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Observations from a small country:

mental health policy, services and nursing in Wales

Abstract

Wales is a small country, with an aging population, high levels of population health need and an economy with a significant reliance on public services. Its health system attracts little attention, with analyses tending to underplay the differences between the four countries of the United Kingdom (UK). This paper helps redress this via a case study of Welsh mental health policy, services and nursing practice. Distinctively, successive devolved governments in Wales have emphasised public planning and provision. Wales also has primary legislation addressing sustainability and future generations, safe nurse staffing, and rights of access to mental health services. However, in a context in which gaps always exist between national policy, local services and face-to-face care, evidence points to the existence of tension between Welsh policy aspirations and realities. Mental health nurses in Wales have produced a framework for action, which describes practice exemplars and looks forward to a secure future for the profession. With policy, however enlightened, lacking the singular potency to bring about intended change, nurses as the largest of the professional groups involved in mental health care have opportunities to make a difference in Wales through leadership, influence and collective action.

Key words

health systems, mental health, nursing, policy, Wales

Introduction

Health policy matters, for a number of reasons. It reflects prevailing ideologies and power, shapes priorities for the organisation and provision of services, and frames the availability of resources (Buse, Mays, and Walt 2012). Health care practitioners therefore neglect the wider policy context for the work they do at their peril. Informed by an approach for the study of policy which emphasises the study of cases (Walt et al. 2008), this paper presents an account of mental health policy and the associated direction of services and practice in Wales. In addressing 'practice' it focuses particularly on mental health nursing, in recognition of the fact that nurses and their contributions are often overlooked in both the creation, and the analysis, of health policy despite being the largest workforce in global health care (Rafferty 2018).

In a context in which both the country of Wales and the profession of mental health nursing have attracted little attention, two broad aims are identified for this paper. First is to redress the tendency found in analyses of mental health policy and service organisation, even in an era of political devolution, to conflate England with the United Kingdom (UK) and to thereby underplay the differences found across the UK's four countries. This aim is accomplished via a critical account of developments in Wales set alongside the dominant, Anglocentric, narrative which typically prevails in the health policy, mental health and nursing fields. Framed by a perspective which recognises that change in any complex system requires more than mechanistically creating and implementing the 'right' policy (Chapman 2004), a second aim for this paper is to reveal the connections and tensions between mental health policy aspirations in Wales and service and workplace realities. This is achieved through an analysis of selected formal frameworks, laws and strategies and then of reviews, inquiries and research. The paper closes with the identification of a place for mental health nurses in Wales and beyond to lead, influence and act.

Dominant narratives: Anglocentric accounts of mental health policy, services and nursing practice

England, Wales, Scotland and Northern Ireland all have well-developed, complex, systems of mental health care with shared roots in the era of the asylums (Hannigan and Allen 2006). Where Victorian planners saw the building of supersized psychiatric hospitals as both an enlightened response to mental illness and a way of reducing burden on communities and families to better support industrialisation (Rogers and Pilgrim 2001), their mid-twentieth century successors came to see large, out of town, institutions as a problem to be solved (Hannigan and Coffey 2011). In all parts of the UK the subsequent journey away from institutions was an important one for the mental health professions, with interdisciplinary community mental health teams (within which nurses were the most numerous of the occupations represented) emerging from the 1970s (Sayce, Craig, and Boardman 1991).

Following years of relative neglect, mental health services in the UK from the end of the 1990s began to attract particular policymaking attention. This was initially demonstrated by the New Labour government, elected in 1997, through new investment and commitments to the reshaping of services reflecting ideological concerns with 'modernisation' (6 and Peck 2004). More recent mental health policy and approaches to the funding and development of services, across all parts of the UK, need to be viewed in the light of the global economic recession of the late 2000s onwards and the subsequent appearance of austerity as an explicit political choice (Stuckler et al. 2017).

Analyses of the impact of investment and reform, and then of austerity, on mental health services have consistently focused on England with little regard paid to other parts of the UK. Evidence of disproportionate reductions in the funding of England's mental health services (Docherty and Thornicroft 2015) have been contrasted with policymakers' appeals to 'parity of esteem', referring to the standard that people living with mental health difficulties might expect to receive care of the same quality and timeliness as the care received by people living with physical health difficulties (Health and Social Care Act 2012). In the case of the mental health professions, and mental health nursing in particular, attention has also centred, almost exclusively, on developments in England.

Unlike in many other parts of the world where initial nursing education is generalist, in the UK mental health nursing is recognised as a distinct pre-registration field of practice (Nursing and Midwifery Council 2018). It is estimated that the world in 2018 was short of 5.9 million registered nurses (World Health Organization 2020), with specific concerns over shrinking nursing numbers in England reflected in a recent review of workforce needs indicating vacancies for mental health nurses in excess of 14% (Health Education England 2017). Widely reported, too, has been the impact on the future of the profession of removing bursary and tuition fee support for students commencing their nursing degrees in English universities from the 2017-18 academic year onwards, a policy partially reversed more recently with the announcement of maintenance grants from 2020 (Department of Health and Social Care 2019). With the introduction of fees, applications for all nursing degree places declined for two years in a row (Universities and Colleges Admissions Service 2018) with mental health nursing in England singled out as an occupational group in particular need of help to improve both recruitment and retention (Health Education England 2019). It is against this general background that mental health nursing has been described as being at risk of its 'final farewell' (Simpson 2018).

Wales: devolution and policy for health

Despite longstanding appeals by policymakers in Wales to be making a difference in conditions of difficulty (Drakeford 2006), the distinctiveness of the country and its particular approach to health care remains routinely under-appreciated. In this context, assumptions that the well-rehearsed narrative outlined above of mental health policy, services and practice in England describes conditions elsewhere risks glossing over important differences in the characteristics of the systems, the directions of travel and the opportunities and threats found across the UK.

Wales has a population of just over three million, with the proportion of people aged 65 or over (more than 20% in the middle of 2019) greater than in the other countries of the UK (Welsh Government 2020a). Almost a quarter of people in Wales live in poverty, a figure

higher than the UK average (Welsh Government 2020c), with population health need estimated as greater than in both England and Scotland (National Audit Office 2012). Deindustrialisation from the 1970s onwards saw the decline of heavy industries, including coalmining, with the economy becoming increasingly reliant on public services (Bristow 2018). In 1997 a closely run referendum produced a slim majority in favour of a devolved administration, with 60 elected members of the Senedd (the Welsh Parliament, until May 2020 known as the Welsh Assembly) currently sitting from whom are drawn cabinet members of the Welsh Government (Torrance 2018). Following a further referendum held in 2011 the Senedd is now able to pass laws, independently, in 20 substantive policy areas without the need to secure additional approval (as had been the case) from the Westminster Parliament (Wyn Jones and Scully 2011). Whilst the Welsh Government therefore has no authority to make independent foreign policy, or to raise an army, it does have devolved responsibility for policy and services in many of the areas which most directly affect day-to-day life: education, housing, the environment, and both health and social care.

Funding for public services in Wales is raised through UK-wide taxation, and is allocated to the Welsh Government via a block grant (Poole, Ifan, and Phillips 2016) with a partial devolution of taxation being introduced in 2019 (Ifan and Poole 2018). The country has also been a net recipient of income from the EU, although a majority of Welsh voters taking part in the 2016 European Union (EU) membership referendum nonetheless chose 'leave' (Hunt, Minto, and Woolford 2016). Of the estimated £40.8 billion spent in 2017-18, health spending comprised £7.3 billion, representing the second largest area of expenditure next to social protection (a sum including benefits, social care and state pensions) (Ifan, Siôn, and Poole 2019). Post-devolution legislators and the Welsh executive have consistently demonstrated ideological commitments to the role of public services in promoting equality (Sayers et al. 2017), and have resisted the use of market mechanisms in the organisation and provision of health services (Greer 2016). Under current arrangements, comprehensive services at local level are both planned and delivered by seven health

boards supplemented by some provision of specialised services by other NHS bodies (Cylus et al. 2015). New words and phrases have started to appear in the Welsh health lexicon, including 'prudent health care' (Aylward, Phillips, and Howson 2013). Rhetorical connections are sometimes made between this term and the original ideals underpinning the foundation of the NHS in the post-second world war years (the architect of the NHS being a Welshman, Aneurin Bevan) with prudent health care emphasising 'doing no harm', 'carrying out the minimum appropriate intervention' and 'promoting equity between professionals and patients'. A new plan for the nation's health reaffirms commitments to a prudent approach and sets out to meet the 'quadruple aim' of improving population health, developing quality and accessibility of both health and social care services, adding value, and sustaining a motivated health and social care workforce (Welsh Government 2018a).

None of the individual components of the quadruple aim appear particularly new, though their combination in a single strategy may serve to increase their potency. More obvious distinctiveness is added in the way that national plans are required to reflect the ambitions set out in the Well-being of Future Generations (Wales) Act (2015). This is a piece of independent legislation, claimed as a world-first, which binds public bodies (including those in the NHS) to jointly plan and provide services in ways which take account of sustainability and resilience, and which promote social, cultural, environmental and economic wellbeing for both the present and the future (Greenwell and Antebi 2017). Whilst an alliance of trade unions, professional organisations and patient groups (notably, the Royal College of Nursing, Unison and the Patients Association) has been campaigning across the UK since 2013 for safe nurse staffing (Safe Staffing Alliance 2015) it is notable that it is Wales which has led in this area (Nurse Staffing Levels (Wales) Act 2016). Legislative change has seen calculations of safe staffing levels being made using three elements: professional judgement; use of an evidence-based workforce planning tool; and a consideration of the extent to which patients' wellbeing is sensitive to nursing care (Welsh Government 2017). The absolute duty to calculate safe staffing numbers was initially limited

to adult acute medical and surgical inpatient wards, but following lobbying (Royal College of Nursing Wales 2019) a recent delivery plan for mental health services now includes a commitment to extending the principles to this field (Welsh Government 2020e).

Mental health policy, services and practice in Wales

In the initial post-devolution period, Wales saw the launch of a principles-based national strategy for mental health which had in its title the words 'equity, empowerment, effectiveness and efficiency' (National Assembly for Wales 2001). This purposefully lacked many of the detailed high-level targets for the setting up of new, differentiated, types of community team (such as those providing assertive outreach services, crisis resolution and home treatment and early intervention) characteristic of mental health policy and service frameworks appearing around that time in England (Department of Health 2000, 2001). Wales, in contrast, saw recommitments to the ideal of the locality, interprofessional, community mental health team (Hannigan, Coffey, and Coyle 2002) with local health and social care organisations explicitly given latitude by policymakers at the centre to establish teams and models of provision which reflected immediate needs and circumstances (Hannigan 2013). Closer specification of services, and targets to be locally achieved, came later with the publication of an original (Welsh Assembly Government 2002) followed by a revised (Welsh Assembly Government 2005) national service framework.

In a context of relative political continuity and health system organisational stability, but also of austerity bringing reductions in funding for NHS services (Roberts and Charlesworth 2014), in 2012 the still-current decade-long strategy for improving mental health and services in Wales was launched. Many of the leitmotifs found in this document, *Together for Mental Health* (Welsh Government 2012b), are shared with equivalent frameworks found elsewhere in the UK and internationally. The idea of 'recovery', for example, has become central to mental health policy around the world (Leamy et al. 2011), and the word itself appears 16 times in 75 pages with Welsh mental health service-providing organisations urged:

to demonstrate that the support, interventions and treatment offered are evidence-based, safe and therapeutic; that they maintain people's dignity and independence, promoting recovery or enablement.

(Welsh Government 2012b, p35)

Elsewhere in *Together for Mental Health* distinct Welsh health policy themes emphasising continuous, open, engagement between policymakers, local managers and communities (Stewart et al. 2020) are reflected in the idea that new relationships between the public and the mental health system are needed. This new relationship is premised on appeals to an approach which places people using services at the centre of their care as equal and active partners with professionals, and which tackles stigma, promotes equality and awareness of mental health issues across whole populations. Reflecting longstanding public health commitments (Greer 2016), without using the precise phrase *Together for Mental Health* also takes aim at the challenge of mental ill-health as a 'wicked problem' (Hannigan and Coffey 2011) by firmly identifying poverty and inequality as contributors to psychosocial distress and by stating, clearly, that joined-up action at all levels is necessary to tackle its root social and economic causes.

Cross-referenced 25 times in *Together for Mental Health* is a piece of novel Welsh legislation, the Mental Health (Wales) Measure (2010), which is significant for attempting to embed a human rights perspective into national law. Although mental health legislation varies across countries in terms of criteria for detention and the roles of professionals (Georgieva et al. 2019), laws in this field are mostly concerned with the identification of the conditions under which people can be lawfully detained for the purposes of mental health assessment and/or treatment, or can be compelled to receive treatment in the community. England and Wales' Mental Health Act, passed in 1983 and amended in 2007 and recently subjected to independent review (Independent Review of the Mental Health Act (1983) 2018), does exactly this. Although the English and Welsh Act has various checks and balances, referring to the rights of the individual and their nearest relative including the right

to statutory aftercare, in essence it exists to give professionals the authority to compel service users to do certain things, such as enter hospital for assessment or treatment. This remains the case even though attempts have been made over the years to revise this Act, for example to place greater emphasis on the principle of reciprocity (so that people who are detained can expect services of the highest quality in return), and to assert the idea of consensual care as the norm (Department of Health 1999, Pilgrim 2007). More recently, an international debate has opened up on the extent to which the United Nations Convention on the Rights of Persons with Disabilities may (or may not) be violated by statutes, like the Mental Health Act for England and Wales, which allow compulsory treatment (Szmukler, Daw, and Callard 2014).

The Mental Health (Wales) Measure 2010 is a different kind of law in being concerned with positive rights of access and quality of mental health care in both primary and secondary settings, set against a framework of promoting recovery. The word 'Measure' in this context is a piece of legalese, where the word 'Act' (as in Acts of the Senedd Cymru, or the Welsh Parliament) is the one used now. The Mental Health (Wales) Measure was lobbied for by Hafal, a third sector organisation which both campaigns for improved mental health care and directly provides services. The Measure first sets out, in law, an obligation on the NHS and local authorities to provide primary mental health services. Supported by a Code of Practice (Welsh Government 2012a) the Measure mandates that people accepted by secondary mental health services will have a care coordinator, and that each care coordinator will be a registered mental health professional (for example, a nurse or a social worker). It also places a legal requirement on care coordinators to produce care and treatment plans, and affords people the right to a re-assessment of their needs for a period of three years following their discharge from mental health services. Finally, the Measure extends independent advocacy to all people admitted to inpatient mental health wards, and not just to those (as is currently the case in England, for example) detained under compulsory treatment legislation.

Amongst the professional groups in Wales providing mental health care in secondary services nurses are the most numerous, with over 3,100 registered mental health nurses recorded as being in employment in NHS Wales at the end of 2019 (Welsh Government 2020b). In this part of the UK it has continued to be possible to progress through pre-qualification education whilst in receipt of an NHS bursary and without the payment of tuition fees, in return for committing to work in the country for two post-qualification years (Welsh Government 2019). As a country Wales is small enough for senior professionals to directly meet and work together, and senior mental health nurses working in Welsh health boards and universities convene nationally as members of the All Wales Senior Nurse Advisory Group for Mental Health. This is a long-established collective which has recently published, unbidden by government, a ten year framework for mental health nursing (All Wales Senior Nurse Advisory Group 2019). The framework seeks to cement and advance a particular place for the profession by setting out:

> […] our vision and aspirations for mental health nursing in Wales underpinned by key strategy and policy. It articulates our sense of identity as mental health nurses and how we plan to expand our role to ensure that people with mental health difficulties are treated with dignity and respect and receive the care and support they need and deserve.

> (All Wales Senior Nurse Advisory Group 2019, p7)

Echoing the language of national and international policy the framework asserts the importance of recovery, and of nursing as a values-based profession (between them, the words 'recovery' and 'values' appear over 40 times), where strengths, working in partnership, tolerance and acceptance, humanity and honesty are all recognised. Exemplars of mental health nursing practice in Wales included in the framework are listed in Figure 1:

Figure 1

Exemplars of mental health nursing practice in Wales

- the incorporation of traditional storytelling into everyday secure unit practice;

- advanced practice in the care of older people living in rural communities;

- community engagement and mental health promotion and information provision involving mental health nurse academics, practitioners and the people of Grangetown, a diverse community in Cardiff;

- parent and carer skills development in a young persons' inpatient mental health unit;

- the involvement of mental health nurses, including in leadership roles, in the work of the Welsh Ambulance Services Trust;

- research projects (for example, focusing on care planning and coordination, young people's mental health, and shared decision-making) led by or involving nurses in Wales characterised by strong partnerships between investigators, service users and practitioners;

- nurse leadership in the provision of physical treatments;

- the establishment of a recovery centre in West Wales, run by a third sector organisation and led by nurses.

Making a difference?

The policy direction for public services in Wales, including mental health services, is distinct and the example given above of mental health nursing complete with its new framework reveals proactivity amongst the professions. However, across the Welsh health system evidence of workplace realities gathered from reports, inquiries, statutory reviews and research paints a mixed picture of both progress and challenge. Nursing, as a profession, is depleted. Although data on the NHS workforce in Wales is published annually (Welsh Government 2020b) no data are routinely produced on nursing vacancies. Drawing on information from different sources in 2018 and 2019, the RCN estimates 1,651 nursing vacancies across NHS Wales in all fields of practice and a 24% one-year increase in the

sum spent on agency nursing in 2018-19, reaching a total one-year expenditure of £63.8 million (Royal College of Nursing Wales 2019).

Within the mental health system, indications can be found of improvement but also of stubborn and significant gaps between policy intention and reality, with government-sponsored reports tending to emphasise progress in contrast to more critical reviews produced elsewhere. Expert advice given to policymakers prior to the enactment of the Measure cautioned against an over-reliance on legislation to drive changes in professional practice, concluding that the resources associated with making this new law might be better used for the direct provision of services (Fennell 2010). With the passing of the Measure came a statutory obligation to examine its impact, and a final report from this process claimed (amongst other things) evidence of the 'change in culture required to ensure the intention behind the Measure is becoming more evident across all areas in Wales' (Welsh Government 2015, p15). However, whilst formal post-legislative scrutiny of the Measure by Senedd members (as opposed to by the Government) pointed to improved access to primary care and greater use of care and treatment plans, it also drew attention to pressures in the system in the face of high demand and to a particular need to develop services for children and young people (National Assembly for Wales 2015). Routine data collection relating to the Measure is limited to the reporting of compliance figures (for example, the numbers of people in receipt of secondary mental health care who have a care and treatment plan) (Welsh Government 2020d). A more detailed review of the quality of care and treatment planning, however, found evidence that whilst statutory duties were being met care plans tended to be poor and were not being produced with the involvement of people using services (NHS Wales Delivery Unit 2018).

In the case of *Together for Mental Health*, the most recent Welsh Government update on progress in meeting the aims of this ten year plan highlighted improvements in primary mental health care, in stigma reduction and in the provision of services to people in crisis (Welsh Government 2018b). However, in a recent independent report commissioned

by the political party Plaid Cymru it was argued that the absence of outcome measures used in everyday mental health services in Wales has made it impossible to assess the impact of investment, and that progress on integrated mental health and social care services has been slow (Johnson 2019). With mental health remaining a priority for quality improvement across the country (Improvement Wales 2020), making better use of routinely collected data is now identified as a particular goal (1000 Lives Improvement Mental Health and Learning Disabilities Team 2019).

Detailed pictures of the state of mental health services in Wales have also come from independent, and sometimes comparative, research. Collaborative Care Planning Project (COCAPP) (Simpson, Hannigan, Coffey, Barlow, et al. 2016) and Collaborative Care Planning Project (Acute) (COCAPPA) (Coffey, Hannigan, Barlow, et al. 2019) were two large-scale, mixed methods, studies set up to examine, compare and contrast mental health care planning and coordination and their relationships to recovery and personalised care in England and Wales. Both studies used a case study design, with two organisational cases being NHS local health boards (LHBs) in Wales. Data were generated using surveys (measuring recovery, therapeutic relationships and empowerment in both studies, and in addition in COCAPPA service users' views of inpatient care), along with interviews, observations and documentary review.

Across the two linked investigations 152 questionnaires were returned by staff working in the two Welsh LHBs and by 243 users of Welsh mental health services, with interviews conducted with 29 members of staff and 31 service users and carers. In COCAPP, during interviews many senior mental health managers and practitioners in Wales repeatedly referred to the Mental Health (Wales) Measure as a driver for service improvement. However, when frontline care coordinators' and service users' views and experiences across the two countries were compared it was hard to detect the impact of a legislative framework in Wales over a regulatory one in England in terms of how far service users were involved in care planning or how far practitioners talked of their orientations

towards a recovery approach (Simpson, Hannigan, Coffey, Barlow, et al. 2016). Many service users, equally across both the Welsh and English COCAPP data generation sites, talked of their care plans as having limited value, and of having scarce opportunity to collaborate in their production. Care coordinators in Wales additionally spoke of administrative burden in operating the new statutory requirements of care and treatment planning (Hannigan et al. 2018).

Recovery values in COCAPP were also talked about in different ways, including in the two Welsh sites specifically. For some, 'recovery' meant setting goals and working in new, more collaborative, ways with service users, but for others national aspirations were limited by a lack of available resources and of practice being constrained to 'firefighting', to use the phrase employed by one Wales-based care coordinator (Simpson, Hannigan, Coffey, Jones, et al. 2016). Collaboration in care planning, across both the Welsh and English sites, was found not to extend to the assessment and management of risk with practitioners describing a belief that to do so would be upsetting for people using services (Coffey et al. 2017). In COCAPPA, some staff described the all-Wales care and treatment planning template as poorly suited to the short-term context of acute, inpatient, mental health care (Coffey, Hannigan, Barlow, et al. 2019).

Further recent evidence of the experience of providing and receiving mental health care in Wales comes from Plan4Recovery, a mixed methods study of quality of life, recovery and decision-making for people using mental health social care services in Wales which involved the generation of survey and interview data along with assessments of need derived from the analysis of service user records. One hundred and twenty two service users completed initial questionnaires and 41 service users, significant others and nominated care workers took part in interviews, with many service users speaking of limited opportunities to be involved in making decisions about their care and in co-producing recovery (Coffey, Hannigan, Meudell, et al. 2019). Many service users also scored highly on a measure of decisional conflict, with greater conflict associated with lower levels of quality of life and both

quality of life and recovery shown to be lower in this group of participants than in groups of people taking part in comparator studies in other locales.

A further recent study of mental health care continuity in the context of the Mental Health (Wales) Measure, involving in-depth interviews with 32 service users and practitioners, concluded that the Measure represents a 'colonised' variant of recovery (Weaver 2019). In this analysis, recovery is recognised as a polyvalent concept in which the foundational, service user-led, version has been usurped by a top-down, neoliberal, form leading to misaligned expectations. Another recently completed study of Welsh mental health nurses' work in an era of service user involvement, drawing on interview and focus group data with 35 registered and student mental health nurses and with 13 service users, found people using services describing nurses as task-focused and too busy to collaborate (Terry and Coffey 2019).

Conclusions

Reflecting consistently stated commitments to high-quality public services, and often in the context of lobbying from external organisations, the still-young Welsh Government has shown a willingness to legislate and create policy to enhance public services for population benefit. Examples summarised in this paper include advancing the cause of sustainability and long-term resilience, and preserving and developing a role for nurses via favourable funding regimes for pre-registration education and the passing of legislation mandating safe staffing. In the mental health field, initiatives in Wales suggest policymakers take seriously the potential for national and local planning to improve mental health and wellbeing. Recent policy confirms confidence in the idea that joined-up action is needed across different agencies and organisations because mental health is intimately intertwined with economic and social conditions and because different people, and different agencies, have parts to play.

Serious challenges lie ahead. Cooperation and intersectoral collaboration will become even more essential in Wales and beyond as responses are marshalled to the cumulative health, economic, social and political shocks triggered by global climate change, the ending of the transition period following the UK's exit from the EU and, now, the coronavirus pandemic (Green, Wood, and Bellis 2020). The COVID-19 crisis has magnified intergovernmental tensions within the UK, and new uncertainty has emerged surrounding future territorial relationships (McEwen et al. 2020). Even in the best of times, evidence from reports, inquiries and research reviewed in this paper shows that forward-looking and well-intentioned public policy and legal frameworks may lack the singular potency to bring about the kinds of changes intended to service provision and face-to-face practice. This should not be entirely surprising. The connections between large-scale policy, local service organisation and everyday working practices are always complex, with all health systems vulnerable to the opening up of distance between policy aspiration and everyday practice (Braithwaite et al. 2017). Translating national policy into frontline change is never simply a matter of pulling the right levers, waiting for the prescribed transformations to occur, and reaping the benefits of improvement (Hannigan and Coffey 2011). Context always matters, and austerity has made an unwelcome appearance in the last decade serving to increase demand on Welsh public services at precisely the time when services themselves have faced squeezes on funding. Staff shortages, competing priorities for hard-pressed organisations and professions, and resistance to new ideas and working practices may also have had parts to play.

Relative to their numbers, mental health nurses have often been typified as lacking influence (Butterworth and Shaw 2017), but as Rafferty (2018) observes cases can readily be found of nurses using their collective strength to effect change. Examples from the UK include lobbying for state registration, securing degree-level initial preparation, obtaining medication prescribing authority and advancing independent nurse-led practice. For mental health nurses in Wales a new, national, professional framework opens up a window of

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opportunity for action. Diverse exemplars of nursing work improving quality and care

provision in local areas serve as beacons for practice and service development more widely.

Mental health nurses will want to press for investment in recruitment and staff support, and

can point to extant policy emphasising the importance of the workforce to support their case

(Welsh Government 2018a). Many will also want to play their parts in leading and

contributing to the work of translating into everyday practice progressive ideas for integrated,

high-quality, services and closer partnerships between professionals, service users and the

public. Research evidence cited here identifies that people living with mental health

difficulties particularly value nurses as providers and coordinators of genuinely collaborative

care, accomplished through helpful relationships characterised by open decision-making

(Simpson, Hannigan, Coffey, Barlow, et al. 2016). This paper suggests there is space for

work to be done by mental health nurses in these areas, and that in seizing the opportunity

what nurses do now and in the future can make a difference.

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