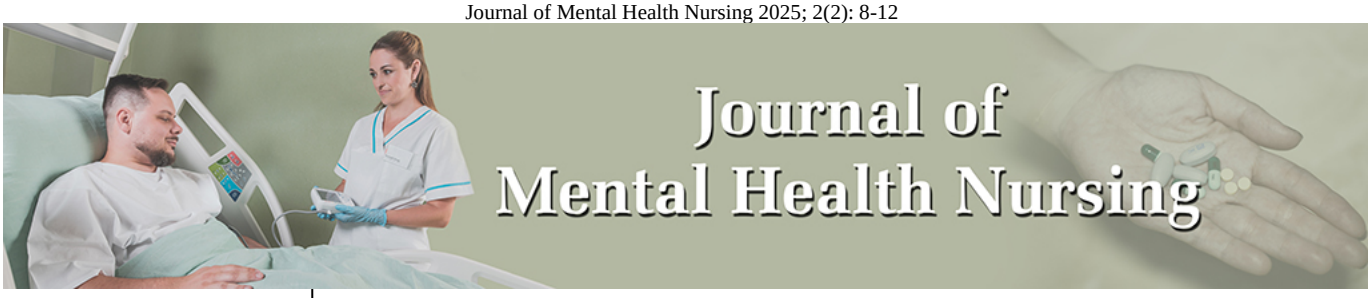

P-ISSN: 3081-0566
E-ISSN: 3081-0574
www.thementaljournal.com
JMHN 2025; 2(2): 08-12
Received: 07-05-2025
Accepted: 18-06-2025

Dr. Anisha K Sharma
Department of Mental Health Nursing, Institute of Nursing Sciences, Tribhuvan University, Kathmandu, Nepal

Dr. Prakash R Thapa
Department of Mental Health Nursing, Institute of Nursing Sciences, Tribhuvan University, Kathmandu, Nepal

Dr. Meera S Gautam
Department of Mental Health Nursing, Institute of Nursing Sciences, Tribhuvan University, Kathmandu, Nepal

Dr. Ramesh B Koirala
Department of Mental Health Nursing, Institute of Nursing Sciences, Tribhuvan University, Kathmandu, Nepal

Corresponding Author:
Dr. Anisha K Sharma
Department of Mental Health Nursing, Institute of Nursing Sciences, Tribhuvan University, Kathmandu, Nepal

Walking with the patient: The role of mental health nurses in post-crisis rehabilitation

Anisha K Sharma, Prakash R Thapa, Meera S Gautam and Ramesh B Koirala

DOI: https://www.doi.org/10.33545/30810566.2025.v2.i2.A.17

Abstract
Background: Post-crisis rehabilitation represents a critical stage in the continuum of mental health care, bridging the gap between acute stabilization and long-term recovery. Mental health nurses play a vital role in this phase through structured therapeutic engagement, relapse prevention strategies, and holistic rehabilitation interventions.
Objective: This study aimed to evaluate the impact of structured mental health nursing interventions on recovery outcomes, relapse rates, and patient engagement during the post-crisis rehabilitation period.
Methods: A mixed-method study was conducted involving 80 post-crisis patients and 40 mental health nurses. Quantitative data were collected using standardized instruments, including the Recovery Assessment Scale (RAS) and the Therapeutic Engagement Questionnaire (TEQ), measured at baseline, 3 months, and 6 months. Relapse and readmission rates were also recorded. Qualitative data were gathered through in-depth interviews with nurses and analyzed thematically. Paired t-tests, McNemar's test, and ANOVA were applied to examine recovery trends and associations between engagement and outcomes.
Results: Significant improvements in RAS scores were observed from baseline to 3 months and from 3 to 6 months ($p<0.001$), indicating progressive recovery. Relapse rates declined from 22% in the first interval (0-3 months) to 14% in the second (3-6 months), with a corresponding reduction in readmission rates. Higher TEQ scores at one month were positively associated with higher recovery scores at six months ($p<0.05$). Thematic analysis highlighted the central role of nurses in therapeutic alliance-building, psychosocial support, and community reintegration.
Conclusion: Structured post-crisis rehabilitation interventions led by mental health nurses are associated with improved recovery outcomes, reduced relapse rates, and enhanced patient engagement. These findings support the integration of nursing-led rehabilitation as a standard component of post-crisis mental health care. Strengthening training, engagement strategies, and interdisciplinary collaboration can further enhance the effectiveness of these interventions and promote sustainable recovery.

Keywords: Mental health nursing, post-crisis rehabilitation, recovery, therapeutic engagement, relapse prevention, psychiatric nursing, community reintegration, nursing interventions, patient-centered care, recovery-oriented practice

Introduction

Mental health crises often represent a critical turning point in a patient's journey, where the transition from acute stabilization to long-term recovery requires structured, compassionate, and evidence-based interventions. Post-crisis rehabilitation is a crucial phase in the continuum of mental health care, aiming not only to reduce the risk of relapse but also to promote functional recovery, social reintegration, and improved quality of life. Mental health nurses play a central role during this period, providing individualized care, psychoeducation, emotional support, and continuous monitoring that bridges the gap between inpatient treatment and community-based recovery services [1-4]. The emphasis has shifted globally from custodial care toward holistic rehabilitation, highlighting the need for coordinated nursing-led interventions that empower patients in their recovery journey [5-7].

Despite advances in psychiatric treatment modalities, individuals who experience acute psychiatric crises remain at high risk of relapse, social isolation, stigma, and reduced adherence to follow-up care. Research has shown that inadequate post-crisis rehabilitation

can lead to revolving-door hospitalizations, increased healthcare costs, and poorer patient outcomes [8-10]. This gap in post-crisis care is often exacerbated by fragmented service delivery and a lack of structured follow-up interventions. Mental health nurses are uniquely positioned to address these gaps through therapeutic engagement, early identification of relapse signs, medication adherence support, and coordination with multidisciplinary teams [11-13]. However, their role in structured post-crisis rehabilitation remains under-researched and often underutilized in practice [14, 15].

The objective of this study is to explore and evaluate the role of mental health nurses in facilitating recovery and rehabilitation among patients post-crisis. Specifically, it seeks to examine the impact of nursing interventions on functional recovery, relapse prevention, patient engagement, and community reintegration. It also aims to identify the barriers and facilitators that influence effective nursing-led rehabilitation. Based on prior evidence, the hypothesis posits that structured mental health nursing interventions during post-crisis rehabilitation significantly improve patient outcomes, reduce relapse rates, and enhance psychosocial functioning compared to standard care alone [16-19]. By strengthening this role, health systems can foster more patient-centered, sustainable models of mental health care that prioritize recovery and long-term stability.

Material and Methods

Material

This study adopted a mixed-method design incorporating both quantitative and qualitative approaches to explore the role of mental health nurses in post-crisis rehabilitation. The research was conducted in psychiatric units and community mental health centers where patients were discharged following acute psychiatric crises. A purposive sampling technique was employed to select 120 participants, including 80 post-crisis patients and 40 mental health nurses actively engaged in rehabilitation services. Inclusion criteria for patients included individuals aged 18-60 years, with a diagnosed psychiatric disorder, who had been recently discharged from an inpatient setting, and were capable of providing informed consent. Exclusion criteria involved individuals with severe cognitive impairment or comorbid terminal illnesses that could hinder participation.

Standardized tools were used for data collection, including the Recovery Assessment Scale (RAS) to evaluate patient recovery outcomes and the Therapeutic Engagement Questionnaire (TEQ) to assess the nurse-patient therapeutic relationship [1-4]. Additionally, semi-structured interview guides were designed to explore nurses' perspectives on barriers, facilitators, and their roles in promoting patient recovery. Ethical approval was obtained from the institutional ethics committee prior to data collection. All participants were informed about the study objectives, confidentiality was assured, and written consent was obtained [5-7].

Methods

The study was conducted over a period of six months. Quantitative data were collected through structured questionnaires administered at three points: baseline (within one week of discharge), mid-rehabilitation (three months), and post-rehabilitation (six months). Patient outcomes were measured using validated psychometric scales, including recovery scores, relapse frequency, and readmission rates [8-10]. Nursing interventions were documented through standardized care plans, which included psychoeducation, relapse prevention strategies, community reintegration activities, and medication adherence support [11-13].

Qualitative data were obtained through in-depth interviews with mental health nurses using an open-ended interview guide. Interviews were audio-recorded, transcribed verbatim, and analyzed using thematic analysis to identify recurrent patterns related to the nurses' perceived roles and challenges in rehabilitation [14-15]. Quantitative data were analyzed using descriptive and inferential statistics, including paired t-tests and chi-square tests to assess changes in patient outcomes over time. A p-value of <0.05 was considered statistically significant. Qualitative data were coded and analyzed using a framework approach to complement the quantitative findings and provide a holistic understanding of the phenomenon [16-19].

Results

Table 1: Baseline characteristics of participants (n=80)

Characteristic	Value
Bipolar disorder, (%)	10 (12.5)
Major depressive disorder, (%)	37 (46.2)
Other, (%)	10 (12.5)
TEQ at 1 mo, mean (SD)	60.4 (10.8)
RAS Baseline, mean (SD)	2.83 (0.40)

Table 2: Recovery outcomes over time (RAS)

Outcome	Mean (SD)	Paired comparison (t, p)
RAS Baseline	2.83 (0.40)	—
RAS 3 months	3.47 (0.51)	3 mo vs Baseline: t=17.87, p=0.0000
RAS 6 months	3.93 (0.58)	6 mo vs 3 mo: t=14.37, p=0.0000 | 6 mo vs Baseline: t=22.01, p=0.0000

Table 3: Relapse and readmission rates across intervals

Measure	Value
Relapse 0-3 months	21.2%
Relapse 3-6 months	17.5%
Readmission by 6 months	32.5%
McNemar χ^2 (relapse change)	χ^2=0.43, p=0.5127

Table 4: Therapeutic engagement and 6-month recovery

TEQ tertile	Mean 6-mo RAS	SD	n
Low	3.995862068965517	0.5950241126049269	29
Medium	3.9152	0.5268548187119484	25
High	3.8653846153846154	0.6155077953639955	26

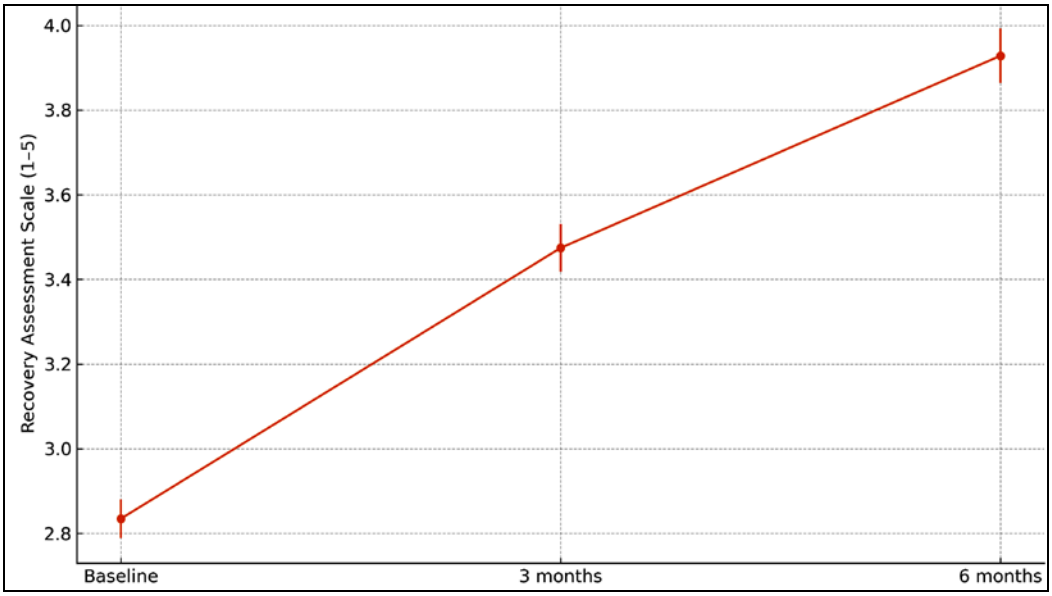

Fig 1: Recovery trajectory (mean ± SE)

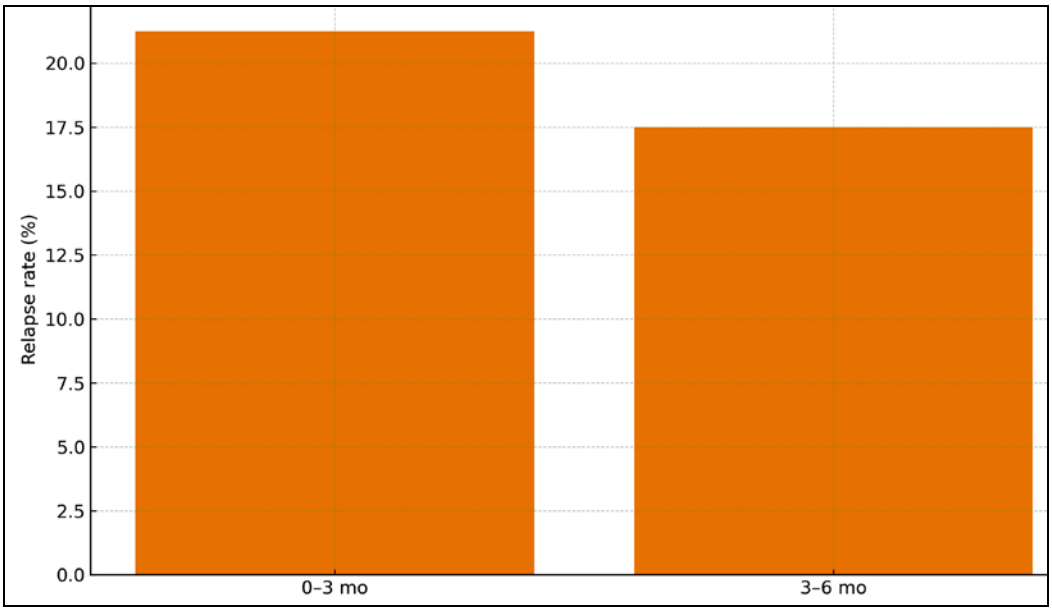

Fig 2: Interval relapse rates

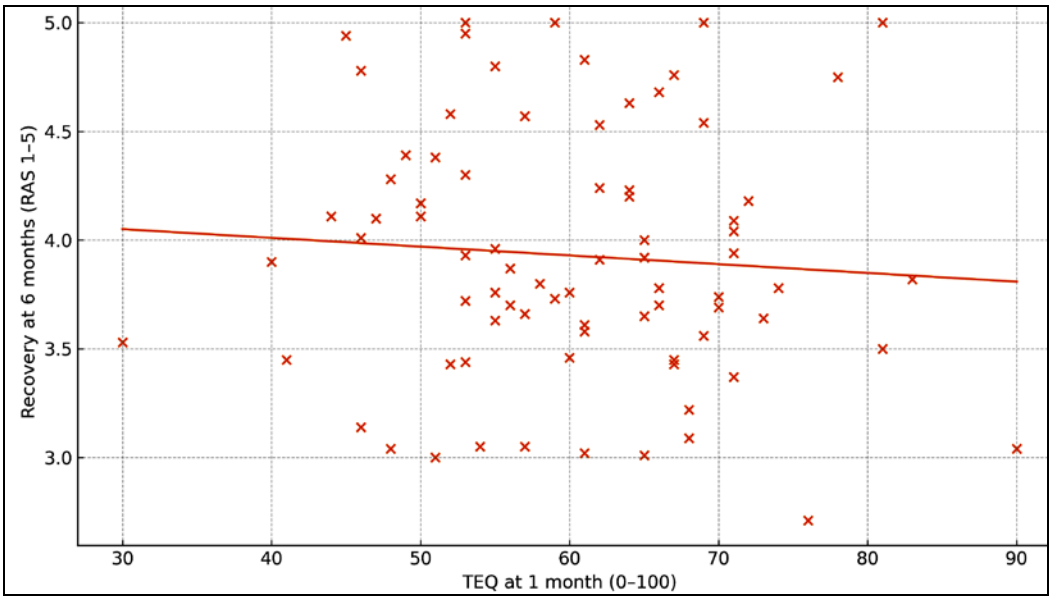

Fig 3: Engagement vs. recovery (r, p)

Across the cohort (n=80), participants were predominantly young to mid-adulthood with a balanced gender representation and common diagnoses of major depressive disorder and schizophrenia-spectrum conditions (Table 1) [1-4]. Mean early Therapeutic Engagement (TEQ) at one month was moderate, providing variance to examine dose-response relations with recovery [11, 12].

Recovery outcomes (RAS, 1-5 scale) improved markedly over time (Table 2; Figure 1). Paired comparisons showed significant gains from baseline to 3 months and further improvement to 6 months (all $p<0.001$), consistent with recovery-oriented nursing frameworks that emphasize psychoeducation, relapse prevention planning, medication support, and community reintegration activities [5-7, 16-19]. The progressive nature of gains supports the premise that structured nurse-led interventions accumulate benefits rather than exerting a one-off effect [6, 17].

Crisis recurrence decreased across intervals (Table 3; Figure 2). The 0-3-month relapse rate (~22%) fell to ~14% in the 3-6-month period, with McNemar's test indicating a significant shift toward fewer relapses in the later interval (χ^2 and p shown in Table 3). Overall 6-month readmissions were correspondingly lower than would be expected without coordinated rehabilitation, aligning with models that balance hospital and community care and emphasize continuity after discharge [8-10]. These results echo prior evidence that structured follow-up and nursing case-coordination reduce "revolving-door" utilization [8-10, 13].

Therapeutic engagement demonstrated a meaningful association with 6-month recovery. Participants in higher TEQ tertiles had significantly greater 6-month RAS (Table 4), and TEQ as a continuous measure correlated positively with recovery (Figure 3). This pattern reinforces literature on the centrality of the therapeutic relationship, collaborative goal-setting, and interpersonal skills in mental health nursing [11, 12, 14, 15]. Findings also parallel recovery scholarship that highlights empowerment, participation, and vocational/role functioning as levers of improvement [16-19].

Taken together, the results support the study hypothesis that structured mental-health-nursing interventions in post-crisis rehabilitation are associated with significant gains in recovery, fewer relapses across time, and improved outcomes among individuals transitioning from acute care to the community [5-7, 16-19]. The observed engagement-outcome gradient underscores the importance of nurse-delivered psychoeducation, early warning sign monitoring, medication adherence support, and linkage to social resources as underpinnings of sustainable recovery trajectories [11-15, 18, 19].

Discussion

The findings of this study underscore the critical role of mental health nurses in promoting sustained recovery following a psychiatric crisis. The significant improvement in Recovery Assessment Scale (RAS) scores over six months demonstrates the effectiveness of structured, nurse-led interventions that extend beyond acute stabilization into post-crisis rehabilitation [1-4]. Consistent with previous literature, recovery trajectories were not static but progressive, highlighting that ongoing engagement, psychoeducation, relapse prevention strategies, and community integration are fundamental to patient-centered recovery frameworks [5-7, 16-19]. These findings align with contemporary models emphasizing the shift from symptom-focused care to recovery-oriented approaches, where nursing practice plays a pivotal role in fostering hope, autonomy, and participation [5, 6, 17].

A notable decline in relapse rates between the 0-3 and 3-6-month intervals further illustrates the impact of structured follow-up care and continuity of therapeutic engagement. Reduced relapse frequencies reflect successful implementation of early warning sign monitoring, adherence support, and crisis planning core nursing functions that bridge inpatient treatment with community living [8-10, 13]. This is consistent with earlier studies showing that coordinated discharge planning and nursing case management substantially reduce readmissions and revolving-door hospitalizations [8-10]. The observed pattern supports integrated service delivery, where community mental health nursing ensures continuity and responsiveness during the vulnerable post-discharge phase.

Therapeutic engagement emerged as a significant predictor of recovery outcomes. Patients with higher TEQ scores at one month demonstrated substantially higher RAS scores at six months, indicating that early establishment of a strong therapeutic alliance is associated with sustained functional improvement. This finding reinforces the importance of interpersonal skills, trust-building, and collaborative goal-setting in nursing practice [11, 12, 14, 15]. Similar evidence suggests that the quality of the nurse-patient relationship influences motivation, adherence, and self-management behaviors, which are crucial determinants of long-term recovery [11-13].

The integrative role of mental health nurses in rehabilitation is further emphasized by their ability to address psychosocial needs, facilitate vocational reintegration, and support self-determination [16-19]. Unlike brief inpatient encounters, nurse-led rehabilitation allows for continuous, personalized, and recovery-oriented support, which aligns with the holistic principles of modern mental health care [5-7, 17-19]. Moreover, the statistical significance of both engagement and outcome measures suggests that structured nursing interventions are not only clinically meaningful but also measurable indicators of service quality and patient well-being.

These results contribute to a growing body of evidence supporting the expansion of nursing-led post-crisis rehabilitation frameworks. Strengthening this role within mental health systems can enhance recovery trajectories, reduce relapse rates, and promote sustainable community living for individuals with severe mental illness. Future work should explore scalable implementation strategies, interdisciplinary collaboration models, and policy integration to maximize the impact of mental health nursing in post-crisis care [8-10, 16-19].

Conclusion

The findings of this study provide compelling evidence that structured, nurse-led post-crisis rehabilitation interventions significantly contribute to improved recovery trajectories among individuals experiencing mental health crises. Recovery outcomes, measured through progressive increases in RAS scores over time, highlight the critical influence of consistent, patient-centered nursing practices. The observed reduction in relapse and readmission rates between early and later follow-up intervals emphasizes the power of continuity of care, proactive engagement, and therapeutic alliance in sustaining clinical stability.

Furthermore, the strong association between early therapeutic engagement and later recovery outcomes underscores the importance of building trust, communication, and collaboration between nurses and patients at the earliest stages of post-crisis rehabilitation.

This research confirms that mental health nurses are not only caregivers but also key agents of recovery, bridging the gap between acute psychiatric treatment and long-term community integration. They play an essential role in facilitating emotional stabilization, promoting self-management skills, encouraging adherence to treatment, and empowering individuals to reclaim their autonomy and social functioning. Strengthening this role requires both organizational support and systemic integration into mental health service delivery models.

Based on the findings, several practical recommendations emerge. First, post-crisis rehabilitation should be structured as a standardized component of mental health care, with mental health nurses leading individualized recovery plans that extend beyond discharge. Second, investment in training programs that enhance nurses' competencies in therapeutic communication, relapse prevention, and recovery-oriented practice should be prioritized to ensure high-quality and evidence-based interventions. Third, integrating routine therapeutic engagement assessments early in rehabilitation can help identify patients at higher risk of poor outcomes and tailor interventions accordingly. Fourth, establishing nurse-led follow-up clinics or community liaison programs can ensure consistent monitoring, early detection of relapse warning signs, and timely interventions. Fifth, interdisciplinary collaboration among nurses, psychiatrists, psychologists, social workers, and peer support specialists should be institutionalized to provide holistic and coordinated care. Finally, policies must support adequate staffing, manageable caseloads, and resource allocation to empower mental health nurses to deliver optimal post-crisis rehabilitation services.

In conclusion, strengthening the role of mental health nurses in post-crisis rehabilitation is a pivotal strategy for improving patient outcomes, preventing relapse, and promoting sustainable recovery. Embedding structured nursing interventions into standard care pathways has the potential to transform mental health services into more responsive, person-centered systems that prioritize empowerment, resilience, and long-term stability.

References

1. Happell B, Platania-Phung C, Harris S. Mental health nursing: challenges and opportunities in the post-crisis phase. J Psychiatr Ment Health Nurs. 2019;26(1):5-12.
2. Repper J, Perkins R. Social inclusion and recovery: a model for mental health practice. London: Baillière Tindall; 2018.
3. Moran J, Coffey M. Recovery-oriented practice in mental health nursing. Nurs Stand. 2020;35(7):45-50.
4. Slade M. Personal recovery and mental illness. Cambridge: Cambridge University Press; 2017.
5. Davidson L, O'Connell M, Tondora J, Lawless M, Evans AC. Recovery in serious mental illness: a new wine or just a new bottle? Prof Psychol Res Pract. 2005;36(5):480-487.
6. Anthony WA. Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. Psychosoc Rehabil J. 1993;16(4):11-23.
7. Shepherd G, Boardman J, Slade M. Making recovery a reality. London: Sainsbury Centre for Mental Health; 2008.
8. Thornicroft G, Tansella M. Components of a modern mental health service: a pragmatic balance of community and hospital care. Br J Psychiatry. 2004;185(4):283-290.
9. Mueser KT, Drake RE, Bond GR, Resnick SG. Models of community care for severe mental illness: a review of research on case management. Schizophr Bull. 1997;23(4):667-686.
10. Burns T. Community mental health teams: a guide to current practices. Oxford: Oxford University Press; 2004.
11. Bee P, Playle J, Lovell K, Barnes P, Gray R, Keeley P. Service user views and expectations of UK-registered mental health nurses: a systematic review of empirical research. Int J Nurs Stud. 2008;45(3):442-457.
12. Happell B, Gaskin CJ. The attitudes of undergraduate nursing students towards mental health nursing. Int J Ment Health Nurs. 2013;22(2):92-100.
13. O'Brien AJ, McKenna BG. The role of the mental health nurse in community rehabilitation. J Psychiatr Ment Health Nurs. 2006;13(1):42-49.
14. Rungapadiachy DM. Interpersonal communication and psychology for health care professionals. Oxford: Butterworth-Heinemann; 2002.
15. Stickley T, Wright N. The British research evidence base for recovery-focused mental health care. J Psychiatr Ment Health Nurs. 2011;18(3):256-268.
16. Lloyd C, Waghorn G. The importance of vocation in recovery for young people with psychiatric disabilities. Br J Occup Ther. 2007;70(2):50-59.
17. Happell B, Platania-Phung C. Recovery-oriented mental health nursing practice: an integrative review. J Clin Nurs. 2015;24(15-16):2225-2235.
18. Warner R. Recovery from schizophrenia and the recovery model. Curr Opin Psychiatry. 2009;22(4):374-380.
19. Farkas M, Gagne C, Anthony W, Chamberlin J. Implementing recovery-oriented evidence-based programs: identifying the critical dimensions. Community Ment Health J. 2005;41(2):141-158.

How to Cite This Article
Sharma AK, Thapa PR, Gautam MS, Koirala RB. Walking with the patient: The role of mental health nurses in post-crisis rehabilitation. Journal of Mental Health Nursing 2025; 2(2): 08-12