

ORIGINAL ARTICLE

Psychiatric nurses' experiences in preventing relapse among patients with substance use disorders: a qualitative study

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ABSTRACT

Background: Relapse remains one of the most persistent challenges in the treatment of substance use disorders, with regional readmission rates reaching approximately 30% within 1 year of discharge. Psychiatric nurses occupy a uniquely continuous position within inpatient rehabilitation settings, yet their lived experiences in relapse prevention have received little attention in Saudi Arabia.

Objective: To explore and describe the lived experiences of psychiatric nurses in preventing relapse among patients with substance use disorders at a behavioral rehabilitation center in Riyadh, Saudi Arabia.

Methods: A qualitative design with a phenomenological orientation was used. Semi-structured, individually conducted interviews using a 16-item guide spanning seven thematic domains were completed with 15 psychiatric nurses purposively sampled from a single behavioral rehabilitation center. Written participant responses were analyzed using Braun and Clarke's reflexive thematic analysis.

Results: Nine major themes emerged: (1) enacting relapse prevention as an early and proactive role, (2) navigating patient-level, institutional, and social barriers, (3) emotional labor and professional resilience, (4) building trust-based therapeutic relationships, (5) confronting stigma and engaging in reflective practice, (6) experience-driven competence alongside identified training gaps, (7) hierarchical tension within multi-disciplinary collaboration, (8) structured discharge preparation amid post-discharge continuity gaps, and (9) professional wisdom rooted in patience and non-judgmental care. Nurses overwhelmingly described relapse prevention as beginning "from day one" of admission (13/15) and identified trust-building through consistency and non-judgment (13/15) as foundational to therapeutic engagement.

Conclusion: Psychiatric nurses in this Saudi rehabilitation setting perform a central, often under-recognized role in relapse prevention, grounded in sustained therapeutic relationships and early intervention, but constrained by hierarchical team structures, discontinuous post-discharge follow-up, and gaps in specialized training. These findings provide a contextualized account of addiction-nursing practice in one Saudi setting and carry direct implications for workforce training and institutional protocol development.

Keywords: Psychiatric nursing, substance use disorder, relapse prevention, qualitative research, thematic analysis, Saudi Arabia.

Introduction

Substance use disorders (SUD) represent a substantial and growing burden on global health systems. The Global Burden of Disease Study estimated that 283 million people worldwide were living with alcohol use disorders and 36 million with drug use disorders

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as of the most recent WHO figures [1]. Within Saudi Arabia specifically, the first nationally representative epidemiological survey found a 4.03% lifetime prevalence of SUD, yet only 44.9% of individuals with a lifetime disorder had ever sought treatment of any kind – indicating a substantial unmet-need gap that inpatient rehabilitation centers are only partially positioned to close [1].

Relapse following inpatient treatment remains one of the most persistent challenges in addiction care. International estimates place relapse rates for SUD in the range of 40%–60%, a figure comparable to relapse rates observed in other chronic illnesses such as type 2 diabetes and hypertension – a framing that has been used to argue against viewing relapse as a treatment failure and instead as an expected feature of a chronic, relapsing condition [2]. Regional data reinforce the scale of the problem: a 16-year retrospective cohort from a major Gulf rehabilitation center found that 30.17% of patients were readmitted within 1 year of discharge, with over half of the cohort unemployed at the time of admission [3]. A more recent Saudi follow-up study similarly found that patients who did not complete their rehabilitation program experienced a readmission rate of 26.9%, compared with only 13.1% among those who completed treatment – underscoring the protective effect of continuity and completion of care [4].

Within the inpatient treatment environment, psychiatric nurses occupy a distinctive and clinically significant position. Unlike physicians, psychologists, or social workers who typically interact with patients during scheduled sessions, nurses are present continuously across all shifts and all phases of a patient's admission. This sustained presence positions nursing staff as the primary vehicle for relationship-based, relapse-focused intervention – including behavioral observation, early warning-sign detection, psychoeducation, medication management, and discharge preparation [5]. A recent phenomenological study of patients in SUD treatment programs found that patients themselves identified nurses' emotional support, empathy, and trust-building as central to their recovery experience, while simultaneously describing the nursing role as “invisible and poorly understood” within the broader treatment team [6].

Despite this central clinical position, the professional experiences of psychiatric nurses working specifically in addiction and relapse-prevention care remain markedly under-researched. Existing literature on relapse prevention has focused predominantly on pharmacological and psychotherapeutic interventions, with comparatively little attention paid to the perspective of nurses themselves—their perceived role, the barriers they encounter, the emotional demands of the work, and the adequacy of their professional preparation. Where nursing perspectives have been examined, findings point to a workforce contending with stigma, role ambiguity within multidisciplinary

teams, and significant emotional labor. Qualitative studies of inpatient nurses caring for patients with opioid use disorder describe clinicians who are, in their own words, “kind of at war with” themselves, torn between compassionate care and frustration born of inadequate preparation [7]. A structural equation modeling study of psychiatric nurses further found that the relationship between stigma and moral distress operated substantially through emotional exhaustion – evidence that the emotional and attitudinal dimensions of addiction nursing are deeply intertwined [8].

The influence of cultural and religious context adds a further, largely unexamined dimension to this picture in Saudi Arabia. A recent Saudi qualitative study exploring the relationship between culture, religion, and mental disorders found that greater religious and mental-health knowledge tended to promote compassion consistent with Islamic principles, whereas the absence of such knowledge exacerbated stigma and fear-based beliefs [9]. Because addiction is frequently framed – both within Saudi society and in parts of the healthcare workforce – through a moral or religious lens, the stigma experienced by SUD patients, and the attitudes held by the nurses who care for them, may differ meaningfully from patterns described in Western-centric literature.

Our literature search identified limited evidence on the lived experiences of practicing psychiatric or addiction nurses in relapse-prevention care within Saudi Arabia or the wider Gulf Cooperation Council (GCC) region. The closest methodological precedents are a Jordanian qualitative study of nurses' attitudes in addiction rehabilitation centers [10] and a near-identical qualitative study of psychiatric nurses' perceptions of youth relapse prevention conducted in Botswana, which similarly employed 15 participants, semi-structured interviews, and thematic analysis [11]. Neither study, however, was conducted within a Saudi or GCC setting, and neither addresses the specific cultural, religious, and institutional context that shapes addiction nursing practice in the Kingdom.

The present study addresses this gap directly. Using a qualitative design with a phenomenological orientation, it explores how psychiatric nurses at a behavioral rehabilitation center in Riyadh experience their role in preventing relapse among patients with substance use disorders—including how they define that role, the barriers and emotional demands they encounter, the therapeutic relationships they build, the influence of stigma and cultural context on their practice, their perceived training needs, their experience of multidisciplinary collaboration, and their approach to discharge planning. In doing so, the study aims to provide a locally contextualized account of addiction-nursing practice in Saudi Arabia, with direct implications for nursing education, institutional protocol development, and future relapse-prevention strategy.



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Methods

Study design

This study employed a qualitative research design with a phenomenological orientation appropriate for exploring the subjective meaning nurses attribute to their professional experience of relapse prevention. Data were analyzed using Thematic Analysis following the six-phase framework described by Braun and Clarke [12], a method selected for its methodological flexibility and its suitability for identifying patterned meaning across a moderately sized qualitative dataset. Consistent with contemporary reflexive applications of the method [13,14], coding was treated as an interpretive process shaped by the researcher's clinical and professional positioning, and sample adequacy was evaluated in relation to the richness and depth of the dataset rather than a fixed numerical saturation threshold.

Study setting

The study was conducted at ReLib Behavioral Rehabilitation Center, a specialized inpatient facility providing multidisciplinary treatment for individuals with substance use and co-occurring behavioral health disorders in Riyadh, Kingdom of Saudi Arabia. The center employs a nursing team working alongside psychiatry, clinical psychology, and social work within a structured, multidisciplinary care model.

Participants and sampling

A purposive sampling strategy was used to recruit psychiatric nurses with direct clinical experience caring for patients with substance use disorders. Eligible participants were registered nurses currently employed at the study site with a minimum of one year of direct experience in psychiatric or addiction nursing, and who were actively involved in inpatient care or discharge planning for SUD patients. Nurses with fewer than twelve months of relevant experience, and administrative or managerial staff without direct patient-care responsibilities, were excluded. A total of fifteen ($N = 15$) eligible nurses consented to participate. This sample size is consistent with recommended practice for semi-structured interview-based qualitative studies involving a relatively homogeneous professional population [14].

Data collection

Data were collected using a purpose-built, semi-structured interview guide comprising sixteen main open-ended questions organized across seven thematic domains: (1) role and scope of practice, (2) challenges and barriers, (3) therapeutic relationship, (4) stigma and personal attitudes, (5) training and competence, (6) multidisciplinary team collaboration, and (7) discharge planning. Each main question was accompanied by structured probing questions to elicit further depth where needed. The guide was developed based on a review of the relevant international literature and reviewed for content relevance prior to use.

All interviews were conducted individually by the first author in a private room and lasted approximately 45 minutes. Interviews were not audio-recorded, to protect participant confidentiality within a small nursing workforce and to encourage candid responses given the interviewer's leadership role. The interviewer took detailed contemporaneous handwritten notes and read the key points back to each participant at the end of the interview to confirm, correct, or add to them. The notes were then condensed into a structured written record for each participant; participant extracts are therefore reported as paraphrased accounts rather than direct quotations.

Data analysis

Written interview data were analyzed using the six-phase Thematic Analysis framework of Braun and Clarke [12]: (1) familiarization with the dataset; (2) generation of initial codes across the full dataset; (3) searching for candidate themes by collating related codes; (4) reviewing themes against the coded extracts and the dataset as a whole; (5) defining and naming themes; and (6) producing the final written analysis. Coding was conducted at the level of individual response segments across all sixteen interview questions, with codes subsequently grouped into sub-themes and organized under overarching main themes. Trustworthiness was addressed using the criteria of Lincoln and Guba [15] - credibility, dependability, confirmability, and transferability - operationalized in accordance with the phase-by-phase guidance of Nowell et al. [16].

Ethical considerations

The study protocol, including the interview guide, Participant Information Sheet, and Informed Consent Form, was reviewed and approved by the Institutional Review Board (IRB) of Care Medical Hospitals prior to data collection (IRB Approval No. IRB-025/260726). Written informed consent was obtained from all participants. Participation was voluntary, and participants were informed that they could decline to answer any question or withdraw at any time without any effect on their employment or professional standing. No audio or video recordings were made. All participant data were anonymized and assigned a numerical participant code (P1-P15) prior to analysis; no identifying information is reported in this manuscript.

Results

Fifteen psychiatric nurses ($N = 15$) participated in the study. Analysis of the interview data yielded nine major themes, each comprising two to four sub-themes. Table 1 presents an overview of the theme structure; Table 2 reports the ten most frequently occurring codes across the full dataset. Themes are presented below with illustrative paraphrased accounts of participants' responses. Frequencies are reported as the number of participants (out of 15) whose responses were coded to a given category.



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Table 1. Overview of main themes and sub-themes.

Theme	Main theme	Sub-themes
1	Enacting Relapse Prevention: Role Identity and Scope	Proactive daily interventions; Early and structured orientation; Role clarity and boundaries
2	Navigating Barriers: Structural, Patient-Level, and Social Challenges	Patient-level resistance; Institutional barriers; Family/social context
3	Emotional Labor, Burnout, and Professional Resilience	Emotional impact of relapse; Cognitive reframing; Coping strategies
4	The Therapeutic Relationship: Trust, Boundaries, and Engagement	Trust-building; Professional boundaries; Engaging resistant patients; SUD-specific adaptations
5	Stigma, Personal Attitudes, and Reflective Practice	Structural stigma; Cultural/religious dimensions; Bias management; Non-judgmental strategies
6	Training, Competence, and Identified Skill Gaps	Adequacy of formal training; Experiential learning; Training gaps; Supervision and peer support
7	Multidisciplinary Team Collaboration: Nursing Voice and Power	Positive collaboration; Hierarchical barriers; Desired changes
8	Discharge Planning and Post-Discharge Concerns	Discharge preparation practices; Limited nursing role; Post-discharge risk factors; Continuity gaps
9	Professional Wisdom: Core Values and Knowledge Transfer	Effective practices; Sources of meaning; Advice to new nurses; Core personal qualities

Table 2. Ten most frequently reported codes (N = 15).

Code	n	%
Relapse prevention begins from day one of admission	13/15	86.7
Trust-building through consistency and non-judgment	13/15	86.7
Structured discharge education sessions on triggers and coping	13/15	86.7
Family psychoeducation and involvement in discharge planning	13/15	86.7
Behavioral observation and early warning detection	13/15	86.7
Formal training seen as adequate and relevant	14/15	93.3
Motivational interviewing techniques	12/15	80.0
Continuous learning is essential - the field evolves	12/15	80.0
Return to substance-using social circles or environment	12/15	80.0
Personal effort to counteract stigma through advocacy	11/15	73.3

Theme 1: enacting relapse prevention - role identity and scope

Nurses overwhelmingly described relapse prevention as an active, continuous responsibility that began at the point of admission rather than in preparation for discharge. Thirteen of fifteen participants (86.7%) explicitly stated that their relapse-prevention efforts started "from day one," reflecting a proactive rather than reactive orientation to the nursing role.

P9 described being fully involved from day one and using a structured framework to support safe discharge and relapse prevention.

Daily practice centered on patient education and psychoeducation regarding triggers (11/15), emotional support and active listening (8/15), and behavioral observation for early warning signs (13/15). Most participants (10/15) reported following a structured protocol or care pathway, though several (9/15) emphasized that this structure was combined with an individualized approach shaped by each patient's history.

P9 described combining structured protocols with individualized plans based on patient history and daily nursing assessment.



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Role clarity varied across the sample. While the majority of nurses described their role as clearly defined within the institution, a smaller subset (6/15) characterized their role perception as vague or reported some overlap with the responsibilities of other disciplines.

Theme 2: navigating barriers - structural, patient-level, and social challenges

Participants identified challenges operating at three interacting levels. At the patient level, denial or lack of insight (11/15) and non-compliance with treatment (10/15) were the most commonly cited obstacles to relapse prevention.

At the institutional level, nurses described resource constraints (6/15) and high nurse-to-patient ratios stemming from staff shortages (5/15) as limiting the depth of individualized care they could provide. At the family and social level, enabling behaviors or unsupportive home environments (9/15) and the absence of structured community follow-up services (6/15) were frequently described as undermining the durability of inpatient gains after discharge. A smaller number of participants (3/15) specifically identified cultural or religious barriers as complicating factors, particularly in relation to family engagement.

Theme 3: emotional labor, burnout, and professional resilience

Emotional exhaustion emerged as a prominent feature of nurses' accounts, with compassion fatigue described by the majority of participants (11/15) as a direct consequence of repeated patient relapse.

Rather than viewing relapse as a personal or professional failure, most nurses (9/15) described cognitively reframing relapse as an expected part of the recovery trajectory, while a substantial subset (8/15) reported maintaining a degree of professional detachment as a protective strategy. Coping was most commonly achieved through peer support and informal team debriefing (11/15), with spiritual or religious coping mechanisms also frequently reported (8/15).

P9 described relieving stress through personal activities such as going to the gym, playing football, and swimming.

Theme 4: the therapeutic relationship - trust, boundaries, and engagement

Trust-building emerged as the single most consistently reported foundation of effective nursing practice, cited by 13 of 15 participants (86.7%) as achieved through consistency and a non-judgmental stance.

P9 described setting clear limits while showing empathy, agreeing goals with the patient, and providing support, a safe environment, and good communication.

Maintaining professional boundaries while remaining emotionally available was described as a recurring balancing act, with clear and firm communication of boundaries reported by 11 of 15 participants. Motivational interviewing techniques were the most commonly reported strategy for engaging resistant or ambivalent patients (12/15), and the majority of participants (11/15) felt that SUD patients required more patience and a longer trust-building process compared with patients presenting with other psychiatric conditions.

Theme 5: stigma, personal attitudes, and reflective practice

Stigma was described as operating at both an institutional and a broader cultural level. Eight of fifteen participants reported having witnessed judgmental or dismissive attitudes toward SUD patients among colleagues, and an equal number described stigma as directly reducing the quality of care patients received.

A religious or moral framing of addiction as a personal failure was identified by 8 of 15 participants as a contributing factor to stigma, and 7 of 15 described cultural shame as a barrier preventing patients and their families from seeking help. Despite this, a majority of participants (11/15) described actively working to counteract stigma through advocacy or modeling non-judgmental behavior, and several (9/15) demonstrated reflective awareness of their own occasional frustration or bias, most commonly managed through supervision or peer reflection (10/15).

Theme 6: training, competence, and identified skill gaps

Nearly all participants (14/15) rated their formal training as adequate and relevant to their current role; however, when asked to elaborate, most described the practical skills most critical to their daily work - therapeutic communication, crisis intervention, de-escalation, and relapse-risk assessment - as having been developed primarily through hands-on clinical experience rather than formal instruction.

P8 described developing therapeutic communication, crisis management, de-escalation, risk assessment, and patient-engagement skills through hands-on clinical experience rather than formal training.

When asked to identify specific gaps, participants most frequently expressed a desire for additional training in motivating disengaged or resistant patients (8/15) and in managing patients with dual diagnoses (8/15). Structured training in motivational interviewing, trauma-informed care, and established relapse-prevention models (e.g., the Marlatt model) were commonly named as desired additions to the current curriculum. In the absence of formal supervision structures, most nurses (11/15) reported relying on senior colleagues for guidance in uncertain clinical situations.



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Theme 7: multidisciplinary team collaboration – nursing voice and power

Accounts of multidisciplinary collaboration were mixed. A majority of participants (9/15) described regular, structured team meetings in which nursing input was valued and incorporated into care planning; an equal number, however, identified a hierarchical team structure as limiting nursing autonomy, and a small number (2/15) described their voice as marginalized or ignored within team discussions.

When asked what changes would most improve collaborative relapse-prevention outcomes, the most common recommendations were more frequent and structured multidisciplinary communication (10/15) and greater nursing involvement specifically in care planning and discharge decisions (8/15). A smaller number of participants proposed the creation of a dedicated addiction-nurse specialist role (6/15).

Theme 8: discharge planning and post-discharge concerns

Nursing involvement in discharge preparation was substantial and consistent. Structured discharge education addressing triggers and coping strategies (13/15) and family psychoeducation (13/15) were the two most frequently reported discharge-related practices.

P15 proposed a structured post-discharge follow-up program with regular nursing contact, coordinated with community addiction services.

Despite this consistent investment at the point of discharge, participants expressed considerable concern about what happens after the patient leaves the facility. The most frequently cited post-discharge risk factor was a return to substance-using social circles or environments (12/15), followed closely by inadequate or inaccessible outpatient mental health services (10/15) and an absence of structured hospital-led follow-up (8/15). A recurring recommendation across participants was the establishment of a mandatory, structured post-discharge follow-up protocol.

Theme 9: professional wisdom – core values and knowledge transfer

When reflecting on what they considered most important in their work, participants converged on a small set of core values. Consistent therapeutic presence and relationship-building was the most frequently cited effective practice (10/15), alongside patient empowerment and early identification of warning signs.

Like several colleagues, P4 advised newly qualified nurses not to take relapse personally and to build therapeutic relationships before attempting behavioral change.

Personal connection and genuine concern for the patient (10/15) was the most commonly cited source of professional meaning. When asked what advice they would offer a newly qualified nurse entering this field, the most frequent responses centered on the importance of patience with slow progress (8/15), the necessity of not internalizing relapse as personal failure (8/15), and the value of building therapeutic relationships prior to attempting behavioral change (7/15). A commitment to continuous learning was described by the largest share of participants (12/15) as a defining quality for sustained practice in this field.

Discussion

This study set out to explore the lived experiences of psychiatric nurses in preventing relapse among patients with substance use disorders at a behavioral rehabilitation center in Riyadh, Saudi Arabia—a population and setting that has received little attention in the peer-reviewed literature. The nine themes generated from this analysis converge on a central finding: nurses in this setting perform a continuous, relationship-driven role in relapse prevention that begins at admission and extends conceptually well beyond discharge, yet this role operates within institutional, emotional, and cultural conditions that are only partially supportive of it.

Role enactment and the primacy of early intervention

The finding that the substantial majority of nurses (86.7%) considered relapse prevention to begin “from day one” of admission is consistent with the broader literature positioning nurses as the most consistently present clinical resource within inpatient addiction settings [5]. This early-intervention orientation distinguishes the nursing contribution from that of other disciplines, whose involvement is typically episodic. It also resonates with patient-reported data showing that individuals in SUD treatment programs value nurses' sustained emotional presence and trust-building above discrete clinical interventions [6]. At the same time, the coexistence of strong role enactment with inconsistent role clarity – six of fifteen participants described their role as vaguely defined or overlapping with other disciplines – echoes a broader pattern documented in community mental health nursing, where role ambiguity persists despite nurses' de facto centrality to care coordination [17]. This suggests that role performance and role recognition may be only loosely coupled: nurses in this study were enacting a clearly defined clinical function without necessarily experiencing that function as institutionally validated.

Emotional labor as a structural, not individual, phenomenon

The prominence of compassion fatigue (73.3%) and the widespread reliance on peer debriefing and spiritual coping mechanisms align closely with international evidence describing emotional labor as a defining – and under-supported – feature of psychiatric nursing [18,19].



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Importantly, participants in this study did not describe their emotional exhaustion as a personal failing but rather reframed repeated relapse as an expected feature of a chronic illness trajectory, a coping strategy that parallels the clinical framing recommended by the National Institute on Drug Abuse [2]. This cognitive reframing may itself function as a protective factor against burnout, consistent with findings that emotion-regulation strategy moderates the relationship between emotional labor and burnout in psychiatric nursing populations [20]. However, the near-total reliance on informal peer support, in the apparent absence of structured institutional supervision for emotional processing, raises a question this study cannot resolve: whether current coping mechanisms are sustainable at scale, or whether they represent an adaptive response to an unmet structural need.

Trust as the operational core of therapeutic engagement

Trust-building through consistency and non-judgment was the single most frequently reported code in the entire dataset (86.7%), a finding that positions the therapeutic relationship not as one component of nursing practice but as its organizing principle. This finding is consistent with the wider nursing literature on rapport and therapeutic relationship-building [21] and with qualitative accounts describing addiction nurses as engaged in a continuous, effortful process of balancing empathy against professional boundaries [7]. Notably, participants in this study did not describe boundary-setting and emotional warmth as competing demands but as complementary – clear boundaries were frequently framed as a precondition for, rather than an obstacle to, authentic therapeutic engagement. This nuance may reflect a culturally inflected model of professional care in which explicit boundary communication is itself an expression of respect and structure rather than emotional distance.

Stigma and the cultural-religious dimension of addiction care

The identification of religious or moral framing of addiction as a contributor to stigma (53.3%) adds nursing-level evidence on a phenomenon previously documented at the patient and community level in Saudi Arabia. A recent qualitative study exploring the relationship between culture, religion, and mental disorders in Saudi Arabia found that greater religious literacy tended to promote compassion consistent with Islamic principles, while the absence of such knowledge exacerbated stigmatizing beliefs [9]. The present findings extend this observation into the nursing workforce itself: nurses did not describe themselves as merely bystanders to societal stigma but as active agents attempting to counteract it through advocacy and modeling – a form of stigma resistance work that has received little attention in the addiction-nursing literature to date. This finding also nuances existing evidence that religion can function as either a barrier or

a facilitator of help-seeking in Gulf healthcare contexts [22]: in this study, several nurses appeared to actively reframe religious values toward compassion rather than judgment, suggesting that individual practitioners may play a mediating role in how religious framing translates into patient-facing stigma.

Training: confidence without full preparedness

A striking pattern in this dataset was the near-universal endorsement of formal training as adequate (93.3%), set against detailed, unprompted descriptions of core clinical skills – de-escalation, motivational interviewing, dual-diagnosis management – having been acquired primarily through hands-on experience rather than structured instruction. This apparent contradiction mirrors findings from motivational interviewing training research, where technical competency improved following brief training interventions but relational competency did not [23], and is consistent with broader evidence that addiction-specific content is frequently underrepresented in nursing curricula [24]. One interpretation is that participants were evaluating “adequate training” against a general nursing education standard rather than an addiction-specialist standard; a second, complementary interpretation is that experiential learning has become normalized as an implicit, unacknowledged component of professional preparation in this setting. Either interpretation supports the same practical conclusion: formalizing structured training in motivational interviewing, trauma-informed care, and relapse-prevention models (e.g., the Marlatt framework) would likely convert experience-dependent competencies into more consistently acquired, curriculum-based skills.

Hierarchy within collaboration: a qualified success

Findings regarding multidisciplinary collaboration were more ambivalent than in other thematic areas. While a majority of nurses described valued participation in structured team meetings, an equally substantial proportion identified hierarchical structures as constraining nursing autonomy. This pattern is consistent with systematic review evidence showing that community mental health nurses frequently report role ambiguity and diminished professional confidence within multidisciplinary structures, despite functioning as de facto care coordinators [17]. The specific recommendation – voiced independently by multiple participants – for a dedicated addiction-nurse specialist role suggests that nurses in this setting perceive existing generalist role definitions as insufficient to capture the specialized nature of their clinical contribution, a finding with direct implications for workforce planning.

The discharge paradox: strong preparation, weak continuity

Perhaps the most policy-relevant finding of this study is the contrast between the consistency of nursing-led discharge preparation (structured education and family psychoeducation reported by 86.7% of



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participants) and the near-universal concern about what happens after the patient leaves the facility. This pattern directly parallels quantitative evidence from the Gulf region: a large retrospective cohort found a 30.17% one-year readmission rate at a major regional rehabilitation center [3], while a more recent Saudi follow-up study found that program completion nearly halved the six-month readmission rate compared with non-completion (13.1% vs. 26.9%) [4]. Taken together with the present qualitative findings, this suggests that the nursing contribution to relapse prevention is front-loaded at the point of discharge but structurally unsupported thereafter - a gap consistent with scoping review evidence showing that post-discharge care-transition strategies for SUD patients are inconsistently implemented and measured across settings [25]. The nurses in this study appeared acutely aware of this discontinuity, repeatedly and independently proposing structured, mandatory post-discharge follow-up protocols - a recommendation that aligns closely with existing evidence that scheduling a community appointment prior to discharge is one of the most consistently effective transition strategies identified in the broader literature [25].

Professional wisdom and the foundations of sustainable practice

The convergence of experienced nurses' advice around patience, non-personalization of relapse, and relationship-first practice reflects an internally coherent professional philosophy that appears to have developed organically, in the relative absence of formal institutional articulation. This body of tacit knowledge - accumulated through years of frontline experience rather than transmitted through structured mentorship - represents a valuable but currently informal resource. Formalizing this knowledge, for example through structured peer-mentorship programs pairing experienced and newly qualified nurses, may offer an efficient, low-cost mechanism for addressing the training gaps identified in Theme 6 while simultaneously validating the professional expertise this study has documented.

Study limitations

- As a qualitative study conducted at a single center, findings are not intended to be statistically generalizable; transferability to other institutions will depend on the similarity of institutional structure, patient population, and cultural context.
- Data were collected through written interview responses rather than audio-recorded and transcribed dialogue; while this approach preserved participant anonymity and comfort in discussing sensitive professional experiences, it may have limited the depth of spontaneous elaboration compared with a fully transcribed oral interview.
- Several participant responses combined predefined response categories with free-text

elaboration, which may have introduced a degree of response anchoring; however, the consistency between structured codes and unprompted free-text elaboration across participants strengthens confidence in the thematic patterns identified.

- As the Principal Investigator holds a clinical leadership role within the study setting, social desirability bias cannot be entirely excluded, particularly in relation to questions concerning institutional support and multidisciplinary hierarchy; this positionality was addressed through reflexive attention during coding but remains a relevant limitation.
- The cross-sectional design captures nurses' perspectives at a single point in time and cannot speak to how role experience, training needs, or attitudes toward stigma may evolve over the course of a nursing career.

Conclusion

This study provides an account of psychiatric nurses' experiences in preventing relapse among patients with substance use disorders within a Saudi Arabian treatment setting. Nurses in this study enacted a proactive, relationship-centered role beginning at admission, grounded in trust-building, sustained emotional labor, and active resistance to stigma - often extending their professional identity to include informal advocacy against the cultural and religious framing of addiction as moral failure. This role was performed, however, within institutional structures that did not always recognize its centrality: hierarchical barriers within multidisciplinary teams, reliance on informal rather than formal training pathways, and a marked discontinuity between well-developed discharge preparation and near-absent post-discharge follow-up all emerged as significant constraints on the full realization of nursing-led relapse prevention.

These findings carry direct and actionable implications. At the institutional level, the study supports the development of a structured, mandatory post-discharge follow-up protocol coordinated by nursing staff, and consideration of a dedicated addiction-nurse specialist role to formalize an already highly specialized clinical contribution. At the educational level, the findings support the introduction of structured, competency-based training in motivational interviewing, trauma-informed care, and established relapse-prevention frameworks, delivered in a manner that recognizes and builds upon the substantial experiential knowledge nurses already possess. At the cultural level, the study suggests that nurses may be uniquely positioned - given their sustained contact with patients and families - to serve as agents of stigma reduction within a religiously and culturally informed care environment, a role that merits explicit institutional support rather than reliance on individual initiative.



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Future research should examine the effectiveness of structured post-discharge nursing follow-up protocols on relapse and readmission outcomes in the Saudi context, explore the perspectives of patients and family members alongside those of nursing staff, and extend this line of inquiry to additional rehabilitation centers across the Kingdom and the wider GCC region to establish the transferability of these findings.

Conflict of interest

The authors declare no conflict of interest.

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Ethical approval

This study was approved by the Institutional Review Board of Care Medical Hospitals (approval No. IRB-025/260726). Written informed consent was obtained from all participants.

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