# Recent Advances in Psychiatric Nursing Practice: A Systematic Review

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**Abstract**

Psychiatric and mental health nurses play a central role in promoting safety, therapeutic engagement, and continuity of care across inpatient, community, and transitional mental health services. In recent years, rising service acuity, workforce pressures, and increased emphasis on rights-based and recovery-oriented care have driven developments in psychiatric nursing practice. This systematic review synthesised empirical evidence on recent advances in psychiatric nursing practice published between January 2011 and December 2021. Searches of PubMed/MEDLINE, the Directory of Open Access Journals, and Google Scholar identified 223 records. After removal of duplicates and completion of title, abstract, and full-text screening, 29 primary studies met inclusion criteria. Owing to heterogeneity in study designs, settings, interventions, and outcome measures, findings were synthesised narratively. Included studies comprised randomised and cluster randomised controlled trials, observational and quasi-experimental studies, quality improvement initiatives, mixed-methods research, and qualitative investigations. Evidence was organised into thematic domains reflecting contemporary practice priorities: ward safety and reduction of restrictive practices; structured psychosocial and recovery-oriented nursing interventions for severe mental illness; family and caregiver psychoeducation and support; therapeutic milieu innovations such as sensory modulation; workforce-focused interventions; and service delivery adaptations including tele-mental health. Reported outcomes commonly related to conflict and containment, restraint and seclusion use, caregiver burden, medication adherence, psychosocial functioning, continuity of care, and staff wellbeing. The findings indicate a shift toward integrated, relational, and prevention-focused psychiatric nursing practices, while also highlighting areas where further evaluative research is needed.

**Keywords:** Psychiatric nursing; mental health nursing; restrictive practices; recovery oriented care; family psychoeducation; tele mental health

## 1. Introduction

Psychiatric and mental health nurses are at the heart of contemporary mental health care, offering therapeutic services, ensuring safety, and facilitating the transfer of care between all inpatient wards, community services, and the points of interface between them. The increased clinical acuity, a continuing workforce shortage, and higher expectations regarding rights-based and recovery-oriented practice have expanded the demands placed upon nurses and have brought innovation in everyday nursing work into the spotlight. The protocols do not define how that innovation is applied in the daily care. It is further influenced by the local ward cultures, professional rules and the practical judgement nurses make in a complicated situation (Lakeman, 2013).

Aggression and escalation of behaviour is quite a persistent problem in inpatient services as it can be destructive to service users and staff and can instigate other restrictive measures like restraint and seclusion. There is also evidence that the aggression that occurs in psychiatric wards can hardly be decreased to patient behaviour. It is an expression of interacting, patient-related, environmental, and organisational states that nurses have to handle in real time (Weltens *et al.,* 2021). Such framing justifies the abandonment of containment as the paradigm response and the embrace of prevention-based nursing care practices that can include primary recognition of escalation, regular relational reactions and de-escalation skills inherent in daily ward routines.

Psychiatric nursing is also becoming more importantly placed as an avenue to scaling structured psychosocial and recovery-oriented interventions in places where specialist resources are scarce. The mental health priorities in the world have encouraged scalable mental interventions that should be administered by trained non-experts in order to enhance coverage (World Health Organization, 2017). This is in line with demands to restore and maintain mental health systems by service redesign, even following disruption (World Health Organization, 2013; Patel *et al.,* 2018). Supporters of evidence Task sharing evidences indicate that expanded roles may be effective when supported by training and administration and where the roles and responsibilities are well defined (Fulton *et al.,* 2011).

Another fundamental nursing area is continuity of care particularly at inpatient community interface. Transitions may reveal lack of coordination, follow up and engagement. The community mental health care is intimately linked with international views, which highlight that access and continuity is determined by service organisation and integration, with nurses playing a central role of coordinator in this process (Thornicroft *et al.,* 2016). Digital models can be used to enhance access to continuity by technology-enabled methods that include clinician-guided internet-based treatments with proven effectiveness in complicated groups, and demonstrates how digital models can reach more people when combined with professional supervision (Johansson *et al.,* 2019). Service delivery innovations also indicate the way in which the nursing practice is evolving to new circumstances. The acceptability and effectiveness of telemental health can be evidenced in

the case of its adequate governance and risk and engagement consideration (Hilty *et al.,* 2013; Lawes-Wickwar *et al.,* 2018). Simultaneously, trauma-informed care conceptualizes the ward practice based on the idea of safety, choice, collaboration, and emotionally responsive reaction to distress, and it directly relates to the nursing work (Sweeney *et al.,* 2018). The development of the capacity to apply such strategies should be based on the system capacity and leadership, such as the capacity of planners to transfer evidence into the development of the workforce and service design (Keynejad *et al.,* 2016).

It is against this backdrop that the research on the field of psychiatric nursing progress is spread across interventions, setting and outcome traditions. This systematic review co-ordinates the current nursing-led and nursing-supported innovations in the areas of ward safety and restrictive practice reduction, structured psychosocial and recovery-oriented interventions, family-oriented support, innovative therapeutic milieu, and the development of service delivery models, including digital and transitional care. It is to provide the understanding of the areas where evidence is best established, how nursing input is being operationalised, and where additional assessment and implementation efforts are required.

## 2. Methods

### 2.1 Study Design and Reporting Standards

The present study was carried out as a systematic literature review (SLR) to retrieve the current evidence pertaining to the recent developments in the sphere of psychiatric nursing care in the context of inpatient, community, and service-delivery settings. The analysis and the presentation of the findings were informed by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 statement to enhance transparency and reproducibility of the study search, screening, eligibility, and synthesis.

### 2.2 Data Sources and Search Strategy

A structured literature search was conducted across PubMed/MEDLINE (including PubMed Central), the Directory of Open Access Journals (DOAJ), and Google Scholar. These sources were selected to capture peer-reviewed and full-text literature relevant to psychiatric and mental health nursing practice across inpatient, community, and service delivery contexts. Google Scholar was used to supplement database searching by identifying potentially relevant articles not indexed in PubMed/MEDLINE or DOAJ and by supporting citation and reference chasing. All retrieved citations were exported and compiled for duplicate removal and screening. The search covered publications from January 2011 to December 2021 and was limited to English-language studies.

Search terms combined controlled vocabulary (where applicable in PubMed/MEDLINE) and free-text keywords. Core concepts included psychiatric nursing and mental health nursing alongside intervention and practice terms reflecting contemporary developments, such as nurse-led interventions, Safewards, de-escalation, restraint reduction, seclusion reduction, trauma-informed care, sensory modulation or sensory rooms, family psychoeducation, tele-mental health, and severe mental illness (including schizophrenia/psychosis and bipolar disorder). Boolean operators (AND/OR) were used to combine concepts and broaden retrieval, with minor adjustments made to reflect database-specific syntax.

### 2.3 Eligibility Criteria

Articles were included if they were peer-reviewed primary research studies reporting findings relevant to advances in psychiatric nursing practice. Eligible designs included randomized controlled trials (including cluster trials), quasi-experimental and observational studies, quality improvement/time-series evaluations, mixed-methods studies, and qualitative studies conducted in psychiatric/mental health settings and/or involving psychiatric/mental health nurses as providers or key participants. Studies were required to be English-language, published between January 2011 and December 2021, and full-text accessible.

Exclusion criteria included protocol-only publications, systematic reviews/meta-analyses (retained only for background citation and not counted as included studies), case reports/series, editorials, letters, conference abstracts, commentaries, dissertations/theses, non-English publications, and studies without extractable outcomes relevant to psychiatric nursing practice. Protocol-only papers and secondary syntheses were excluded from inclusion; however, selected protocols and reviews were cited in the Introduction/Discussion to contextualise emerging interventions and methodological directions.

### 2.4 Study Selection Process

The database search [PubMed/MEDLINE (including PubMed Central), the Directory of Open Access Journals (DOAJ), and Google Scholar] yielded 214 records. In addition, 9 records were identified through manual reference checking of included full-text articles and relevant background papers, giving 223 total records. After removal of 41 duplicates, 182 studies remained for screening based on titles and abstracts. At this stage, 118 articles were excluded because they were not directly related to psychiatric nursing practice or did not address practice advances (e.g., nurse-led interventions, restrictive practices reduction, Safewards, trauma-informed care, sensory modulation, psychoeducation/caregiver support, tele-mental health, or transitional care). The remaining 64 full-text articles were assessed for eligibility. Following full-text review, 35 studies were excluded due to ineligible study design (e.g., protocols, systematic reviews), non-psychiatric settings, or insufficient extractable outcomes relevant to psychiatric nursing practice. Finally, 29 studies were included in the qualitative narrative synthesis, and the study selection process was documented using a PRISMA flow diagram (Figure 1).

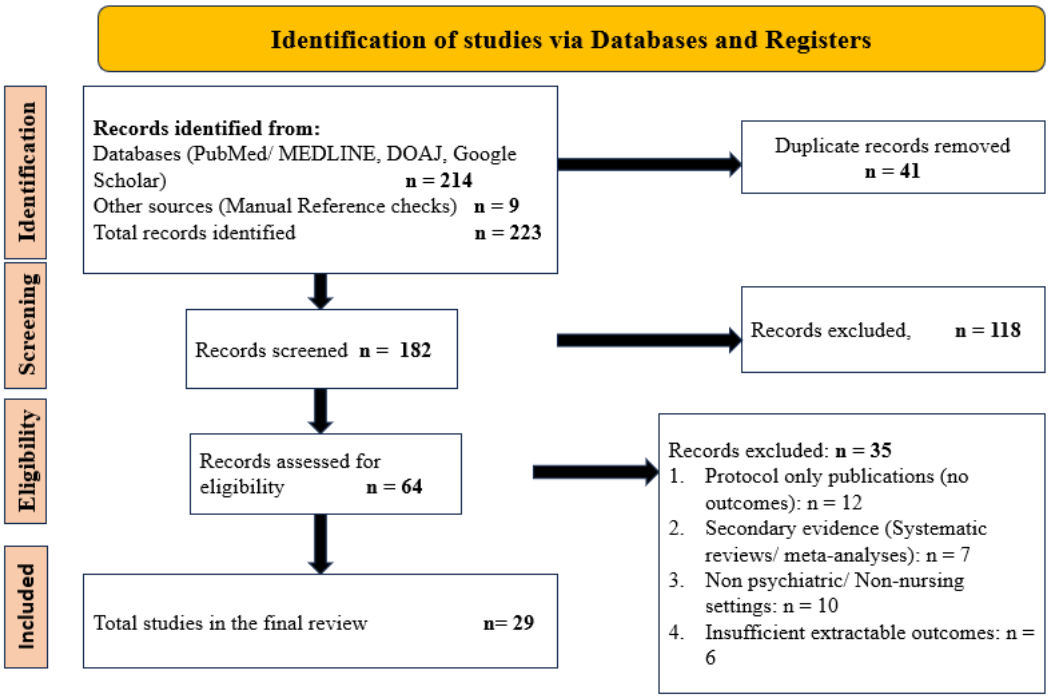


**Figure 1.** PRISMA Flow Diagram Illustrating the Study Selection Process

### 2.5 Data Synthesis

Given heterogeneity in study designs, settings, interventions, and outcome measures, a quantitative meta-analysis was not appropriate. Therefore, findings were synthesized narratively and grouped into domains relevant to psychiatric nursing practice, including restrictive practices reduction and ward safety, trauma-informed care, family and caregiver psychoeducation/support, nurse-led recovery and continuity/transitional care, sensory modulation/sensory room interventions, and tele-mental health and service-delivery innovations.

### 2.6 Ethical Considerations

Since this research was going to be done through the synthesis of already published material, there was no need of ethical approval and informed consent. The systematic review was done in line with ethical standards of systematic reviews, such as the clear reporting of the methods, proper citation, and reliable description of the original results. All the studies included were presumed to have been appropriately granted ethical approvals and also to have been conducted and published within ethical standards at the time of their initial conduction.

### 2.7 Limitations

This review has limitations. The differences in study designs and settings and outcome measures could not have been meta-analyzed and necessitated narrative synthesis. It has also restricted itself to English-language research and thus may have missed out on pertinent evidence. No formal methodological quality appraisal was conducted and thus no weighting of findings was done using the rigor of the studies. Nursing-led or nursing-supported interventions were also reviewed, which could be inadequate to capture the broader developments of service-level that are not frame as psychiatric nursing practice.

## 3. RESULTS

### 3.1 Overview of Selected Studies

The 29 studies incorporated in this review study the current trends in psychiatric nursing practice in the inpatient, community settings as well as in service delivery. Among the included studies, there is a report on progress in ward safety and the reduction of restrictive practices, a higher rate of structured psychosocial and recovery-oriented nursing intervention use with individuals with severe mental illness. Simultaneously, a number of studies discuss the widening scope of psychiatric nurse functions in supporting families and caregivers, and the advances to the therapeutic setting and the service delivery models, such as the sensory modulation strategies and the tele-mental health. The features of the studies used are summarised in Table 1 and the distribution of the studies across the thematic domains is given in Table 2.

**Table 1.** Characteristics of Included Studies (n = 29)

| Study | Study design | Setting / context | Focus / intervention | Primary outcome domain(s) |
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|---|---|---|---|---|
| Tang *et al.,* 2021 | Randomized controlled trial | Inpatient schizophrenia services | Mindfulness-based cognitive therapy | Stigma, self-esteem, psychosocial functioning |
| Chien *et al.,* 2018 | Randomized controlled trial with 4-year follow-up | Early psychosis services | Mutual support groups for families | Caregiver burden, family functioning, patient outcomes |
| Chien *et al.,* 2020 | Intervention study (mechanism analysis) | Recent-onset psychosis | Mindfulness-based psychoeducation | Mental health, psychosocial outcomes |
| Puspitasari *et al.,* 2021 | Open nonrandomized trial | Psychiatric day program | Group-based teletherapy | Feasibility, acceptability, symptom change |
| Zarvijani *et al.,* 2021 | Randomized controlled trial | Psychiatric nursing workforce | Acceptance and commitment therapy | Perceived stress, psychological flexibility |
| Barbic *et al.,* 2019 | Qualitative study | Acute inpatient psychiatry | Sensory modulation rooms | Self-regulation, service-user and staff experience |
| Bowers *et al.,* 2015 | Cluster randomized controlled trial | Acute psychiatric wards | Safewards model | Conflict rates, restraint and seclusion |
| Bell & Gallacher, 2016 | Quality improvement study | Inpatient psychiatric units | Improvement model for restraint reduction | Frequency and sustainability of restraint reduction |
| Berry *et al.,* 2016 | Qualitative process evaluation embedded in RCT | Acute inpatient wards | Ward-based psychosocial intervention | Staff and patient experience, therapeutic mechanisms |
| Ye *et al.,* 2021 | Cluster randomized controlled trial | Psychiatric hospitals | CRSCE-based de-escalation training | Physical restraint incidence |
| Florisse & Delespaul, 2020 | Ward-based observational evaluation | Acute psychiatric ward | Routine risk monitoring | Aggression, seclusion, nursing behaviour |
| Shiraishi *et al.,* 2019 | Randomized controlled trial | Caregivers of young adults with schizophrenia | Standard family psychoeducation | Caregiver mental health and burden |
| Smith & Jones, 2014 | Descriptive evaluation | Psychiatric intensive care unit | Sensory room use | Distress regulation, behavioural incidents |
| Staggs, 2020 | Observational analysis | Psychiatric facilities | Facility-level restraint and seclusion reporting | Variability in restrictive practices |
| Baumgardt *et al.,* 2019 | Implementation evaluation | Locked inpatient wards | Safewards implementation | Coercive measures, ward safety indicators |
| Bobier *et al.,* 2015 | Pilot study | Child and adolescent inpatient unit | Sensory modulation room | Engagement, perceived usefulness |
| Higgins *et al.,* 2018 | Qualitative evaluation | Public mental health facilities | Safewards implementation | Staff perceptions, ward culture |
| Azeem *et al.,* 2017 | Quasi-experimental study | Child and adolescent psychiatry | Trauma-informed six core strategies | Seclusion and restraint rates |
| Fletcher *et al.,* 2019 | Qualitative study | Adult inpatient mental health units | Safewards implementation | Staff perceptions of safety impact |
| Putkonen *et al.,* 2013 | Cluster randomized controlled trial | Secure psychiatric care | Multicomponent restraint reduction program | Seclusion and restraint use |
| McAllister *et al.,* 2021 | Case study | Acute mental health ward | Co-designed therapeutic engagement intervention | Nurse–patient engagement |
| Chambers *et al.,* 2021 | Cross-sectional study | Acute inpatient wards | Measurement of therapeutic engagement | Engagement indicators |
| Yellowlees *et al.,* 2020 | Service evaluation | Outpatient psychiatry | Rapid conversion to telepsychiatry | Service feasibility, continuity of care |
| Price *et al.,* 2018 | Qualitative study | Mental health inpatient settings | De-escalation techniques | Patient perspectives on violence management |
| Hasan *et al.,* 2015 | Randomized controlled trial | Schizophrenia services | Psychoeducational intervention | Patient outcomes, caregiver burden |
| Chien *et al.,* 2016 | Randomized controlled trial | Schizophrenia spectrum disorders | Adherence therapy | Medication adherence |
| Markle-Reid *et al.,* 2021 | Pragmatic randomized controlled trial | Hospital-to-home transition | Nurse-led transitional care | Continuity of care, depressive symptoms |

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|---|---|---|---|---|
| Maki *et al.,* 2021 | Cross-sectional study | Inpatient schizophrenia care | Nursing care processes | Early psychiatric readmission |
| Uslu & Buldukoglu, 2020 | Randomized controlled trial | Schizophrenia outpatient care | Telephone-based nursing intervention | Medication adherence |

**Table 2.** Thematic Mapping of Included Studies (n = 29)

| **Thematic domain** | **Included studies** |
|---|---|
| Ward safety and reduction of restrictive practices | Bowers *et al.,* 2015; Bell & Gallacher, 2016; Berry *et al.,* 2016; Putkonen *et al.,* 2013; Azeem *et al.,* 2017; Florisse & Delespaul, 2020; Staggs, 2020; Baumgardt *et al.,* 2019; Higgins *et al.,* 2018; Fletcher *et al.,* 2019; Ye *et al.,* 2021; Price *et al.,* 2018 |
| Psychosocial and recovery-oriented nursing interventions for severe mental illness | Tang *et al.,* 2021; Chien *et al.,* 2020; Chien *et al.,* 2016; Uslu & Buldukoglu, 2020; Maki *et al.,* 2021 |
| Family and caregiver psychoeducation and support | Chien *et al.,* 2018; Hasan *et al.,* 2015; Shiraishi *et al.,* 2019 |
| Therapeutic milieu innovations (sensory modulation and sensory rooms) | Smith & Jones, 2014; Bobier *et al.,* 2015; Barbic *et al.,* 2019 |
| Service delivery and continuity of care innovations | Yellowlees *et al.,* 2020; Markle-Reid *et al.,* 2021; Puspitasari *et al.,* 2021 |
| Therapeutic engagement and nursing care processes | McAllister *et al.,* 2021; Chambers *et al.,* 2021 |
| Workforce-focused interventions and nurse wellbeing | Zarvijani *et al.,* 2021 |

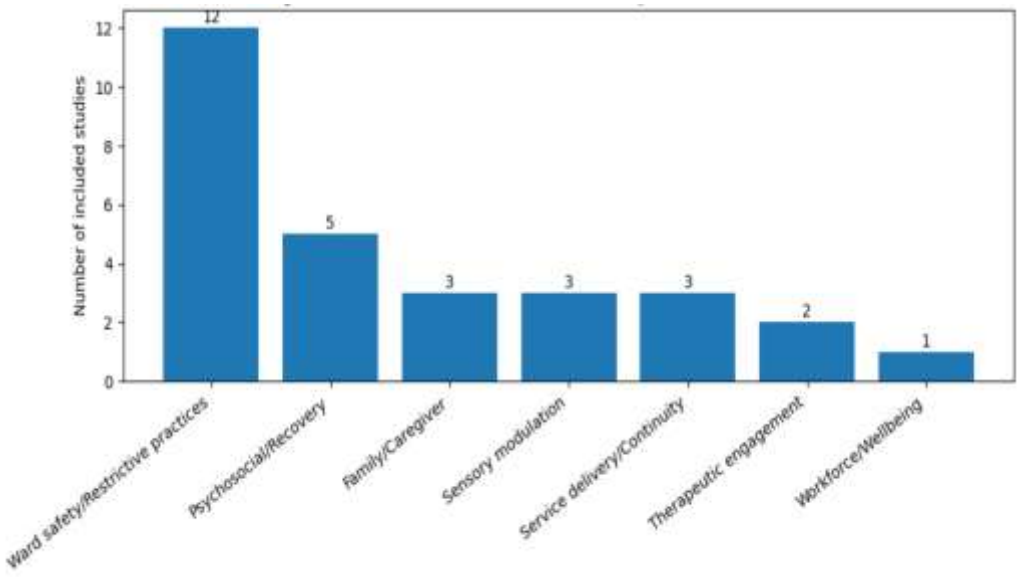


**Figure 2.** Distribution of included studies across thematic domains.

As Figure 2 shows, "Ward safety/Restrictive practices" is the most represented domain, followed by "Psychosocial/Recovery" and "Family/Caregiver" domains.

### 3.2 Ward Safety and Restrictive Practices Reduction

The included studies had a considerable percentage of the studies that looked at the safety of wards and the decrease in the use of restraint and seclusion, especially in acute and secure psychiatric units. The Safewards cluster randomized controlled trial was the most effective evidence in terms of statistically significant differences between the conflict events and containment practices across adult acute psychiatric wards after the introduction of the Safewards model (Bowers *et al.,* 2015). The implementation-based studies that subsequently followed showed the decrease in the number of coercive practices and the increase in both the culture of safety and perceptions towards the staff members in the locked wards and in the public mental health facilities after the introduction of Safewards (Baumgardt *et al.,* 2019; Higgins *et al.,* 2018; Fletcher *et al.,* 2019). Strategies that prevent escalation were also considered. The use of CRSCE-based training on de-escalation (a cluster randomized controlled trial revealed a significant decrease in the use of physical restraint in psychiatric hospitals), which supports the efficacy of organized personnel academic programs in aggression management (Ye *et al.,* 2021). Ward-based risk observation was linked to decrements in aggressive episodes and seclusion as well as alterations in the nursing behaviour of earlier and more proactive intervention (Florisse & Delespaul, 2020). Further

evidence of sustainable decrease of restraint and seclusion was provided by quality improvement and controlled intervention studies in inpatient and secure psychiatric care (Bell and Gallacher, 2016; Putkonen *et al.,* 2013). The Six Core Strategies and other trauma-informed practices were related to lower restrictive practices in child and adolescent psychiatric care (Azeem *et al.,* 2017). The results of qualitative studies were used as a supplement to the outcomes, as the researchers discovered that therapeutic relationships and communication and consistency of nursing responses were the core aspects of safer ward environments (Berry *et al.,* 2016; Price *et al.,* 2018).

Table 3 provides a summary of the ward safety interventions, restrictive practice outcomes, the study designs, and the setting in this thematic area.

**Table 3.** Ward safety and restrictive practice reduction outcomes across included studies

| **Practice focus** | **Approach / intervention** | **Outcome focus reported** | **Study design** | **Reference** |
|---|---|---|---|---|
| Ward safety and containment reduction | Safewards model | Conflict events; restraint and seclusion rates | Cluster randomized controlled trial | Bowers *et al.,* 2015 |
| Safewards implementation in locked wards | Safewards implementation | Coercive measures; ward safety indicators | Implementation evaluation | Baumgardt *et al.,* 2019 |
| Safewards implementation in public facilities | Safewards implementation | Staff perceptions; ward safety culture | Qualitative evaluation | Higgins *et al.,* 2018 |
| Safewards impact on inpatient practice | Safewards implementation | Staff perspectives on safety and containment | Qualitative study | Fletcher *et al.,* 2019 |
| Preventive escalation management | CRSCE-based de-escalation training | Physical restraint incidence | Cluster randomized controlled trial | Ye *et al.,* 2021 |
| Routine safety management | Ward-based risk monitoring | Aggression; seclusion; nursing behaviour | Observational ward evaluation | Florisse & Delespaul, 2020 |
| Sustained restraint reduction | Improvement Model approach | Frequency and sustainability of restraint reduction | Quality improvement study | Bell & Gallacher, 2016 |
| Restrictive practice reduction in secure care | Multicomponent reduction programme | Seclusion and restraint use | Cluster randomized controlled trial | Putkonen *et al.,* 2013 |
| Trauma-informed care implementation | Six Core Strategies | Seclusion and restraint rates | Quasi-experimental study | Azeem *et al.,* 2017 |
| System-level variation in safety outcomes | Facility-level reporting | Variability in restraint and seclusion rates | Observational analysis | Staggs, 2020 |
| Mechanisms of ward safety interventions | Ward-based psychosocial intervention | Therapeutic mechanisms; staff and patient experience | Qualitative analysis embedded in trial | Berry *et al.,* 2016 |
| De-escalation practice perspectives | De-escalation techniques | Barriers and enablers to violence management | Qualitative study | Price *et al.,* 2018 \| |

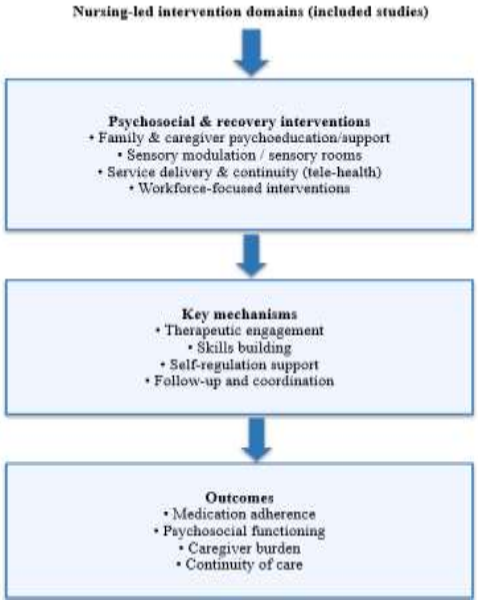


**Figure 3.** Conceptual flow diagram linking nursing-led intervention domains to key mechanisms and outcomes across included studies. *Source: Author*

As Figure 3 illustrates, nursing-led interventions such as family and caregiver psychoeducation, sensory modulation, and service delivery continuity play a crucial role in promoting key mechanisms like therapeutic engagement and self-regulation support, which in turn influence outcomes such as medication adherence and psychosocial functioning.

**3.3 Psychosocial and Recovery-Oriented Nursing Interventions for Severe Mental Illness**

Some of them assessed the effectiveness of structured psychosocial and recovery based interventions administered or facilitated by psychiatric and mental health nurses to individuals with schizophrenia and psychosis. Randomized controlled trials were focused on mindfulness-based interventions as the nursing-supported therapeutic methods. Mindfulness-based cognitive therapy was linked with this in an inpatient population of schizophrenia, which reduced internalised stigma and enhanced psychosocial functioning (Tang *et al.,* 2021). On the same note, psychoeducation based on mindfulness in people with new-onset psychosis showed a positive impact on mental health and psychosocial functioning, and particular aspects of mindfulness led to differences in outcomes (Chien *et al.,* 2020).

Interventions on treatment engagement and adherence were also represented. The randomized controlled trial of adherence therapy versus normalized psychiatric treatment has shown the increased adherence to medications in individuals with schizophrenia spectrum disorders undergoing the nursing-assisted intervention (Chien *et al.,* 2016). Follow-up by telephone-based nursing proved to be complementary evidence of a randomized controlled trial and showed greater medication adherence when applied to outpatient care of schizophrenia (Uslu & Buldukoglu, 2020).

The processes of recovery-oriented nursing care were also studied in the inpatient settings. A cross-sectional study reported a set of in-hospital nursing care practices related to lower rates of early psychiatric readmission among schizophrenic patients, which show the importance of systematic nursing interactions in the process of recovery (Maki *et al.,* 2021). Moreover, an effective randomized controlled trial based on empirical data about a practical intervention led by nurses that included hospital to home transitional care showed the superiority of continuity of care condition and mental health outcomes of adults with complex needs and depressive conditions, which points to the relevance of recovery-oriented nursing in the process of care transitions (Markle-Reid *et al.,* 2021).

Table 4 provides a summary of the psychosocial and recovery-oriented nursing interventions, domains of outcomes, and the study designs in this thematic area.

**Table 4.** Psychosocial and recovery-oriented nursing interventions and outcomes across severe mental illness

| Clinical focus | Intervention / approach | Outcome focus reported | Study design | Reference |
|---|---|---|---|---|
| Schizophrenia (inpatient) | Mindfulness-based cognitive therapy | Internalised stigma; psychosocial functioning | Randomized controlled trial | Tang *et al.,* 2021 |
| Recent-onset psychosis | Mindfulness-based psychoeducation | Mental health; psychosocial outcomes; mindfulness facets | Intervention study (mechanism-focused analysis) | Chien *et al.,* 2020 |
| Schizophrenia spectrum disorders | Adherence therapy | Medication adherence | Randomized controlled trial | Chien *et al.,* 2016 |

| | | | | |
|---|---|---|---|---|
| Schizophrenia (outpatient) | Telephone-based nursing intervention | Medication adherence | Randomized controlled trial | Uslu & Buldukoglu, 2020 |
| Schizophrenia (inpatient) | In-hospital nursing care processes | Early psychiatric readmission | Cross-sectional study | Maki *et al.,* 2021 |
| Severe mental illness / depression (transition phase) | Nurse-led hospital-to-home transitional care | Continuity of care; mental health outcomes | Pragmatic randomized controlled trial | Markle-Reid *et al.,* 2021 |

**3.4 Family and Caregiver Support, Therapeutic Milieu Innovations, and Service Delivery Developments**

Some of the studies that were included involved family-oriented and caregiver-oriented nursing interventions, especially in the context of schizophrenia and psychosis management. Randomized controlled trials showed that structured family psychoeducation, provided or facilitated by psychiatric nurses, was linked to the decrease of caregiver burden and a better mental health outcome in caregivers (Hasan *et al.,* 2015; Shiraishi *et al.,* 2019). A randomized trial provided further long-term evidence that mutual support group interventions have sustained benefits to families of individuals of psychosis, who have only recently developed the condition, and that family functioning and outcomes of caregivers may improve over a long-term follow-up period (Chien *et al.,* 2018). Together all these studies endorse the importance of psychiatric nursing in providing structured family-facing interventions as routine care pathways.

The studies of sensory modulation and sensory room interventions were the main representatives of the innovations in the therapeutic milieu. The qualitative and pilot assessments on adult and child and adolescent inpatient units described positive service-user and staff experiences, where sensory environments were used to help them regulate their emotions, overcome distress, and help them manage agitation (Smith and Jones, 2014; Bobier *et al.,* 2015; Barbic *et al.,* 2019). The base of evidence that is currently emerging, as reflected by these studies, is focused on acceptability and perceived usefulness as opposed to controlled outcome effects.

Service delivery model innovations involved the launch of nurse-led service adaptation and tele-mental health. The practicability and acceptability of group-based teletherapy psychiatric day programme was proved in an open nonrandomized trial with adults suffering serious mental illness, with early signs of symptom improvement reported (Puspitasari *et al.,* 2021). Service level assessment also reported the fast and ongoing adoption of telepsychiatry in outpatient psychiatric services, which contributes to continuity of care in case of service disruption (Yellowlees *et al.,* 2020). Evidence-based findings also showed that acceptance and commitment therapy intervention can lessen the perceived stress and enhance psychological flexibility in psychiatric nurses, hence the significance of staff wellbeing in supporting the continued innovation of the practice (Zarvijani *et al.,* 2021).

**4. Discussion**

The review used evidence of 29 studies that explored the recent advances in psychiatric nursing practice in inpatient, community settings, and service delivery environments. In general, the modern state of psychiatric nursing is becoming more characterised by an integrated, prevention-oriented, and recovery-based approach as opposed to a single-method approach. The four areas of practice development are connected in a way that they are interrelated: the safety of wards and the minimization of restrictive practices; the increased number of structured psychosocial and recovery-oriented nursing interventions; the enhanced family and caregiver support; and the modified delivery model, such as digital and transitional care.

The best coherent evidence and the most methodologically sound evidence are associated with ward safety and restrictive practice minimization. The supremacy of Safewards-oriented research is symptomatic of a wider move towards reactive containment as opposed to active conflict and escalation prevention. This is in line with research that suggests that aggression and containment are due to the interaction of the patient-related, environmental, and organisational factors and not individual behaviour (Weltens *et al.,* 2021). In the literature, the decrease in the use of restraint and seclusion was linked with structured communication, coherent responses, team-based interventions, and sustaining the culture change, assisted by considering the implementation fidelity, ward patterns, and staff involvement.

Qualitative data supports the idea that safer ward environments are based on therapeutic relationships and consistency in relationships. The use of de-escalation and emotional containment, as well as an explicit delineation of interpersonal boundaries, as nursing competencies, are highlighted in staff and service-user accounts, which aligns with the literature on the emotional labour of dealing with suicidal or highly vulnerable patients in high-risk situations (Hagen *et al.,* 2017). Combined, these results put ward safety as a relational and organisational outcome.

The second theme is the growth of psychosocial and recovery-based nursing interventions of severe mental illness. Nurses are providing or facilitating increasingly structured interventions that aim to address stigma, psychosocial functioning, medication adherence, and continuity of care and evidence of trials suggests measurable benefits. This is in line with the skill mix and task shifting of the workforce as nurses take on the role of increased therapeutic tasks due to increasing demand and the lack of specialist resources (Fulton *et al.,* 2011). Role expansion seems plausible in cases where the interventions are well-organized and integrated into the nursing procedures.

Recovery oriented practice was also evident in studies on inpatient to community care transitions. Orderly nursing procedures along with the hospitalisation and discharge were associated with less early readmission and continuity. Nevertheless, the inconsistency of outcome measures remains a limitation of comparison and synthesis, which is why

further standardisation and a set of standard outcome frameworks of discharge and transition-oriented interventions should be considered (Tyler *et al.,* 2020). Another area that was consolidated was family and caregiver support. As has been shown, structured family psychoeducation and mutual support interventions lead to better caregiver burden, mental health, and family functioning, which is connected to larger findings of small to moderate benefits of psychoeducational interventions to carers of people with psychosis (Sin *et al.,* 2017). This is indicative of a long-standing trend of acknowledging families as active participants in care, especially as inpatient stay duration gets shorter and the community dependence grows.

There is an increasing interest in the field of non-pharmacological regulation of distress by innovations in the therapeutic milieu, especially sensory modulation and sensory room interventions. Even though the evidence remains mostly qualitative and exploratory, the regular reports of acceptability indicate that sensory methods can be used to support the ward safety strategies and adhere to trauma-informed models that focus on creating a safe environment, choice, and emotional regulation (Sweeney *et al.,* 2018). Additional evaluative sophistication is required.

The changes in service delivery models such as tele-mental health demonstrates accommodation to the changing environments. Digitally mediated care is potentially feasible to maintain continuity and access, with a modest contribution to pathways, just as earlier reviews have shown that digitally mediated care is acceptable and effective among psychiatric populations (Hilty *et al.,* 2013; Lawes-Wickwar *et al.,* 2018). In these models, nurses are still in the center of maintaining engagement, coordinating care, and managing risk.

Although the study by Markle-Reid *et al.* (2021) addressed older adults with multimorbidity and depressive symptoms, including it was because it is related to transitional care and continuity, key issues in severe mental illness. Yellowlees *et al.* (2020) reported swift transition to telepsychiatry at the time of COVID-19; the study is indicative of the topical service delivery innovation, and the role of nurses was also indirect.

Altogether, the current psychiatric nursing practice is characterized by the growing definition of integrated, relational, and system-level interventions beyond the symptom management. The evidence emphasises the pivotal role of nurses in creating safer ward environments, providing structured psychosocial care and supporting families and changing service delivery as an organisational and societal pressure.

**5. Implications and Future Directions**

The implications of this review on the psychiatric nursing practice are significant and indicate key areas in the service delivery and nursing interventions to continue developing. Integrated and prevention-oriented models that incorporate the concept of ward safety, engagement in therapeutic interactions, and continuity of care ought to become the priority of psychiatric nursing. System-level interventions aimed at curtailing restrictive practices need to be put in place with staff training, systematic nursing response, and focus on workforce wellbeing. The increased application of the structured psychosocial and recovery-oriented interventions reflects the growing therapeutic role of psychiatric nurse and this must be supported by clear competency models, supervision and support of the organisation to ensure sustainability.

The further studies should be aimed at aligning outcome measures in the main areas, such as restrictive practices, therapeutic engagement, caregiver outcomes, and continuity of care, to enhance comparability between studies. Better disclosure of elements of intervention and conditions of implementation should be applied to facilitate replication and scale-up. New methods, including sensory modulation and tele-mental health, need to be evaluated, and the perspective of safety, equity, and compatibility with the face-to-face care pathways should be addressed.

**6. Conclusion**

This systematic review compiled data on 29 peer-reviewed studies that explored the current trends in psychiatric nursing practice in an inpatient, community and service-delivery environment. The results demonstrate that psychiatric nursing has persisted in shifting away to a limited scope of managing symptoms to strategies that promote safety, therapeutic interaction, recovery and continuity of care. In all settings, nurses found themselves being placed as care providers as well as the primary agents of practice change in an ever more complex mental health system. A large percentage of the evidence concerned the safety of the wards and minimization of restrictive practices. Safewards, de-escalation training, regular risk observation and frameworks based on trauma-informed care were prevalently linked to conflict, restraint and seclusion reduction when implemented in the everyday nursing care. These studies point to the fact that enhancement of safety has a close relationship with relational work, communication within the team and long term cultural change, as opposed to depending on reactive containment behavioral strategies. The review also shows a growing therapeutic role of the psychiatric nurses. Psychosocial and recovery-oriented interventions led by nurses and supported by nurses were found to have good results in the case of the severely ill mentally. The idea of family-based interventions also supported the role of advising the caregivers to be active collaborators in care with evidence of better caregiver burden and functioning of the family. Sensory modulation methods and a digitally mediated care were emerging innovations that indicated the continuous changes in nursing practice in response to service pressures and evolving care delivery modes. Although these areas are under-assessed, the evidence at hand indicates that these areas are acceptable and viable, given the fact that they have to be supported accordingly. Combined, these results indicate that modern psychiatric nursing practice is being characterised more and more by structured, relational and system level interventions. Further progress will rely on the strength of assessment, focus on the process of implementation, and the support of the nursing potential to maintain safe and recovery-oriented mental health care.

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