is frequently at full occupancy. The remaining 19% of mothers were admitted to units in England.
- Accessibility: While 73% of Welsh mothers travelled less than one hour for treatment, significant regional inequalities exist. Mothers from Betsi Cadwaladr University Health Board travelled the furthest, with an average time of 1 hour 45 minutes.
- Economic Impact: MBU beds are high-cost interventions, with an annual occupancy cost per bed of £350,000–£400,000.

Conclusion:
- Current Welsh MBU provision is operating at capacity, often necessitating out-of-area placements.
- To eliminate delays, South Wales requires access to 8–9 beds (up from 6), and North Wales requires 2–3 beds.
- The opening of Seren Lodge in Chester (Autumn 2025) is projected to increase the percentage of North Wales mothers travelling less than one hour from 13% to 69%.
- Future planning must balance inpatient bed expansion with investment in community services to reduce admission needs.
- Mathematical modelling, which has proven effective across various industries, offers a toolbox to help optimising mental health services by improving resource allocation, staff scheduling, and patient care pathways.

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Physical Activity for People Using Mental Health Services: A Framework for Action in Wales

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Aims: To evaluate the implementation and mental health outcomes of physical activity-based interventions within contexts specifically relevant to Wales.

We aimed to identify existing gaps in the literature, explore implications for local clinical practice, and provide a strategic solution for common mental health settings.

We sought to establish a framework for action and quality statements to embed physical activity within routine mental health care.

Prioritise action that will support the improvement of the physical health of people with severe and enduring mental health conditions, reducing the mortality gap between people who have severe and enduring mental health conditions and those that do not. This is inkeeping with aspirations of Welsh Government's Mental Health and Wellbeing Strategy Delivery Plan 2025–2028.

Methods: We utilised a multi-faceted methodology, including a structured mapping and narrative analysis of the broader international evidence base alongside a systematic review of Wales-specific evidence.

The systematic search followed PRISMA guidelines, targeting databases such as MEDLINE, PubMed, and PsycINFO using key terms like "mental illness", "exercise", and "Wales".

Grey literature sources were also analysed to capture real-world practical challenges. Articles were screened, with inclusion limited to those published after 2007 to remain consistent with modern legislative definitions.

Results: The findings indicate that physical activity interventions significantly improve mental wellbeing across various settings in Wales, including community-based programmes, secure units, and exercise referral schemes.

Key benefits identified include reduced symptom severity for both common mental disorders and severe mental illness (SMI), improved sleep quality, and mitigation of premature mortality risks.

However, significant barriers to implementation were identified:
- Systemic Barriers: Limited funding, a shortage of qualified physical activity professionals, and insufficient training for healthcare staff.
- Individual Barriers: Low motivation, poor baseline physical health, and low self-esteem among service users.
- Environmental Barriers: The "obesogenic" nature of secure inpatient units, which often lack the flexibility or resources to prioritize physical activity.

Conclusion: Integrating physical activity into mental health services is essential but requires a shift in clinical culture and investment.

We propose four Quality Statements to guide leaders, emphasising collaborative design with physical activity professionals, inclusive programming for diverse needs, equitable care in secure settings, and sustainable investment in community programmes.

Effective implementation depends on moving toward a person-centred, evidence-informed approach that addresses both social and commercial determinants of health.

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Rethinking Parent-Mediated Intervention in Early Autism: A Model for Developmental, Relational, and Scalable Care

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Aims: This integrative thematic synthesis aims to synthesise evidence on (1) neurodevelopmental and relational mechanisms hypothesised to drive Parent-Mediated Intervention effects; (2) lived experience and acceptability of parents, and (3) feasibility of widespread implementation into early-years services. Results were shaped into a translational model to inform sustainable, scalable, and ethical early-intervention delivery.

Methods: A scoping review was conducted in-line with PRISMA-ScR guidance. The databases Medline, PubMed, Scopus, and PsycINFO were searched for studies published between 2010 and 2025. Eligible papers included infants up to 24 months old at increased risk of autism and reported on at least one of the following areas: proposed neurodevelopmental mechanisms, parental experience, or implementation and scalability. Two reviewers independently screened and synthesised data from qualitative studies, clinical trials, and service evaluations using thematic analysis and cross-domain integration.

Studies were excluded if they focused solely on pharmacological interventions or diagnostic procedures, as well as those only including children older than 24 months.

Studies that were not addressing the practical delivery or feasibility of the intervention within real-world service settings were also excluded. This approach enabled inclusion of both trials examining efficacy and underlying mechanisms, alongside research exploring lived experience and system-level implementation.

Results: The thematic analysis identified three interconnected domains: (1) Parent-Mediated Intervention shapes early social attention and arousal regulation by increasing the predictability of caregiver social signals without altering core neuro development

trajectories; (2) parental empowerment and stress regulation act as key mediators of sustained engagement and parent–infant synchrony; and (3) feasibility and equity are determined by delivery model, workforce capacity, accessibility and adaptability (for example, hybrid or telehealth models).

Heterogeneity in terminology, study design, intervention duration, and outcome measures (including criteria used to define autism likelihood) was acknowledged as a limitation constraining synthesis across the studies in this review.

Despite these limitations, findings were integrated into a Developmental-Relational-Implementation model to support clinicians and commissioners in selecting, timing, and delivering Parental-Mediated Interventions that are feasible and adaptable within real-world health systems.

Conclusion: The Developmental-Relational-Implementation model offers a pragmatic framework for clinicians, commissioners, and policymakers to guide the delivery of Parental-Mediated Intervention in early autism care. This review positions Developmental-Relational-Implementation-informed approaches as family-centred, equitable, and scalable by capitalising on relational engagement, developmental neuroplasticity, and the practical realities of healthcare delivery. To support scalable and sustainable expansion, furtherresearch should incorporate mechanistic markers, qualitative assessments of parental outcomes, and health economic evaluation.

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Examining Unmet Need for Adults Presenting Self-Harm and Suicidality in Jaywick

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Aims: Adults living in deprived coastal communities face disproportionately high rates of self-harm and suicide, yet little is known about the barriers they experience when attempting to access preventative and mental health support. This study explored how Jaywick residents navigate existing support pathways, identified key barriers and unmet needs associated with accessing services for self-harm and suicidality, and examined approaches that may strengthen engagement and early intervention within this coastal setting.

Methods: Two stakeholder workshops were conducted with 14 participants from statutory health providers and community and voluntary organisations operating in Jaywick. Workshops were audio-recorded, transcribed verbatim, and analysed using reflexive thematicanalysis. Discussions focused on experiences of service navigation, barriers to accessing care for self-harm and suicidality, and opportunities for system improvement.

Results: Three overarching themes were identified. First, access barriers: digital exclusion, low literacy, and poor signposting impeded residents' ability to access mental health support, leaving many dependent on others for referrals. Second, social and cultural dynamics: deep-rooted mistrust of statutory services, normalisation of symptoms, and strong community tribalism hindered help-seeking and engagement. Third, vulnerability and risk: entrenched cycles of poverty, addiction, trauma, and isolation were prevalent, with migrants and refugees experiencing added disadvantages. Fragmented service provision meant that those with co-occurring needs frequently fell between service thresholds and were often only supported at crisis point.

Conclusion: Barriers to accessing support for self-harm and suicidality in Jaywick are complex, intersecting, and reinforced by long-standing structural inequities. Enhancing trust, embedding services locally, and reducing digital exclusion are essential to improving early intervention and access. Co-produced, community-based models, including health navigation and outreach approaches, offer promising routes to addressing the significant unmet needs within this coastal community.

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Carriers of Care-Cultural Translation, Recognition, and Belonging Among International Medical Graduates in the NHS

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Aims: International Medical Graduates (IMGs) are essential to the delivery of care in the UK National Health Service (NHS) but their work is often examined through workforce metrics rather than lived clinical practice. So far, this study presents one of the first in-depth UK-based ethnographic analyses of IMG doctors, examining how they negotiate professional belonging, authority, and recognition, and how cultural translation and plural clinical reasoning operate under conditions of rota pressure, visa constraint, and racialised evaluation.

Methods: An interpretative qualitative study was conducted using ethnographic methods. Data were generated through 13 life-history interviews with IMG doctors working across NHS hospital settings, supported by reflexive field diaries and digital ethnography within IMG professional WhatsApp groups. Participants represented a range of specialties, grades, contract types, and intersectional identities. Data were analysed thematically using concepts from medical anthropology and sociology, with attention to recognition, translation practices, and institutional governance. Ethical approval was obtained from the relevant institutionalethics committee, all participants provided informed consent, and data were anonymised in accordance with governance and data protection requirements.

Results: IMGs contributed more than clinical labour. Participants described sustained cultural translation work, rendering care credible across accents, professional rubrics, and patient moral worlds. Many enacted plural clinical rationalities, making small, evidence-tested adaptations to standard protocols that stabilised pressured services and supported patient trust. These practices were frequently unrecognised or misread as inefficiency. Professional recognition was unevenly distributed and patterned by race, accent, grade, and visa status, with service-heavy posts limiting access to protected training and clinical voice. Performance, strategic silence, and low-visibility resistance emerged as everyday tactics through which IMGs preserved dignity, mitigated risk, and advocated for patients.

Conclusion: The NHS already functions as a global medical system but its infrastructures of recognition remain misaligned with this reality. Recognising cultural translation as clinical work and embedding safe mechanisms to evaluate plural practices could improve equity, patient safety, and workforce retention. Practical implications include protecting training in service-heavy roles, decoupling communication assessment from accent policing,