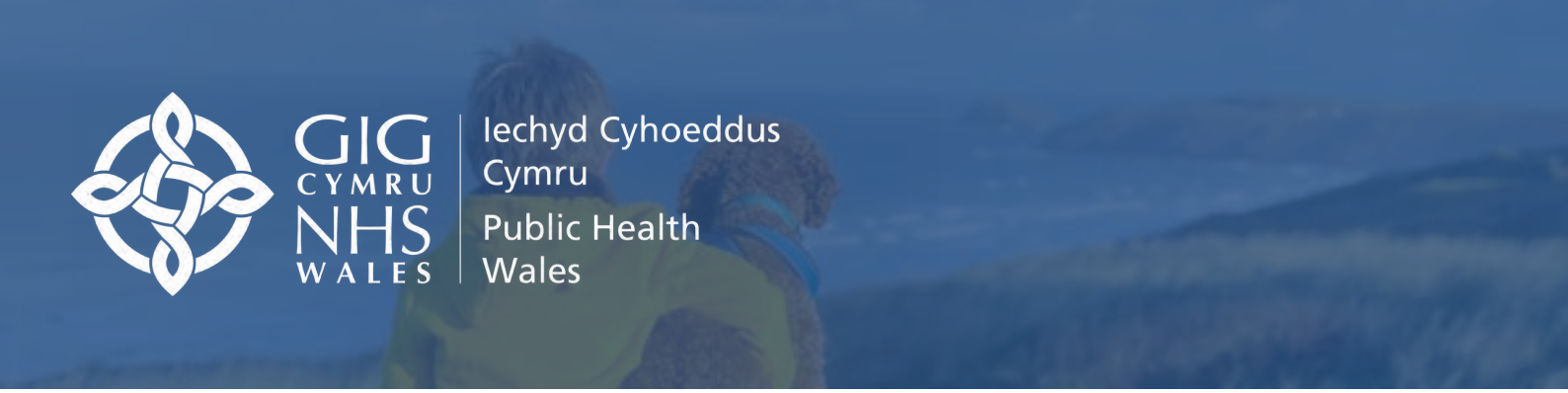

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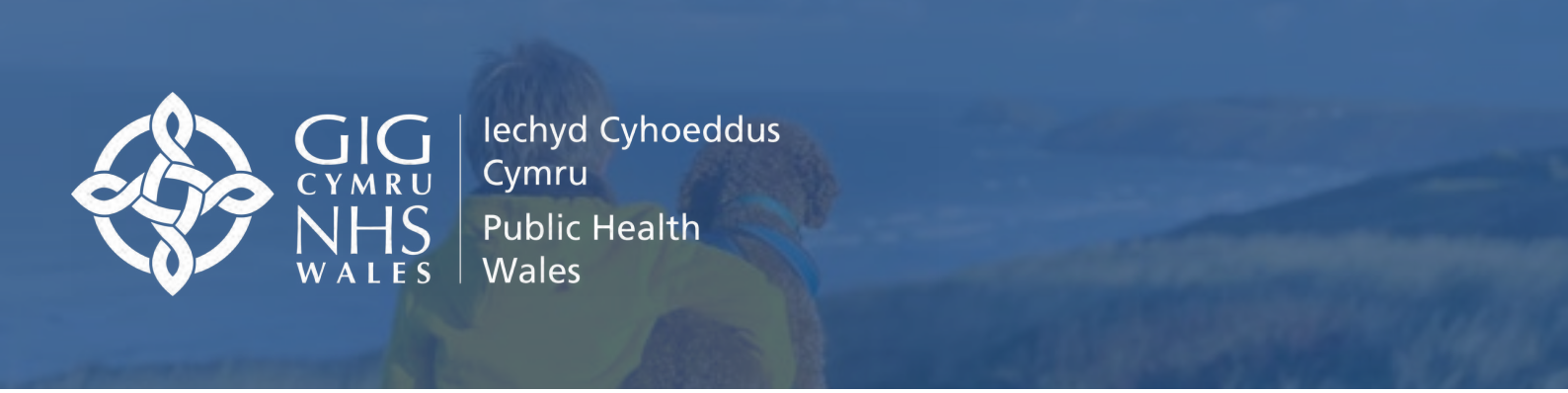

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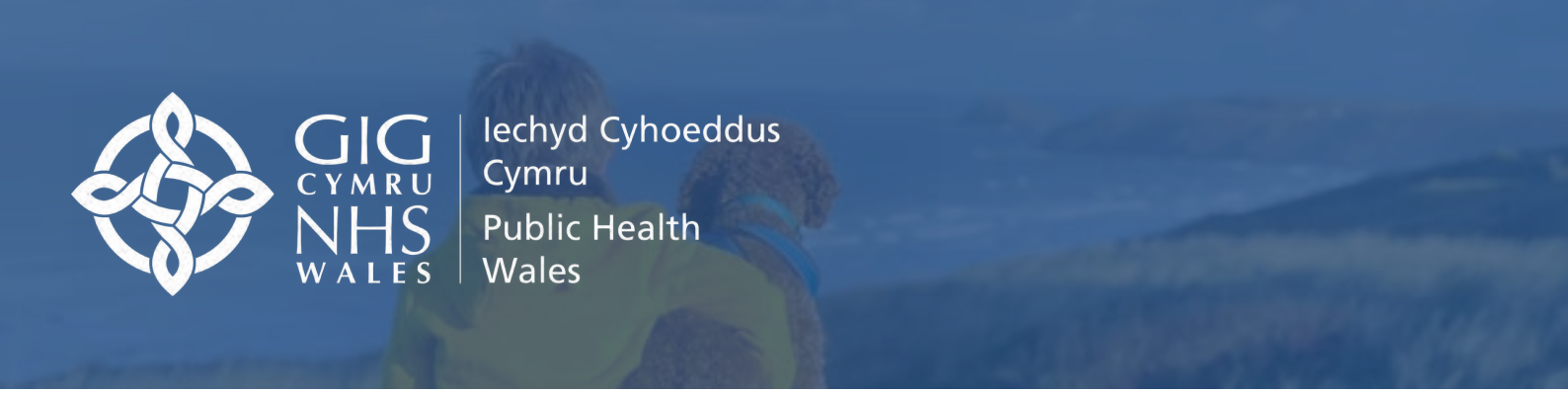

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Executive Summary

Health Needs Assessment:
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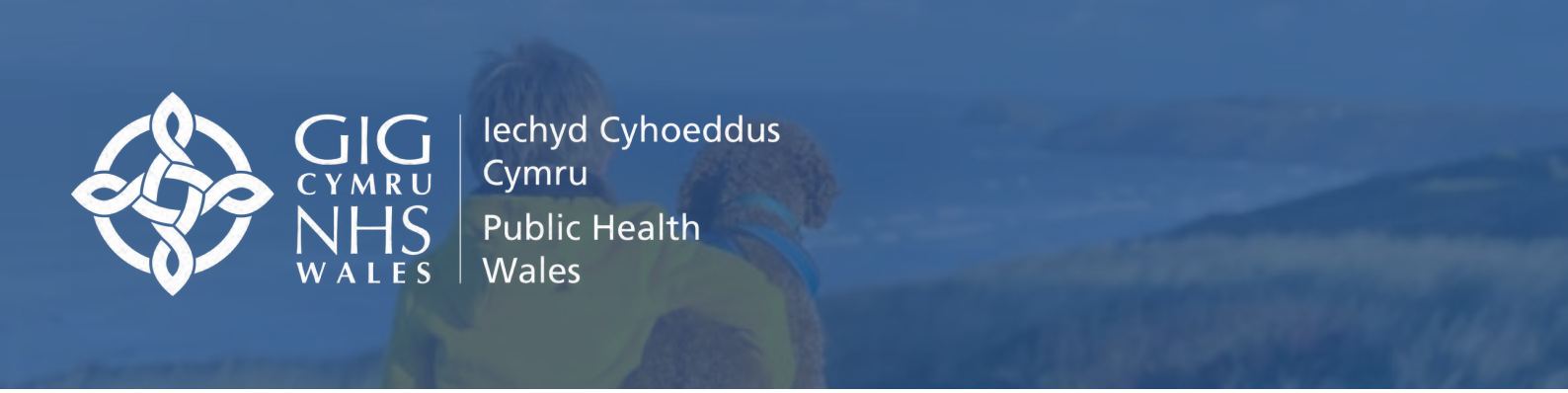

Executive Summary

Introduction

Supporting the mental health and wellbeing of babies, children and young people (BCYP) is a national priority. An increasing number of BCYP are experiencing mental and emotional difficulties, driven by a complex interplay of social, environmental, economic, and technological risk and protective factors.
Even before the COVID-19 pandemic, mental health concerns among young people were on the rise. In 2019 mental health problems were estimated to cost the Welsh economy £4.8 billion each year. These costs—linked to both healthcare and wider social and economic impacts, have increased since the pandemic, due to the exacerbation of existing vulnerabilities and increased population need.
The all-age Mental Health and Well-being Strategy 2025-35 prioritises prevention, early intervention, and timely access to care to improve mental health and wellbeing in Wales.

The mental health and wellbeing of babies children and young people

Babies: 25-30% parent-infant dyads are likely to benefit from support to improve mental health and wellbeing in the first 1,000 days, two thirds of those are unlikely to receive support before age two.

Young Children: 36% of reception children are below the expected level of personal and social development for their age.

Mental Wellbeing: An estimated 1 in 4 girls, 1 in 6 boys and 1 in 2 trans or gender-questioning secondary school learners are experiencing low mental wellbeing.

Mental health conditions: Over 135,000 CYP are estimated to have a diagnosable mental health condition; 1 in 6 aged 8 to 10; 1 in 5 aged 11 to 16, and 1 in 4 aged 17 to 24.

Emotional difficulties present the greatest burden, with increases among all genders; higher rates among girls and gender questioning learners emerge from primary school increase with age.

Behavioural difficulties have increased amongst all genders with the highest rates seen in boys and gender questioning learners.

Neurodevelopmental conditions appear to be relatively stable, however demand for services has been rising, likely due to improved awareness among parents and professionals. Diagnostic over-shadowing risks under-identification of mental health needs among neurodivergent groups.

Eating disorders have increased most sharply in females, highlight a growing need for prevention and early intervention, including action to address body image concerns.

Psychoses prevalence remains relatively low and stable, but support to deal with symptoms, often emerging during late adolescence is crucial for reducing relapse and improving outcomes.

Self-harming behaviours have increased in prevalence and frequency, signaling increasing distress among young people.

Suicide prevention strategies should consider the needs of emerging adults and opportunities to improve identification of distress and access to support.

Services, Support and Barriers to Access

Service data further re-iterates growing needs among children and young people, particularly for emotional difficulties/anxiety-related conditions and eating disorders. Increased capacity and access to early support and psychological interventions in non-stigmatising environments, including schools, communities, GPs and remote services is needed to address needs prior to the need for crisis care.
Increased awareness of how to access early support is needed among young people, and when help is sought children and young people should be enabled to engage with age- and-culturally appropriate support.

Risk and Protective Factors

Systematic action is required to address the range of risk and protective factors for mental health and wellbeing; addressing child poverty must continue to be a priority. BCYP need to be protected from harms, be provided with opportunities to play, develop social and emotional skills and to grow in environments which support healthy behaviours. Action is needed to improve infant and care-giver relationships, parenting support, opportunities for play and social and emotional learning during childhood. Action in the early years is cost-effective and improves social, emotional and developmental outcomes.

Schools can take action to address bullying, schoolwork pressure and access to early support. Action to address body image, sleep, physical activity levels, opportunities to build friendships and access to trusted adults is likely to improve outcomes.

Healthy behaviours, engagement with meaningful activities, and connections with community assets improve resilience and should be promoted during service contacts.

Non-pharmacological approaches, including social prescribing, promoting nature-connection and arts-based programmes should be extended and evaluated for BCYP, both in early intervention and recovery pathways.

National policies to address the determinants of mental health and wellbeing need continued focus in order to reduce inequalities in mental health outcomes.

Vulnerable Groups

The specific needs of BCYP and families facing conditions and experiences that place them at higher risk of poor mental health and wellbeing, including poverty, discrimination and marginalisation and neurodevelopmental conditions, should be considered when designing services. Mental health support should include support for individuals and families to address social and environmental factors that contribute to poor mental health and wellbeing.

Shifting services to be trauma-informed is likely to be particularly beneficial for babies, children and young people from vulnerable groups. Promotion and prevention activities should be delivered universally with weighting towards those groups at higher risk of poor mental health and wellbeing.

Lived Experience Insights

The views of BCYP and families should shape the future design of services and support in communities, utilising co-production and genuine engagement to listen and respond to their views and lived experiences. Insights from a diverse group of young people highlighted the importance of taking a needs-based approach and supporting mental health and co-occuring conditions including neurodevelopmental and physical health conditions.

Mental health services alone cannot address the growing mental health and wellbeing needs of BCYP; improving mental health literacy and access to third spaces, community infrastructure and meaningful activities is also required.

BCYP do not live in isolation; collaboration with families, universal health services, schools and education settings and wider community organisations are vital in addressing growing needs and improving recovery and outcomes.

Evidence-informed approaches and international models of care

Wales has a strong policy environment which encourages a shift to prevention and early intervention. Building on this to strengthen investment in and implementation of preventative approaches across the system is vital for improving mental health and wellbeing and the future sustainability of services.

Learning from international models for delivering mental health services and support provides opportunities to improve access and outcomes for BCYP. Providing the appropriate level of care and support at the right time, in non-stigmatising environments can reduce waiting times, improve access and outcomes. A combination of early identification and intervention, digital tools and self-help information, family-centred care, open access services and supporting transition between adolescence and adult services are both effective and cost-effective.

Summary and recommendations

There has been a rise in poor mental wellbeing and mental health conditions among BCYP in Wales in recent years. Emotional difficulties, self-harming behaviours and eating disorders—often tied to body image concerns, have become increasingly prevalent across all genders. These trends are not affecting all groups equally. Girls, non-binary young people, and those from the most deprived backgrounds are bearing the brunt of these challenges. Symptoms are appearing at younger ages, with many issues deeply rooted by adolescence and early adulthood.

This rise in mental health difficulties is due to a range of factors, and further research is needed to fully understand drivers behind the rise. However evidence suggests increased school-work/academic pressures and social inequalities have influenced worsening mental health among BCYP. Other risk factors including poor early relational care, bullying, sleep problems, parental mental health conditions and physical inactivity remain important areas to address.

Over recent years the demand for mental health support for BCYP has outpaced service capacity, creating a widening gap between those who need help and those who can access timely, person-centred care. Meeting this growing need requires a bold, coordinated response across sectors. The Mental Health and Wellbeing Strategy for Wales, 2025-35 calls for such action.

Evidence highlights the urgent need to strengthen prevention, early intervention and timely mental health support BCYP in Wales. The below recommendations aim to drive system-wide action.

- ***Prioritise co-production and active involvement*** - embed the voice of babies, children and young people's in the design, delivery, and evaluation of services to ensure that support is relevant, empowering, and responsive to their lived experiences.

- ***Focus action on rising mental health conditions*** – enhance prevention, early intervention and access to timely support for children and young people experiencing emotional difficulties, particularly anxiety, eating disorders and self-harm.

- ***Prioritise prevention –*** take action to give babies and young children the best start in life and address risk and protective factors for BCYP including building supportive relationships, healthy lifestyles, quality sleep and engagement with meaningful activities.

- ***Strengthen early intervention*** – enable emerging mental health needs to be identified and addressed promptly, through upskilling and supporting those working with BCYP and develop pathways to early support to reduce the risk of escalation and improve outcomes.

- ***Protect infant mental healt***h – strengthen parent-infant relationships, through developing workforce capacity and community-based approaches to promote secure attachment. Opportunities exist to improve early identification of parent and infant difficulties include through antenatal and postnatal checks, childcare settings and courts.

- ***Protect parental mental health*** - strengthen support for parental mental health, including early support for mothers, fathers and care-givers during the perinatal period and when children and young people access support.

- ***Target inequalities in access and outcomes*** – take a proportionate response to addressing disparities arising from geography, socioeconomic status, ethnicity, neurodiversity, and other vulnerabilities to ensure equitable access to mental health support.

- ***Address the social determinants of mental health*** - coordinated action to address child poverty, housing security and living conditions, education and employment opportunities and inclusive communities to positively influence the mental health of BCYP and our future generations.

- ***Embed whole-school approaches to emotional and mental wellbeing*** - continue to support education settings in Wales to improve supportive cultures and access to support.

- ***Develop social prescribing approaches for families, children and young people*** – develop pathways to strengthen social support and connections with community assets and activities, including evidence-based arts and nature-based approaches.

- ***Address the digital determinants of mental health –*** Promote the benefits of online connectivity while adapting frameworks to keep pace with emerging digital risks such as harmful content, excessive screen time, and cyberbullying, alongside addressing the digital exclusion.

- ***Provide tailored support for key life stage transitions and life events –*** strengthen resilience and support during critical periods such as the first 1000 days, starting school, adolescence, leaving care and transitioning to Adult Mental Health Services.

- ***Transform the support system –*** prioritise the development of a cohesive, connected system that ensures a timely, person-centred and collaborative approach and provides support at the right time, in the right place and without delay.

- ***Enhanced data, research and evaluation –*** develop consistent data collection, analysis, and sharing to inform evidence-based policy, drive service improvement and monitor progress.

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Introduction

Health Needs Assessment:
Mental Health of Babies, Children and Young People in Wales

Introduction

Supporting the mental health and wellbeing of babies, children and young people (BCYP) is a national priority. An increasing number of BCYP are experiencing mental and emotional difficulties, driven by a complex interplay of social, environmental, economic, and technological factors. The more risk factors BCYP are exposed to, the greater the potential impact on their mental health. Strengthening protective factors can help to mitigate against the risk of poor mental health.[1]

Even before the COVID-19 pandemic, mental health concerns among young people were on the rise. In 2019 mental health problems were estimated to cost the Welsh economy £4.8 billion each year.[2] These costs—linked to both healthcare delivery and wider social and economic impact will have increased since the pandemic, due to the exacerbation of existing vulnerabilities and the increase in population need.

With approximately 75% of mental health conditions emerging before the age of 24,[3] the growing prevalence of mental health difficulties among BCYP presents a critical challenge—not only for Child and Adolescent Mental Health Services (CAMHS) now, but also for adult mental health services in the future. Too many young people experiencing mental health difficulties do not receive timely or appropriate support. Bridging this gap requires a multifaceted approach that prioritises both prevention and intervention. This includes:

- Mitigating risks and strengthening protective factors to foster resilience and reduce vulnerability
- Scaling up early intervention and community-based support, ensuring help is accessible before mental health difficulties escalate
- Enhancing specialist mental health services to improve access, quality of care, and recovery outcomes.

The new All-Age Mental Health and Well-being Strategy for Wales provides a whole-system approach that prioritises prevention and early intervention, aiming to improve mental health outcomes across the population.

2.1 The Mental Health and Wellbeing Strategy (2025-2035)

The Mental Health and Wellbeing Strategy for Wales[4] sets out a comprehensive framework for improving mental health outcomes that connects across organisations and reaches into communities.

The services that surround BCYP are already working together to adapt to changing needs, from creating mentally healthier family and school environments through to establishing Sanctuary Spaces. Healthcare Inspectorate Wales (2024) identified key areas of good practice but also highlighted that many young people struggle to access support, often only receiving help when their needs have significantly worsened.[5] In response, the new strategy, adopts a rights-based approach that prioritises equitable access and outcomes for all, without exception. It calls for coordinated delivery to promote wellbeing, prevent mental health difficulties and improve outcomes. Ensuring all BCYP receive timely, person-centred, and equitable support for their mental health and wellbeing is essential to enable current and future generations to thrive.

The overarching strategic vision is to achieve:
• There is action to make sure the building blocks are in place to support good mental health and wellbeing
• Everyone has the knowledge, opportunities and confidence to protect and promote good mental health and wellbeing
• There is a connected system where all people receive the appropriate level of support wherever they reach out for help
• There are seamless mental health services – person-centred, needs led and guided to the right support first time, without delay

2.2 Defining Mental health and Mental wellbeing

TTo ensure alignment with national policy, the definitions of mental health, mental health conditions, and mental wellbeing presented are those set out in the Welsh Government's All-Age Mental Health and Wellbeing Strategy for Wales 2025–2035.[6]

Mental health is a state of mental wellbeing that enables people to cope with the stresses of life, realise their abilities, learn well and work well, and contribute to their community. It is an integral component of health and wellbeing that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in. Mental health is a basic human right. And it is crucial to personal, community and socio-economic development.[7] People with poor mental health can have a mental health condition but this is not always or necessarily the case.

Mental health conditions is a broad term covering conditions that affect emotions, thinking and behaviour, and which substantially interfere with our life. Mental health conditions can significantly impact daily living, including our ability to work, care for ourselves and our family, and our ability to relate and interact with others. Mental health conditions can range from mild through to severe and enduring illness. People with mental health conditions are more likely to experience lower levels of physical and mental wellbeing, but this is not always or necessarily the case. Some mental health conditions like eating disorders and schizophrenia are associated with a higher risk of mortality.

Mental wellbeing is the internal positive view that we are coping well with the everyday stresses of life.

2.3 Purpose

The purpose of this Health Needs Assessment (HNA) is to understand the current mental health needs of BCYP in Wales. This insight will inform future planning and configuration of mental health services and support. The HNA draws on a wide range of population-level and health service data to identify key mental health needs, highlight opportunities to prevent poor mental health, and improve access and outcomes for those requiring support.

This HNA focuses on the needs of BCYP aged 0–24 years, aligning with Welsh Government policy to improve support during key developmental periods and through key transition periods from infancy to early adulthood.

Information on the demographic profile of all BCYP is first presented, followed by data on overall mental health status and specific disorders. Where possible, data on groups at higher risk of poor outcomes is included. Data specific to Wales is presented where available, where gaps exist, evidence from England and the UK is used to supplement findings. In addition, evidence-based risk and protective factors are explored to inform targeted support and intervention.

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National Demographic Profile

Health Needs Assessment:
Mental Health of Babies, Children and Young People in Wales

3.1 Population and population change

In 2024, it was estimated that around 3,1866,00 people (all ages) were living in Wales, an increase of 1.7% (32,000 people) since mid-2022 (Figure 1).[8] Population growth was recorded in 21 of Wales' 22 local authorities. The largest increases were in Cardiff (+3.4%), Swansea (+1.9%), and Ceredigion (+1.6%). Merthyr Tydfil was the only area to see a decline, with a 0.5% decrease (around 300 people).

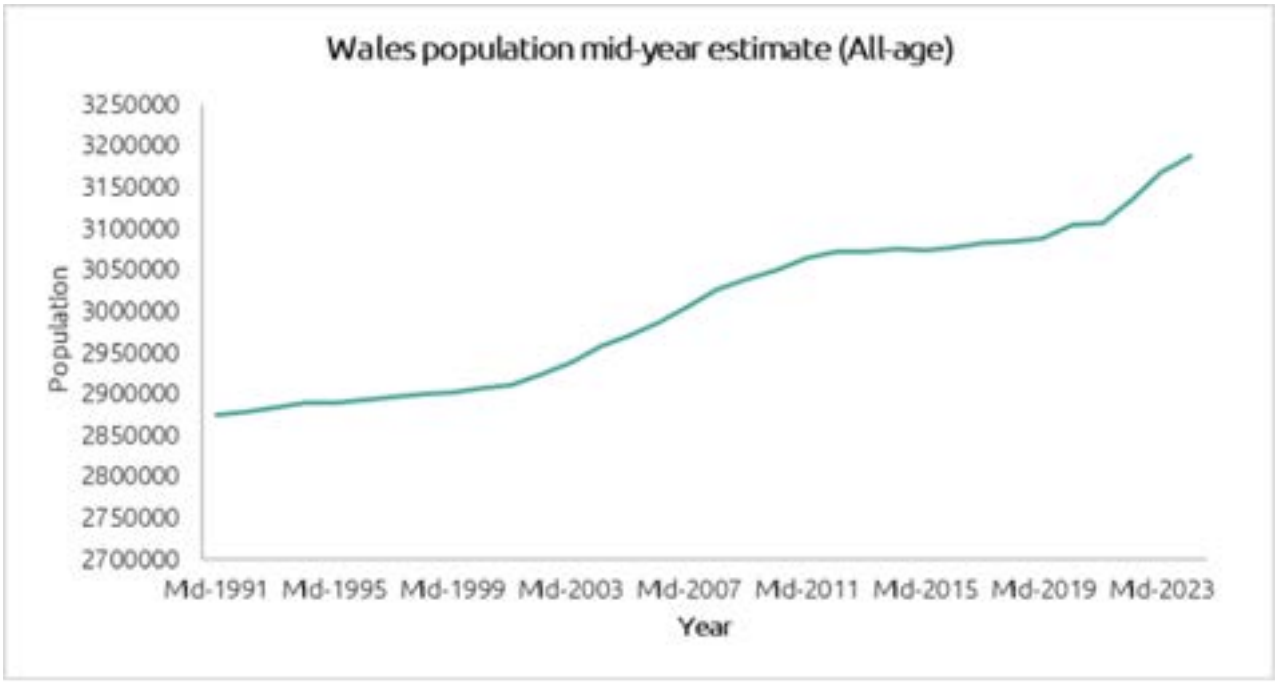

Figure 1. Population estimates in Wales, 1991 to 2023 (Source: Estimates of the population for the UK, England, Wales, Scotland, and Northern Ireland - Office for National Statistics)

An estimated 886,200 BCYP (0–24 years) live in Wales, making up 28% of the total population (Table 1).[9] Of these:

- 28.5% aged 0–7 years.
- 12.1% aged 8–10 years
- 25.3% aged 11–16 years
- 34% aged 17–24 years
-

The BCYP population in Wales is projected to reach 900,600 by 2035, a 1.6% increase from current levels but slightly below the 2025 projection (902,400).

By 2035:

- The 0–7-year-old group is expected to grow by 2.9%
- The 17–24-year-old group is expected to grow by 9.3%.

In contrast, the 8–10-year-old and 11–16-year-old groups are projected to decline by 5.9% and 6.5%, respectively.

	Age groups (years)							
	0-7y		8-10y		11-16y		17-24y	
Area	Count*	% of all 0-24y in Health Board	Count*	% of all 0-24y in Health Board	Count*	% of all 0-24y in Health Board	Count*	% of all 0-24y in Health Board
Betsi Cadwaladr UHB	53,300	29.4	23,100	12.7	49,000	27	56,000	30.9
Powys THB	9,300	30.1	4,100	13.3	8,600	27.7	9,000	29
Hywel Dda UHB	28,400	28	12,400	12.3	26,500	26.2	33,900	33.5
Swansea Bay UHB	30,400	26.5	12,800	11.2	27,300	23.8	44,200	38.5
Cwm Taf Morgannwg UHB	37,100	30.1	15,700	12.8	32,500	26.4	38,000	30.8
Cardiff and Vale UHB	43,000	24.9	17,900	10.4	37,100	21.5	74,400	43.2
Aneurin Bevan UHB	51,500	31.7	21,100	13	43,500	26.8	46,300	28.5
All Wales	253,000	28.5	107,100	12.1	224,400	25.3	301,700	34

Table 1. Mid-year population estimates*, all persons, 0-24 years, Wales health boards, 2023
Produced by Public Health Wales Observatory, using POPU0005 MYE (ONS) from StatsWales. *ONS mid-year population estimates to nearest hundred.

3.2 Population Characteristics

3.2.1 Material deprivation

In 2023, 29% of children (< 18 years) in Wales lived in relative income poverty, up slightly from 28% in 2022 (Figure 2).[10] Of these, 11% were in material deprivation and low-income households. Children are considered materially deprived and low income if their family scores 25 or more out of 100 on a 21-item affordability measure and has an equivalised household income below 70% of the UK median before housing costs;[11] comparable rates were 12% in England, 10% in Scotland, and 8% in Northern Ireland. Parental employment status was strongly linked to deprivation:

- 5% of children in Wales with employed parents experienced material deprivation
- 29% of those with economically inactive parents experienced material deprivation.

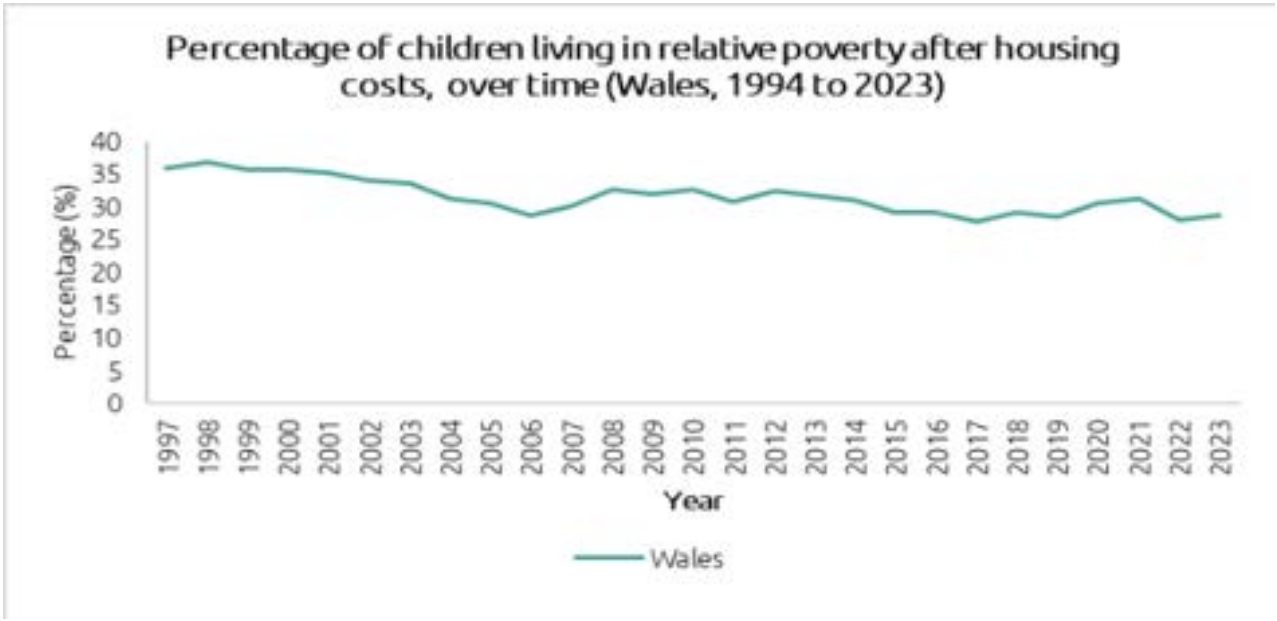

Figure 2. Percentage of children in Wales living in relative income poverty (after housing costs). (Source: Households Below Average Income: an analysis of the UK income distribution: FYE 1995 to FYE 2024 - GOV.UK)

3.2.2 Education

3.2.2.1 Free School Meals (FSM)

In Wales, all primary school pupils (ages 5-11 years) are universally eligible for free school meals (FSM). Nevertheless, data continues to be collected to show which pupils would qualify under the previous means-tested system. FSM eligibility remains a useful indicator of the proportion of children from low-income households; Pupils qualify if their parents or guardians receive certain means-tested benefits.[12] In 2024 FSM eligibility in Wales remained above pre-pandemic levels (Figure 3).
As of January 2024:

- 81,316 pupils aged 5–15 years (21.3%) were eligible for FSM — slightly down from 22.2% in 2023, but up from 17% in 2008
- Across all age groups, 90,108 pupils (19.3%) were eligible — down from 20.3% in 2023, yet well above the 15.5% in 2008.

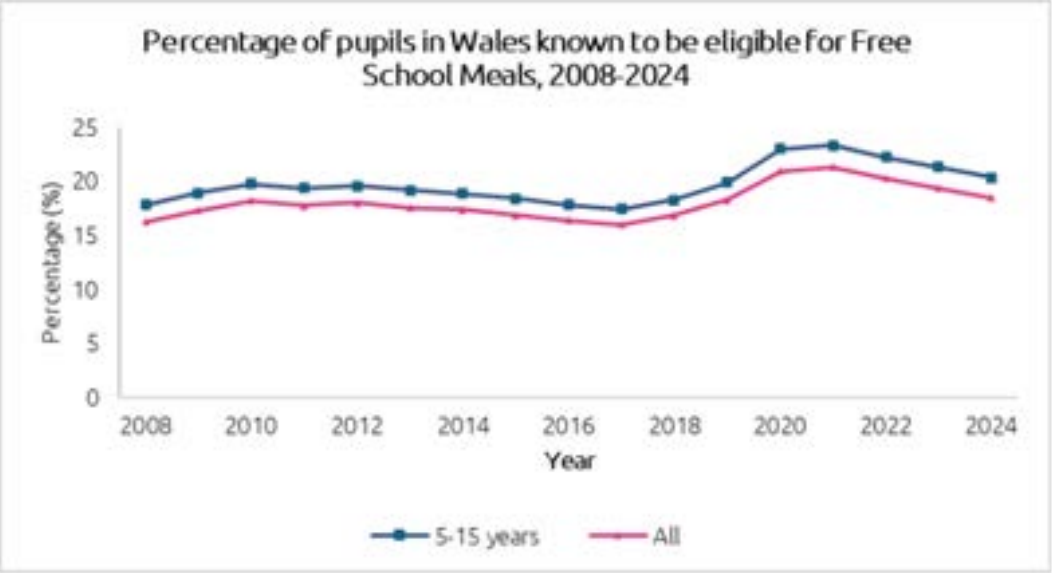

Figure 3. Percentage of pupils in Wales known to be eligible for Free School Meals, 2008 to 2024 (Source: Schools' census results: January 2025 [HTML] | GOV.WALES)

3.2.2.2 Attendance

School attendance in Wales declined notably in 2023/24. Average attendance for pupils aged 5–15 years was 90.5%, down from 94.3% in 2018/19.[13]

- Persistent absence (missing ≥10% of sessions) rose from 14.7% to 30.4%

FFSM-eligible pupils had lower attendance:

- 84.8% in 2023/24, down from 91.2% in 2018/19
- 53.3% were persistently absent, up from 30.4% in 2018/19.

Gender trends:

- Males had slightly higher attendance than females in 2022/23 and 2023/24
- Both saw declines of at least 3.7 percentage points since 2018/19.

Year-level differences:

- Year 11 had the lowest attendance: 85.3% (↓ 8% from 2018/19)
- Year 3 had the highest attendance: 92.6%
- Primary years saw a 2–3% drop in attendance since 2018/19.

Illness-related absences rose to 4.4% of all sessions, up from 3% in 2018/19. Education other than at school (EOTAS) pupils increased to 2,279 in 2023/24, or 4.9 per 1,000 pupils, the highest rate since 2009/10.[14]

3.2.2.3 Additional learning needs (ALN) and special educational needs (SEN)

In 2024, 52,152 pupils in maintained schools had ALN or SEN, representing 11.2% of all pupils, down from 13.4% (63,089) in January 2023.[15]
Under the new ALN system:

- 21,319 pupils (40.9%) had individual development plans (IDPs), nearly doubling from 10,499 (16.6%) in 2023.

Most common needs among pupils with ALN or SEN:

- Speech, language and communication difficulties – 35%
- Behavioural, emotional and social difficulties – 31.8%
- Moderate learning difficulties – 22.5%.

3.2.3 Ethnicity

According to the 2021 Census,[16] 87.1% of BCYP (0–24 years) in Wales identified as White British (English, Welsh, Scottish, Northern Irish or British). Among those from minority ethnic backgrounds, the largest groups were:

- Asian, Asian British or Asian Welsh – 4.1%
- Mixed or multiple ethnicities – 1.3%
- Black, Black British, Black Welsh, Caribbean or African – 3.1%
- White Other – 2.7%.

3.2.4 Sexual orientation

Among 16–24-year-olds in Wales, 84% identify as straight or heterosexual, while fewer than 5% identify as gay, lesbian, bisexual, or another sexual orientation. The highest proportions identifying as LGB+ are in the Cardiff and Vale and Hywel Dda University Health Board areas, where nearly 1 in 10 young people report a minority sexual orientation.

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Epidemiology Of The Mental Health And Wellbeing Of Babies, Children And Young People

Health Needs Assessment:
Mental Health of Babies, Children and Young People in Wales

4.1 International overview

The mental health challenges facing BCYP in Wales reflect a wider global trend. Population surveys across multiple Western, Educated, Industrialised, Rich, Developed (WEIRD) countries show rising adolescent mental health difficulties since the early 2000s, with a sharp increase over the past decade (Figure 4).[17] While the COVID-19 pandemic intensified this trend, the decline in adolescent mental health outcomes began well before it.

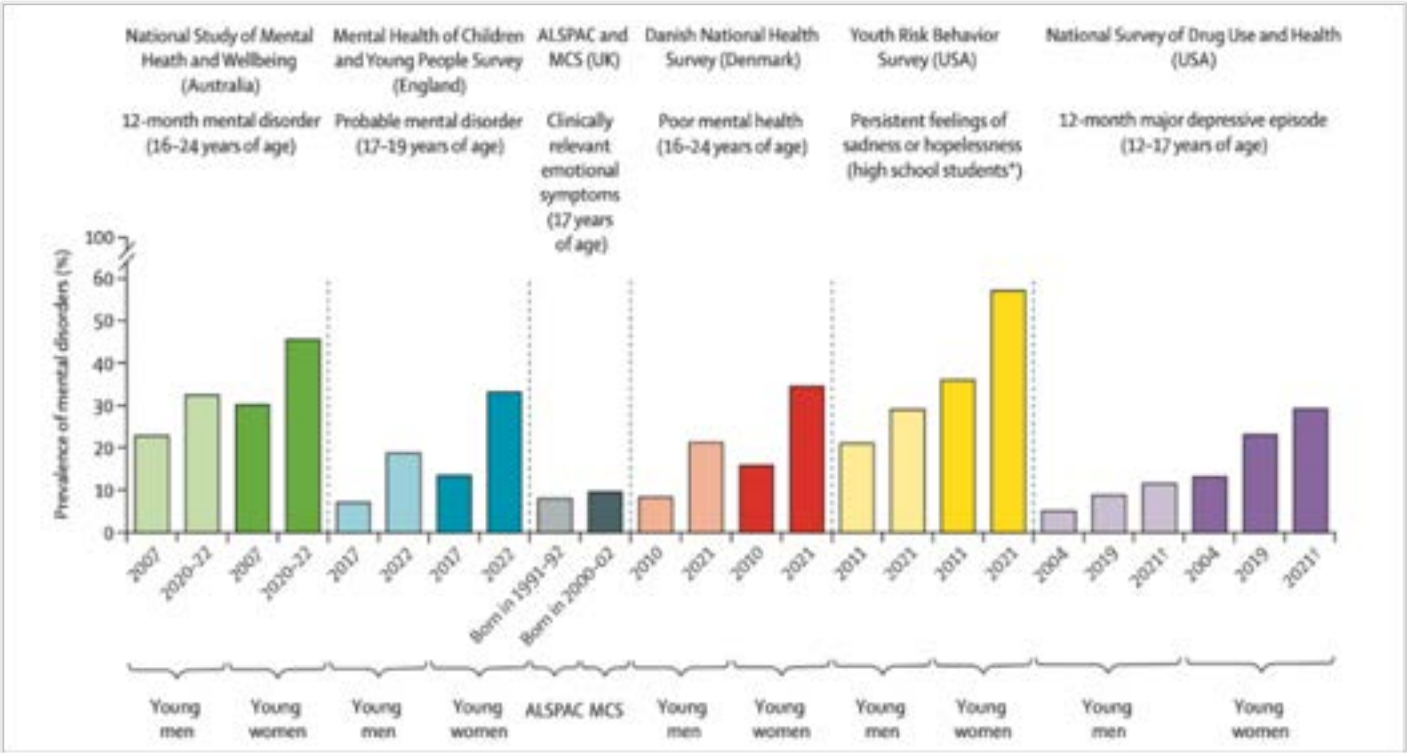

Figure 4. Youth mental health trends by country and sex (Source: https://doi.org/10.1016/S2215-0366(24)00163-9)

Evidence shows increases have been particularly pronounced among emotional difficulties. longitudinal cohort studies in the UK indicate emotional difficulties are emerging earlier and persisting through adolescence for young people born at the turn of the century, compared to people born in the early 1990s. Differences between generations appear to be most pronounced in mid-adolescence (Figure 5).[18]

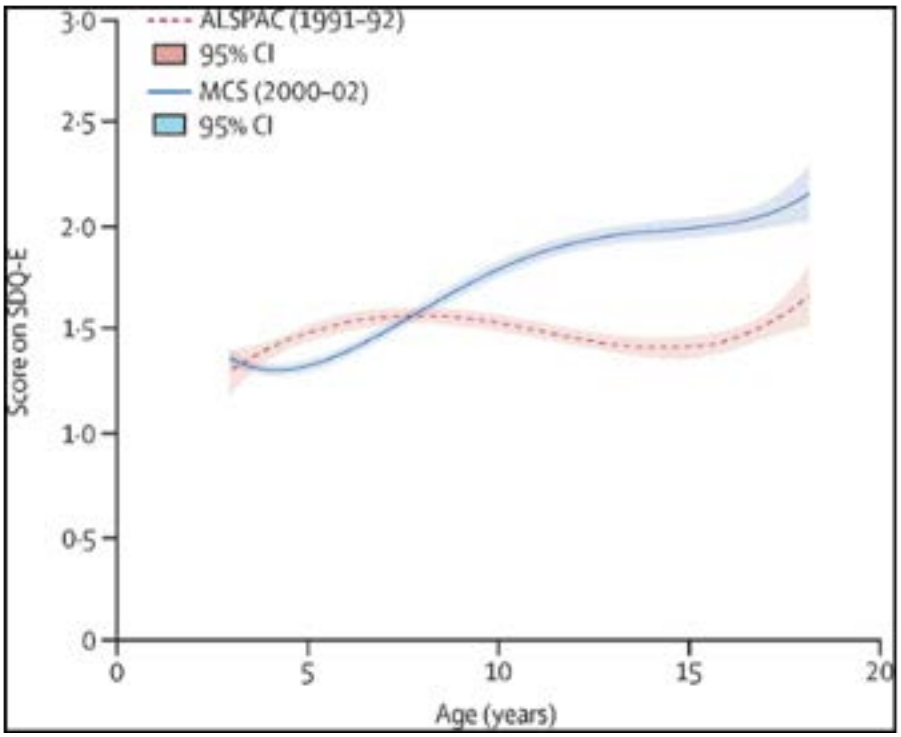

Figure5. Average population trajectories of emotional problems in the Avon Longitudinal Study of Parents and Children (ALSPAC) and Milenium Cohort Study (MCS) cohorts by age (Source: http://doi.org/10.1016/S2215-0366(24)00163-9)

4.2 Infant mental health

Due to the rapid brain development that occurs in the first years of life, experiences and relationships during early childhood have a significant influence on child development and wellbeing. Infants learn to interact with the world around them, not only physically but socially and emotionally too. Infants who have responsive care givers are more likely to develop secure attachments with caregivers and feel confident that their needs will be responded to. This can influence relationships throughout life and influence mental health, wellbeing and health behaviours and outcomes.

Infant mental health is shaped by a complex interplay of risk factors that influence the quality of parent-infant relationships. A cohort study in Wales found a strong link between maternal depression and depression in children:[19]

- Children whose mothers experienced depression only before birth had a 32% higher risk of developing depression themselves
- If the mother experienced depression both before and during the child's life, the child was more than twice as likely to be diagnosed with depression.

However, many other risk factors lie outside traditional mental health pathways. These include:

- Poverty and socioeconomic stress
- Domestic violence
- Intergenerational trauma
- Substance misuse
- Abuse and neglect
- Premature birth
- Developmental delays.

Understanding this full spectrum of influences is essential for promoting healthy early development. It highlights the need for integrated, cross-sector approaches that address both clinical and social determinants of infant mental health, ensuring that families receive timely and holistic support.

Wales lacks routine population-level data on development and wellbeing in the first 1,000 days. However, consistent with other countries, recent health board data suggests 15–20% (~ 15,750 to 21,000)[20] of babies in Wales could benefit from specialist parent-infant interventions.21 Actual demand for support remains lower than predicted need, due to complex barriers to access.

International research suggests 25-30% of infants experience insecure attachment, with only around a third of those accessing early support. As such estimates suggest:

- Almost 20% of parent–infant dyads may have insecure attachment and are unlikely to receive support before the child is age two
- Around 15% are estimated to experience disorganised attachment, with the majority not receiving early support and being at higher risk of requiring later social care.[21]

By reception age, many children in Wales and England are not meeting early developmental milestones which can negatively impact longer term academic, social and emotional outcomes.[22]

- 36% of reception children are below the expected level of personal and social development for their age. [23]

- Nearly one-third of children struggle to follow simple instructions or engage with peers
- 54% of teachers report boys are less school-ready than girls
- 80% of teachers believe missing these milestones affects long-term academic achievement.

These early developmental challenges often reflect broader patterns in family mental health.[24] Poor maternal mental health is rising in Wales, particularly among younger women (Figure 6).[25] In 2023 nearly 40% of pregnant women aged 20–29 years reported a mental health condition at their first antenatal assessment, compared with 27% among women aged 30–44 years.

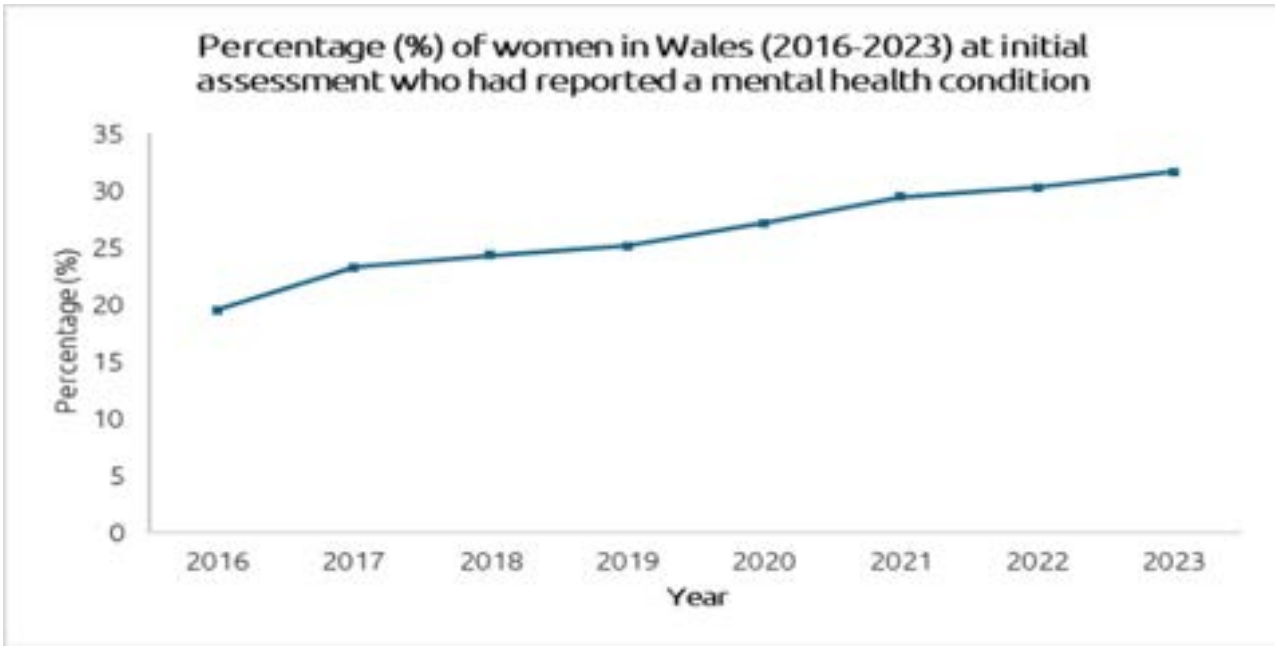

Figure 6. Percentage (%) of women in Wales (2016-2023) at initial assessment who had reported a mental health condition (Source: Maternity and birth statistics: 2024 [HTML] | GOV.WALES)

Infants exposed to Adverse Childhood Experiences (ACEs) face a higher risk of mental health difficulties. Infants living with someone with a mental health condition are nearly two-thirds more likely to develop mental health problems.[26]
Victims of maltreatment or assault are 90% more likely to experience childhood mental health difficulties and 65% more likely to be diagnosed with developmental disorders.
A population cohort study of parents in care proceedings found that, in the two years preceding court proceedings, parents exhibited diverse health vulnerabilities and higher use of routine and emergency healthcare than a matched comparison group.[27]
Amongst these parents:

- Over 40% of had infants (under one year old), compared to 15% in the comparison group
- Nearly half of lived in the most deprived areas of Wales
- Common mental health conditions were around three times higher than the comparison, depression being the most common condition (44% mothers, 24% fathers)
- One in five cohort had substance use-related conditions (19%, and to 2% in comparators).

Estimated prevalence of mental health disorders among infants and children (ages 1–7 years) for each health board is presented in Table 2. Prevalence estimates, derived from the Mental Health of Children and Young People (MHCYP) survey in England (2017) for 2–4-year-olds,[28] and pooled estimates for 1–7-year-olds[29] demonstrate why intervention in early life is critical. Further details on the specific measurement tools used in these studies are provided in Section (7).

	2-4 year olds			1-7 year olds		
Area	**Population (2-4yrs)**	**2-4yr olds as % of all 0-24y**	**Estimated mental health**	**Population (1-7yrs)**	**1-7yrs as % of all**	**Estimated mental health**
Betsi Cadwaladr	19,445	12.30%	1,070	47,466	30.00%	9,540
Powys THB	3,427	11.10%	190	8,356	27.00%	1,680
Hywel Dda UHB	10,317	10.20%	570	25,345	25.10%	5,090
Swansea Bay UHB	11,103	9.70%	610	27,118	23.70%	5,450
Cwm Taf Morgannwg	13,641	11.10%	750	32,976	26.80%	6,630
Cardiff and Vale UHB	15,745	9.10%	870	38,305	22.20%	7,690
Aneurin Bevan UHB	18,921	11.70%	1,040	45,759	28.20%	9,190
All Wales	92,599	10.50%	5,090	225,325	25.40%	45,270

Table 2. Prevalence estimates of mental health disorders in 2-4y and 1-7y in Wales [Totals may not sum due to rounding] * Prevalence estimated using "probable mental health disorder" percentage (5.5%) from the MHCYP Survey (2017) England for 2-4 year olds[30] ** Prevalence estimated using pooled prevalence from meta-analytical data (20.1%) for 1-7 year olds[31]

4.3 Relationship between mental wellbeing and mental health

Mental health and mental wellbeing are distinct but related concepts which often interact. People can experience poor mental wellbeing whilst not having a mental health condition, conversely people can live with a mental health condition and still experience periods of good mental wellbeing.

A Public Health Wales analysis of School Health Research Network (SHRN) data has provided insights into the relationship between mental wellbeing and mental health in young people. Data for adolescent leaners in Wales (2019-2021) shows a clear association as mental wellbeing declines, reported mental health difficulties increase (see Figure 7). Further findings from this study are presented in the risk factors (Section 8), where common risk factors were identified for both poor mental wellbeing and poor mental health.

SWEMWBS scoring interpretation	
Score Range	**Interpretation**
<20	Low mental wellbeing
20-27	Average/moderate mental wellbeing
>27	High mental wellbeing

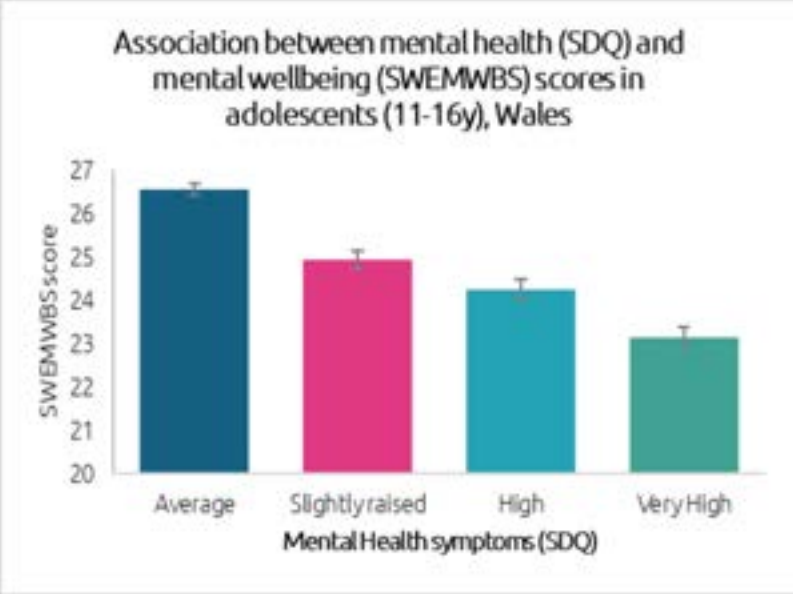

Figure 7. Relationship between mental health (SDQ) and mental wellbeing (SWEMWEBS) (Source: publichealthwales.shinyapps.io/SHRN_Dashboard/)

4.4. Mental wellbeing of Babies, Children and Young People in Wales

Mental wellbeing is the internal positive view that we are coping well with the everyday stresses of life; we can be said to have good mental wellbeing when we are "feeling good and functioning well". It is influenced by our relationships, environments and our sense of purpose and belonging.

The SHRN survey, uses the 7-questions Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) to monitor mental wellbeing and highlights a declining trend among adolescents in Wales.[32] The National Survey for Wales incorporates the 14 item Warwick Edinburgh Mental Wellbeing Scales (WEMWBS) to assess wellbeing among over 16s.

4.4.1 Secondary school learners

- The proportion of young people reporting low mental wellbeing increased from 18% in 2017 to 22% in 2023, following a peak of 25% in 2021
- Those reporting high mental wellbeing declined slightly, from 26% to 24% over the same period.

The highest rates of low mental wellbeing were observed in:

- Cwm Taf Morgannwg: 24%
- Betsi Cadwaladr: 23%.

4.4.1.1 Gender and Identity Differences

- Girls experienced a notable decline in mental wellbeing, with low mental wellbeing rising from 22% in 2017 to 28.1% in 2023 (Figure 8)
- Boys showed a modest increase, from 14% to 15.1% (Figure 9) over the same period
- Young people identifying as neither girl nor boy reported the poorest outcomes, with 54% experiencing low mental wellbeing in 2023.

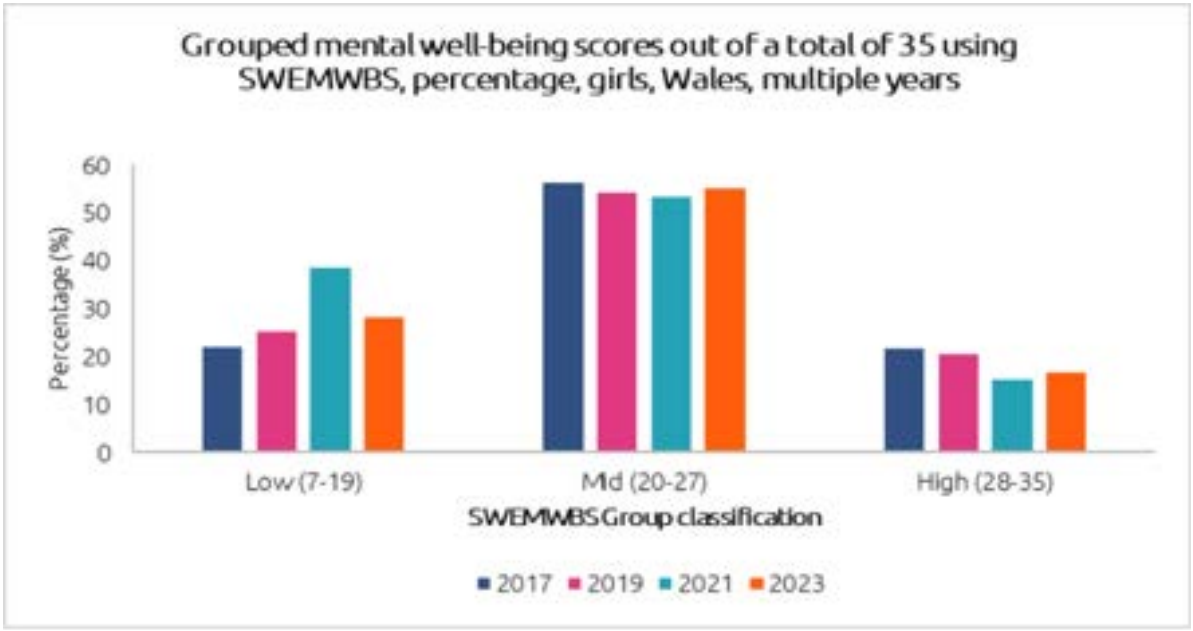

Figure 8. Percentage of adolescent girls (11-16 years) in Wales experiencing low, medium or high mental wellbeing using the SWEMWBS (Source: publichealthwales.shinyapps.io/SHRN_Dashboard/)

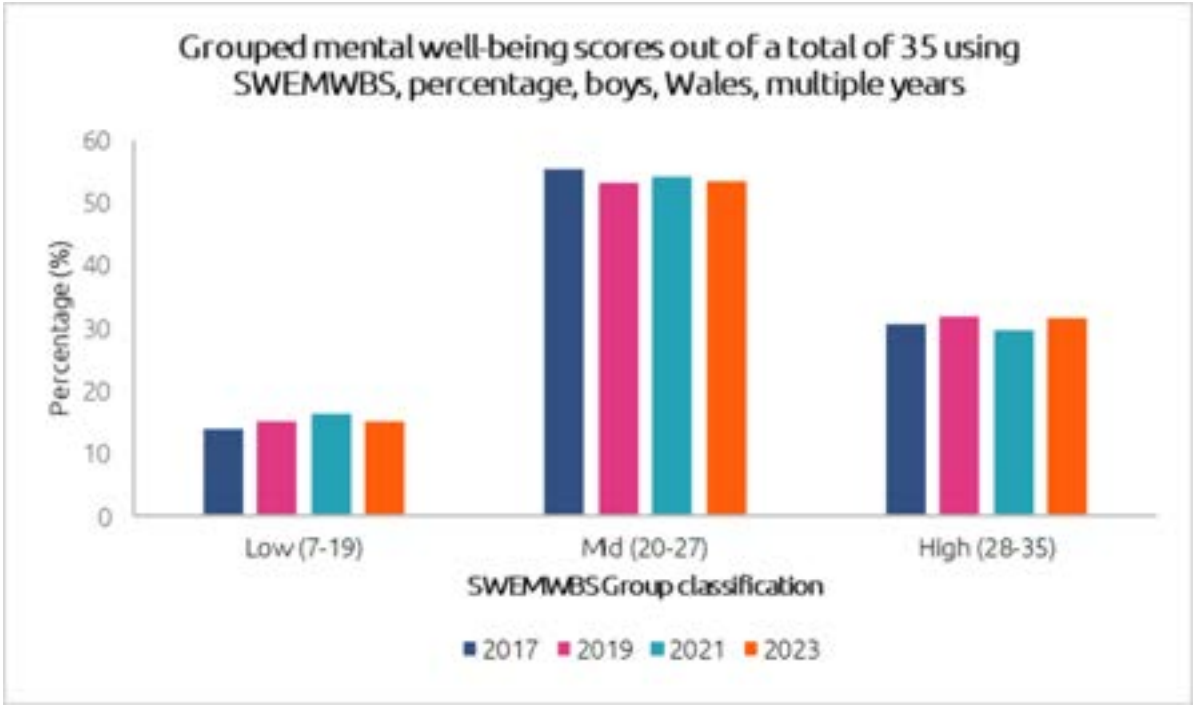

Figure 9. Percentage of adolescent boys (11-16 years) in Wales experiencing low, medium or high mental wellbeing using the SWEMWBS (Source: publichealthwales.shinyapps.io/SHRN_Dashboard/)

4.4.1.2 School Year

Mental wellbeing among young people declines with each advancing school year (Figure 10):

- In Year 7, 19.7% of students reported low mental wellbeing
- This rose to 23.1% by Year 11, with a peak of 24% in Year 10.

The decline is especially pronounced among girls:

- 22.7% in Year 7 reported low wellbeing
- This increased sharply to 31.4% by Year 10.

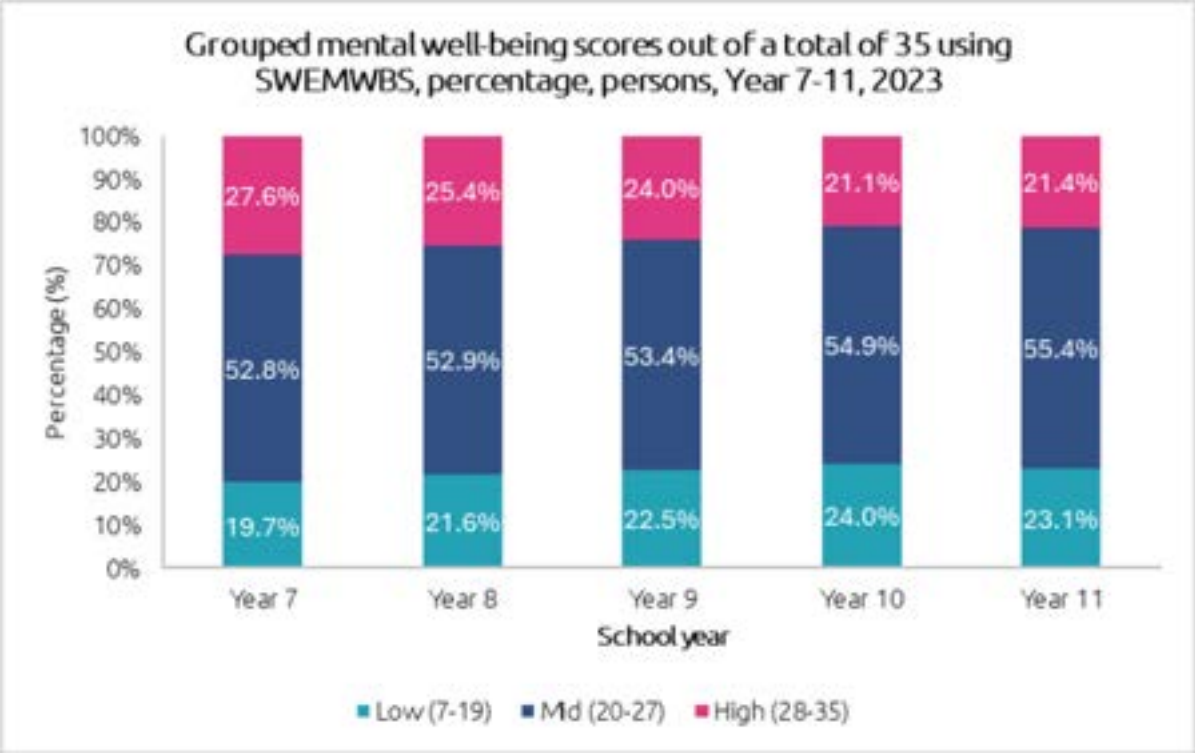

Figure 10. Percentage of adolescents (11-16 years) in Wales experiencing low, medium or high mental wellbeing using the SWEMWBS, presented for each school year (Source: publichealthwales.shinyapps.io/SHRN_Dashboard/

4.4.1.3 Ethnicity

- In 2023 average mental wellbeing was highest among Black/Black British (average SWEMWBS score 24.6) and Asian and Asian British (average 24) secondary school learners. Scores were similar across other ethnic groups (White 23.5, mixed ethnicity 23.3, other ethnicity 23.6).

4.4.3 Emerging Adults (Ages 16–24)

Average mental wellbeing, measured by the 14-item Warwick Edinburgh Mental Wellbeing Scale (WEMWBS). among emerging adults in Wales has declined in recent years. Current scores are similar to those in for the same age group across other UK nations. [33]

- WEMWBS in 16-24 year olds declined from 50.6 in 2018/19 to 47.4 in 2024/25, a change of 3 points on the scale is considered a 'meaningful' change.

4.5 Measuring Mental Health Difficulties in Children and Young People in Wales

Data and evidence used in this report to assess the mental health status of children and young people in Wales comes from population surveys, health service data and published research.

Two key data sources are the School Health Research Network (SHRN) survey from Wales and the Mental Health of Children and Young People (MHCYP) survey from England; both use the "Strengths and Difficulties Questionnaire (SDQ) to assess mental health difficulties. SHRN figures are based on self-reported answers by secondary school learners (aged 11-16 years). MHCYP uses a combination of responses from children and young people, their parents and teachers. MHCYP provides data for a broader range of ages (8-10, 11-16 and 17-24 years) and other mental health conditions not captured by the SDQ questionnaire. For Primary School learners in Wales the "Me and My Feelings" questionnaire provides estimates of emotional difficulties and behavioural difficulties.

Findings are initially presented for "Total Difficulties Scores" to provide an overview of mental health status. This is followed by findings for the SDQ sub-domains of emotional difficulties and behavioural difficulties. Subsequent sections on neurodevelopmental disorders, eating disorders, psychoses and self-harm use MHCYP and diagnostic data. Suicide figures are the Office for National Statistics and the National Confidential Inquiry into Suicide and Safety in Mental Health.

Triangulation between MHCYP and SHRN data suggest findings are broadly comparable. MHCYP findings are based on a smaller sample size but provide a reliable indicator of clinical need. SHRN figures are specific to Wales and include data for the majority of learners in Wales.

Each survey categorises results slightly differently; SHRN uses “high” and “very high” categories and MHCYP uses “possible” and “probable” mental health condition. Within the SHRN survey a ’High’ score (18-19 out of 40) is indicative of emerging mental health difficulties; ’very high’ scores (≥20 out of 40) are likely to indicate the presence of diagnosable mental health conditions. [34]
In order to review the applicability of MHCYP findings to Wales we compared estimates for 11-16 year olds from both datasets. Whilst SHRN figures provide slightly higher estimates the figures are broadly comparable (see table 4), hence the MHCYP findings for wider age groups, and for topics not covered by SHRN, are considered relevant to Wales (Table 3, 4, 5).

	8-10 Years			
			MHCYP	
Area	Count*	% of all 0-24y in Health Board**	Possible MH disorder (count)	Probable MH disorder
Betsi Cadwaladr UHB	23,100	12.7	2,800	3,630
Powys THB	4,100	13.3	500	640
Hywel Dda UHB	12,400	12.3	1,500	1,950
Swansea Bay UHB	12,800	11.2	1,550	2,010
Cwm Taf Morgannwg UHB	15,700	12.8	1,900	2,460
Cardiff and Vale UHB	17,900	10.4	2,170	2,810
Aneurin Bevan UHB	21,100	13	2,550	3,310
All Wales	107,100	12.1	12,960	16,810

Table 3. Mid-year population estimates*, including possible and probable mental health disorder prevalence (estimate)
[Totals may not sum due to rounding] *Produced by Public Health Wales Observatory, using POPU0005 MYE (ONS) from StatsWales. *ONS mid-year population estimates to the nearest hundred. Prevalence estimated using “probable mental health disorder” percentage (15.7%) from the MHCYP Survey (2023) England for 8-10 year olds

	11-16 Years				
			MHCYP		
Area	Count*	% of all 0-24y in Health Board	Possible MH disorder (count)	Probable MH disorder (count)	V. High Total SDQ (count)
Betsi Cadwaladr UHB	49,000	27	5880	11070	12990
Powys THB	8,600	27.7	1030	1940	2280
Hywel Dda UHB	26,500	26.2	3180	5990	7020
Swansea Bay UHB	27,300	23.8	3280	6170	7230
Cwm Taf Morgannwg UHB	32,500	26.4	3900	7350	8610
Cardiff and Vale UHB	37,100	21.5	4450	8380	9830
Aneurin Bevan UHB	43,500	26.8	5220	9830	11530
All Wales	224,400	25.3	26930	50710	59470

Table 4. Mid-year population estimates*, including possible and probable mental health disorder prevalence (estimate) and Very High SDQ total score. [Totals may not sum due to rounding]. *Produced by Public Health Wales Observatory, using POPU0005 MYE (ONS) from StatsWales. *ONS mid-year population estimates to the nearest hundred. Prevalence estimates use "probable mental health disorder" (22.6%) from the MHCYP Survey (2023) England for 11-16 year olds

	17-24 Years			
			MHCYP	
Area	Count*	% of all 0-24y in Health Board	Possible MH disorder (count)	Probable MH disorder (count)
Betsi Cadwaladr UHB	56,000	30.9	8600	12600
Powys THB	9,000	29	1380	2030
Hywel Dda UHB	33,900	33.5	5200	7630
Swansea Bay UHB	44,200	38.5	6780	9950
Cwm Taf Morgannwg UHB	38,000	30.8	5830	8550
Cardiff and Vale UHB	74,400	43.2	11420	16740
Aneurin Bevan UHB	46,300	28.5	7110	10420
All Wales	301,700	34	46310	67880

Table 5. Mid-year population estimates*, including possible and probable mental health disorder prevalence (estimate) [Totals may not sum due to rounding].*Produced by Public Health Wales Observatory, using POPU0005 MYE (ONS) from StatsWales. *ONS mid-year population estimates to the nearest hundred. Prevalence estimated use "probable mental health disorder" (22.5%) from the MHCYP Survey (2023) England for 17-23 year olds

Based on SHRN and MHCYP findings an estimated 135,500 children and young people aged 8-25 in Wales are estimated to have a diagnosable mental health condition. By 2035, if current rates remain the same, this would equate to 145,000. A larger number of young people may have emerging symptoms and would benefit from early intervention

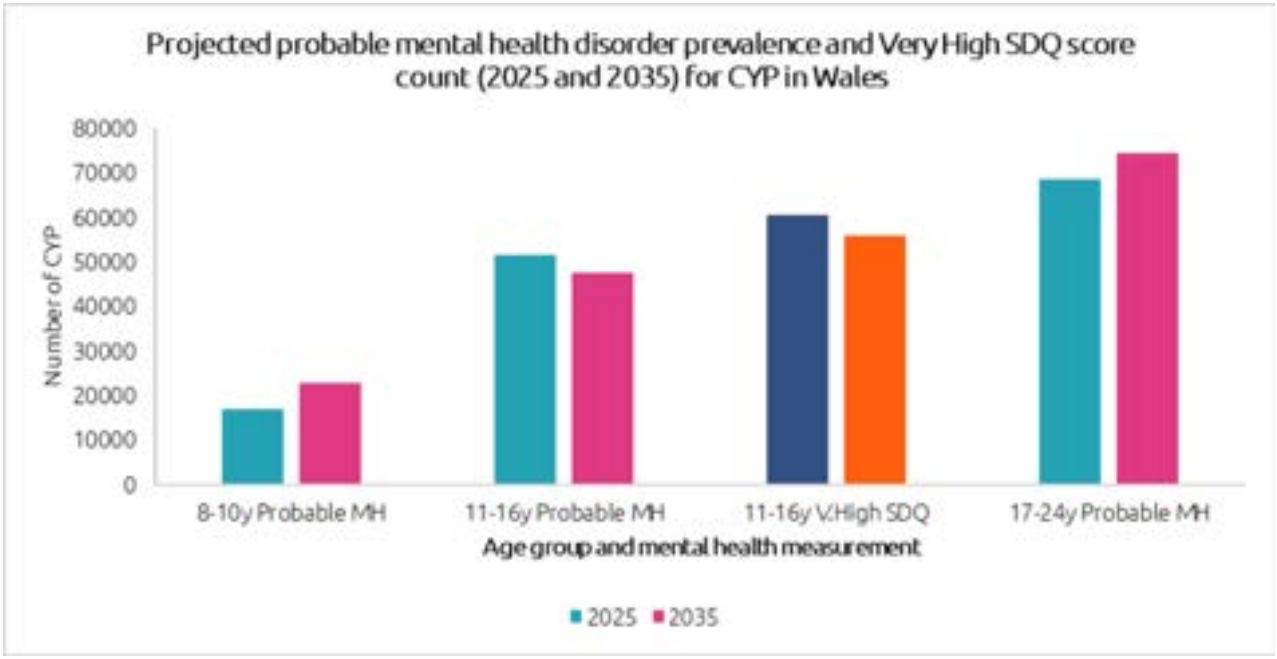

Figure 11. Projected probable mental health disorder prevalence and Very high SDQ score count (2025-2035) for young people in Wales (Source: Mental Health of Children and Young People Surveys - NHS England Digital; publichealthwales.shinyapps.io/SHRN_Dashboard/)

4.6 Overall mental health of Children and Young People

SHRN and MHCYP data indicate around 1 in 5 children and young people aged 8 to 24 in Wales were estimated to have a diagnosable mental health condition in 2023, compared with 1 in 10 in 2004.[35] Prevalence rises with age:

- 1 in 6 aged 8 to 10 years
- 1 in 5 aged 11 to 16 years
- 1 in 4 aged 17 to 24.

4.4.1 Secondary school learners

The 2023 SHRN survey findings show:

- 35% of young people aged 11-16 years scored in the 'high' or 'very high' range, an increase of nearly 10 percentage points since 2019
- 27% reported 'very high' symptom levels
- The highest rates were in Cwm Taf Morgannwg (29%) and Betsi Cadwaladr (28%) University Health Boards.

4.6.1.1 Gender and Gender Identity Trends

- Girls are significantly more affected than boys, with 32% of girls showing high or very high SQD scores—over 10% higher than boys (Figure 12)
- Among young people who identify as neither girl nor boy the risk is greatest: nearly 70% (69.6%) show high or very high SDQ scores (Figure 12).

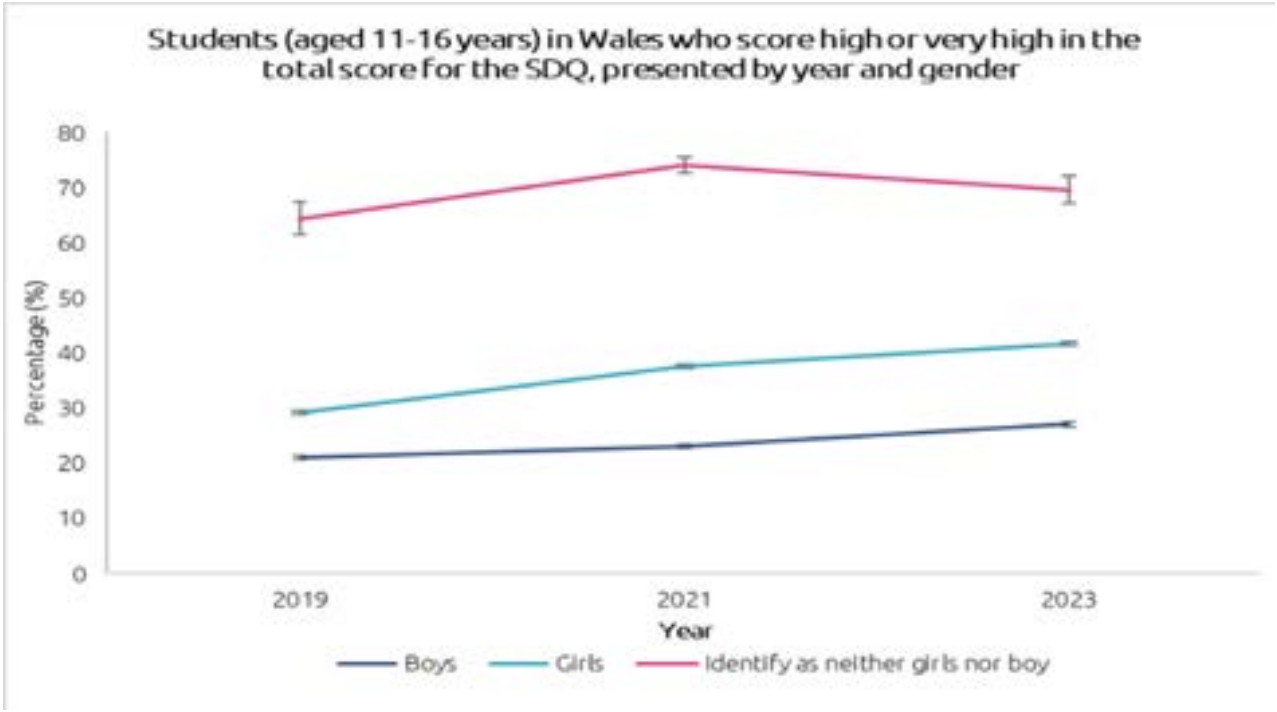

Figure 12. Students (aged 11-16 years) in Wales who score high or very high in the total SDQ score (Source: publichealthwales.shinyapps.io/SHRN_Dashboard/)

4.6.1.2 School Year

- Gender disparities in mental health symptoms widen as learners progress through secondary school
- Among secondary school learners the sharpest rise in prevalence occurs between Year 7 and Year 8, where the proportion of girls with high or very high SDQ scores was 10% higher among Year 8 learners (Figure 13)
- In Year 7, 31% of girls and 24% of boys have high or very high SDQ scores—a 7% gap
- By Year 11, this gap more than doubles to 16%, with 45% of girls and 29% of boys showing high or very high scores overall.

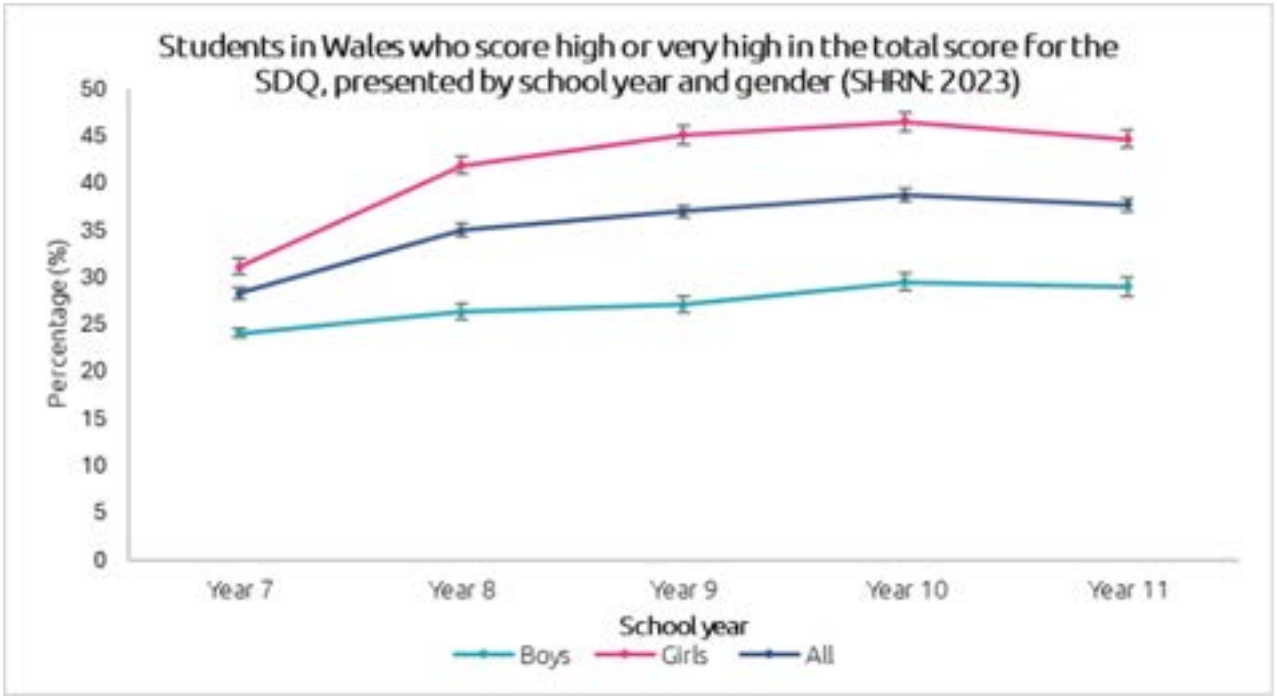

Figure 13. Percentage (%) of adolescents (11-16 years) in Wales who score high or very high in the total score for the SDQ in 2023, by school year and gender (Source: publichealthwales.shinyapps.io/SHRN_Dashboard/)

4.6.1.3 Family Affluence

Mental health symptoms are more common among adolescents from less affluent families, and this gap has widened in recent years.

- In 2023, 44% of young people from low-affluence families had high or very high SDQ scores—up from 33% in 2019
- Among those from high-affluence families, the rate rose from 22% to 30.8% over the same period (Figure 14).

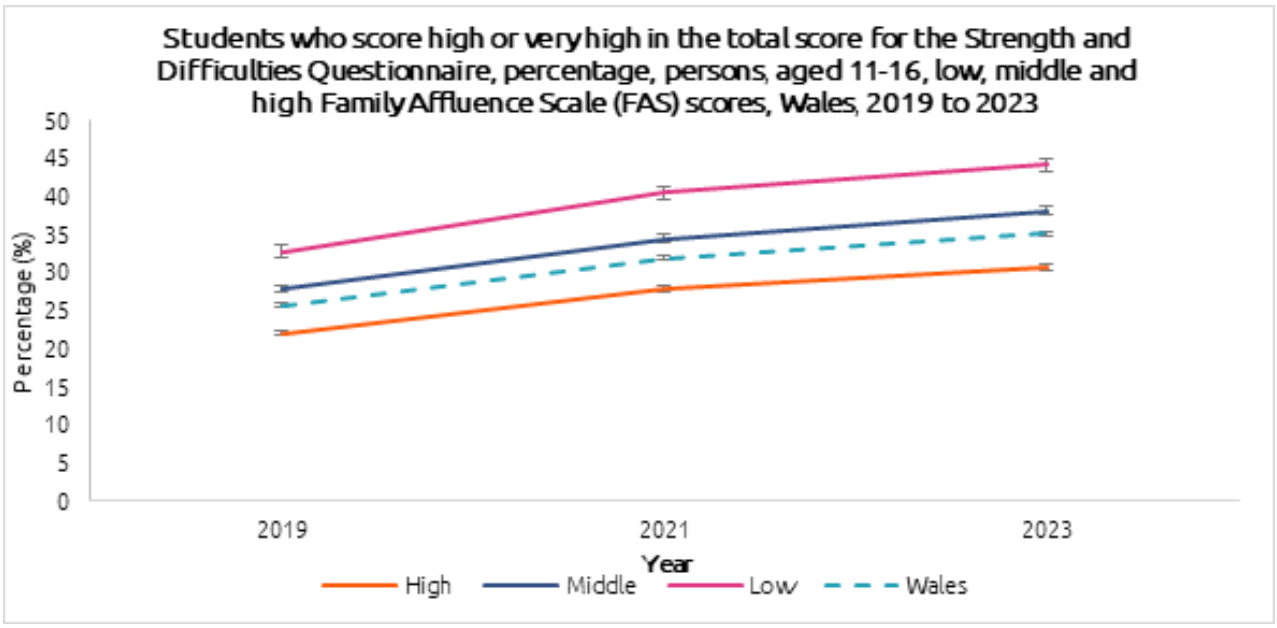

Figure 14. Percentage (%) of adolescents (11-16 years) in Wales who score high or very high in the total score for the SDQ, family affluence scale scores, 2019-2023 (Source: publichealthwales.shinyapps.io/SHRN_Dashboard/)

4.6.1.4 Ethnicity

In 2021/22 adolescent mental health difficulties were highest in white gypsy/travelers. [36]

- 41% of white gypsy/travelers reported very high mental health difficulties
- Among white British adolescents, nearly a quarter (24%) reported very high difficulties
- Asian, black and other ethnic minorities show lower levels, with a fifth or less reporting very high difficulties.

In 2023 people of mixed ethnicity had the highest levels of "very high" scores at 38%, followed by White groups at 36%. Lower proportions were seen in Black/Black British learners (26%), Asian/Asian British (23%) and 'other' ethnicities (31%). At the time of writing this report figures were not available for white gypsy/traveler learners for 2023.

4.6.2 Young and emerging adults

A study of young and emerging adults compared diagnosed mental health conditions among university students and non-students in Wales between 2012/13 and 2017/18. During this time a number of diagnosed mental health conditions rose among both groups. Rates were generally higher among non-students but rose at a faster rate among students[37] (Figure 15).

- A significant rise was seen in anxiety prevalence for both students and non-students
- Depression and rose more among students, although remained lower overall than among non-students
- ADHD and ASD diagnoses rose slightly among students, bringing diagnoses among student rates in line with non-students—suggesting these were pre-existing conditions identified during university.

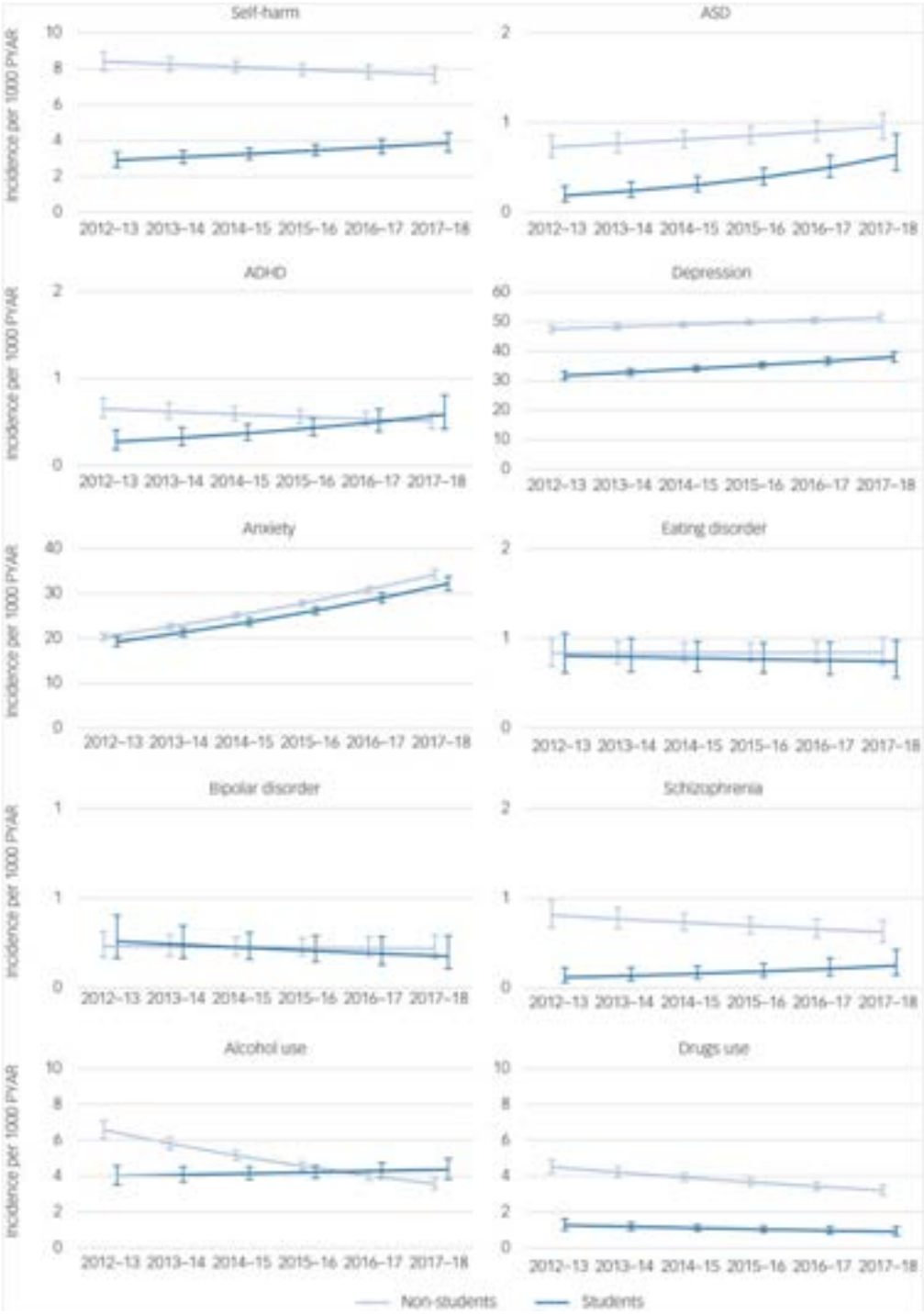

Figure 15. Self-harm, neurodevelopmental disorders and mental health conditions for students and non-students in Wales, adjusted for sex, deprivation gradient, age at entry, study years, self-harm and mental health diagnoses before the index date (Source: https://doi.org/10.1192/bjp.2024.90)

4.7 Emotional difficulties

This section presents findings from SHRN on emotional difficulties among primary and secondary school learners. Emotional difficulties suggest the presence of symptoms that may be indicative of anxiety and depression, it does not however provide a diagnosis.

4.7.1 Primary school learners

Population-level data from SHRN (2024), shows relatively stable emotional difficulties across primary school year groups (see Figure 16).[38] However, overall levels have increased over recent years.

- In 2024, 30% of primary school children reported elevated emotional difficulties, with half of these classified as potentially clinically significant
- This marks a 16% increase since 2017.[39]

4.7.1.1 Gender and Identity Differences

- Girls in primary school report higher rates of emotional difficulties than boys:
- 17% of girls compared with 13% of boys scored as having elevated difficulties
- 18% of girls compared with 11% of boys scored as having clinically significant symptoms
- Children identifying as neither boy nor girl show the highest levels of need, with 39% scored as having clinically significant emotional difficulties.

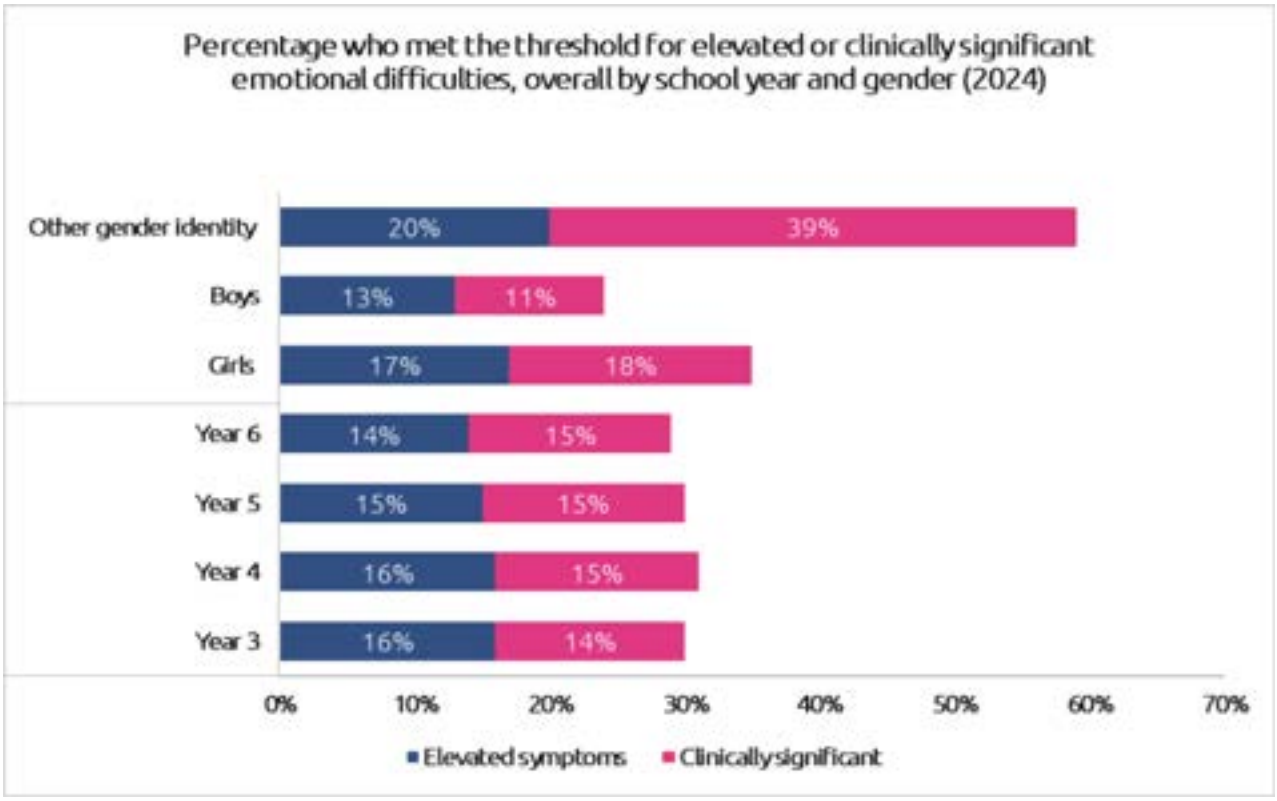

Figure 16. Percentage of primary school children (ages 7-11 years) in Wales (N = 30,000 – 32,000) reporting elevated or clinically significant emotional difficulties (M&MF), by age and gender (Source: 2024-Primary-SHRN-National-Report-V4-FINAL-en.pdf)

4.7.2 Secondary school learners

In 2023, over one-third (35%) of secondary school learners in Wales had high or very high levels of emotional difficulties and rates increase across school years.[40]

- The highest rates were in Cwm Taf Morgannwg (37%), Aneurin Bevan (36%), and Betsi Cadwaladr (36%) University Health Boards—all above the national average
- By Year 11, 38% of learners had high or very high emotional difficulties scores, with 25% in the very high range—significantly higher than 29% in Year 7.

4.7.2.1 Gender and Identity Differences

- In Year 11, 55% of girls were scored as having high or very high emotional difficulties, compared to 20% of boys
- Among learners identifying as neither girl nor boy, rates of those scored as having high or very high emotional difficulties rose from 56% in 2019 to 65% in 2023—a 17% increase.[41]

4.7.2.2 Trends Over Time

- Between 2013 and 2019, high and very high emotional difficulties in young people rose from 23% to 38%
- In 2023, 48% of adolescent girls scored as having high or very high emotional difficulties, up from 41% in 2019
- Over the same period (2019-2023) reported emotional difficulties in adolescent boys showed a smaller increase, from 17.7% to 19.6% in 2023.

4.8 Behavioural difficulties

This section presents findings from SHRN on behavioural difficulties among primary (using 'Me and My Feelings' questionnaire) and secondary school learners (using SDQ). Behavioural difficulties suggest the presence of conduct problems at a level that may interfere with the child's development.

4.8.1 Primary school learners

In 2024, behavioural difficulties among primary school learners in Wales showed a clear age-related increase.[42]

- Average Me and My Feelings (M&MF) scores rose from 3.2/10 in Year 3 to 3.3/10 in Year 6 (a score of 3-5 indicates mild behavioural difficulties)
- 7% of primary school learners showed elevated behavioural difficulties, with 10% in the clinically significant range

4.8.1.2 Gender and Identity Differences

- Boys reported higher rates of elevated or clinically significant behavioural symptoms than girls (18% compared to 14% respectively)
- Learners identifying as neither girl nor boy had the highest rates, with 37% experiencing significant behavioural difficulties.

4.8.2 Secondary school learners

- Behavioural difficulties among secondary school learners in Wales have increased in recent years,[43] albeit at a slower rate than emotional difficulties.
- According to the SDQ Conduct Problems subscale, the proportion of learners with high or very high scores rose from 15% in 2019 to 20% in 2023
- The highest rates were in Betsi Cadwaladr and Cwm Taf Morgannwg University Health Boards (22%), exceeding the national average.

4.8.2.1 Gender Differences

- Learners identifying as neither female nor male reported the highest rates, with 35% scoring high or very high
- Girls (19.9%) and boys (19.8%) reported similar levels in 2023, but girls saw a sharper rise—from 13.5% in 2019.

4.8.2.2 Trends by School Year

- Behavioural difficulties increase with each school year up to Year 10, followed by a decline in Year 11 (see Figure 17).

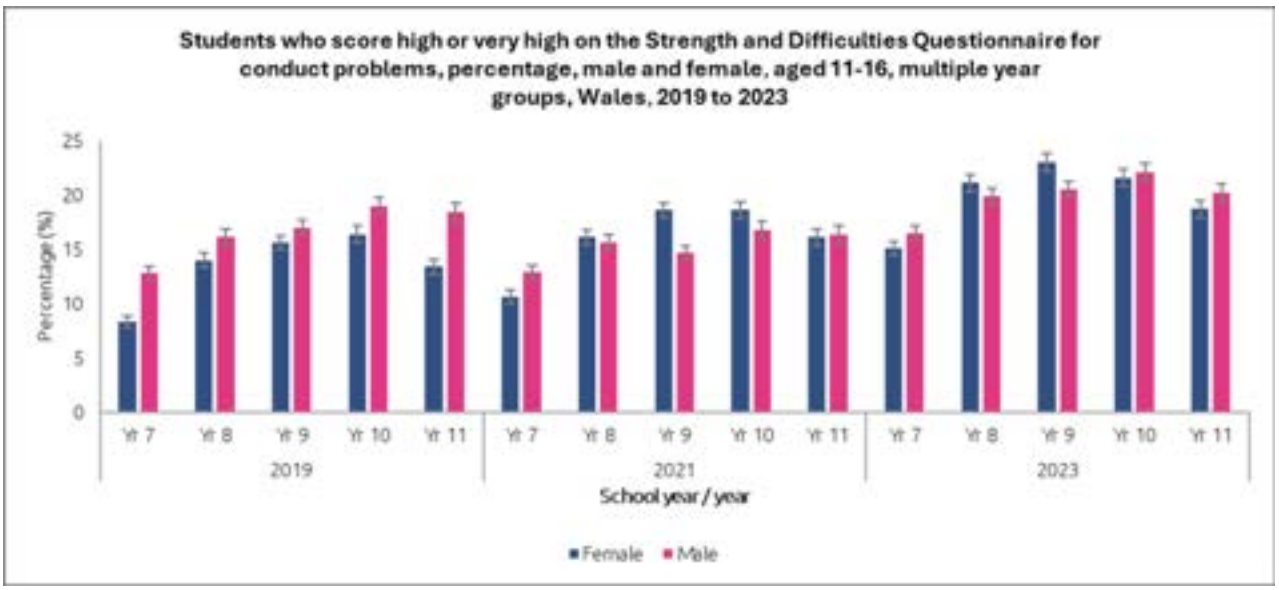

Figure 17. Percentage (%) of adolescents (11-16 years) in Wales with high or very high behavioural difficulties symptoms (SDQ), by females and males by school year (Source: publichealthwales.shinyapps.io/SHRN_Dashboard/)

4.9 Neurodevelopmental conditions

4.9.1 Learning disabilities

In Wales, approximately 12,303 BCYP on learning disability registers.[44] However, there remains a significant lack of data for this group, as Wales does not routinely collect information on BCYP with learning disabilities who access mental health and well-being services.

Young people with learning disabilities face a markedly higher risk of poor mental health, with increased vulnerability evident from at least age three. This increased risk stems from a complex interplay of social, economic, psychological, emotional, and biomedical factors, including barriers to inclusion, stigma, and limited access to tailored support services.

Evidence indicates that poorer mental health outcomes are driven less by the learning disability itself and more by the wider risk factors experienced by these BCYP and their families. While many of these risk factors—such as poverty, adverse life events, and parental mental health difficulties affect all BCYP, those with learning disabilities are disproportionately exposed, amplifying their vulnerability.[45]

A 2020 meta-analysis found that 49% of children with learning disabilities exhibited psychiatric symptoms, compared to 14% of typically developing peers, as measured by the Child Behavior Checklist.[46]

UK data from the Millennium Cohort Study further highlight this disparity:

- Across all domains of the SDQ, adolescents with intellectual disabilities were twice as likely to score in the clinical range for mental health conditions compared to those without intellectual disabilities.

Additional evidence indicates that children with intellectual disabilities represent 14% of all UK children with a diagnosable psychiatric disorder.

Parent carers of BCYP with learning disabilities also face a heightened risk of mental health difficulties. A recent study in England reported that one-third of parent carers had reported having suicidal thoughts in the previous year, exceeding 5% of parents in the general population.[47]

4.9.2 Autism and Attention Deficit Hyperactivity Disorder

Among children born in Wales between 1991 and 2000, 1.4% were diagnosed with ADHD and 0.9% with ASD by age 18. [48] These figures rely on diagnosed cases and as such may represent an under-estimate of true population prevalence.

- Boys were more likely to be diagnosed:
- ADHD: 2.2% of boys vs. 0.6% of girls
- ASD: 1.5% of boys vs. 0.4% of girls

Among this cohort children with diagnosed ASD or ADHD were had significantly higher risks of experiencing co-occuring anxiety or depression, self-harm and drug or alcohol use compared with those without ASD or ADHD.

Although waiting list data for assessments isn't routinely reported, Freedom of Information requests show an 87% increase in the number of young people awaiting ADHD or ASD assessments between February 2022 and December 2023.[49]

UK data show a relatively stable population prevalence of ADHD in children, rising modestly from 1.5% in 1999 to 1.9% in 2017.[50]

Whilst population prevalence rates have been relatively stable over time, diagnosis rates have increased. This is likely to have been driven by greater awareness and recognition among professionals and the public

The highest diagnosis rates are seen in children aged 6–9 years (see Figure 18), while rates among 3–5-year-olds have declined—potentially reflecting increased recognition in schools, waiting times and the time taken for complex assessments to be completed and a diagnosis confirmed

There is evidence of a shifting gender ratio in new ADHD diagnoses across age groups. Among children aged 3–15 years, diagnosis rates were approximately four times higher in boys than girls.[51]

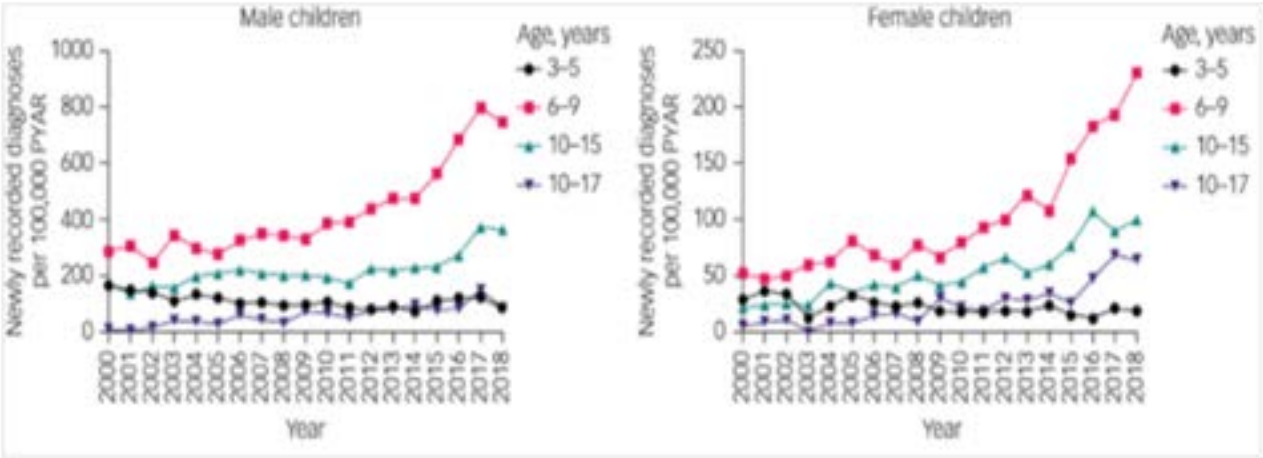

Figure 18. Time trends of new diagnoses in children, by gender and age group in the UK. (Source: https://doi.org/10.1192/bjo.2023.512)

4.9.3 Diagnostic Overshadowing

Despite the increased risk of mental health difficulties among neurodivergent BCYP, their mental health needs are often overlooked or symptoms misinterpreted[52], perpetuating existing inequalities. Diagnostic overshadowing is a key contributor to this, defined as:

"The tendency to attribute all behavioural, emotional, physical, and social issues to a person's learning disability or a pre-existing condition, while overlooking the possibility that they could be symptoms of other conditions or difficulties."[53]

Factors driving diagnostic overshadowing, include:

- Prioritising support for autism or learning disability as the primary need
- Professionals lacking the training or time to respond to mental health needs
- Limited awareness among carers and parents of the potential for co-occurring mental health difficulties.

Under-diagnosis due to diagnostic overshadowing risks excluding cohorts of children and young people from key performance indicators for BCYP mental health and from service improvement support e.g., (funding for training, service specification updates and workforce development reviews).

Evidence from England[54] highlights the impact of this issue:

- Only 27.9% of children and young people with both a learning disability and a mental health problem had any contact with mental health services
- Nearly one in four (23%) reported waiting more than six months to receive any contact.

4.10 Eating disorders

Comprehensive data on eating disorders among young people in Wales is limited, but UK-wide trends offer important insights.

- Eating disorders affect young people of all ages, genders, ethnicities, and sexualities. Despite being among the most serious mental illnesses, they are fully treatable with inclusive and accessible support[55]
- In England, an estimated 360,000 young people are affected, yet only 19,500 accessed NHS specialist services in 2022–2023.

4.10.1 Prevalence in Adolescents

- In 2023, the MHCYP survey estimated 12.5% of 17–19-year-olds in England were living with an eating disorder—up from <1% in 2017
- Among 11–16-year-olds, prevalence rose from 1% to 2.6% over the same period.

4.10.1.1 Gender Differences

- Among 11–16-year-olds:
- 4.3% of girls compared with 1.0% of boys were estimated to have an eating disorder
- Among 17–19-year-olds:
- 20.8% of females vs. 5.1% of males were estimated to have an eating disorder (Figure 19).

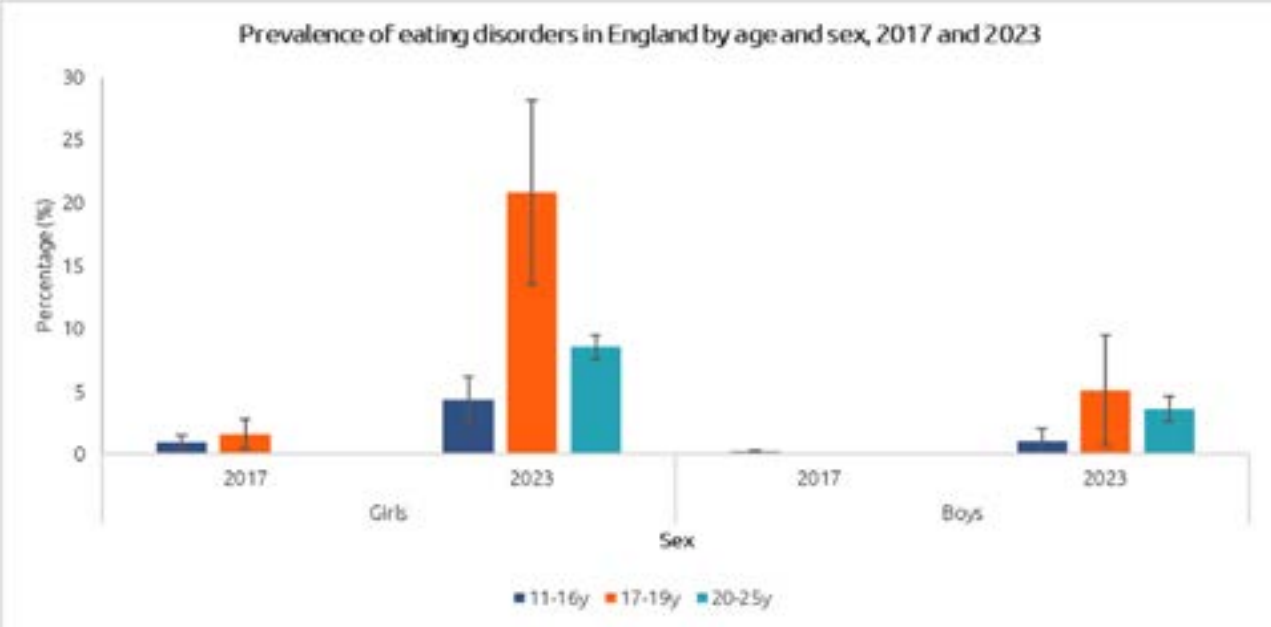

Figure 19. Percentage (%) of young people who screen positive for any eating disorder by age and sex, 2017, 2023, England (Source: Mental Health of Children and Young People Surveys - NHS England Digital)

The MHCYP England survey also tracks behaviours linked to possible eating problems—such as concerns about food, body image, and compensatory behaviours. These are not diagnostic criteria but provide an early indication of potential food/eating-related difficulties. Findings show prevalence of possible eating problems has risen sharply in recent years, especially among adolescents, with concerns over weight and body image being the main areas of concern.[56]

4.10.1.2 Gender and Age Differences

Girls consistently report higher rates of eating disorders than boys, with the largest gap seen in 17–19-year-olds (see Figure 20).

- Among 11–16-year-olds:
- 8.4% of girls showed possible eating problems in 2017, rising to 14.9% in 2023
- 5.1% of boys showed possible eating problems in 2017, rising to 9.8% in 2023.

- Among 17–19-year-olds:
- 60.5% of girls showed possible eating problems in 2017, rising to 77.5% in 2023
- 29.6% of boys showed possible eating problems in 2017, rising to 42.3% in 2023.

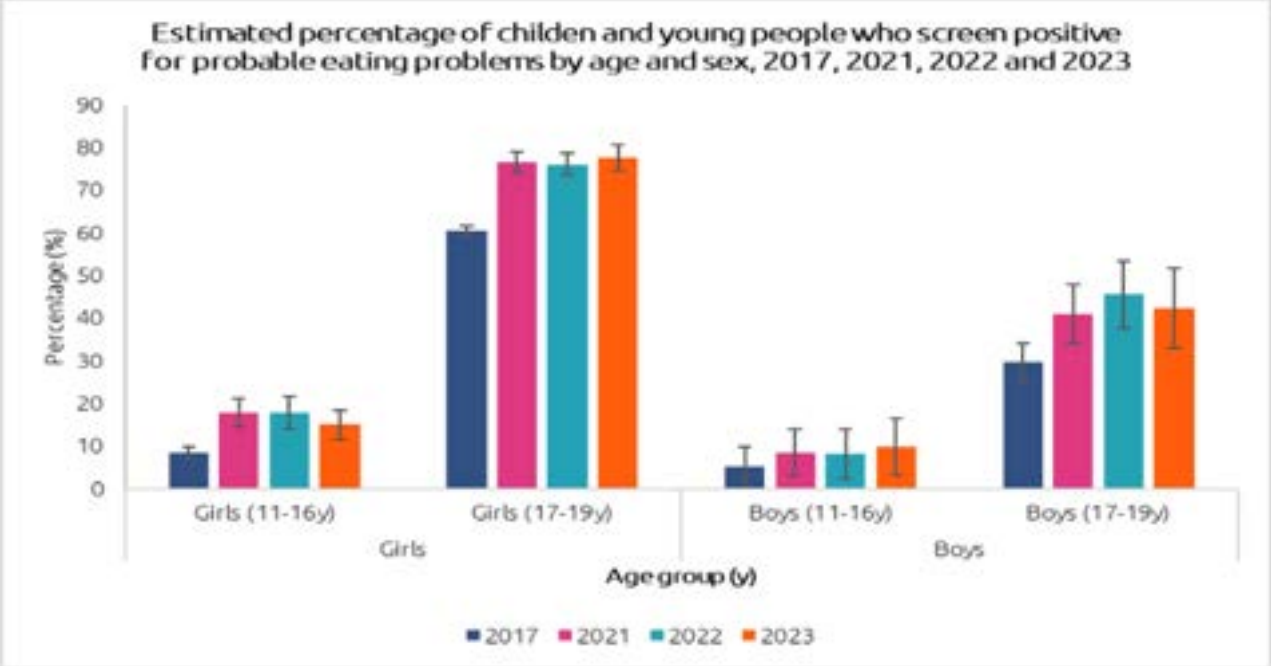

Figure 20. Percentage (%) of young people who screen positive for possible eating problems by age group and sex, 2017, 2021, 2022 and 2023, England (Source: Mental Health of Children and Young People Surveys - NHS England Digital)

4.11 Psychoses and Severe Mental Illness

In Wales, General Practice mental health registers track diagnoses of schizophrenia, bipolar disorder, and other psychoses, as well as lithium therapy.[57] Between 2020 and 2025, the proportion of young people on the SMI register remained stable (Figure 21):

- 0.1% of 15–19-year-olds
- 0.5% of 20–24-year-olds.

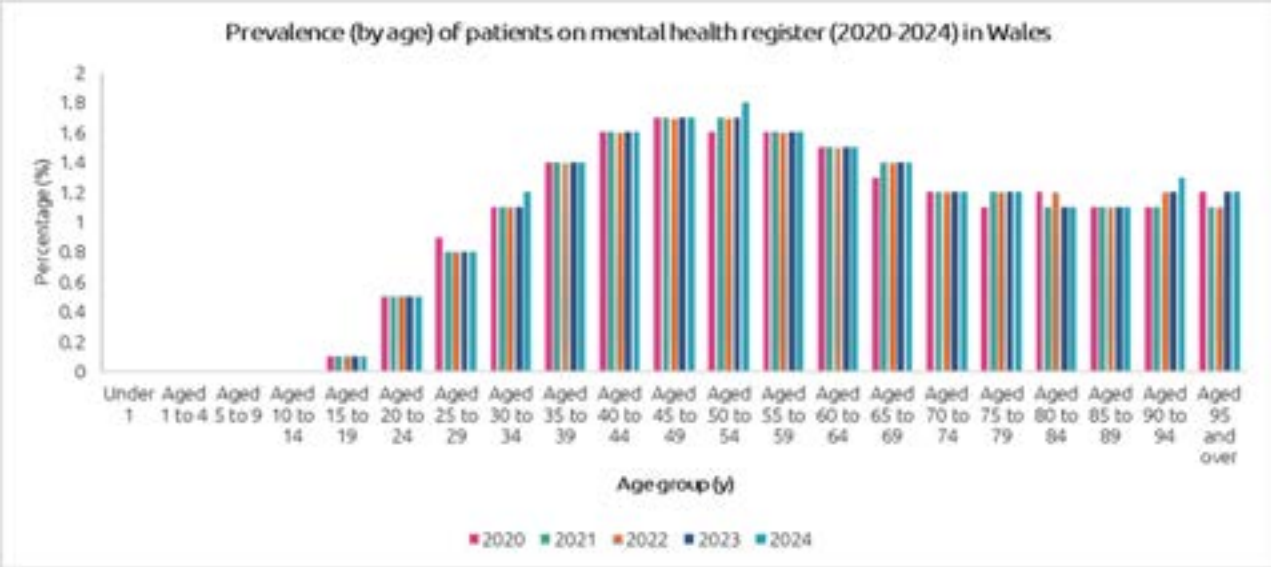

Figure 21. Prevalence (%) by age of patients on mental health disease register, 2019-2024, Wales (Source: Disease prevalence rates by age band and gender)

In the 2022 MHCYP survey 18.4% of 17–24 year olds in England were classified as 'at-risk' for psychotic-like experiences, having reported two or more incidents of such experiences. These experiences are relatively common and not necessarily linked to mental illness but can occur alongside conditions like depression. Psychotic disorders remain rare in this age group, however psychotic-like experiences may signal increased risk of future mental health difficulties.
Rates were higher among young females with 23% classified as 'at-risk' for psychotic-like experiences, compared with 15% of young males. Risk was significantly higher among those with a probable mental disorder with 36% reporting psychotic-like experiences compared to 10% of those unlikely to have a disorder.

4.12 Self-harm

Self-harm—through intentional injury or poisoning—is a key indicator of emotional distress. While many cases go unreported, it remains one of the most common reasons for hospital attendance of young people, with rates rising in recent years.
A UK case series found that 49% of young people who died by suicide had self-harmed at some point, and 26% had done so in the three months prior to death[58]. Conversely only around 1 in 50 people who self-harm go on to make a suicide attempt.

4.12.1 Trends in Self-Harm

- In England, the proportion of 15-year-olds reporting lifetime self-harm (ever having self-harmed) rose from 22% in 2014 to 34% in 2022 (see Figure 22)
- Among girls, rates increased from 32% to 49%
- Among boys, rates nearly doubled—from 11% to 20%.[59]

4.12.2 Socioeconomic Differences

- Among 15-year-old girls, self-harm was more common in those from less affluent families:
- 54% in the least affluent group vs. 47% in the most affluent
- For boys, the difference by family affluence was minimal.

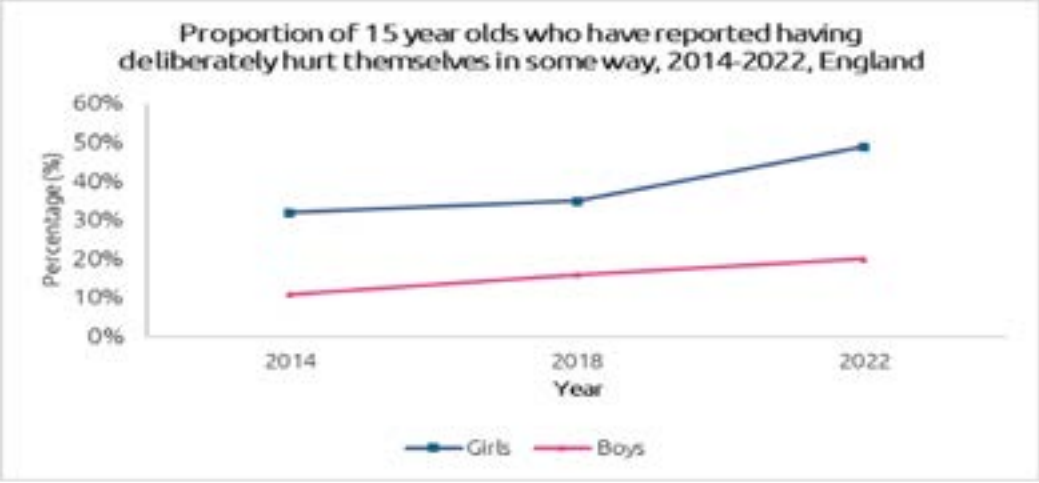

Figure 22. Proportion of 15-year-olds in England who reported deliberately hurting themselves in some way, by sex, 2014-2022 (Source: HBSC England)

Recent data show a rise not only in the prevalence but also in the frequency of deliberate self-harm (DSH) among 15-year-olds (Figure 23).

4.12.3 Gender Differences

Among Boys

- Daily self-harm increased from 2% to 9% between 2018 and 2022
- Self-harming several times a week: 2% to 8%
- Self-harming once per week: 0% to 6%

Among Girls

- Self-harming several times a week rose from 10% in 2018 to 16% in 2022
- Daily or weekly self-harm rates remained stable.

Regardless of gender, the data suggest a shift toward more frequent self-harm episodes among those who engage in self-harming behaviour.

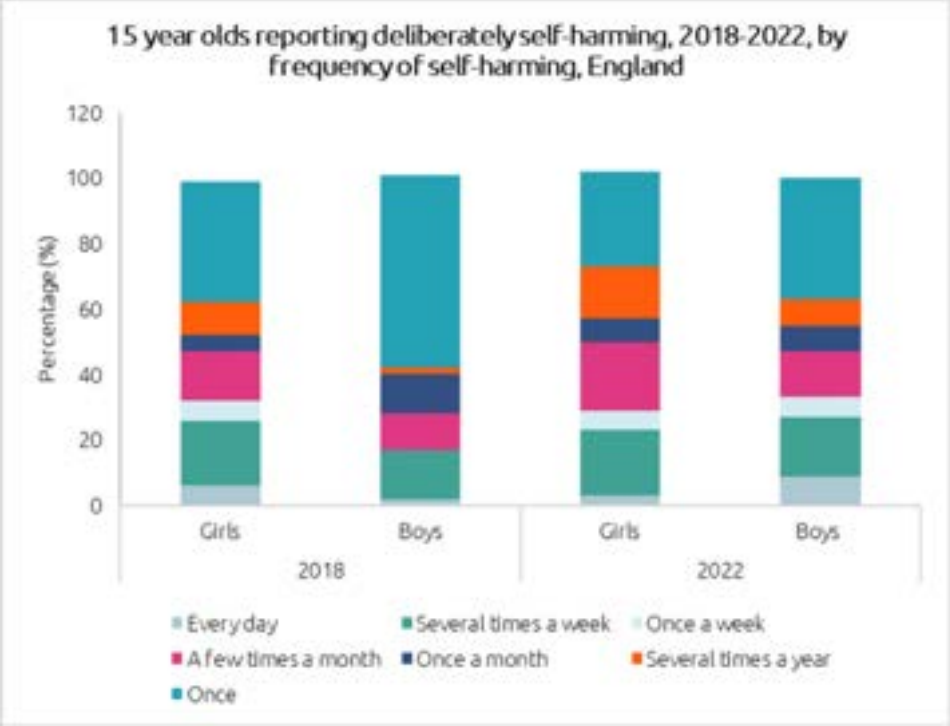

Figure 23. Frequency of self-harming for all 15-year-olds who had reported deliberately self-harming themselves, England: 2018-2022 (Source: HBSC England)

The MHCYP 2023 survey in England found significantly higher rates of self-harm among 11–16-year-olds with a probable mental health disorder, along with variation by gender:

- 24% of boys with a probable disorder reported lifetime self-harm compared to 4% of those unlikely to have a disorder
- 40% of girls with a probable disorder reported self-harm compared to 14% in the general population.

4.13 Suicide

The loss of any life by suicide is tragic and has a devastating impact on families and communities. Whilst the overall number of deaths by suicide among young people is small suicide is the leading cause of death among young people aged 10–19 years in England and Wales. Like self-harm, it results from a complex mix of biological, psychological, social, and environmental factors.[60]

4.13.1 Trends Over Time

- Suicide rates among young people aged 10-24years have shown a small (not statistically significant) increase over the past 15 years (Figure 24)
- Among girls rates rose slightly from 2.9 per 100,000 (2012) to 3.1 per 100,000 (2023)—the lowest among all age groups
- Among boys rates increased from 6.9 per 100,000 (2014) to 7.4 per 100,000 (2023), remaining below the historical peak of 11.8 per 100,000 (1990).

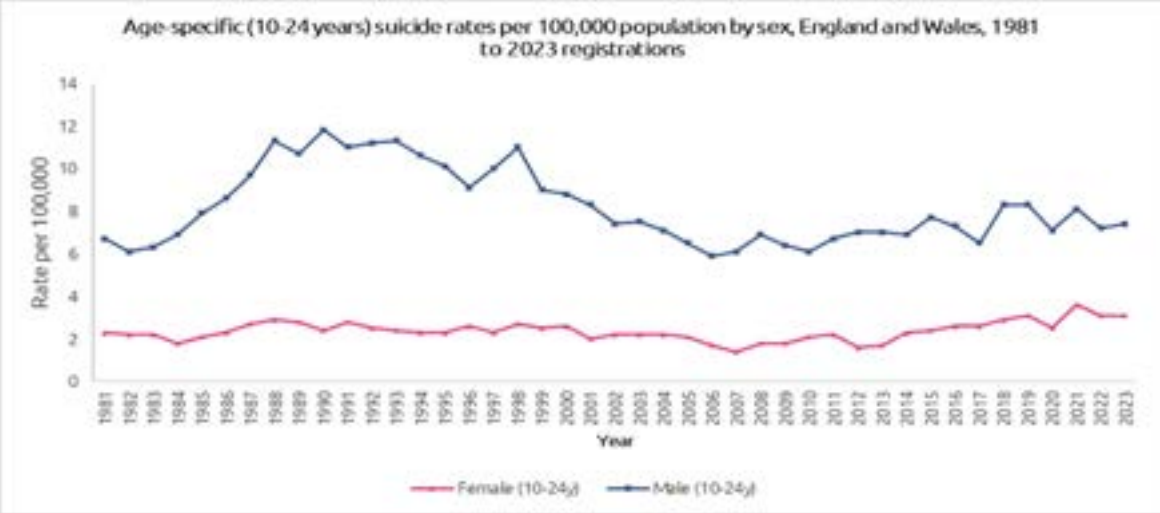

Figure 24. Age-specific (10-24 years) suicide rates per 100,000 population by sex for England and Wales, 1981 to 2023 registrations (Source: Office for National Statistics)

4.13.2 Age and Gender Differences

Rates of death by suicide are higher among boys aged over 15, with similar rates among 10-14 year olds. In 2023 rates were:

- Ages 15–19 years: 8.1 per 100,000 males and 2.6 per 100,000 females
- Ages 20–24 years:13.6 per 100,000 males and 6.1 per 100,000 females.

4.13.3 Service Contacts

- Between 2011–2021, 869 students aged 18–21 died by suicide in England and Wales —of these only 11% had contact with mental health services, compared to 25% of young people who died by suicide and were not in education
- Girls aged 10–19 were more likely than boys to have had contact with services before death:
- Mental health service contact: 37% of girls compared with 22% of boys
- Social care contact: 13% of girls compared with. 6% of boys.[61]

4.13.4 Risk Factors

Among students who died by suicide between 2011 and 2021 common antecedents to suicide included: self-harm, mental illness, academic pressure (e.g., exams), bereavement (including suicide), physical health conditions, substance misuse, bullying (in-person and online).

4.14 Mental Health of Babies, Children and Young People: Summary

- 30% parent-infant dyads are likely to benefit from support to improve mental health and wellbeing in the first 1,000 days, 20% are unlikely to be receiving support before age 2.
- Action in the early years is cost-effective and improves a range of social, emotional and developmental outcomes.
- Opportunities exist to improve early identification of parent and infant mental health and wellbeing difficulties include through antenatal and postnatal checks, and wider contact points with families, such as childcare settings and courts.

- An estimated 1 in 4 girls, 1 in 6 boys and 1 in 2 trans or gender-questioning secondary school learners are experiencing low mental wellbeing.
- Over 135,000 children and young people estimated to have a diagnosable mental health difficulty; 1 in 6 aged 8 to 10; 1 in 5 aged 11 to 16, and 1 in 4 aged 17 to 24.
- Emotional difficulties present the greatest burden, with increases among all genders; higher rates among girls and gender questioning learners emerge in primary school and increase with age.
- Behavioural difficulties have increased amongst all genders with the highest rates seen in boys and gender questioning learners.
- Population prevalence of neurodevelopmental conditions appears to be relatively stable, however demand for services has been rising, likely due to improved awareness among parents and professionals.
- Increases in eating disorders, most sharply seen in females, highlight a growing need for prevention and early intervention, including action to address body image concerns.
- Psychoses prevalence remains relatively low and stable, but support to deal with symptoms, often emerging during late adolescence is crucial for reducing relapse and improving outcomes.
- Increases prevalence and frequency of self-harming behaviours are further signs of increasing distress among young people.
- Suicide prevention strategies should consider the needs of emerging adults and opportunities to improve identification of distress and access to support.

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Public Health Wales

Services and Support

Health Needs Assessment:
Mental Health of Babies, Children and Young People in Wales

5.1 Service Utilisation

5.1.1 Counselling

In Wales, anxiety was the top presenting issue for young people who received counselling, with cases rising by 14% between 2015/16 and 2022/23 (Figure 25).

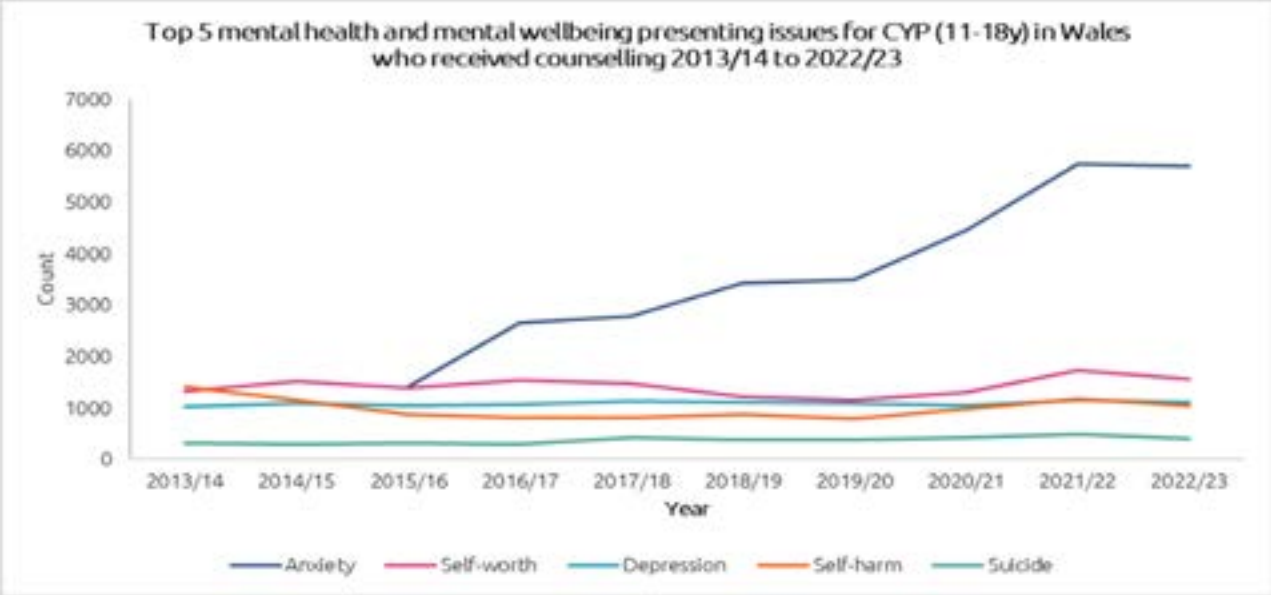

Figure 25. Top 5 mental health and mental wellbeing presenting issues for young people (11-18 years) in Wales who received counselling 2013/14 to 2022/23 (Source: Local Authority School Counselling Services, Welsh Government, StatsWales)

In 2022/23, only a small proportion of young people receiving counselling were referred to specialist CAMHS—just 2.9%, down from 3.5% in 2021/22.[62] More females receiving counselling are referred to specialist CAMHS compared to males. Females now account for nearly three-quarters of all young people referred to specialist CAMHS.[63]

5.1.2 NHS 111

The “NHS 111 Press 2” service provides urgent access to mental health support 24 hours a day 7 days a week. The chart below shows contacts by age group for those contacting the service between December 2022 and September 2025. Contacts may be by or for individuals within the presented age groups.

Contact by or for BCYP during this time represented 19.5% of all contacts (figure 26), compared to the 20% of the population which 0-24 year olds make up. The population of 17 to 24 year olds is around 10% of the population, whereas this age group represents around 14% of calls to NHS 111, suggesting a good level of access for this age group. However, calls relating to younger age groups appear to be low; 5.4% of calls are by or for 11-17 year olds, compared to approximately 7% of the population represented by this age group in the total population.

Figure 26. Calls to NHS 111 Press 2 helpline, December 2022 to September 2025 by age group. Source: NHS 111 Press 2 Dashboard: NHS 111 Wales Press 2: Mental Health Support - NHS Wales Joint Commissioning Committee

5.1.3 Primary care

The incidence rate of GP recorded anxiety-related conditions between 2013 and 2022 reflect the increasing trend seen globally and within Wales school-based surveys. Increases have been larger among females (Figure 27).
During the pandemic there was a dip in GP recorded diagnoses, likely due to service disruption and diagnosis rates have not returned to pre-pandemic levels in 2022, highlighting a gap in early support.

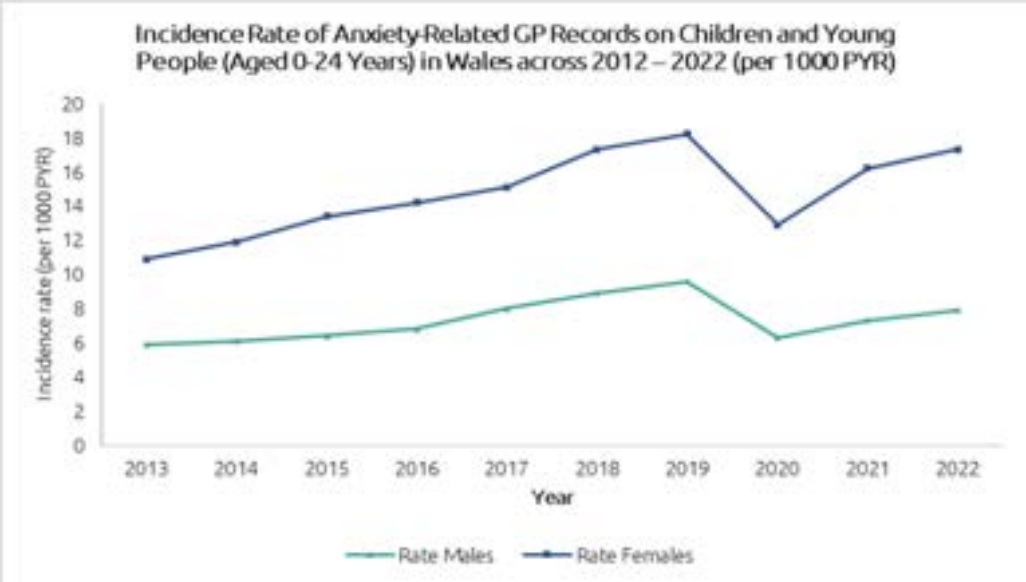

Figure 27. Incidence Rate of Anxiety-Related GP Records on Children and Young People (Aged 0-24 Years) in Wales across 2012 – 2022 by Gender (per 1000 PYR) (Source: GP Data)

Age-specific incidence rates show the highest incidence, and the greatest increases, among young people aged 11 to 24years (figure 28).

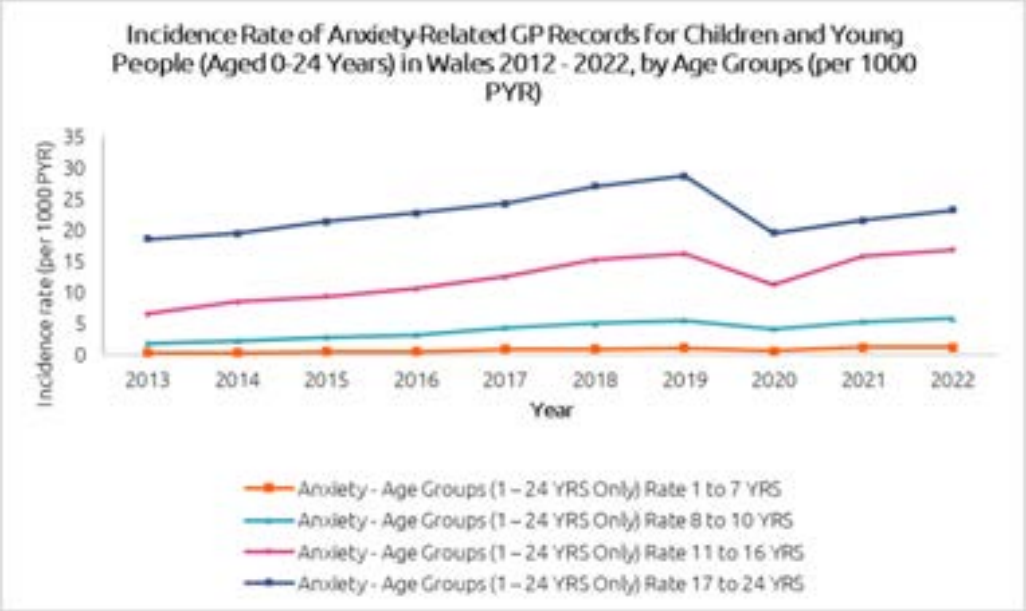

Figure 28. Incidence Rate of Anxiety-Related GP Records on Children and Young People (Aged 0-24 Years) in Wales, by Age Groups (per 1000 PYR, 2012 - 2022) (Source: GP Data.)

Prior to the pandemic the incidence rate of GP recorded depression-related conditions showed an increasing incidence among males, followed by a dip in contacts during the pandemic. Rates were higher among females and showed less of an increase prior to the pandemic (Figure 29).

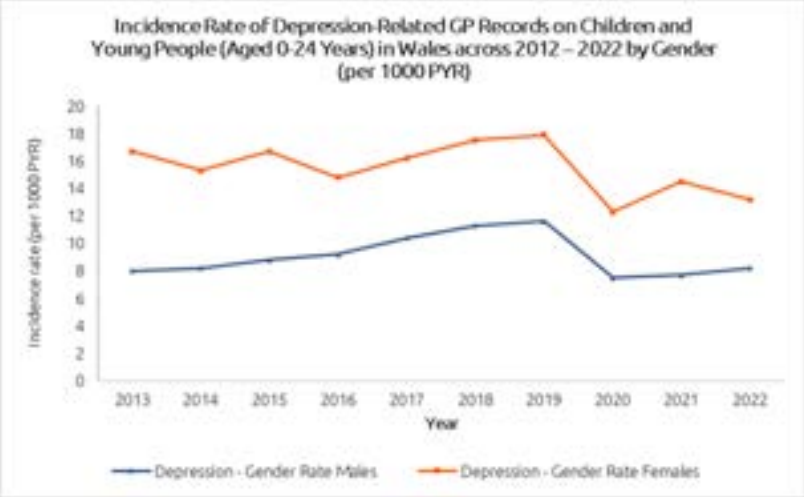

Figure 29. Incidence Rate of Depression-Related GP Records on Children and Young People (Aged 0-24 Years) in Wales across 2012 – 2022 by Gender (per 1000 PYR) (Source: GP Data.)

GP recorded depression diagnoses are highest among 17 to 24 year olds, with significant increases among those aged over 11 since at least 2015 (Figure 30)

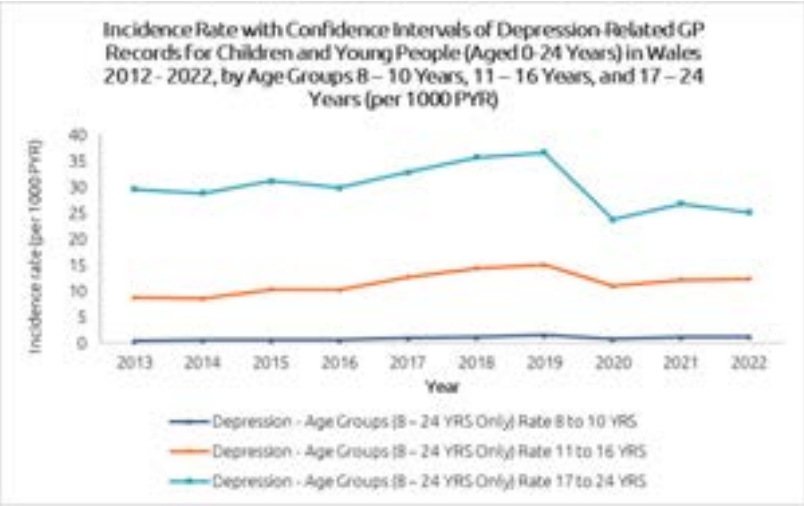

Figure 30. Incidence Rate of Depression-Related GP Records on Children and Young People (Aged 0-24 Years) in Wales, by Age Groups (per 1000 PYR, 2012 - 2022) (Source: GP Data)

GP records suggest the incidence of serious mental illness (covering schizophrenia, bipolar disorder, other psychoses and severe forms of anxiety, depression and somatoform disorders) have shown little change overtime (Figure 31).

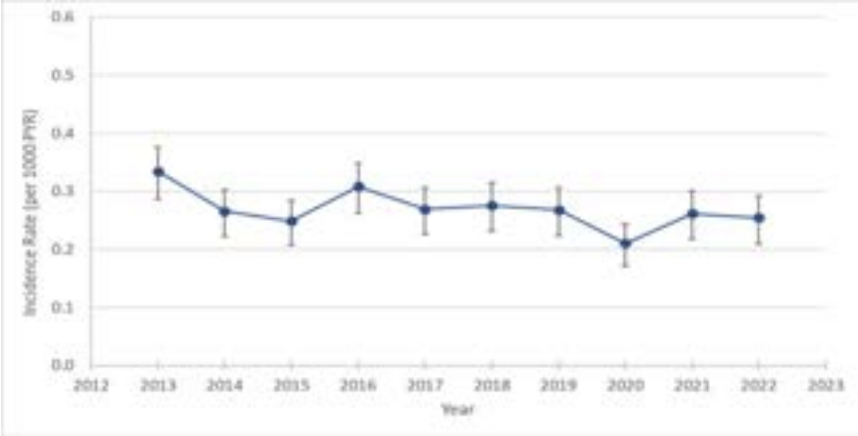

Figure 31. Incidence Rate with Confidence Intervals of Serious Mental Illness-Related GP Records on Children and Young People (Aged 0-24 Years) in Wales across 2012 – 2022 (per 1000 PYR) (Source: GP Data.)

5.1.4 Mental Health Support Services

In Wales data suggests referrals to Local Primary Mental Health Support Services (LPMHSS) over the last 2 years have remained steady (Figure 32).

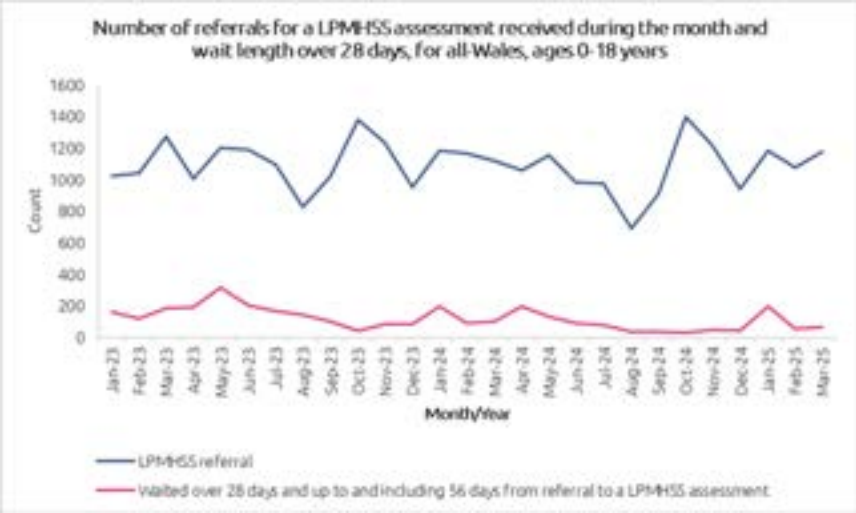

Figure 32. Number of referrals for a LPMHSS assessment received during the month and wait length over 28 days, for all-Wales, ages 0-18 years (Source: Referrals for a LPMHSS assessment, by LHB, age and month)

A Health Inspectorate Wales review found that:[64]

- Half of young people didn't know where to access mental health support
- Only 29% felt confident in accessing support
- Among those who received support, just 42% felt able to ask questions
- Only half felt their views were considered.

in 2023, 16,812 young people were waiting for an ADHD or ASD neurodevelopmental assessment, with 67% waiting over 26 weeks.[65]

5.1.5 Secondary Care

Anxiety: The incidence rate of hospital admissions for anxiety related disorders between 2013 and 2022 mirrors the increasing trend seen for GP recorded diagnoses. The rise has been noticeably greater among females (Figure 33). The difference in incidence rates (per 1,000 PYR) between females and males increased from 0.3 in 2013 to 1.65 in 2022.

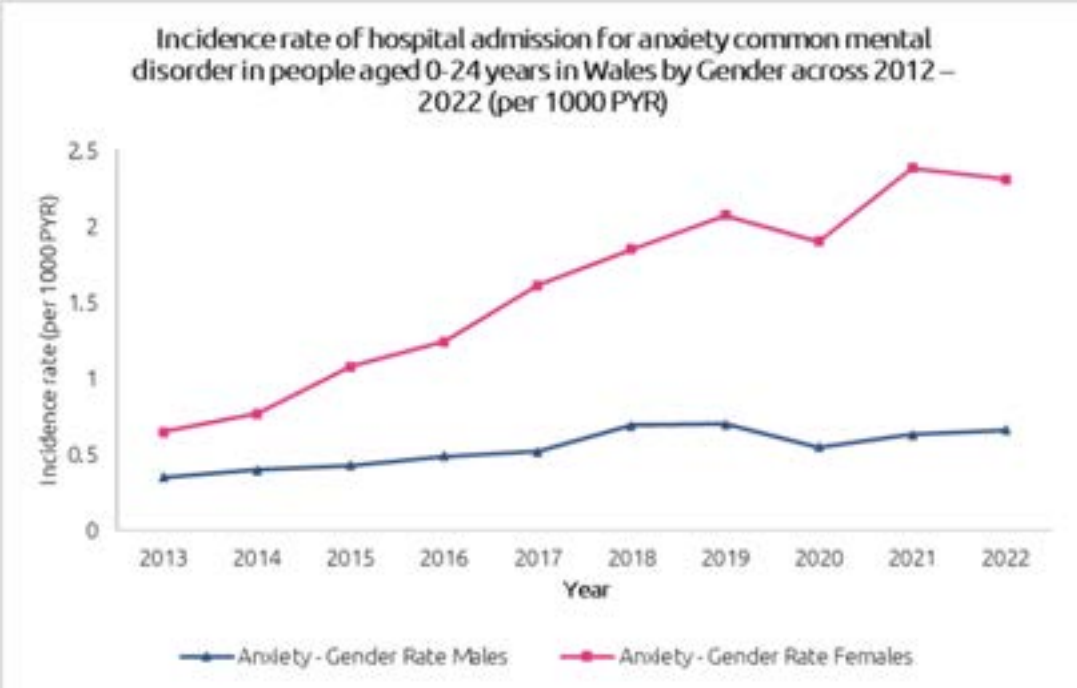

Figure 33: Incidence rate of hospital admission for anxiety common mental disorder in people aged 0-24 years in Wales by Gender across 2012 – 2022 (per 1000 PYR) (Source: Admitted Patient Care Database.)

The incidence rate of hospital admissions for anxiety-related disorders is highest and has increased most sharply among young people aged 17–24. Rates rose from 0.99 per person years in 2013, to 3.39 in 2022 (Figure 34).

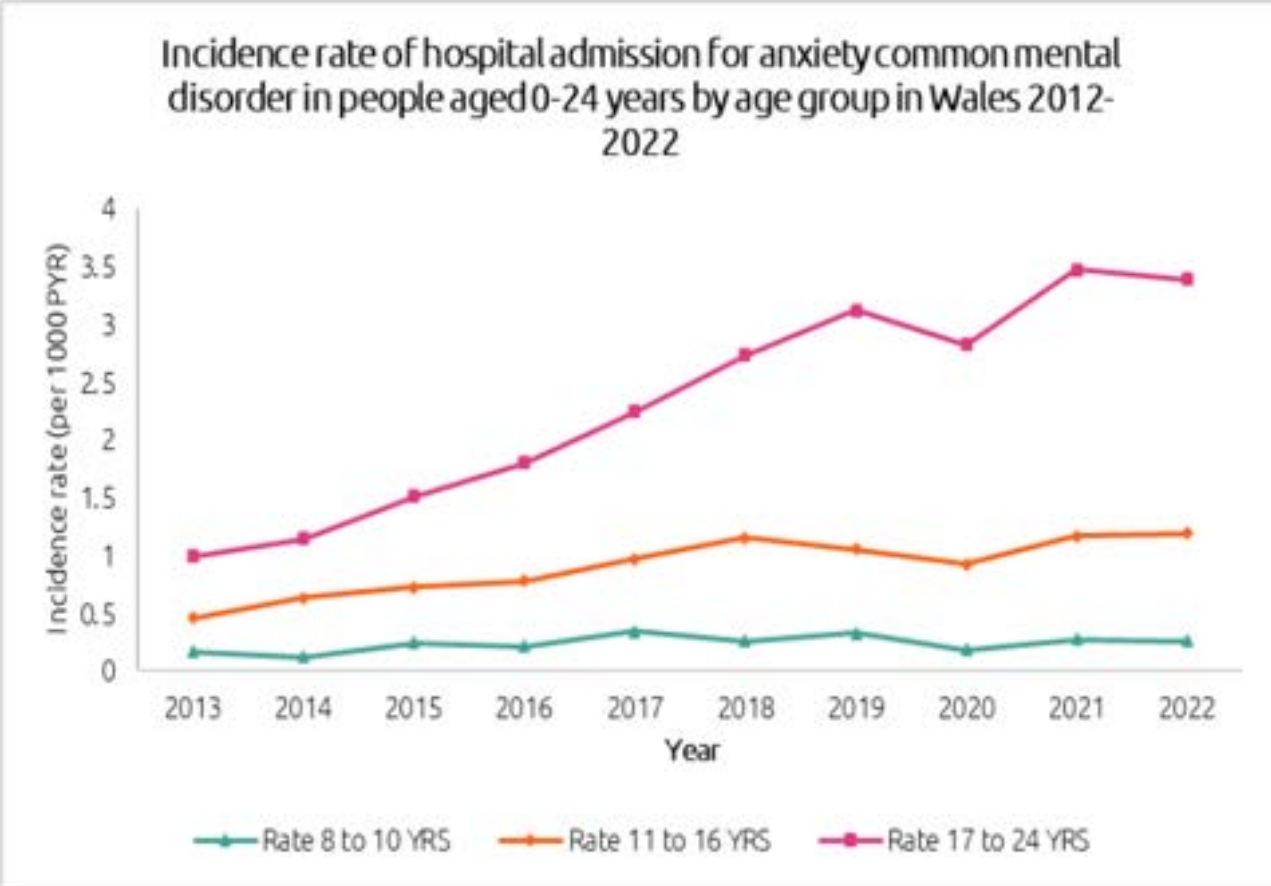

Figure 34. Incidence rate of hospital admission for anxiety common mental disorder in people aged 0-24 years by age group in Wales 2012-2022 (Source: Admitted Patient Care Database.)

Depression: In contrast to the sharp rise in anxiety-related hospital admissions, admissions for depression-related disorders have remained relatively stable over the same period (Figure 35). The incidence rate for males decreased slightly from 0.43 per 1,000 person years in 2013, to 0.29 in 2022, while for females there was a modest increase from 0.99 in 2013 to 1.22 in 2022.

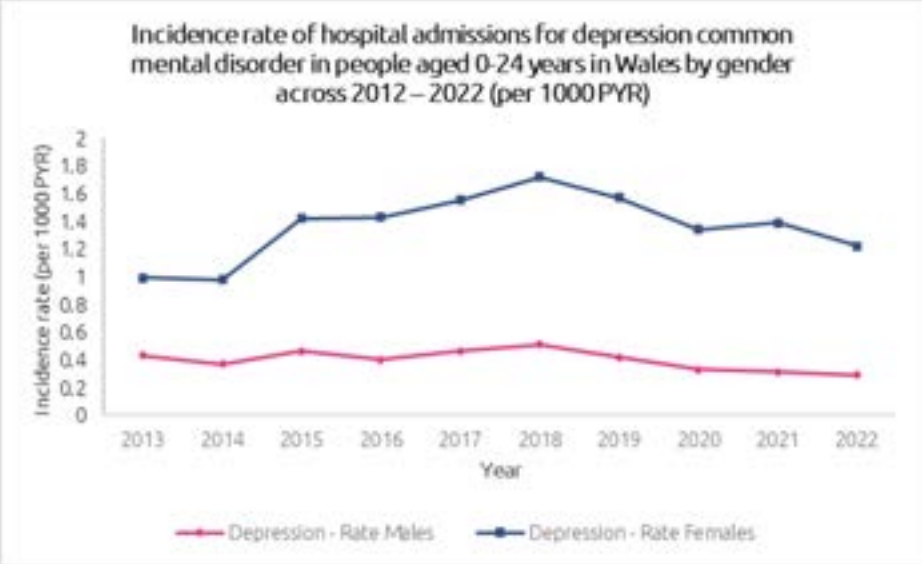

Figure 35: Incidence rate of hospital admissions for depression common mental disorder in people aged 0-24 years in Wales by gender across 2012 – 2022 (per 1000 PYR) (Source: Admitted Patient Care Database)

A similar pattern is seen across age groups, with the highest incidence rate among 17–24-year-olds, which increased modestly from 1.59 in 2013 to 1.91 in 2022. In contrast, those aged 11–16 had a lower incidence, which declined slightly from 0.53 in 2013 to 0.45 in 2022 (Figure 36).

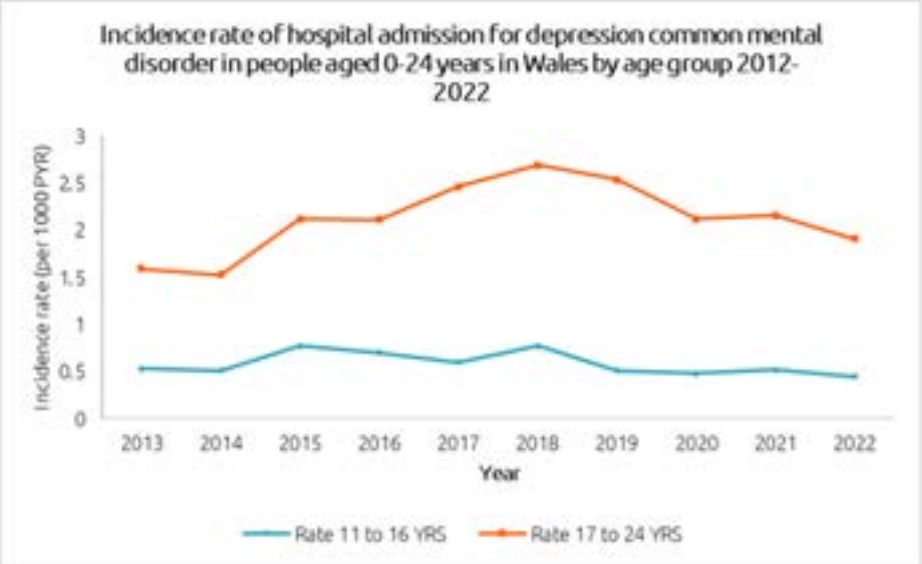

Figure 36. Incidence rate of hospital admission for depression common mental disorder in people aged 0-24 years in Wales by age group 2012-2022 (Source: Admitted Patient Care Database.)

Mental Health Crises: Data from the Welsh Ambulance Service Trust and hospital data shows between 2018 to 2020 there were 4,638 ambulance callouts for young people in mental health crisis in Wales. 21% resulted in hospital admission, while 9% refused care (Figure 37). Crisis rates were twice as high among girls (11–15 years) and young women (16–19 years) compared to boys, and nearly double for young people in the most deprived areas versus the least.[66]

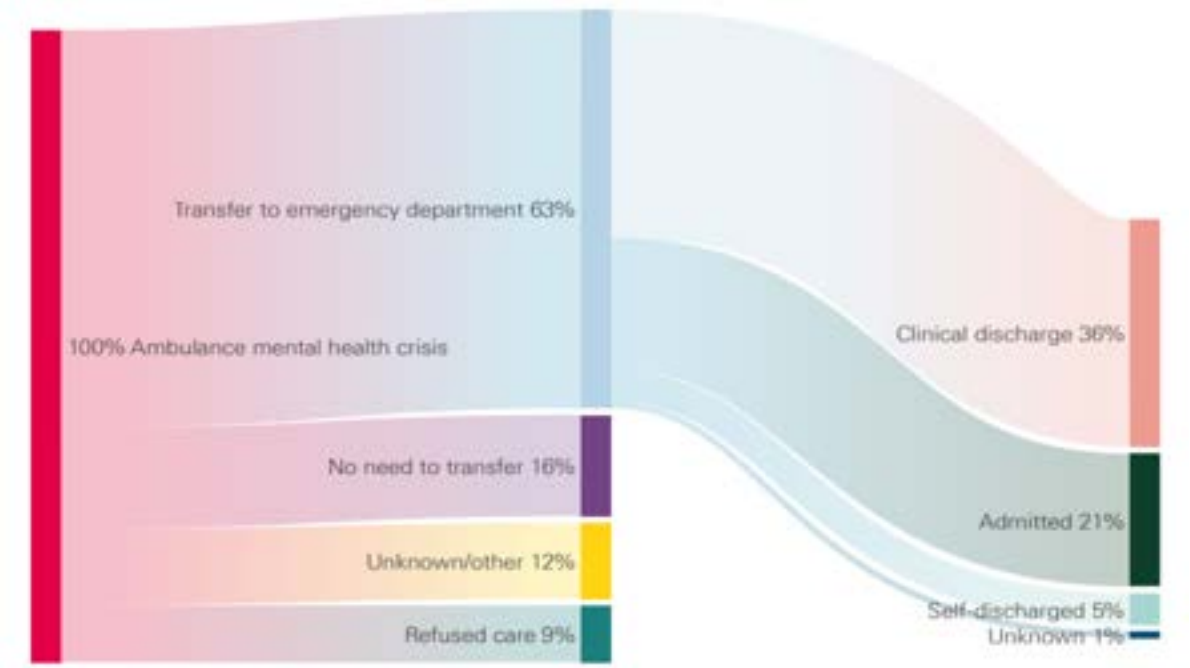

Figure 37. Young people aged 11–24 years presenting to Wales Ambulance Services Trust with mental health crises by outcome, 2018–2020 (Source: CYPMHbriefing_Web_Final.pdf) Note. Unknown/other includes cases where clinicians requested transport, hoax calls or erroneous data, no patient found at the scene or ambulances were cancelled pre-arrival

Emergency care: From 2016 to 2022 there were over 9000 emergency mental health hospital admissions among 11-24year olds following self-presentations or ambulance transfers. Analysis of the primary diagnosis code showed eating disorders accounted for an increasing proportion of emergency admissions, rising from 7% in 2016 to 19% of emergency mental health admissions in 2022.

Emergency department attendances for mental health crises including self-harm (through injury or poisoning) appear to show a fall from an average of around 4,800 a year between 2016-2019 to around 2,800 per year between 2020-2022, however this may relate to changes in services (from the COVID-19 pandemic, introduction of NHS 111 press 2), coding practices or data quality so should be treated with caution.

5.2 Barriers to access

5.2.1 Poor health literacy

Poor health literacy can delay access to mental health support.[67] Young people who struggle to recognise symptoms or understand available services are less likely to seek help—especially when language or cultural barriers exist. Fear of stigma and poor mental health literacy among parents or caregivers can further discourage early intervention.

In Wales, improving mental health literacy is a key focus of the All-age Mental Health and Wellbeing Strategy 2025–2035 and the Whole School Approach to Emotional and Mental Well-being framework.[68]

5.2.2 Poor accessibility to services

A lack of consistency in the accessibility to mental health support across all areas of Wales has been highlighted in several reports.[69] Many BCYP—especially those with complex needs—struggle to access appropriate support if they don't meet the threshold for CAMHS.

5.2.3 Service not age-appropriate

Pain points have been identified in the support offer in Wales for BCYP, including the lack of a specific support offer for those aged 0-5 years, the admitting of some young people into adult mental health service settings, and the sudden transition at age 18 years into adult mental health service provision.[70] CAMHS outcome letters often lack consistency and personalisation. In some cases, they include an overwhelming list of resources, which can hinder continuity of support for BCYP and their families.[71]

5.2.4 Poor coordination between services

Despite strong policy guidance, transitions between child and adult mental health services often lack coordination, leaving young people without the support they need at a critical time.[72]

- Young people aren't consistently informed about their rights or available support
- Care and treatment plans are rarely used effectively or followed through
- High referral thresholds make it difficult to access both Specialist Child and Adolescent Mental Health Services (SCAMHS) and Adult Mental Health Services (AMHS)
- Many feel abandoned or suddenly cut off from SCAMHS when they turn 18 years
- Decisions are still based on age, not individual need or readiness for adult services.

Care-experienced young people are particularly affected, facing fragmented pathways and limited coordination between services, which delays timely and effective outcomes.[73]

5.2.5 Stigma and discrimination

Stigma remains a major barrier to support. A 2022 YoungMinds' survey[74] of nearly 14,000 young people in the UK, 35% reported negative experiences when seeking help—from teachers, GPs, or other professionals. Over half (51%) felt embarrassed or ashamed to ask for support, and 37% hid their struggles to avoid being judged. Young people from ethnic minority communities often face increased stigma and discrimination when seeking mental health support. Services may lack cultural sensitivity, offer limited flexibility, and fail to provide adequate translation.[75]

5.3 Services, Support and Barriers to Access: Summary

- Service data further re-iterates growing needs among children and young people, particularly for emotional difficulties/anxiety-related conditions and eating disorders; increased access to psychological interventions for adolescents and emerging adults is required.
- Increased capacity and access to early support in non-stigmatising environments, including schools, communities, GPs and remote services, are needed to address needs and support children and young people prior to the need for crisis care.
- Increased awareness of how to access early support is needed among young people, and when help is sought children and young people should be enabled to engage with age- and-culturally appropriate support.

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Risk and Protective Factors

Health Needs Assessment:
Mental Health of Babies, Children and Young People in Wales

6.1 Risk Factors

This section presents data on key risk factors which contribute to poor mental health and wellbeing among BCYP in Wales.

A PHW study using SHRN data from 2019 and 2021 to explore the relationship between mental health and mental wellbeing highlighted several key risk factors that negatively impact both mental health and wellbeing. Of the variables available from the SHRN survey significant risk factors were academic pressure, being female, sleep difficulties, lack of teacher care, negative body image, perceived lack of support from friends, and experiences of bullying (Figure 38). Additional data on these, and other established risk factors are presented below.

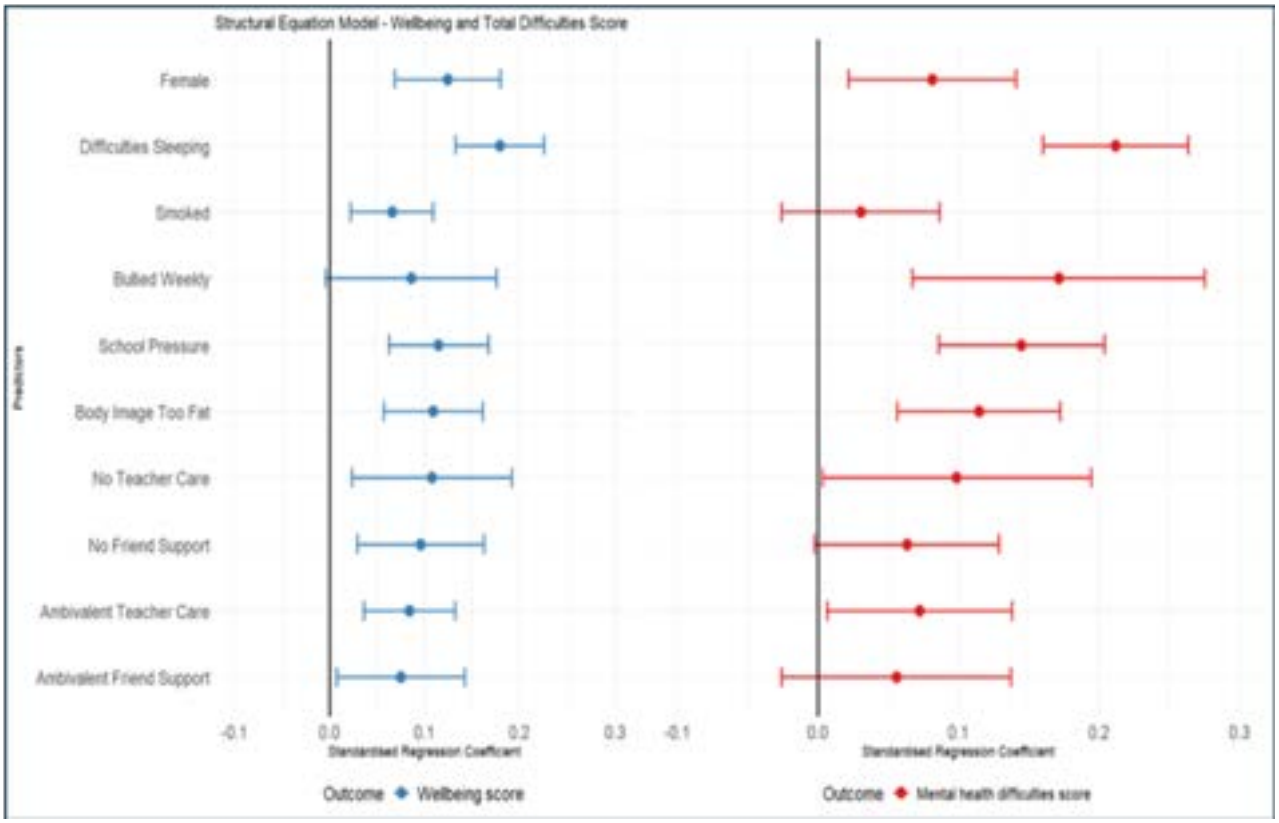

Figure 38. Common and unique risk variables of adolescent mental health and wellbeing in a nationally representative survey of 11-16 years olds in Wales (Source: publichealthwales.shinyapps.io/SHRN_Dashboard/; Public Health Wales)

6.1.1 Living in poverty

Poverty is a well established risk factor for poor mental health, with children from the poorest 20% of households being four times as likely to experience serious mental health problems by the age of 11 than those in the most affluent 20% of households. [76] Poverty can increase stress within a household, impact on family relationships, children and young people may experience shame, stigma or bullying as a result of poverty and may lack access to healthy foods or social activities; all of which can negatively impact mental health and wellbeing.

Recent data show that 31% of children in Wales live in households with incomes below 60% of the UK median (after housing costs), a figure that has shown little change over the past 15 years (Figure 39).

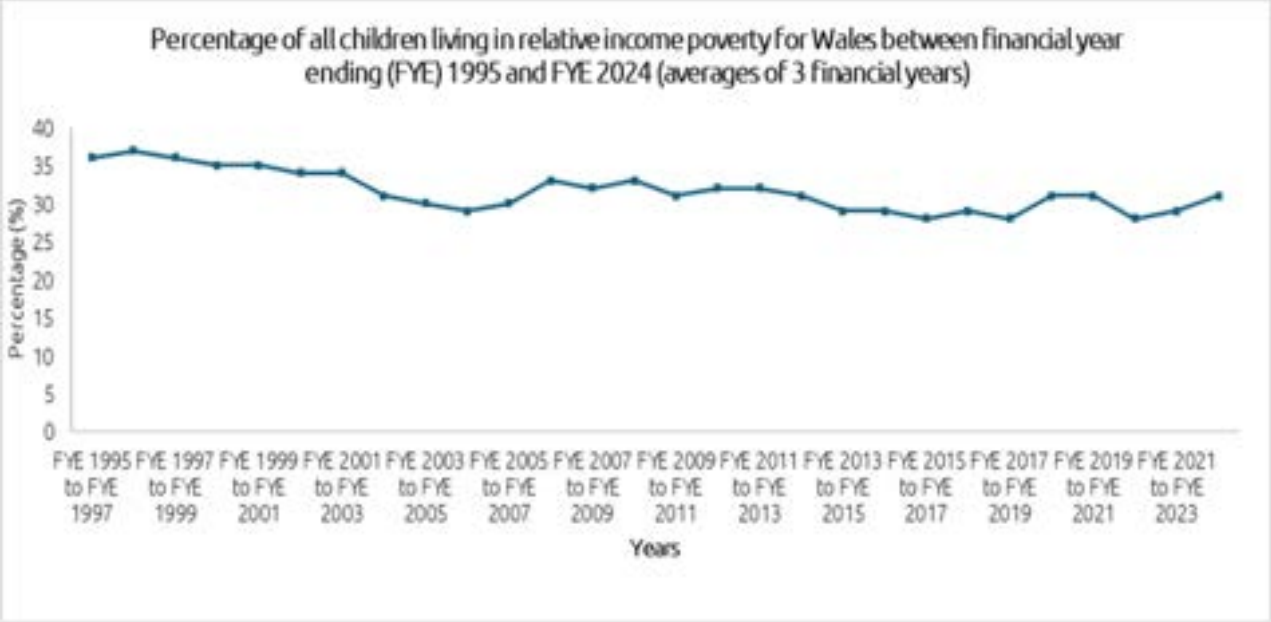

Figure 39. Percentage (%) of all children living in relative income poverty in Wales between financial year ending (FYE) 1995 and FYE 2024, averages of 3 financial years (Source: Family Resources Survey, Department for Work and Pensions)

6.1.2 Sleep

Poor sleep can impact how emotions are processed and experienced, influencing mental health and wellbeing. Conversely poor mental health can lead to difficultly sleeping. Whilst further research is needed to fully understand the relationship between sleep and poor mental health studies show an association between sleep problems in childhood and mental health problems.[77]

6.1.2.1 Primary School learners

Population data show widespread sleep difficulties among primary level children in Wales.[78] In 2024:

- Just over two-thirds (68%) of primary school learners report having problems sleeping, either sometimes or always
- Sleep problems remained consistent across school years
- A higher proportion of learners who identified as neither a boy nor a girl reported sleep
- problems (87%) compared to girls (69%) and boys (66%)
- 15% of children reported a bedtime of after 10pm
- A higher proportion of learners who identified as neither a boy nor a girl reported a bedtime of after 10pm (26%) compared to girls (12%) and boys (18%).

6.1.2.2 Secondary school learners

Population data show widespread sleep difficulties among adolescents in Wales.[79] In 2023:

- 44% of girls and 34% of boys reported difficulty sleeping more than once a week over the past six months
- Rates are highest among those identifying as neither girl nor boy, with 69% reporting sleep difficulties
- Adolescents from less affluent families report higher sleep difficulties (46%), compared to 36% among those from more affluent family backgrounds
- 35% of adolescents reported going to bed after 11:30pm on school nights, an increase from 25% in 2017; among those identifying as neither girl nor boy, this rises to 57%

- Adolescents from less affluent families are more likely to go to bed after 11:30pm on a school night compared to those from higher levels of family affluence (Figure 40)
- 38% of adolescents reported looking at an electronic screen at 11.30pm or later when they have school the next day, an increase from 30% in 2017
- Adolescents from less affluent families are more likely to look at an electronic screen at 11:30pm or later (45%) compared to those from higher levels of family affluence (34%).

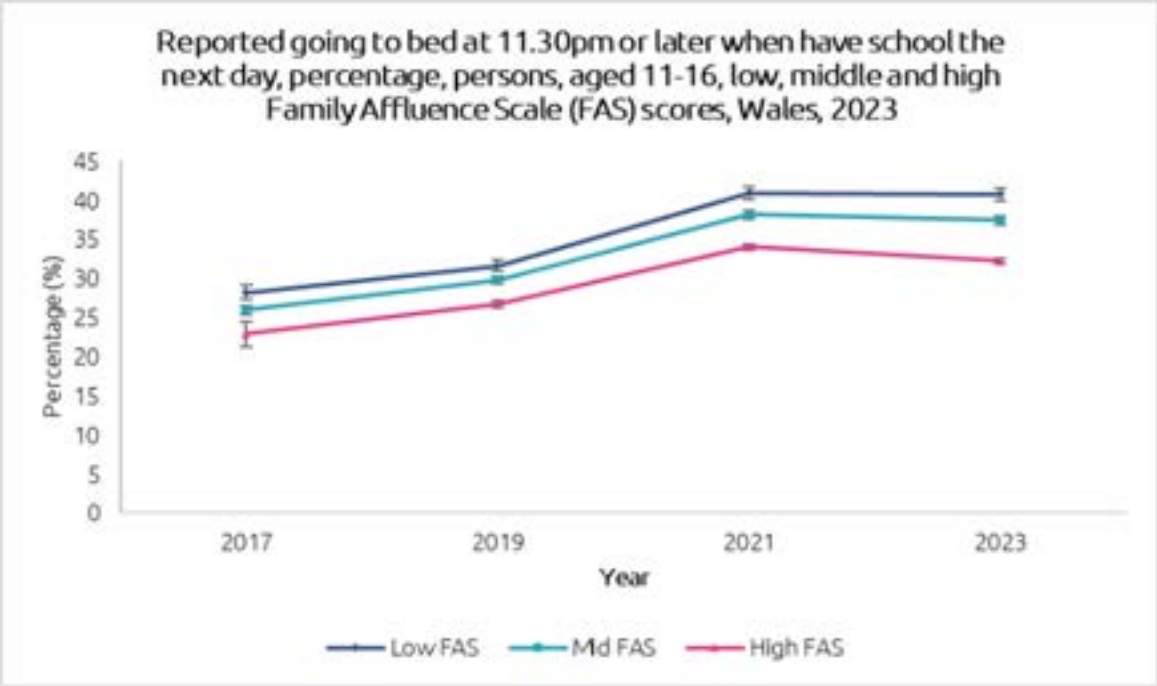

Figure 40. Reported going to bed at 11.30pm or later when have school the next day, percentage, persons, aged 11-16, low, middle and high Family Affluence Scale (FAS) scores, Wales, 2017 to 2023 (Source: publichealthwales.shinyapps.io/SHRN_Dashboard/)

Data from the MHCYP England survey (2023) highlight a strong connection between sleep and mental health:

- 77% of young people with a probable mental health disorder reported sleep difficulties three or more nights a week, compared with 25% of those unlikely to have a disorder (Figure 41).

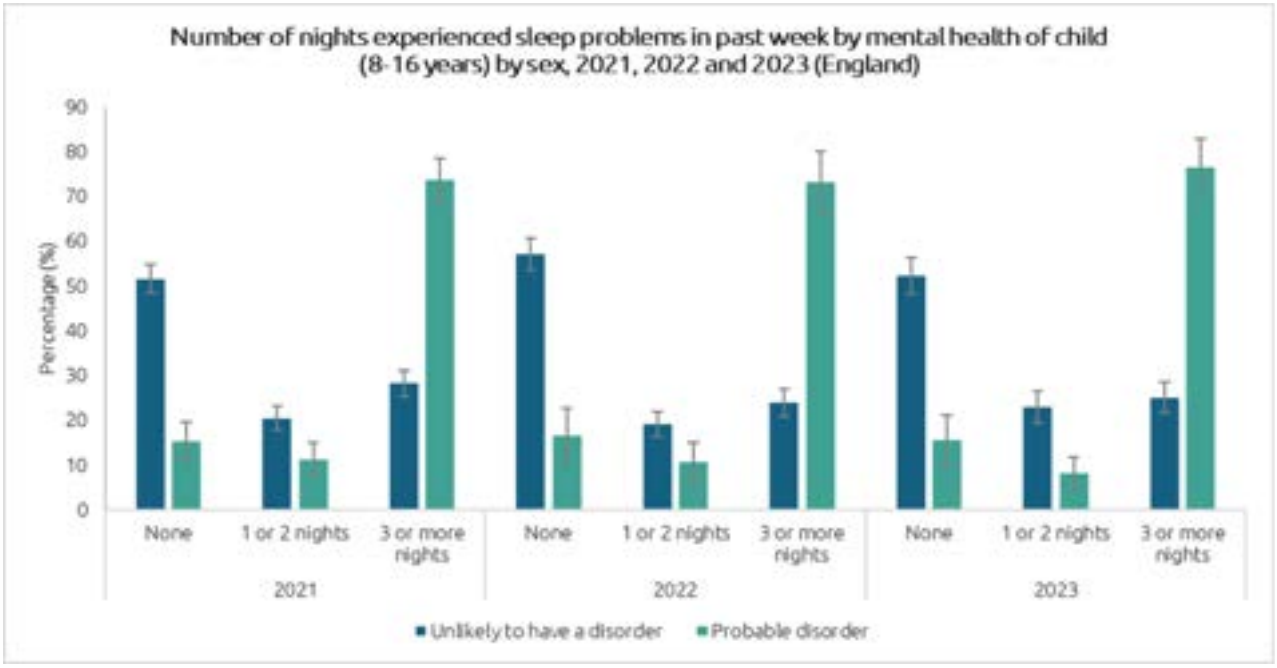

Figure 41. Number of nights experienced sleep problems in past week, by mental of child (8-16 years), 2021, 2022, 2023 (Source: Mental Health of Children and Young People Surveys - NHS England Digital)

6.1.3 Loneliness

- Loneliness or social isolation can increase the risk of poor mental health and wellbeing, particularly feelings of depression and anxiety.[80] Additionally, children and young people with existing mental health conditions, or neurodevelopmental conditions can be at increased risk of experiencing loneliness or social isolation, thus risking exacerbation of mental health problems.[81]
- In 2023, 35% of adolescents in Wales reported feeling lonely during the previous summer holidays.
- 42% of girls reported feeling lonely compared with 27% of boys
- Those identifying as neither girl nor boy experienced the highest rates; 68% reported feeling lonely during the previous summer holidays
- Among girls from the most deprived backgrounds, loneliness rose to 49%, compared to 38% among those from the least deprived areas (Figure 42).

MHCYP survey data from England (2023) show that:

- 18% of 11–16-year-olds with a probable mental health disorder often or always feel lonely
- Compared to less than 2% of those unlikely to have a disorder

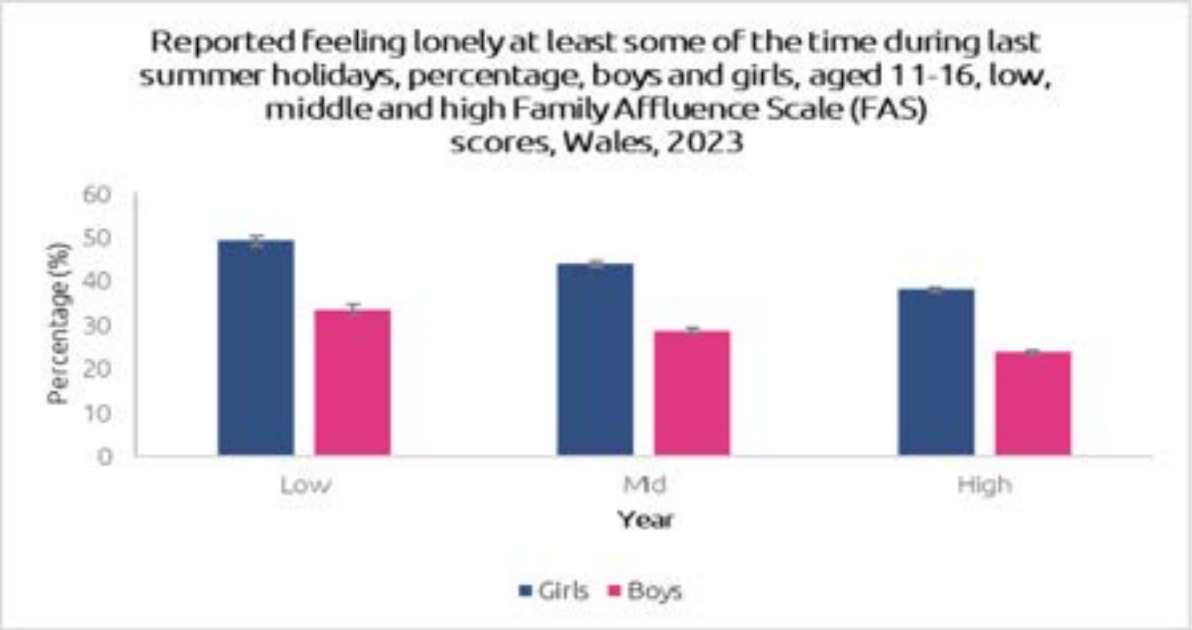

Figure 42. Percentage (%) of adolescents (11-16 years) in Wales reporting feeling lonely at least some of the time during the last summer holidays, 2023 (Source: publichealthwales.shinyapps.io/SHRN_Dashboard/)

6.1.4 Adverse childhood experiences

Adverse childhood experiences (ACEs) are traumatic events that occur during childhood and can include child maltreatment, parental substance use, living in insecure housing or home environments. There is a strong association between ACEs and poor mental health outcomes. Experiencing adversity at home can also increase the risk experiencing adversity in other settings. A survey of over 1,800 adults in Wales found a strong association between experiencing adversity at home and being bullied at school; half of adults who reported experiencing ACEs at home also experienced bullying at school, compared with 6% of those with no ACEs, further compounding the risk of poorer lifetime mental health outcomes.[82]

Living with someone with a serious mental illness, where that illness impacts on the quality of care provided, can also be considered an ACE. The proportion of young people receiving Local Authority care and support services due to parental mental illness has been increasing, highlighting the growing intergenerational burden of mental health difficulties (Figure 43).

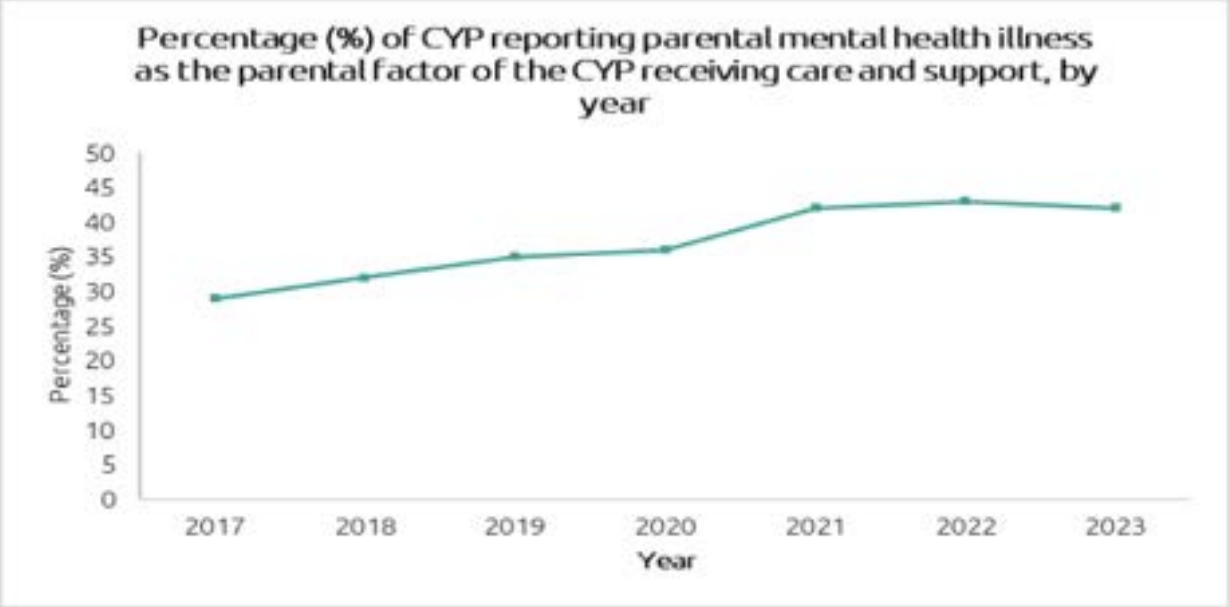

Figure 43. Percentage (%) of Young people in Wales reporting parental mental health illness as the parental factor of the child receiving care and support (Source: Mental health statistics: interactive dashboard | GOV.WALES)

A cohort study[83] found that experiencing childhood victimisation nearly doubled the odds of any mental health diagnosis by the age of 15. An increased risk of childhood mental health diagnoses was also found for children living with an adult with alcohol-related problems or hospital admissions.

6.1.5 Problematic social media use

Social media use can have both positive and negative impacts on young people and evidence is still emerging regarding what types of use are more or less harmful. A recent study found that young people who frequently share content and messaging are more likely to experience negative impacts on their mental health.[84]

Within SHRN, young people are asked 9 “yes” or “no” questions about their social media use and how it affects them and their relationships with others. If young people answer “yes” to 6 or more of the questions their social media use is classed as “problematic”.

In 2023 around 1 in 10 boys in Wales were classed as having problematic social media use throughout secondary school (Figure 44).[85] In contrast, rates among girls rose sharply with age: 12% of Year 7 girls were classified as problematic users in 2023, increasing to 21% by Year 10, with a notable 6% increase between Years 7 and 8.

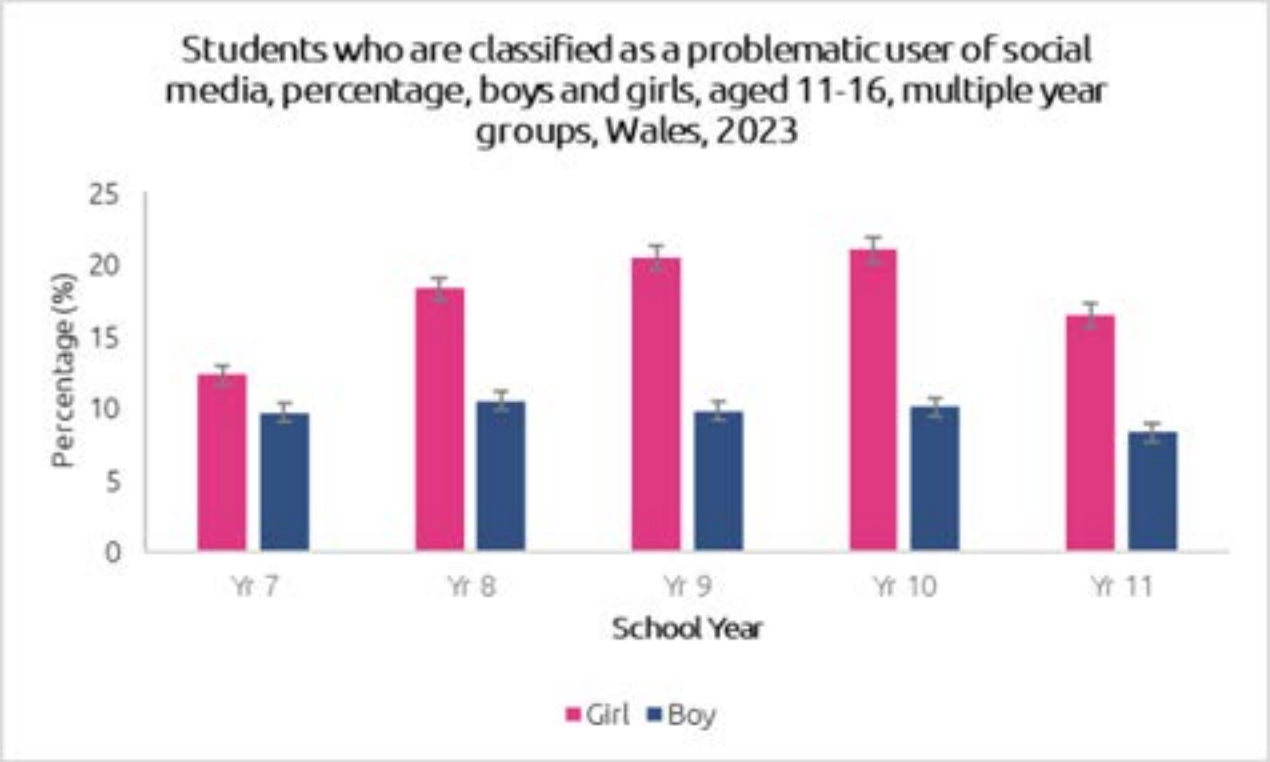

Figure 44. Adolescents (11-16 years) in Wales classified as a problematic user of social media, by gender and school year, 2023 (Source: publichealthwales.shinyapps.io/SHRN_Dashboard/)

6.1.6 Bullying

There is a strong causal relationship between bullying and poor mental health outcomes, including depression, anxiety, self-harm and suicidal thoughts and attempts. Bullying is also associated with an increased risk of engaging with damaging health behaviours such as smoking and substance misuse.[86] The negative impacts of bullying in childhood can last into adulthood. Increased rates of mental health conditions, poor social relationships, economic hardship and reduced quality of life evidenced have been evidenced among 50 year olds who were bullied in childhood.[87]

Bullying remains a significant concern for young people in Wales, with rates exceeding those reported in England. Recent data highlights a rise in both in-person and online bullying, particularly among non-binary young people (Figure 45).[88]

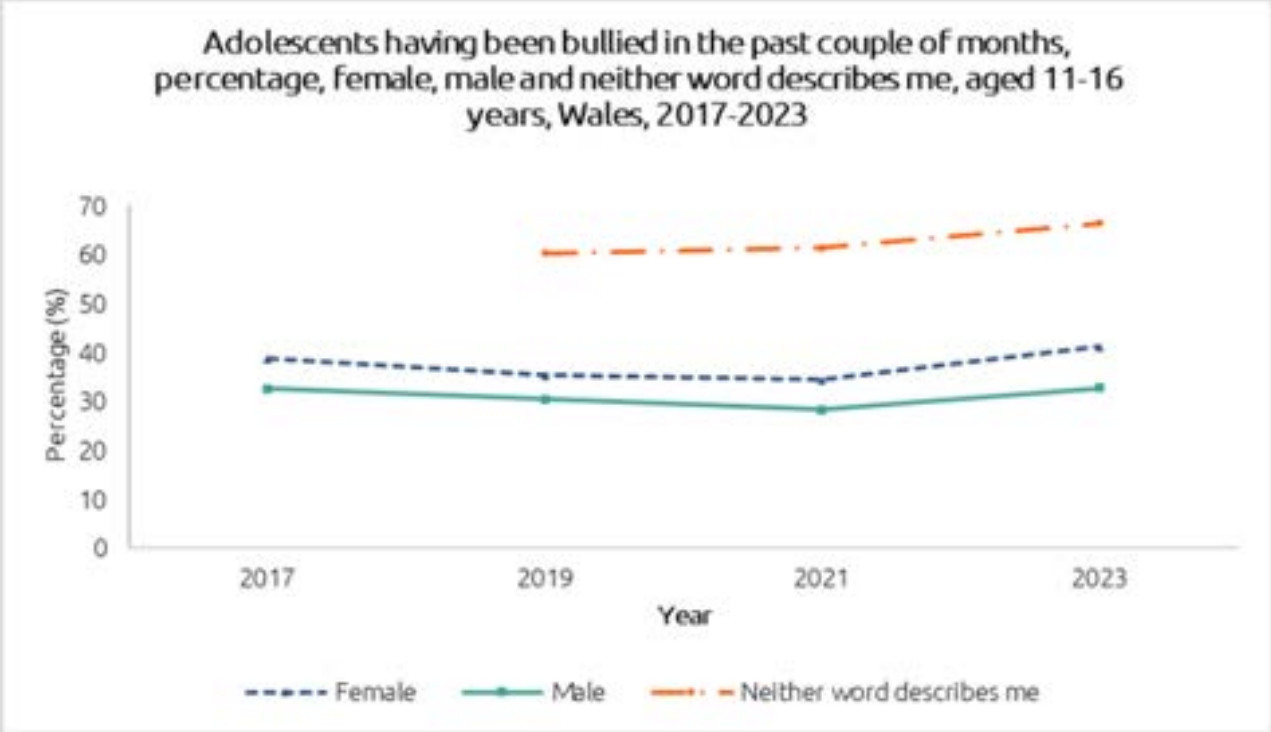

Figure 45. Adolescents having been bullied in the past couple of months, percentage, female, male and neither word describes me, aged 11-16 years, Wales, 2017-2023 (Source: publichealthwales.shinyapps.io/SHRN_Dashboard/)

6.1.7 In-person Bullying

6.1.7.1 Primary School learners

In 2024, 51% of primary school children reported experiencing bullying in the past couple of months, a rise of 5% from the previous year.[89]

- Bullying rates were slightly higher in girls (52%) than in boys (49%) in primary school
- Non-binary children reported the highest rates of bullying (71%) in the past couple of months
- Bullying peaked in Year 4 children (54%)

6.1.7.2 Secondary School learners

In 2023 in-person bullying was experienced by 38% of secondary school learners in Wales, compared with 16% in England.

- Bullying rates increased across all genders in Wales between 2021 and 2023
- Non-binary young people in Wales reported the highest rates: around two-thirds experienced bullying in the past two months
- Bullying peaked among Year 8 girls in Wales, rising 40% from Year 7; rates gradually declined in later school years for both girls and boys in Wales (Figure 46).
- Being bullied was highest among White (38%), mixed (39%) and other (38%) ethnic groups.

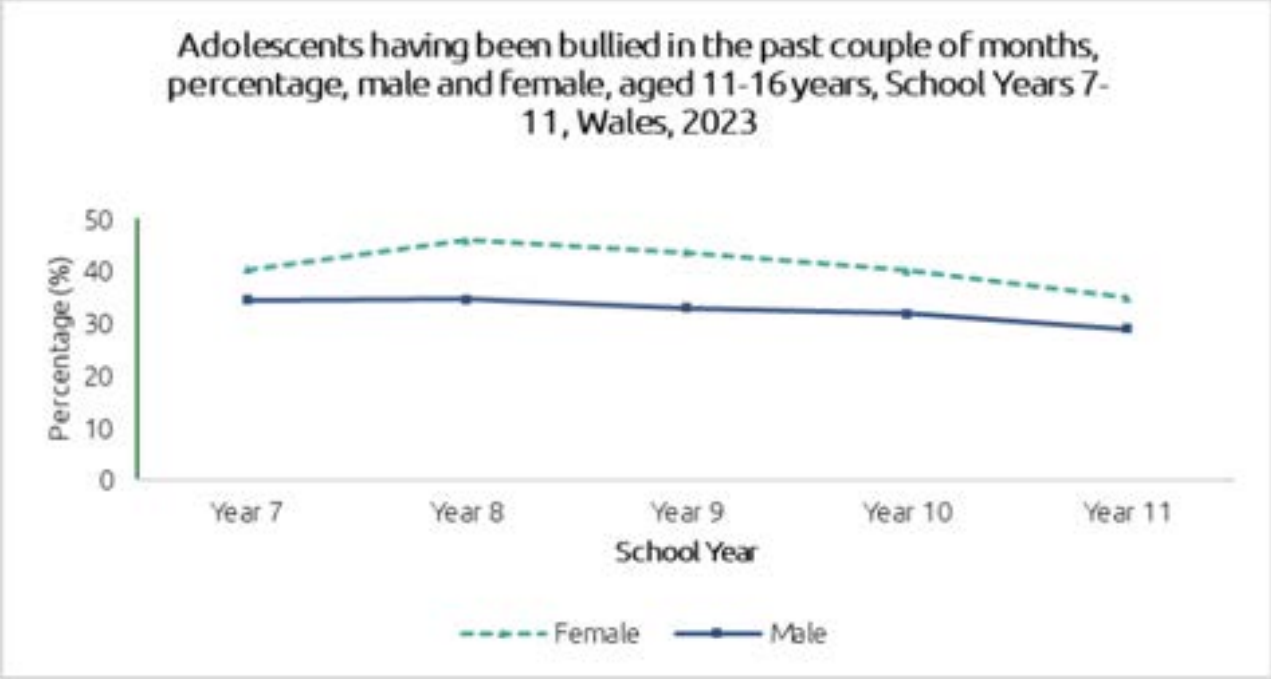

Figure 46. Adolescents having been bullied in the past couple of months, percentage, male and female, aged 11-16 years, School Years 7-11, Wales, 2023 (Source: publichealthwales.shinyapps.io/SHRN_Dashboard/)

6.1.8 Cyberbullying

6.1.8.1 Primary School Learners

- In 2024, 29% of Year 6 primary school learners experienced cyberbullying in the past two months.[90]

6.1.8.2 Secondary School Learners

- In 2023, 21% of secondary school learners in Wales experienced cyberbullying
- Cyberbullying was highest among girls in Year 8 at 26%[91]
- Around 1 in 4 girls in Years 8, 9, and 10 experienced cyberbullying in the past two months
- Being cyberbullied was highest among learners of mixed ethnicity (24%).
- 1 in 6 boys reported cyberbullying, with rates remaining relatively stable across year groups (Figure 47).

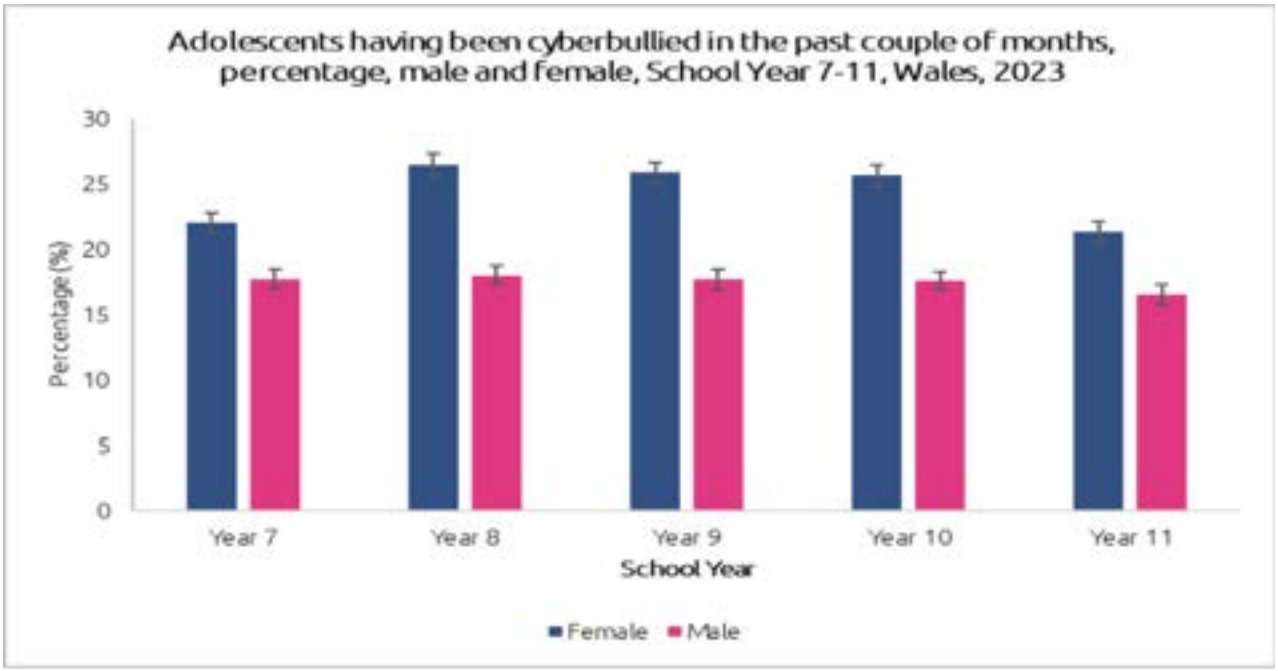

Figure 47. Adolescents having been cyberbullied in the past couple of months, percentage, male and female, School Year 7-11, Wales, 2023 (Source: publichealthwales.shinyapps.io/SHRN_Dashboard/)

6.1.9 Academic pressures

Pressures from school work can have negative impacts on young people's mental health. Evidence suggests increases in perceived school work pressures have contributed to increases in emotional difficulties, particularly among females over the last 15 years.[92]
Academic pressures rise through secondary school and affects girls more strongly than boys in Wales.

- By Year 11, over half of girls report feeling a lot of pressure from schoolwork, compared to 28% of boys—a 27% gender gap (Figure 48).

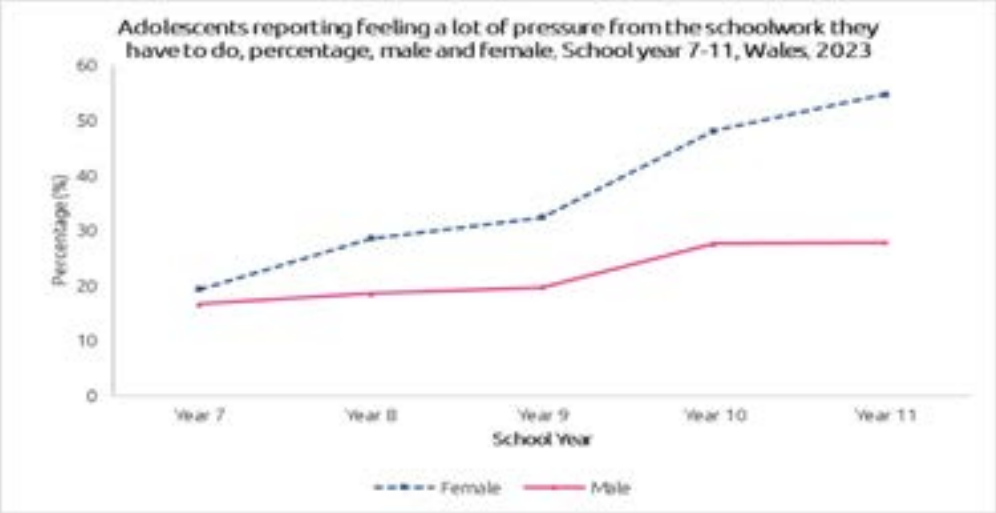

Figure 48. Percentage (%) of adolescents (11-16 years) in Wales reporting feeling a lot of pressure from the schoolwork they have to do, by School Year and gender (Source: publichealthwales.shinyapps.io/SHRN_Dashboard/)

6.1.9.1 Gender differences

- The rise in academic pressure has been sharper for girls, rising from 28% in 2017 to 36% in 2023
- The highest levels are reported by students who identify as neither girl nor boy, with 54% reporting they feel a lot of pressure from schoolwork in 2023 (Figure 49).

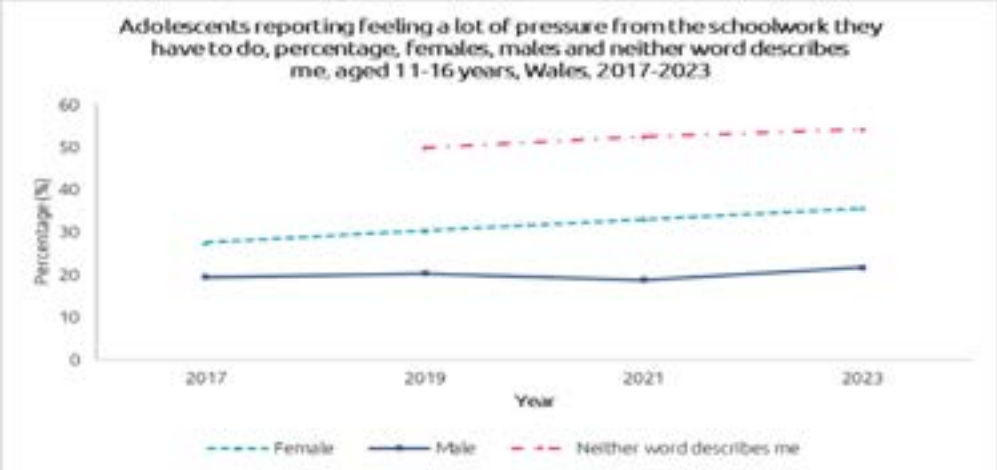

Figure 49. Percentage (%) of adolescents (11-16 years) in Wales reporting feeling a lot of pressure from the schoolwork they have to do, by gender and year (Source: publichealthwales.shinyapps.io/SHRN_Dashboard/)

6.1.10 Support from teachers and friends

Supportive relationships from trusted adults and peers are important protective factors for mental health and can help to mitigate against the risks of experiencing adversity. [93] In Wales, secondary school girls are less likely than boys to feel cared for by their teachers (Figure 50). This disparity is most pronounced in Years 8 and 9, where fewer than half of girls report feeling supported.

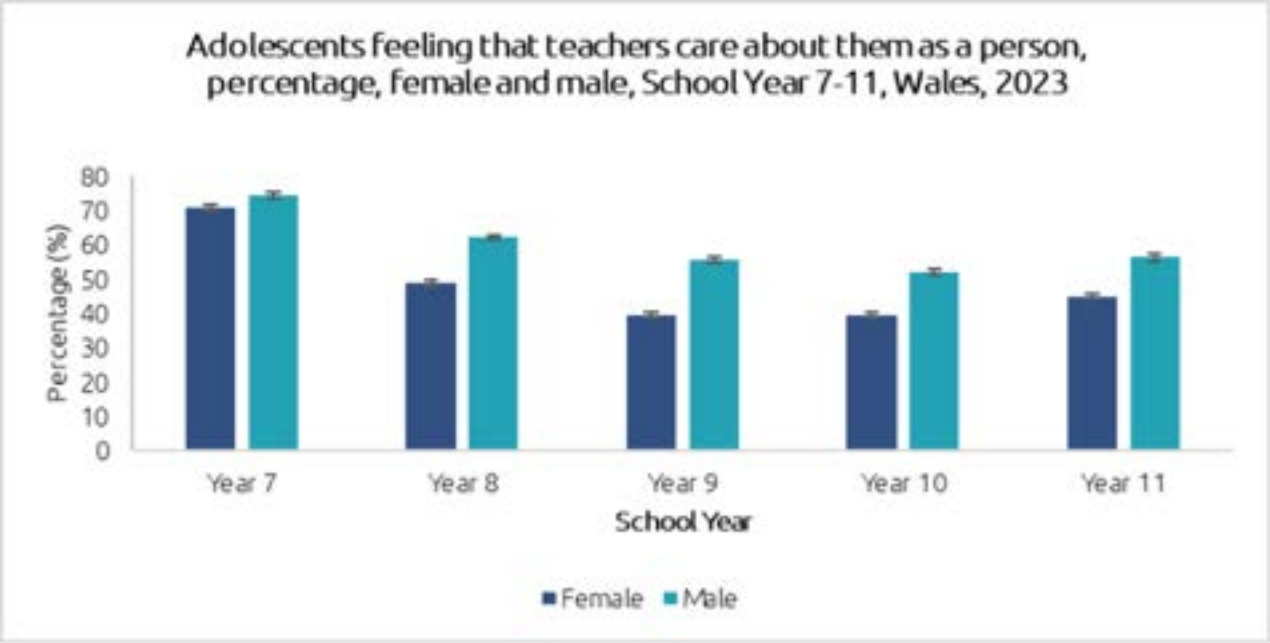

Figure 50. Percentage (%) of adolescents (11-16 years) in Wales reporting feeling that teachers care about them as a person, by gender and School Year (Source: publichealthwales.shinyapps.io/SHRN_Dashboard/)

Since 2017, fewer adolescents in Wales feel they can rely on friends when things go wrong (Figure 51). In 2023 over a third of boys and girls report lacking support from friends, rising to 56% among those who identify as neither girl nor boy.

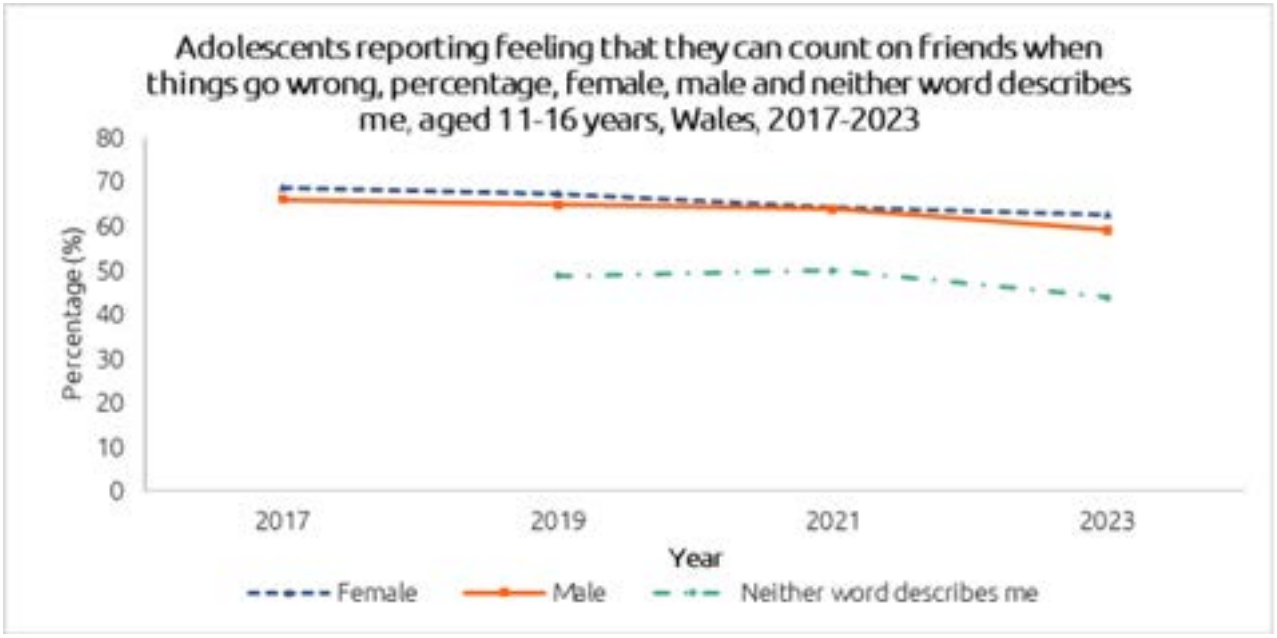

Figure 51. Percentage (%) of adolescents reporting feeling that they can count on friends when things go wrong, percentage, by gender, aged 11-16 years, Wales, 2017-2023 (Source: publichealthwales.shinyapps.io/SHRN_Dashboard/)

6.1.11 Exercise and physical activity

Increasing levels of physical activity among children and young people has been shown to have a positive effect on mental health outcomes, particularly in reducing symptoms of depression.94 However experiencing symptoms of depression and anxiety can also be a barrier to increasing exercise or physical activity levels.[95]

6.1.11.1 Primary School learners

In Wales, the most recent population-level data[96] shows:

- Around half of learners (49%) reported exercising in their free time (so much that they get out of breath and sweat) five times or more a week
- Learners in Year 3 were less likely than other year groups to report exercising five times or more a week (44%)
- Girls (46%) were less likely to exercise five times or more a week compared to boys (52%)
- There is a clear social gradient, with learners from more affluent families (64%) more likely to exercise five or more times a week than those from the least affluent families (42%).

6.1.11.2 Secondary School learners

In Wales, daily physical activity in adolescents shows a clear gender gap:[97]

- 1 in 4 boys are active daily, compared to just 14% of girls—similar to levels in 2017, following a dip during the pandemic
- Activity levels decline with age: by Year 11, fewer than 10% of girls and only 1 in 5 boys are active daily (Figure 52).

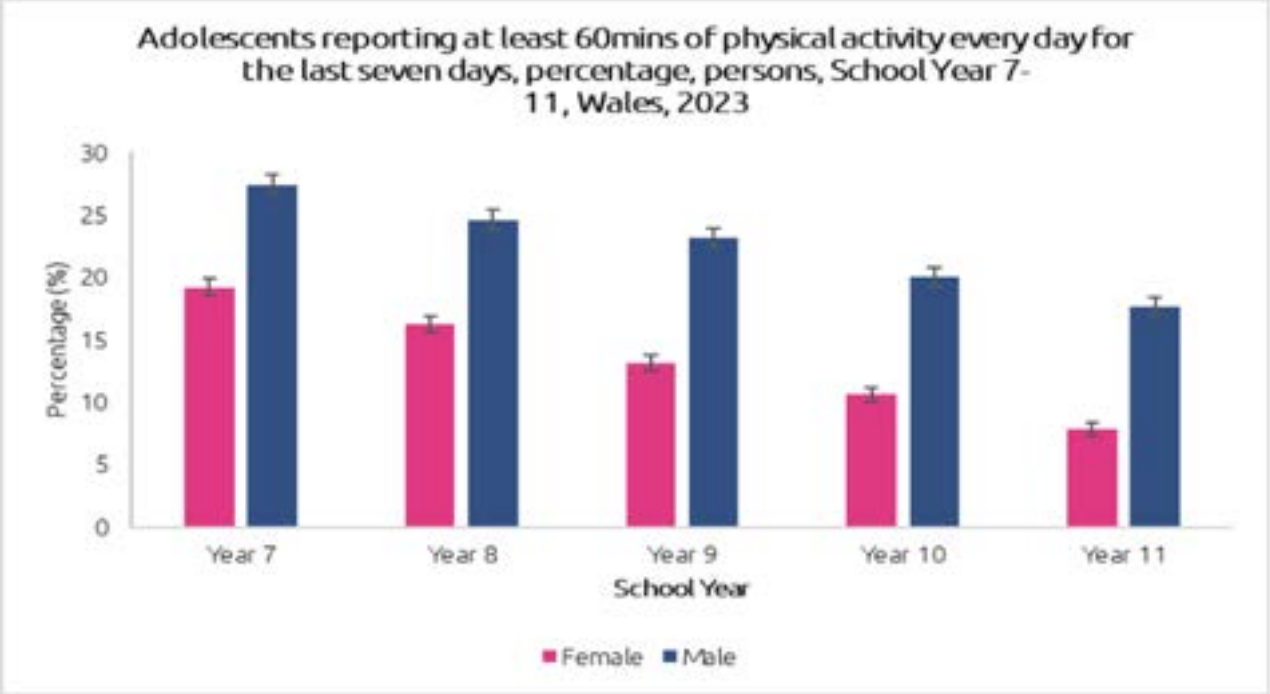

Figure 52. Percentage (%) of adolescents reporting at least 60 mins of physical activity every day for the last seven days, percentage, persons, School Year 7-11, Wales, 2023 (Source: publichealthwales.shinyapps.io/SHRN_Dashboard/)

Data from England[98] shows compared to those without a mental health conditions, adolescents with a probable mental health disorder are:

- More likely to do no exercise
- Less likely to spend time in outdoor green spaces (Figure 53).

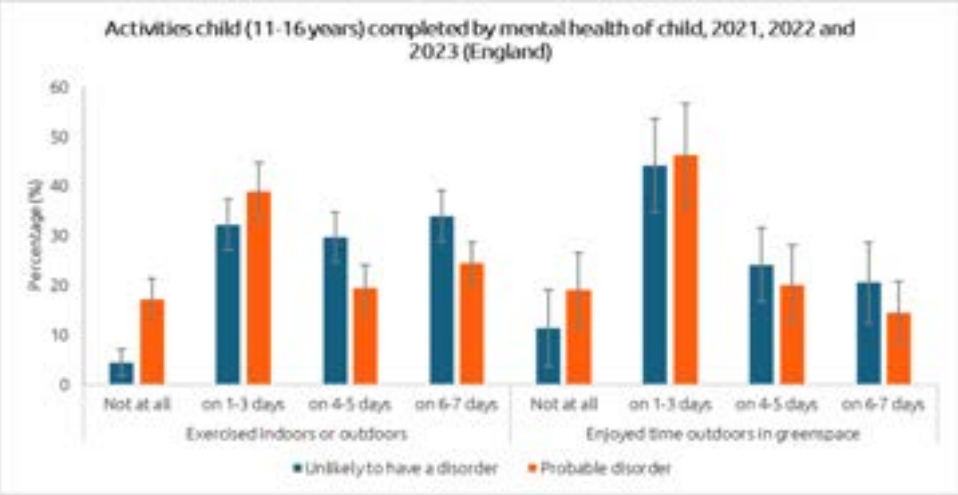

Figure 53. Activities children (11-16 years) completed by mental health of child, 2023, England (Source: Mental Health of Children and Young People Surveys - NHS England Digital)

6.1.12 Body image

More adolescents now see themselves as "too fat," regardless of gender.[99]

- By age 15, 50% of girls (Figure 54) and nearly 30% of boys (Figure 55) in Wales hold this belief
- Rates are higher among adolescents from less affluent families compared to those from more affluent families.

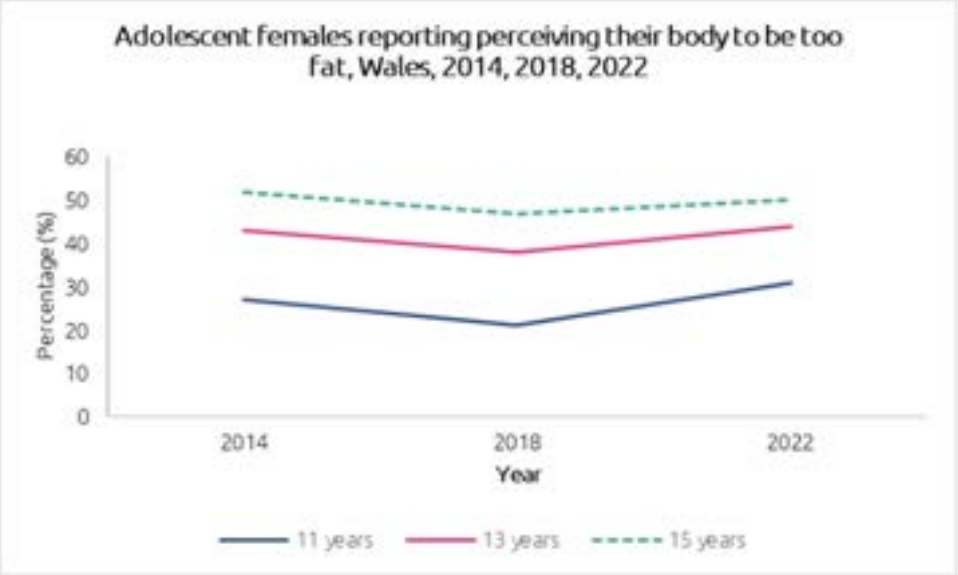

Figure 54. Percentage (%) of adolescent females in Wales reporting their body to be too fat, 2014, 2018, 2022 (Source: Body image - HBSC)

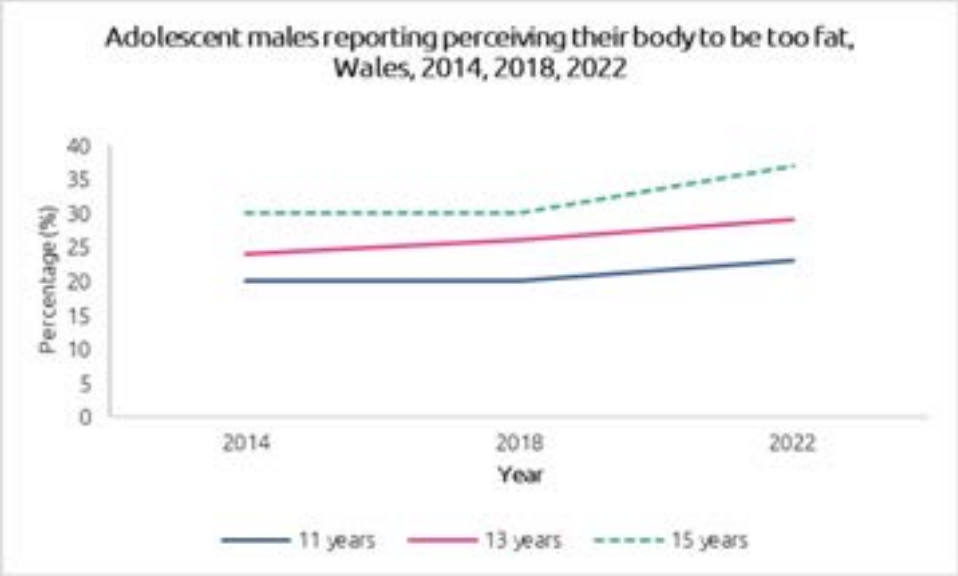

Figure 55. Percentage (%) of adolescent males in Wales reporting their body to be too fat, 2014, 2018, 2022 (Source: Body image - HBSC)

6.1.13 Climate Anxiety

Systematic review evidence highlights a significant relationship between concerns about climate change and a range of mental health outcomes in young people, particularly depression, stress, and state-anxiety. While comprehensive data specific to Wales is limited, UK-wide research provides valuable context for understanding climate anxiety among young people.[100] A UK survey[101] found that 50% of young people felt extremely or very worried about climate change, and 28% said it affected their daily lives. Many young people report feeling powerless due to their limited ability to influence decisions, for example, not being able to vote, make household choices, or participate meaningfully in decision-making. They also frequently describe feeling dismissed when raising climate concerns and believe that authorities are not taking enough action.[102]

In its 2023 report, "A Health Impact Assessment of Climate Change in Wales",[103] BCYP were identified as a population group likely to bear disproportionate adverse effects of climate change. Insight gathered from young people highlighted several local-community risks that concern them when considering how climate change might affect their region. These include:

Access to clean water
• Availability of food
• Caring for vulnerable people
• Damage to homes
• Stability of the power supply
• Ensuring future-proof jobs
• Deforestation
• Inability of people on low incomes to respond effectively.

The assessment also points to the potential for adverse impacts on ACEs, noting that secondary stressors, such as parental anxiety or financial strain following flooding or other climate-related events may place further pressure on families and BCYP.

The National Survey for Wales (2021/22)[104] found that:
• 98% of 16–24-year-olds believe the world's climate is changing
• 79% are fairly or very concerned about climate change — an increase from 65% in 2016/17.

Data from the WISERD Multi-Cohort Study in Wales (2022)[105] revealed:
• 69% of secondary school pupils are at least somewhat worried about climate change
• Girls and older children report higher levels of concern
• 56% feel it is very urgent to act on climate change, with another 37% saying it is quite urgent
• Over 75% believe that everyone has a role to play in protecting the environment.

A Save the Children UK survey (2022)[106] of 12–18-year-olds reported:
- 75% want stronger government action on climate and inequality
- 70% are worried about the world they will inherit
- 60% believe climate change and inequality are affecting their generation's mental health
- 56% feel these issues are contributing to a global decline in child mental health.

The socio-economic status (SES) of young people is also shown to relate to their experiences of climate anxiety, climate knowledge, engagement with pro-environmental behaviour. Young people from lower SES backgrounds demonstrated less worry towards, and emotional engagement in, the climate crisis.[107]

6.1.14 Substance misuse

Illicit drug use and alcohol use have negative impacts on mental health and wellbeing. Whilst the immediate effects of use may provide temporary relief from stress or other mental health problems the long-term impacts are detrimental. Long-term use can increase the risk of conditions such as anxiety, depression and psychosis.[108]
In England (2022–23), 12,418 under-18s accessed alcohol and drug services—a 10% increase from the previous year, but 13% lower than in 2019–20.[109]

- Cannabis was the most common substance (87%), followed by alcohol (44%), powder cocaine (9%), and ecstasy (7%)
- 48% of young people starting treatment reported a mental health need, up from 32% in 2018–19
- Girls were more likely to report this than boys (65% vs. 39%).

In Wales, the health burden of illicit drug and alcohol use appears to be declining:

- Alcohol-related hospital admissions among under 25 year olds have shown a declining trend and fell by 35% in 2022–23 compared to the previous year[110] (Figure 56)
- In 2023/24 among young people aged under 25, there were 631 admissions for conditions related to illicit drugs, a decrease of 8.6 % from 2022/23.

Whilst hospital admissions due to drug and alcohol use have been declining substance misuse continues to present a significant social burden.

- As of March 2022, 630 children (4% of those receiving care and support) were identified as having substance misuse problems
- In 2021–22, there were 869 school exclusions related to alcohol or drugs—a 119% increase from 2020–21 and 17% higher than in 2018–19; this marks the highest number of exclusions since 2011–12.

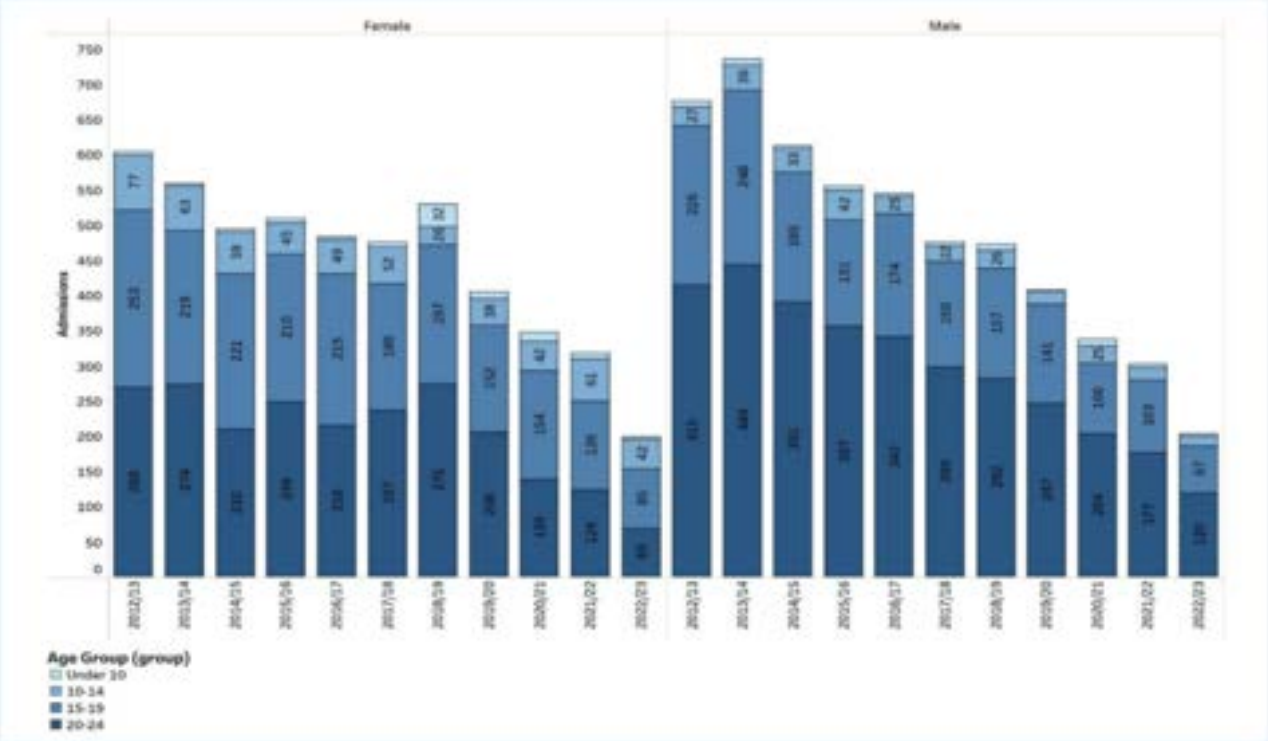

Figure 56. Hospital admissions of Wales residents aged under 25 years for an alcohol-specific condition, by year and sex 2012-13 to 2022-23 (Source: Substance Misuse Programme, Digital Health and Care Wales, 2024)

6.1.15 Social care

Care-experienced BCYP in the UK face the highest mental health needs and poorest outcomes:

- Attempted suicide rates are over 4 times higher than among non-care experienced peers (3.6% compared with 0.8% respectively)[111]
- 46% of children in residential care settings show signs of a probable mental health disorder
- Externalising problems (49%) are more common than internalising issues, including conduct disorders and emotional difficulties.[112]

Mental health difficulties among BCYP receiving Local Authority care and support services remain high (Figure 57). Among children aged 10 and over, the prevalence of reported mental health problems has increased from 13% in 2017 to 18% in 2023.

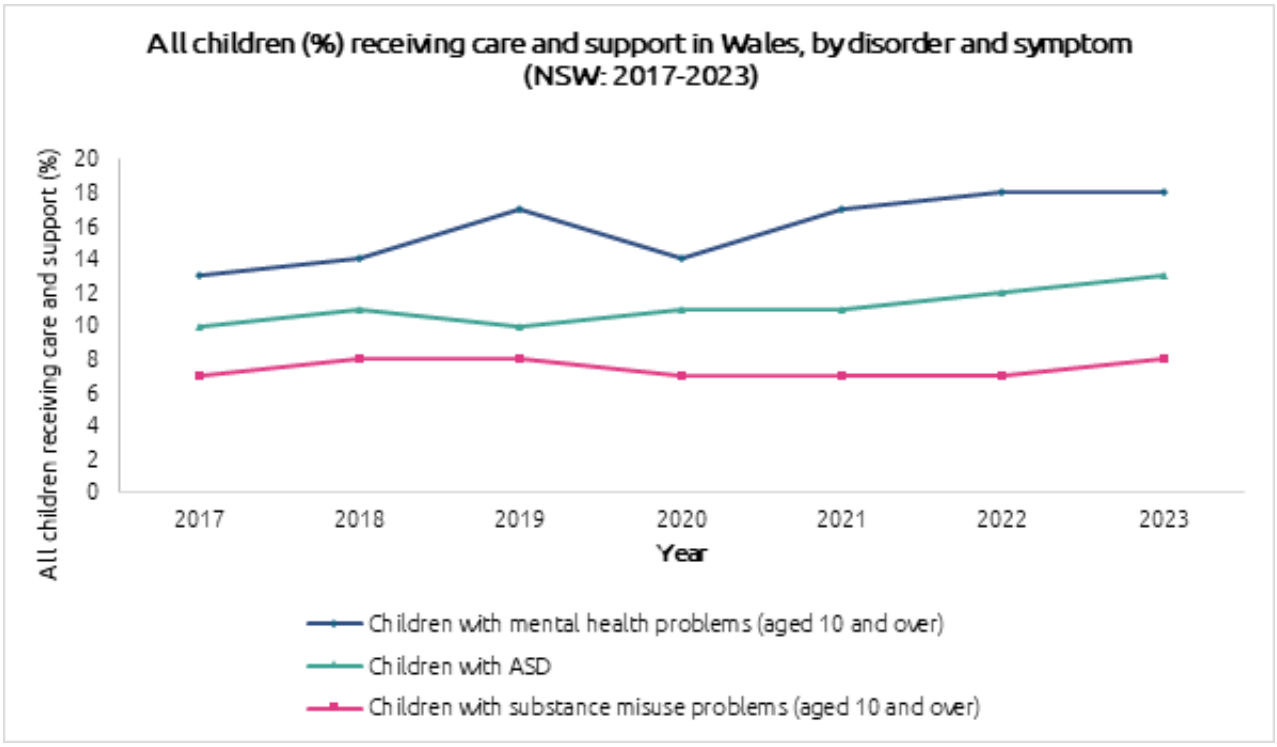

Figure 57. Percentage (%) of all children (aged 10 and over) receiving care and support in Wales (2017-2023), by disorder and symptom (Source: Children Receiving Care and Support Census, 2017-2023, StatsWales)

- Among children on the child protection register, mental health problems rose from 14% (2017) to 20% (2023)
- Rates of recorded ASD in this group doubled from 2% to 4%
- Around half of young people in care have experienced abuse or neglect
- Reports of family dysfunction or acute stress among those receiving care and support increased from 22.7% to 29.2% between 2017 and 2023.

6.1.16 Local authority expenditure

Research suggests that funding reductions for public services seen over the last 15 years, particularly in youth service funding, may be associated to worsening mental health among BCYP[113] (Figure 59). These reductions haven't impacted all communities equally; with the impact influenced by existing conditions such as transport infrastructure. However, the overall effect appears to have been a widening of inequalities and reduced access to the early support that protects mental wellbeing.

During 2017–2018 alone reductions to local government funding across the UK led to the closure of 760 youth centres, the loss of 4,500 youth work posts, and the disappearance of 139,000 youth service places. At least 35,000 hours of outreach work were also lost across the UK—eroding a vital layer of support for young people.[114]

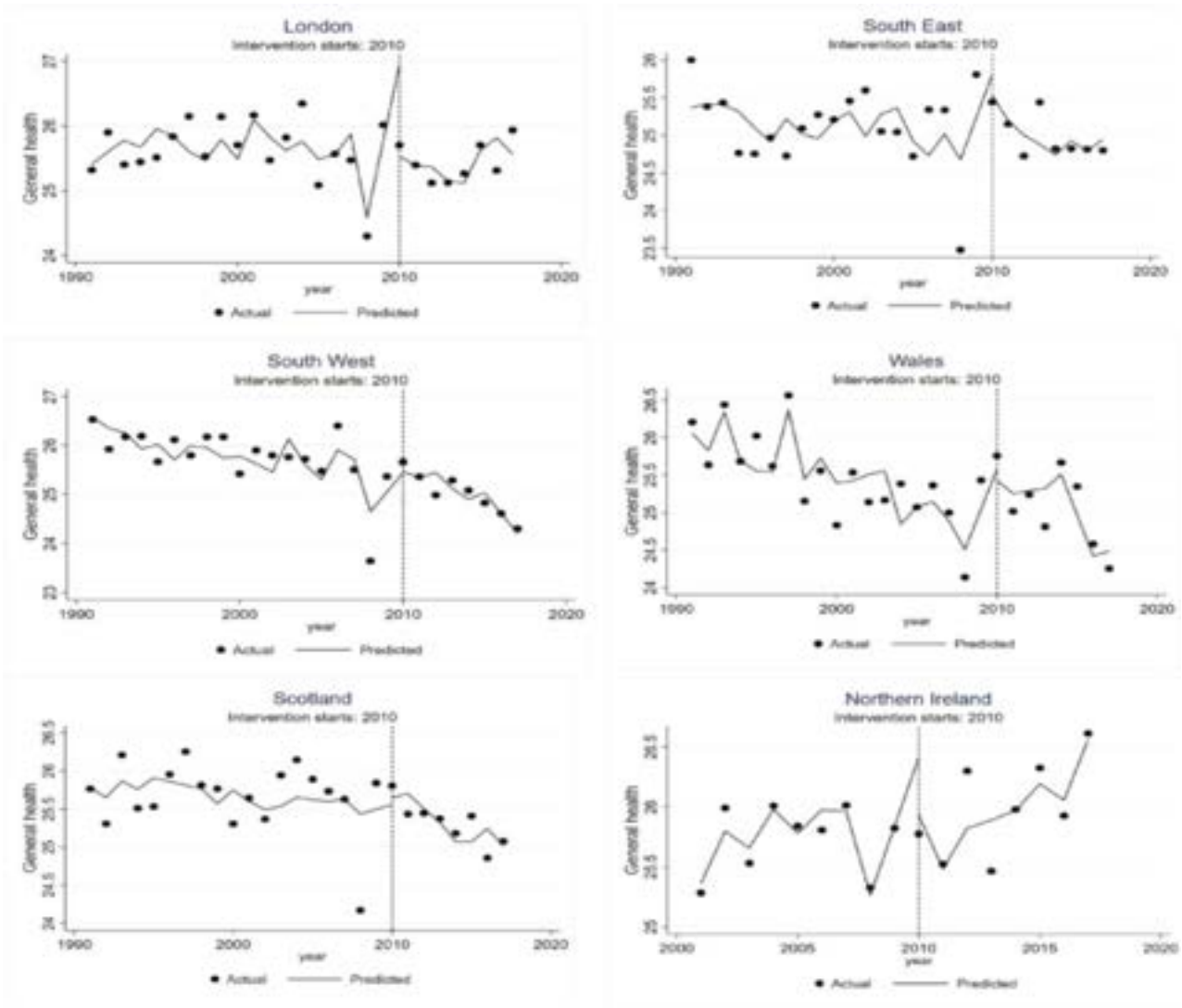

Figure 58. ITS Analysis showing trends in young people mental health over time and how these trends have changed since the introduction of austerity measures in 2010 (Source: https://doi.org/10.1016/j.socscimed.2024.117068)

6.2 Protective factors

The Department of Health and Social Care (DHSC) present approaches that can be implemented at an individual, community and societal level to protect and promote BCYP mental health and wellbeing[115] (Figure 55).

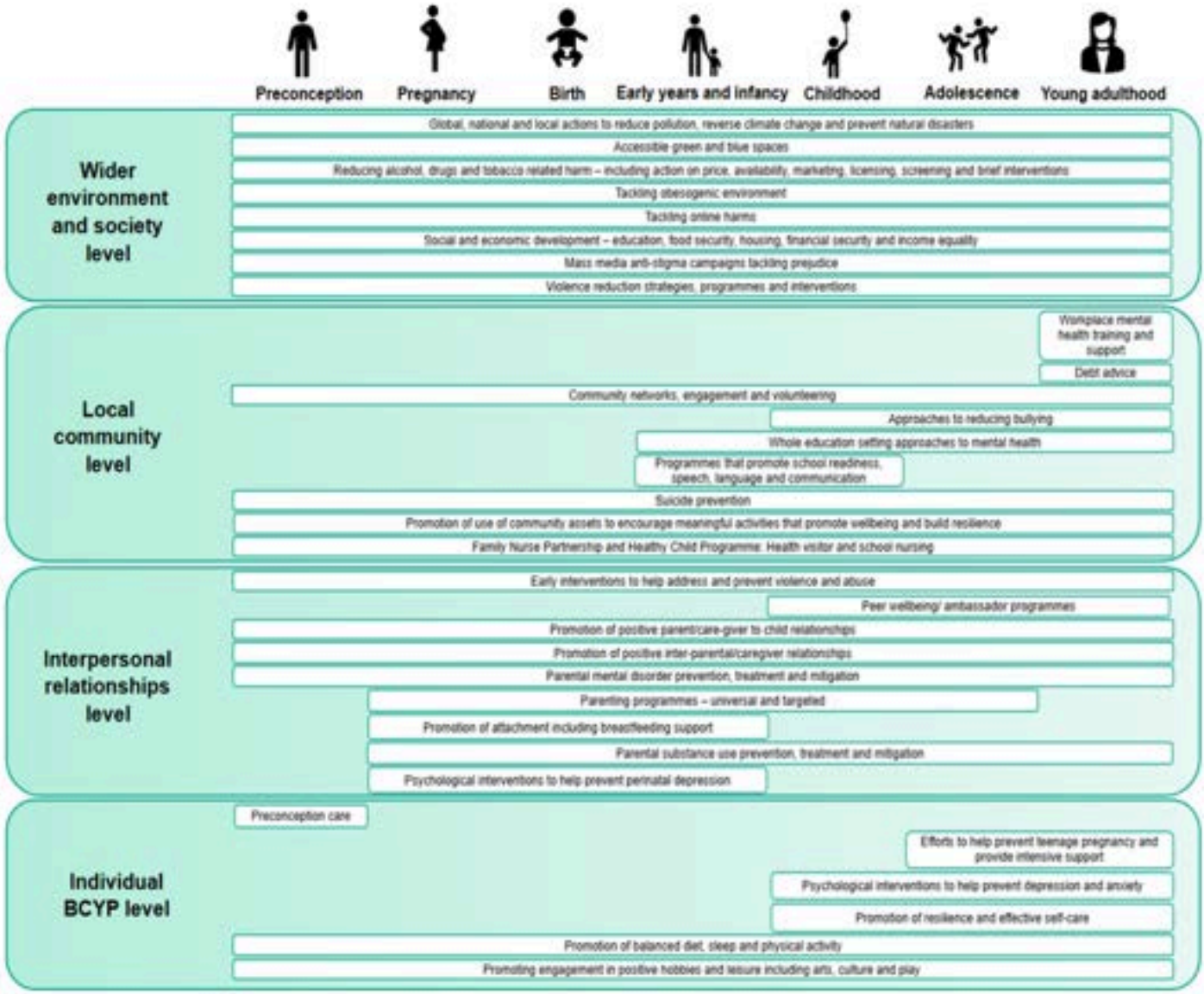

Figure 59. Examples of approaches for BCYP mental health promotion and prevention (Source: Improving the mental health of babies, children and young people - GOV.UK)

6.2.1 Individual level

Consistent evidence highlights the protective effect of good physical health on the mental health of BCYP. Key factors include a balanced, nutrient-rich diet, regular high-quality sleep, and frequent physical activity. For example, young people who engage in physical activity at least three times a week consistently report better mental health across multiple domains.[116] Similarly, data from MHCYP England (2022)[117] show that those with stronger emotional recognition and regulation skills experience significantly fewer mental health difficulties. Body confidence and a secure sense of identity are especially important—particularly for young women and LGBTQ+ young people. Notably, young people with low self-esteem are ten times more likely to report poor mental health.[118]

6.2.2 Interpersonal

Positive Childhood Experiences (PCEs)—such as supportive relationships, stable routines, community connection, trusting friendships, and consistent nurturing by adult figures (e.g., teachers)—play a key role in emotional and social development. In infancy, breastfeeding and responsive care help lay these foundations by fostering maternal sensitivity, attachment, and early emotional regulation.[119]

Across childhood and adolescence, higher levels of PCEs consistently predict better mental health in adulthood, including lower rates of depression, anxiety, and PTSD. Importantly, PCEs can occur alongside adversity and help buffer its impact on mental health outcomes.[120] For high risk BCYP, evidence suggests that child, family, social and lifestyle factors, such as co-parent emotional support and quality of social relationships, contribute to increased resilience.[121]

6.2.3 Community level

Community-level factors play a vital role in helping BCYP build resilience, reduce isolation, and navigate adversity. Access to arts, sports, volunteering, and cultural activities—as well as trusted adults in the community, such as youth workers, sports coaches, and mentors can be especially valuable for BCYP who lack consistent support at home.

In Wales, schools actively promote safety, inclusion, and belonging, supported by clear and enforced anti-bullying and equalities policies. These efforts align with the Welsh Governments Whole School Approach to Emotional and Mental Wellbeing Framework, ensuring that every child feels seen, supported, and safe.

Access to social prescribing initiatives can empower individuals to better manage their health by recognising their own needs and signposting them to opportunities for connection within their community.[122] There is concern that there has been an over-medicalisation of mental health, over 80% of GPs in the UK believe that a medical response (prescribed medications) is being provided when more effective, non-pharmacological alternatives exist.[123]

Whilst the National Framework for Social Prescribing[124] does not explicitly set out the role of social prescribing for BCYP within its objectives, it does recognise that a life course approach is appropriate in social prescribing, with opportunities to expand its use with people under 18 in Wales. Projects within Wales, such as Arts Boost in Hywel Dda University Health Board, and 'Community Connections' in Cardiff and Vale University Health Board, have already been launched to support young people facing mental health and wellbeing challenges.

Research from Barnardo's shows positive outcomes for young people participating in their LINK Cumbria social prescribing service and suggests a benefit to the Government and wider economy of around £1.80 for every £1 invested.[125]

A recent study in Wales found reaching 5% of children and young people on NHS mental health pathways through arts and health initiatives could generate £9.5million in mental health and wellbeing benefits per year.[126]

Volunteering with The Wildlife Trusts' conservation programme significantly boosted mental wellbeing, generating a social return of £6.88 for every £1 invested among people with low mental wellbeing; a greater social return of £8.50 per £1 was seen among those with average to high wellbeing.[127]

Integrating social prescribing into support pathways improves mental health and wellbeing while reducing pressure on primary care. The Open Data Institute estimates that a national rollout in England, reducing GP appointments by just 2.5–3%, could save up to 3 million appointments annually.

This model empowers young people,[128] and their families to choose support that suits their needs, often through community-based options. In turn, it fosters community cohesion and helps address inequalities linked to socioeconomic disadvantage.

6.2.4 Societal level

At the societal level, protective factors that support the mental health of BCYP are shaped by the wider systems, policies, and strategies that influence their environment. These factors stem not only from initiatives directly targeting mental health, but also from broader efforts addressing known determinants of mental wellbeing. In Wales, examples include:

- The Mental Health and Wellbeing Strategy 2025–2035: This long-term strategy[129] puts prevention, accessibility, and equity at the heart of mental health support across the lifespan. It takes a whole-system approach, acting on the wider determinants of mental health and wellbeing—such as ensuring access to comfortable homes, safe communities, and secure employment. The strategy also places a strong emphasis on tackling inequalities by empowering individuals with the knowledge, opportunities, and confidence to foster good mental health. When support is needed, it is designed to be person-centred and delivered without delay.

- Well-being of Future Generations (Wales) Act 2015; This landmark legislation[130] establishes seven national well-being goals, each closely linked to mental health—such as creating a healthier Wales, a more equal Wales, and cohesive communities. It compels public bodies to make long-term, integrated decisions that consider the future mental health of today's BCYP. The Act also provides a foundation for wider national strategies that directly impact BCYP mental health, including the Mental Health and Wellbeing Strategy (2025–35) and the Whole School Approach to Emotional and Mental Wellbeing.

- All-Wales Social Prescribing Framework; Although the framework[131] does not explicitly address social prescribing for BCYP, it is designed to reduce social isolation and strengthen community connections. The framework provides a structured approach for how non-clinical support, such as community activities, advice services, and peer support can be integrated into health and care systems to improve mental wellbeing. By fostering these links, the framework helps connect BCYP with local assets that support and enhance mental wellbeing.

- Child Poverty Strategy for Wales; The Child Poverty Strategy for Wales 2024[132] outlines Welsh Government actions to reduce child poverty and support children's wellbeing and potential. It focuses on reducing costs, maximising incomes, creating pathways out of poverty, and promoting wellbeing, while encouraging collaboration across national, regional, and local levels. The strategy includes a monitoring framework to track progress and ensure policies effectively improve equity and outcomes for BCYP.

- Digital Resilience in Education Action Plan; Wales's Digital Resilience in Education Action Plan[133] outlines workstreams to support children, families, and schools in navigating the online world safely, including support around cyber hygiene, misinformation, online sexual harassment, and digital safeguarding for all schools via the Hwb platform.

- Healthy Weight Healthy Wales; Wales' national strategy[134] (2019, updated 2023) is centred around four core themes that are indirectly linked to BCYP mental health through a whole-system approach. The core themes aim to empower families with knowledge, motivation, and support to adopt healthy behaviours, embed healthy behaviours in settings such as schools, make healthy choices easier in the communities where BCYP grow up and ensure accountability of these themes at a local and national level.

- Nest Framework; The NEST Framework (Nurturing, Empowering, Safe, and Trusted) [135] provides a whole-system, trauma-informed approach to supporting the mental health and wellbeing of BCYP and families in Wales. NEST shifts the focus from accessing traditional "tiers" of mental health services to creating a "no wrong door" system where every interaction with a child or family is therapeutic and supportive. The framework promotes early intervention, co-production, and collaboration across sectors (including education, health, social care, and the third sector) to ensure that children and young people receive help when and where they need it. Central to NEST is the idea that all services and settings should provide nurturing environments, empower children and families to take part in decision-making, and build safe, trusting relationships. The framework is being implemented across Wales as part of regional partnership working.

- *Trauma-informed Wales*; The framework[136] provides a national approach for services and organisations to recognise and respond to the impact of trauma on BCYP and families. Developed by Public Health Wales and the Welsh ACE Hub, it emphasises safety, trust, choice, collaboration, and empowerment, aiming to reduce re-traumatisation and promote resilience. The framework supports workforce development and organisational change to create environments that are predictable, supportive, and healing-oriented, ensuring every contact contributes to a trauma-informed system. It complements initiatives like NEST and the Whole System Approach to mental health and emotional wellbeing in Wales.

- The *Whole School Approach for Emotional and Mental Wellbeing Framework* in Wales provides guidance to enable schools to create environments and cultures that protect and promote mental wellbeing and improve access to support when needed. The majority of Local Authority maintained schools, pupil referral units and special schools in Wales are working to embed the framework and continually-improve their approach with support from the Welsh Network of Health and Wellbeing Promoting Schools.

6.3 Risk and Protective Factors: Summary

- Systematic action is required to address the range of risk and protective factors for mental health and wellbeing; addressing child poverty must continue to be a priority.
- Schools can take action to address bullying, schoolwork pressure and access to early support.
- Action to address body image, sleep, physical activity levels, opportunities to build friendships and access to trusted adults is likely to improve outcomes.
- Health behaviours, engagement with meaningful activities, and connections with community assets improve resilience and should be promoted during service contact points.
- BCYP need to be protected from harms, be provided with opportunities to play, develop social and emotional skills and to grow in environments which support healthy behaviours.
- Action to improve infant and care-giver relationships, parenting support, social and emotional learning during childhood.

- Non-pharmacological approaches, including social prescribing, promoting nature-connection and arts-based programmes should be extended and evaluated for BCYP, both in early intervention and recovery pathways.
- National policies to address the determinants of mental health and wellbeing need continued focus in order to reduce inequalities in mental health outcomes.

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Vulnerable Groups

Health Needs Assessment:
Mental Health of Babies, Children and Young People in Wales

The mental health of BCYP is shaped by multiple risk factors, and the more they are exposed to, the greater the potential impact.[137] Identifying which groups are most vulnerable is crucial for targeted prevention, early intervention, and effective service planning.

7.1.Priority population groups

The table below summarises key 'at-risk' populations based on UK and Welsh data, highlighting associated risk factors to guide where support should be focused.

Vulnerable group	Risk factors	Evidence	Identified need or demand: Wales
Babies	Biological/Neurological Premature birth Complications during pregnancy Social/Environmental Living in poverty or experiencing housing instability. Exposure to unsafe environments Limited access to early childhood services, healthcare, or supportive social networks Family/systemic Parents with mental health difficulties Parents with previous involvement with children's services or history of neglect/abuse Domestic violence Parental ACEs or unresolved relational trauma affecting caregiving Identity/personal factors Early attachment difficulties due to inconsistent caregiving or neglect. Disrupted bonding experiences	Meta-analysis data (1999) estimates that around 15% of babies in the general population show disorganised attachment[138] Health board data in Wales indicate that 20% of babies require specialist parent-infant intervention[139] A UK-wide cohort found that almost 1 in 4 children (~23.2 %) were exposed to maternal mental illness by age 16[140] Between 10-25% of young children experience significant difficulties in the relationship with their main caregiver(s)[141] The proportion of adults reporting both having been bullied and having lower school belonging increased with ACE count (0 ACEs 6%, 4 + ACEs 51%)[142]	Approximately 116,617 babies (0-3 years) in Wales in 2024[143] In Wales, congenital anomalies in babies are recorded at about 4.8 % of all births1[44] In Wales, 34.5 % of mothers and 18 % of fathers (or father figures) had a diagnosis of depression in a study of children born 1987-2018[145] For children receiving care & support) in Wales, parental mental ill-health is recorded as a factor in 42 % of such children[146]

Neurodiverse children	Biological/Neurological Emotional regulation difficulties Executive function challenges Social/Environmental Lower educational attainment Bullying Diagnostic delay Increased interaction with criminal justice system Family/systemic Parental stress Service access barriers Identity/personal factors Lower self-esteem Co-occurring conditions	In ASD, prevalence of depression is estimated to be five times that seen in typically developing young people[147] 71% of children with ASD found to have at least one current psychiatric disorder[148]	16,812 young people waiting for an ADHD or ASD neurodevelopmental assessment (2023) An academic study (2023), found prevalence of ADHD diagnosis by aged 18 to be 1.4%, and ASD diagnosis to be 0.9%[149]
Children with ACEs	Biological/neurological Disrupted brain development Chronic stress response Heightened physiological reactivity Social/environmental Unstable/disrupted living conditions Poverty Social exclusion School exclusion Bullying Learning difficulties Family/systemic Parental mental illness Parental substance abuse Family incarceration Neglect Identity/personal factors Low self-esteem Emotional dysregulation Increased risk of self-harm/suicide	Experiencing two or more ACEs is, on average, linked with over three times higher risk of having high symptoms of depression or anxiety throughout adulthood[150] Conditional increased risk of any child mental health diagnosis, associated with victimisation (90% heightened risk), and living with an adult with a common mental health diagnosis (63% heightened risk) [151] Odds of adult mental illness nearly 4 times higher in those with 4+ ACEs in childhood[152]	For every 100 adults in Wales, 47 suffered at least one ACE during their childhood and 14 suffered 4 or more[153]

Young carers	Biological/neurological Sleep deprivation Chronic stress response Social/environmental Social isolation Stigma Increased responsibilities Educational absenteeism Lower educational attainment Family/systemic Family illness/disability Lack of support Lack of visibility to services Identity/personal factors High responsibility Suppressed emotional expression	Anxiety and depression 1.47 times more likely in woman caring for one hour or less per day and 2.47 times in those caring for 2h compared with women not providing care[154] Odds of depression 1.71 increased in men providing up to one hour of care a day and 2.38 increased in those caring for more than two hours as compared to non-carers[155]	Approximately 22,550 young carers and young adult carers under the age of 25 in Wales (2021)[156] Approximately 8,230 young carers aged 5 to 17 in Wales[157]
Gypsy, Roma and travellers	Biological/neurological Social/environmental Poor school attendance School exclusion Housing insecurity Discrimination and racism Cultural marginalisation Family/systemic Intergenerational trauma Poor engagement with health services Lack of culturally competent services High poverty Identity/personal factors Low self-efficacy Internalised racism Cultural identity strain	No differences in rates of mental health difficulties and self-harm when compared to general population[158] Non-attendance rate for follow-up psychiatric appointments significantly higher in the Gypsy and Traveller cohort (36.9%), compared with the non-Gypsy and Traveller cohort (15.1%)[159]	Approximately 32,630 BCYP (25 years and younger) identified as Gypsy or Irish traveller in England and Wales, 31,342 identified as Roma[160]

Children with learning disabilities	Biological neurological Communication difficulties Co-occurring neurodevelopmental conditions Social/environmental Social exclusion/bullying Stigma Barriers to mainstream activities Poor educational support Low academic expectations Family/systemic Carer burn out Diagnostic overshadowing Lack of accessible services Identity/personal factors Low self-efficacy Trauma Lack of autonomy	Approximately 40% of children and adolescents with intellectual disability present with a mental health problem that is either diagnosed or at diagnosable levels[161] Children with learning disabilities are four and a half times more likely to have a mental health problem than children without a learning disability[162]	Around 31,082 children aged 5–15 are identified as having ALN, equating to 8% of that age group (2023) [163] Approximately 15,000 BCYP aged 0–17 have a learning disability (2023) [164]
LGBTQ+	Biological/neurological Heightened physiological stress Gender dysphoria* Social/environmental Bullying and victimisation Social isolation Homelessness Non-inclusive academic curricula and settings Family/systemic Limited support or non-acceptance Lack of accessible services Discrimination Identity/personal factors Low self-esteem Lack of representation Fear of coming out Internalised homophobia / transphobia	LGBTQ+ youth with experiences of self-harm and suicide more than 2.5 times more likely to have mental health difficulties than cisgender, heterosexual peers[165] Half of LGBTIQ+ people had experienced depression, and three in five had experienced anxiety[166] One in eight LGBTIQ+ people aged 18 to 24 had attempted to end their life169 Almost half of trans people had thought about taking their life169 The majority of LGBTQ+ young people reported recent symptoms of depression (62%), anxiety (70%), and self-harm in the past year (58%)[167]	Census data (2021) indicates that 6.9% of individuals aged 16 to 24 in England and Wales identified as lesbian, gay, bisexual, or another minority sexual orientation (LGB+)[168]

Looked after children	Biological/neurological Trauma and adversity Attachment disruption Higher incidence of neurodevelopmental conditions Social/environmental Stigma and exclusion Placement instability Disrupted education Lack of educational support Family/systemic Parental trauma/addiction/mental illness Lack of accessible support Gaps in continuity of care Identity/personal factors Low self-efficacy Grief and/or loss Difficulty forming relationships	Approximately 45% of looked-after children in England have a diagnosable mental health condition, such as depression, anxiety, or conduct disorders[169]	7,198 children and young people looked after by local authorities in Wales[170] 67.7% were in foster care placements, with 34.2% of those placed with relatives or friends. 65.6% were placed within their home local authority
Low-income families	Biological/neurological Chronic stress and anxiety Food insecurity/poor nutrition Sleep deprivation Social/environmental Social exclusion Stigma Heightened neighbourhood crime Educational disengagement Low academic expectations Family/systemic Parental stress/mental illness Housing instability Homelessness Lack of accessible support Disrupted education Lack of culturally appropriate academic support Identity/personal factors Low self-efficacy Lack of role models High responsibility	Mental disorders 3- to 4-fold more prevalent in children with parents in the lowest compared with the highest income percentiles[171]	Approximately 28% of children in Wales are living in relative income poverty after housing costs (2023). This equates to around 180,000 children across the country[172]

Refugees and asylum seekers	Biological/neurological Trauma exposure Physical ill-health Developmental delays Social/environmental Bullying Social exclusion Language barriers Housing instability Disrupted education Lack of culturally appropriate academic support Family/systemic Insecure status Family separation Parental trauma/separation Identity/personal factors Identity loss Survivor guilt Trauma history shame	Lifetime prevalence for PTSD in the general population is 3.9%, and 12% for any depressive disorder. In contrast, among adult asylum seekers and refugees, the prevalence of PTSD was 31.5%, and depression was 31.5%[173] Among refugee children aged 8 and under, up to 80% experience problems such as depression, anxiety/PTSD, and behavioral issues[174]	230 children receiving care and support who were members of asylum-seeking families[175] 35 unaccompanied asylum-seeking children receiving care and support
Young women	Biological/neurological Hormonal fluctuations Sensitivity to social and interpersonal stressors Social/environmental Gender based harassment and violence Body image disorders Social media/cyber bullying Academic pressure Balancing responsibilities Family/systemic Gendered expectations Parental conflict/abuse Lack of appropriate support Identity/personal factors Low self-efficacy Trauma and emotion internalisation Increased risk of self-harm/suicide	England-wide data shows young women aged 16–24 are almost three times more likely (26%) to experience CMHCs than their male peers (9.1%) [176] Girls aged 16–19 years are about twice as likely to present with mental health crises and had the highest rates of emergency crisis events in Wales compared to boys of any age[177]	1,586,600 women in total in Wales (2021), accounting for about 51.1% of the population[178] Approximately 190,392 would be aged 16-25 years (based on 12% of the overall female population)

Youth justice	Biological/neurological Neurodevelopmental conditions Substance exposure Emotional dysregulation Social/environmental Exposure to violence/trauma Social exclusion Poverty Peer influence School exclusion Lack of academic support Family/systemic Family dysfunction/instability Care experience Identity/personal factors Low self-efficacy Emotional suppression Stigma	Of UK children sentenced in 2020, there were concerns in relation to mental health in 72 per cent of cases[179]	667 children (2.3 per 1000 population aged 10-17 years) received a caution or sentence (2022/23)[180]
Pupils not in education, employment or training (NEET)	Biological/neurological Pre-existing mental health conditions Neurodevelopmental conditions Substance misuse Social/environmental Social isolation Financial instability School exclusion Lack of tailored pathways Family/systemic Lack of parental support Generational unemployment Lack of accessible support Identity/personal factors Low self-efficacy Stigma Lack of purpose	Nearly 60% of NEET youths had experienced more than one mental health problem in childhood or adolescence, compared to around 35% of young people who were in education, employment or training 35 per cent of NEET participants suffered from depression compared to 18 per cent of non-NEET youths[181] Analysis from the Annual Population Survey (APS) suggests that 1 in 6 of NEET (16-24 years) currently report having a mental health condition[182]	46,100 young people aged 16-24 were NEET183 An estimated 11,000 individuals (10.1%) were aged 16-18 years, approximately 35,100 (15.2%) were aged 19-24 years

Young adults	Biological/neurological Pre-existing neurodevelopmental/ mental health conditions Substance misuse Hormonal/brain development Social/environmental Social isolation Transitional stress Financial pressures and responsibility Academic pressure/uncertainty Employment status/insecurity Employment conditions Family/systemic Intergenerational trauma Reduced support and service access Barriers to accessing adult services Identity/personal factors Identity instability/transition Stigma Heightened risk of self-harm/suicide	In 2023/24, 25.8% of young adults aged 16–24 exhibited symptoms of a common mental health condition, up from 17.5% in 2007[184] Younger adults were more likely to report lifetime non-suicidal self-harm and to screen positive for PTSD and ADHD than older age groups[185]	It is estimated that there are around 373,000 young adults aged 16 to 24 in Wales (based on 12% of the overall population)[186]
Homelessness	Biological/Neurological Prenatal exposure to alcohol/drugs Chronic health conditions Sleep deprivation Social/Environmental Exposure to violence Academic pressure/uncertainty Social isolation Discrimination Family/systemic Domestic violence exposure Parental mental health Neglect or abuse Care experience Identity/personal factors Low self-esteem Loneliness Stigma	Mental health issues were reported in over half (54.1%) of homeless young people, the most frequently experienced mental health issues were often feeling anxious (34.3%), feeling depressed (33.1%), and often feeling stressed (26.4%), three quarters suffering from two or more mental health issues[187]	The most recent data (April 2025), shows 2596 young people (under the age of 16) were homeless individuals being temporarily accommodated by a local authority in Wales[188]

Table 6. Key 'at-risk populations for poor mental health in BCYP in Wales
*For trans youth

7.2 Vulnerable Groups: Summary

- The specific needs of BCYP and families facing conditions and experiences that place them at higher risk of poor mental health and wellbeing should be considered when designing services; co-production approaches enable services to be re-designed to better respond to the needs of distinct groups.
- Mental health support should include support for individuals and families to address social and environmental factors that contribute to poor mental health and wellbeing.
- Shifting services to be trauma-informed is likely to be particularly beneficial for babies, children and young people from vulnerable groups.
- Promotion and prevention activities should be delivered universally with weighting towards those groups at higher risk of poor mental health and wellbeing.

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Lived Experience Insight

Health Needs Assessment:
Mental Health of Babies, Children and Young People in Wales

Understanding and improving the mental health of BCYP is most effective when research evidence and routine data are brought together with the lived experiences of young people themselves.

8.1 Babies

'Here I Am: A Pledge for Babies in Wales' is a co-produced statement from the voice of babies in Wales,[189] developed in collaboration with parents, professionals, and researchers, that outlines what babies need in their first 1000 days. It expresses that babies require consistent love, safety, hygiene, nutrition, and emotional care; they need to be comforted, held, talked to, and encouraged to explore and grow.

The pledge also highlights that parents and caregivers themselves must be supported: they need timely information, emotional and practical support, and environments that allow them to meet their baby's basic needs (e.g., food, safe housing). The pledge calls on communities and systems to listen, provide welcoming spaces, include families in shaping services, and offer accessible advice and support.

8.2 Children and young people

To ensure the needs assessment reflects the lived experiences and priorities of young people, a dedicated engagement session was conducted with members of the Wolfson Centre for Young People's Mental Health - Youth Advisory Group.

Key themes identified:

- Need-based not risk-based support: Many young people will experience symptoms or mental health challenges that do not meet a clinical threshold but still need support. A need-based approach prioritises prevention, which along with being more cost-effective, helps build resilience and coping strategies. It can also prevent many young people suffering from long-term impacts of trauma.

- Educational curriculum and support: Embedding mental health in education is essential for early intervention, reducing stigma, and fostering lifelong emotional wellbeing. Education settings are one of the only universal services that nearly all BCYP engage with regularly.

Open conversations about mental health in school help to challenge harmful stereotypes and encourage young people to ask for help early. Support for young people experiencing difficulties can keep them connected to learning, which boosts long-term outcomes in education and life. Investing in school-based prevention can also reduce future strain on specialist Child and Adolescent Mental Health Services (CAMHS) and NHS services, crisis teams and social care staff.

- Third spaces and outdoor activities: Third spaces and outdoor activities are more accessible and less intimidating than clinical settings. Spaces like youth hubs, community gardens, or libraries make young people feel more comfortable and encourage open communication. These opportunities also encourage engagement with seldom heard young people or those with particular needs. For example neurodivergent young people or those who have experienced trauma may struggle with sitting in a room and talking about feelings, or find clinical settings intimidating.

- Understanding and support for co-occurring conditions: Many young people present with more than one need—for example, anxiety alongside neurodevelopmental conditions like autism or ADHD. Despite this, the system often continues to organise support around single conditions or service thresholds. This carries several risks such as, misdiagnoses, poor coordination within the pathway, and young people reaching crisis before services are joined up. Additionally young people with physical health conditions or disabilities require compassionate care that supports their mental health as well as physical health needs.

- Active engagement of young people: Involvement of young people in mental health prevention, support, and system design provides unique insight. Active engagement builds trust and ensures that services are aligned to the actual needs of BCYP. It also identifies accessibility barriers that adults may overlook, such as digital accessibility, school-related stress, or cultural stigma.

- Supporting the supporters: The circle of supporters, that include parents, carers, teachers, youth workers, social workers, or mental health professionals are key to ensuring effective and sustainable mental health support. Overwhelmed or unsupported supporters may struggle to be present and consistent, key ingredients for effective mental health support. It also promotes continuity of care, with less turnover and absenteeism.

- Accessibility: Ensuring accessibility and removing inequalities, especially those related to geography, socio-economic status, culture, language, disability, or digital access is crucial in supporting the mental health of BCYP. If services are concentrated in cities, BCYP in rural or deprived areas are left behind, leading to unequal outcomes. Young people already dealing with poverty, racism, discrimination, or isolation face higher mental health risks. If they also face barriers to accessing support, these compounding factors can worsen their distress.

- Service continuity: Young people need to feel safe and understood, especially when discussing vulnerable issues. Having to retell their story to new professionals can be re-traumatising and exhausting. Efficient data sharing and mechanisms to record patient stories can minimise disruption during key transitions such as from child to adult services, moving schools or areas, or starting university.

8.3 Lived Experience Insights: Summary

- The views of BCYP and families should shape the future design of services and support in communities, utilising co-production and genuine engagement to listen and respond to their views and lived experiences.

- Insights from a diverse group of young people highlight the importance of taking a needs-based approach and supporting mental health and co-occuring conditions including neurodevelopmental and physical health conditions.

- Mental health services alone cannot address the growing mental health and wellbeing needs of BCYP; improving mental health literacy and access to third spaces, community infrastructure and activities is also required.

- BCYP do not live in isolation; collaboration with families, universal health services, schools and education settings and wider community organisations are vital in addressing growing needs and improving recovery and outcomes.

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Evidence Informed Approaches And International Models Of Care

Health Needs Assessment:
Mental Health of Babies, Children and Young People in Wales

Growing economic evidence highlights the cost-effectiveness, and in some cases, cost-saving potential of early intervention, particularly during the perinatal period and in childhood. A commitment to prevention can reduce the burden and costs of ill health to the health and care system and offers a return of £14 for every £1 invested.[190] Prioritising early years interventions,[191] offers opportunity to support infant development and social and emotional wellbeing (otherwise known as Infant mental health) and parental mental health. Furthermore, expanding access to community-based services and support can enable early intervention for parents and infants who may be struggling to help prevent mental health difficulties arising in later life.

9.1 Evidence informed Approaches

9.1.1 Infants

9.1.1.1 Healthy Child Wales Programme

The implementation of the Healthy Child Wales Programme (HCWP) ensures a commitment to support the health and welfare of all children aged 0-7 years. The HCWP aims to address inequalities by having an all Wales approach to child surveillance that is integrated with the provision of immunisation and screening. The HCWP has the following key priorities:[192]

- To deliver key public health messages from conception to 7 years, so that families are supported to make long term health enhancing choices.
- To promote bonding and attachment to support positive parent-child relationships resulting in secure emotional attachment for children.
- To promote positive maternal and family emotional health and resilience.
- To support and empower families to make informed choices in order to provide a safe, nurturing environment.
- To assist children to meet all growth and developmental milestones enabling them to achieve school readiness.
- To support the transition into the school environment.
- To protect them from avoidable childhood diseases through a universal immunisation.
- To ensure early detection of physical, metabolic, developmental or growth problems through an appropriate, universal screening programme.

9.1.1.2 Family Foundations

Family Foundations (FF) is a group-based parenting programme designed for couples expecting their first child. It is delivered by male and female co-facilitators through weekly two-hour sessions with groups of couples. The programme helps parents develop effective communication skills and strategies to support their child's healthy development. Evidence from two randomised controlled trials found improved infant attention and significant improvements in infant sleep and orienting behaviours when compared to non-intervention families.[193]

The first five sessions, held during pregnancy, prepare parents for the common stresses that follow childbirth and explore how these challenges can affect the couple's relationship and co-parenting dynamics. The remaining four sessions take place after the baby is born, focusing on practical strategies for understanding and responding to the child's temperament, promoting healthy sleep and self-soothing, and fostering secure attachment.

9.1.1.3 Understanding and supporting mental health in infancy and early childhood: A Toolkit to support local action in the UK

The resource is designed to help local areas adopt a whole-system approach to supporting mental health during the earliest years of life.[194] Mental health in infancy and early childhood includes the ability of BCYP to:

- Understand and manage emotions
- Experience nurturing, meaningful relationships
- Explore, play, and learn.
-

Infant mental health is often poorly understood, and services can be fragmented. The toolkit aims to address these gaps by:

- Helping professionals across sectors (health, early years, social care, education) develop a deeper, shared understanding of what mental health means for babies and young children, and the factors that influence it

- Supporting whole-system approaches that guide service leaders, commissioners, and policy teams towards creating integrated strategies that ensure babies and young children are mentally healthy now and develop skills to maintain mental health throughout life
- Offering frameworks, conversation guides, and signposting to evidence-based resources to support local discussions, needs assessments, and strategy development (e.g., across mental health, maternity, early years, Family Hubs, and Start for Life initiatives)
- Encouraging multi-sector working and addressing inequalities that affect families, ensuring all babies have the best start in life.

9.1.2 Children and young people

9.1.2.1 Stepped-Care Approach

The stepped-care model is an evidence-based framework, beginning with the least intensive, least intrusive interventions and escalating only as clinically indicated. It aligns closely with guidance from the National Institute for Health and Care Excellence (NICE), which advocates for a continuum of support tailored to the severity and complexity of each individual's mental health needs.

Within a stepped-care model, BCYP and their families presenting with mild to moderate emotional distress and/or mental health difficulties are first supported through low-intensity interventions such as, self-help tools, psychoeducation, or brief psychological support. Where these initial approaches are insufficient, more intensive interventions, including structured psychological therapies or specialist assessments, are introduced. This model prioritises the least restrictive and most cost-effective interventions, ensuring that more resource-intensive treatments are used only when clinically necessary. In the context of early intervention, stepped care reduces reliance on crisis responses by addressing emerging issues at an earlier stage, improving outcomes while alleviating pressure on specialist services.

In Wales, the stepped-care approach has been embedded within services such as the Single Point of Access (SPoA) for young people. This model aims to provide timely assessment and ensure referrals are made to the most appropriate level of support.

While its implementation represents a positive step toward streamlined, needs-led care, persistent challenges particularly related to workforce capacity and resource constraints can impede the consistent and timely delivery of support. The Welsh Government's Mental Health and Wellbeing Strategy (2025–2035) reinforces the strategic value of stepped care, emphasising its potential to improve service efficiency, optimise resource use and the skills of allied health professionals, and reduce bottlenecks across the system.

9.1.2.2 Trauma-Informed Care

Trauma-informed care (TIC) is increasingly recognised as a core principle in the design and delivery of mental health services for BCYP, particularly those who are being affected by adverse childhood ACEs such as abuse, neglect, or exposure to violence. This approach acknowledges the lasting impact that trauma can have on emotional wellbeing, behaviour, and mental health outcomes.

TIC has been shown to enhance therapeutic engagement, reduce the risk of re-traumatisation, and improve clinical outcomes for BCYP with trauma histories. A trauma-informed approach involves recognising the signs of trauma, embedding psychological and physical safety, and building relationships rooted in trust and empowerment.

Emerging research highlights the protective role of positive childhood experiences (PCEs)—such as feeling safe, supported, and having access to stable relationships, in reducing the risk of poor mental health outcomes. While ACEs have a cumulative, detrimental effect on mental wellbeing, PCEs are shown to have an accumulative, mitigating influence, supporting the development of resilience and long-term wellbeing.

In Wales, trauma-informed care is increasingly embedded across the system. The National ACEs Hub plays a key role in building awareness and capability through training and resources for practitioners, including those in CAMHS. Additionally, national frameworks such as the NEST/NYTH model and the Whole-School Approach to Emotional and Mental Wellbeing aim to create trauma-sensitive environments across family homes, preschools, schools and communities. These coordinated efforts reflect a commitment to holistic, preventative care that supports BCYP through consistent, relationship-based, and emotionally safe practices.

9.2.1.3 Integrated Care Pathways

Integrated care pathways (ICPs) are a key mechanism for delivering coordinated, person-centred mental health support to BCYP, bridging health, social care, and education systems. By promoting collaboration across sectors, ICPs ensure that mental health difficulties are addressed in a timely and holistic manner.

This integrated approach is particularly effective in family, school and community settings, where early intervention can significantly improve outcomes. In Wales, School In-Reach Services exemplify this model by embedding mental health practitioners within primary and secondary schools. These services facilitate collaboration among school staff, including teachers, nurses, and educational psychologists, to build capacity and confidence in identifying and responding to emerging mental health difficulties. By providing support at the earliest stages, School In-Reach Services help prevent escalation and enable timely referral to more specialist services where necessary. Further examples exist beyond the school setting, including Flying Start and early help family support models in local authorities.

Integrated care pathways not only streamline access to support but also help to ensure that BCYP receive the right intervention, at the right time, in the most appropriate setting.

9.2.1.4 Digital Innovations

Digital innovations are transforming the landscape of mental health care delivery, particularly for BCYP. Platforms such as SPARX and SilverCloud offer online Cognitive Behavioural Therapy (CBT), providing accessible, evidence-based interventions for those experiencing mild to moderate mental health difficulties. These tools are especially valuable for BCYP living in rural or underserved areas, where access to in-person services may be limited.

Mobile health applications are also playing an increasingly important role, offering features such as mood monitoring, guided relaxation techniques, and crisis support. The flexibility, anonymity, and accessibility of digital interventions help to reduce barriers to help-seeking, including stigma and service availability, while promoting earlier engagement with support.

In Wales, the adoption of digital mental health services is gaining momentum. Initiatives led by Digital Health and Care Wales are expanding the reach of e-mental health support, including the integration of online CBT into NHS services. These approaches are becoming embedded within core CAMHS provision, offering young people timely and non-stigmatising pathways to care.

9.2 International models of care

9.2.1 Australia: The Headspace Model

Headspace[195] is a leading example of youth mental health service reform in Australia, offering an integrated, early intervention model for young people aged 12-25 years. Established in 2007 with an initial 10 centres, the network has since expanded to over 150 sites, supported by a complementary digital service, eheadspace, launched in 2011.

Co-designed with young people, Headspace aims to remove barriers to accessing support by providing a welcoming, youth-friendly environment. Services are free and do not require a formal diagnosis, making it easier to seek help early. While many users present with symptoms of anxiety or depression, the model supports a wide range of needs, including:

- Mental health and wellbeing
- Physical and sexual health
- Alcohol and other drug use
- Work and study support.

Key features of the Headspace model include:

- Youth-friendly, non-stigmatising environments: Centres are purposefully designed to be safe, inclusive, and approachable, encouraging early help-seeking
- Integrated service delivery: Headspace offers a ‘one-stop shop’ approach, bringing together mental health professionals, GPs, social workers, and vocational support teams to provide holistic, person-centred care
- Digital accessibility: *headspace* provides a range of online support, including live chat with clinicians, peer support forums, and personalised wellbeing tools. Dedicated resources are also available for parents and carers, enabling them to create accounts, access guidance, and connect with others in similar situations.

The Headspace model demonstrates how youth participation, integrated care, and digital innovation can work together to create more accessible and effective early intervention services for young people.

9.2.1.1 Evaluating impact

The Headspace model has played a significant role in reducing waiting times for mental health support, enabling more timely interventions for young people in need. A 2013/14 review of Headspace services found that 80% of clients waited less than two weeks for their first appointment, while only 5% experienced waits of four weeks or more.[196]

To maintain timely access amid rising demand and increased complexity of presentations, Headspace introduced the Brief Intervention Clinic (BIC) in 2016.[197] The BIC offers up to six sessions focused on skills development and behavioural strategies, chosen collaboratively with the young person. It specifically targets those with mild to moderate mental health difficulties.

Despite these innovations, growing demand continues to challenge service capacity. While the average wait for an initial intake session is approximately 10.5 days, followed by a further average of 25.5 days to begin therapy, a 2019 survey revealed that 90% of Headspace centre managers viewed waiting times as a significant concern. Workforce shortages were cited as a primary challenge by 90% of respondents, with over half also identifying physical space limitations as a key barrier to delivering timely care.[198]

Outcome data from Headspace indicates that 71% of young people experienced meaningful improvement in at least one domain—psychological distress, quality of life, or psychosocial functioning. Improvements were most notable among females, those who attended more sessions, and individuals with more severe symptoms at baseline.

Overall, Headspace has had a transformative impact on access to mental health care in Australia and continues to inform the design of early intervention models internationally.

9.2.2 Scandinavian Preventive Frameworks

Scandinavian countries, particularly Sweden and Finland, have long prioritised universal, preventative approaches to mental health. These nations have integrated mental health promotion into school environments through evidence informed programmes such as Mental Health First Aid. These initiatives are designed to reduce stigma, build emotional resilience, and equip young people with effective coping strategies before difficulties emerge.

In Sweden, youth clinics play a pivotal role in first line mental healthcare. These services are designed to be easily accessible and youth-friendly, helping to reduce stigma and promote early engagement. They also foster integrated care across health, social, and educational sectors.

9.2.2.1 The Swedish Youth Clinic Model

Established in the 1970s, the Swedish Youth Clinic model has become a foundational element of youth healthcare. Fully integrated within the public healthcare system, youth clinics support individuals aged 12-25 years, offering a comprehensive suite of services including physical health assessments, mental health care, sexual and reproductive health, counselling, and health education.
A key strength of the model is its interdisciplinary approach. Teams typically include nurses, doctors, psychologists, midwives, and social workers who work collaboratively to provide holistic, person-centred care. This integrated model ensures that young people are supported as whole individuals, not just as service users with isolated needs, enhancing both access and outcomes.

9.2.2.2 Evaluating impact

The Swedish Youth Clinic model offers several strengths in the delivery of youth-focused healthcare:

- Accessibility and inclusivity: Clinics are strategically distributed across both urban and rural areas, ensuring access to healthcare services. They are designed to be non-judgmental, providing safe spaces where young people can seek support without fear of stigma

- Youth-centred services: The care provided is tailored to the developmental needs of young people, offering age-appropriate health education, mental health counselling, and general health checks
- Confidentiality: A cornerstone of the model is its strong emphasis on confidentiality, allowing young people to access services without concerns about breaches of privacy
- Multidisciplinary teams: Clinics are staffed by interdisciplinary teams of healthcare professionals, including nurses, doctors, psychologists, and social workers. This integrated approach ensures that young people's needs are addressed holistically
- Integrated mental health support: Mental health services are embedded within the clinic structure, reducing stigma through normalisation of support.

However, several challenges persist within the model:

- **Inequitable access**: Despite efforts to be inclusive, some young people people—particularly from non-Swedish marginalised backgrounds report difficulties accessing services
- **Resource disparities**: Significant differences exist in resource availability between urban and rural clinics. Urban sites typically offer more extensive services
- **Organisational challenges**: Some clinics report unclear leadership structures and coordination issues, which can lead to inefficiencies and delays in service delivery
- **Limited evaluation**: There is a lack of systematic monitoring of the clinics' effectiveness, making it difficult to evaluate impact across the model.

9.2.3 Canada: ACCESS Open Minds

ACCESS Open Minds[199] is a Canadian initiative that provides integrated youth mental health services, with a focus on early identification, family inclusion, and interdisciplinary care. The model is designed to improve access to mental health services, particularly for underserved populations. As a core aspect of the models commitment to rapid access, many sites offer same-day, open access support or aim to provide young people with support within 72 hours.

Key features of ACCESS Open Minds include:

- Early identification: Young people can self-refer and mental health literacy is promoted to reduce stigma and empower individuals

- Comprehensive services: The model provides a wide range of services, from mental health assessment to treatment and support for family members
- Family-cantered care: Families are actively involved in the treatment process, ensuring that services are tailored to the unique needs of the young person and their family system
- Continuity of care: The support offer covers ages 11-25 years, providing a seamless transition between child and adult mental health services.

Evidence shows that the implementation of ACCESS Open Minds has encouraged more young people to seek help, while also significantly improving the speed of initial responses.[200] Preliminary economic evaluations suggest that for every C$1 invested, the initiative delivers approximately C$10 in downstream healthcare savings—equating to around C$4,500 saved per patient each year.[201]

9.2.4 United States: Wraparound Services

The Wraparound approach in the United States is a comprehensive, family-driven and youth-guided model of care designed to support young people with complex and multifaceted needs. It integrates services across mental health, education, housing, and justice systems to ensure a coordinated and individualised response. Central to this model is a multidisciplinary team that collaborates with the young person and their family to co-develop a holistic plan of care, grounded in their strengths, preferences, and cultural context.

Wraparound is particularly effective for young people experiencing severe mental health challenges, providing tailored interventions that address both clinical and social determinants of well-being. Its emphasis on flexible, community-based support and cross-sector collaboration has led to its widespread implementation across the United States, and it is increasingly recognised internationally as a best-practice model for supporting high-risk youth.

Evidence shows that the Wraparound approach delivers modest but positive outcomes, especially compared to routine care.[202] It proves effective across sectors and populations, particularly for those underserved by traditional models, and helps reduce reliance on downstream services. However, successful implementation depends on proper training, adherence to the model, and adequate resources. Challenges such as workforce shortages and limited space can hinder its effectiveness.

9.3 Evidence-informed approaches and international models of care: Summary

- Wales has a strong policy environment which encourages a shift to prevention and early intervention. Building on this to strengthen investment in and implementation of preventative approaches across the system is vital for improving mental health and wellbeing outcomes for babies, children and young people and future sustainability of services.

- Learning from international models for delivering mental health services and support provides opportunities to improve access and outcomes for BCYP.

- Providing the appropriate level of care and support at the right time and in non-stigmatising environments can reduce waiting times, improve access and outcomes.

- A combination of early identification and intervention, digital tools and self-help information, family-centred care and services that support the transition between adolescence and adulthood have been found to be both effective and cost-effective.

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Summary and Recommendations

Health Needs Assessment:
Mental Health of Babies, Children and Young People in Wales

10.1 Summary

This report reveals a troubling rise in poor mental wellbeing and mental health conditions among BCYP in Wales in recent years. Emotional difficulties, self-harming behaviours and eating disorders—often tied to growing concerns about body image, have become increasingly prevalent across all genders. These trends are not affecting all groups equally. Girls, non-binary young people, and those from the most deprived backgrounds are bearing the brunt of these challenges. Concerningly, symptoms are now appearing at younger ages, with many issues deeply rooted by adolescence and early adulthood.

This rise in mental health difficulties is due to a range of factors, and further research is needed to fully understand drivers behind the rise. However current evidence suggests increased reports of experiencing school-work/academic pressure, and increasing social inequalities are correlated with worsening mental health among BCYP. Well-established risk factors, including experiencing poor early relational care, bullying, sleep problems, parental mental health conditions and physical inactivity remain important areas to address.

Over recent years the demand for mental health support for BCYP has outpaced service capacity, creating a widening gap between those who need help and those who can access timely, person-centred care. Meeting this growing need requires a bold, coordinated response across sectors—one that starts in the early years and prioritises prevention, equity, and early intervention, and is co-produced with young people and their communities. The Mental Health and Wellbeing Strategy for Wales, 2025-35 calls for such action.

10.2 Recommendations

Evidence presented in this report highlights the urgent need to strengthen prevention, early intervention and timely mental health support BCYP in Wales. The below recommendations aim to drive coordinated, system-wide action to improve outcomes and experiences for BCYP.

- **Prioritise co-production and active involvement** - embed the voice of babies, children and young people's in the design, delivery, and evaluation of services to ensure that support is relevant, empowering, and responsive to their lived experiences.
- **Focus action on rising mental health conditions** – enhance prevention, early intervention and access to timely support for children and young people experiencing emotional difficulties, particularly anxiety, eating disorders and self-harm.
- **Prioritise prevention** – take action to give babies and young children the best start in life and address risk and protective factors for BCYP including building supportive relationships, healthy lifestyles, quality sleep and engagement with meaningful activities.
- **Strengthen early intervention** – enable emerging mental health needs to be identified and addressed promptly, through upskilling and supporting those working with BCYP and develop pathways to early support to reduce the risk of escalation and improve outcomes.
- **Protect infant mental health** – strengthen parent-infant relationships, through developing workforce capacity and community-based approaches to promote secure attachment.
- **Protect parental mental health** - strengthen support for parental mental health, including early support for mothers, fathers and care-givers during the perinatal period and when children and young people accessing support.
- **Target inequalities in access and outcomes** – take a proportionate response to addressing disparities arising from geography, socioeconomic status, ethnicity, neurodiversity, and other vulnerabilities to ensure equitable access to mental health support.
- **Address the social determinants of mental health** - coordinated action to address child poverty, housing security and living conditions, education and employment opportunities and inclusive communities to positively influence the mental health of BCYP and our future generations.
- **Embed whole-school approaches to emotional and mental wellbeing** - continue to support education settings in Wales to improve supportive cultures and access to support.
- **Develop social prescribing approaches for families, children and young people** – develop pathways to strengthen social support and connections with community assets and activities, including evidence-based arts and nature-based approaches.

- **Address the digital determinants of mental health** – Promote the benefits of online connectivity while adapting frameworks to keep pace with emerging digital risks such as harmful content, excessive screen time, and cyberbullying, alongside addressing the digital exclusion.
- **Provide tailored support for key life stage transitions and life events** – strengthen resilience and support during critical periods such as the first 1000 days, starting school, adolescence, leaving care and transitioning to Adult Mental Health Services.
- **Transform the support system** – prioritise the development of a cohesive, connected system that ensures a timely, person-centred and collaborative approach and provides support at the right time, in the right place and without delay.
- **Enhanced data, research and evaluation** – develop consistent data collection, analysis, and sharing to inform evidence-based policy, drive service improvement and monitor progress.

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Health Needs Assessment:
Mental Health of Babies, Children and Young People in Wales