

# Challenges in Home-Visit Nursing for Individuals with Mental Disorders and Physical Complications in Japan: A Focus Group Study

Natsuko OGINO and Takahiro KIKKAWA

*Faculty of Nursing, Tokai University School of Medicine*

(Received September 17, 2025; Accepted January 9, 2026)

**Objective:** In Japan, many individuals with mental disorders require long-term hospitalization. However, to promote community integration and enable these individuals to live comfortably in their local areas, mental and physical care provided by nurses is essential. Therefore, this study aimed to examine the status of home-visiting health professionals and determine the challenges in providing support to patients with physical and mental health problems.

**Methods:** Focus group interviews with 30 professionals from eight home-visit nursing stations were conducted and analyzed using thematic analysis.

**Results:** The difficulties in providing physical care to patients with mental illness were categorized into three themes: (1) “fragmentation of healthcare, isolation, and adverse effects of long-term retention,” arising from non-integrated medical care for individuals with mental disorders; (2) “background of patients that makes it difficult to participate in physical healthcare,” stemming from mental symptoms or the patient’s own perception; and (3) “loneliness of the patients concerned and lack of security in medical care”.

**Conclusion:** The results showed that Japanese home-visiting health professionals faced several challenges in providing physical care to individuals with mental disorders. To improve patient care, this study suggests that societal efforts addressing the identified challenges are necessary.

**Key words:** Severe Mental Illness, Community Mental Health Services, Home Nursing, Comorbidity

## INTRODUCTION

Individuals with severe mental illness (SMI) experience significantly higher rates of physical health issues compared with the general population [1-4], with a mean life expectancy being 7-20 years shorter in individuals with SMI [5]. Even in developed countries, these individuals tend to have fewer opportunities to receive checkups and treatment compared with the general public [6]. In Japan, statistical data on early deaths among individuals with SMI are limited. According to a survey by Kondo *et al.* [7], the mean years of life lost in such patients is 24 years.

The World Health Organization’s Comprehensive Mental Health Action Plan 2013-2030 recommended that member countries focus on improving physical health conditions among individuals with SMI [8]. Mental health nurses should address such health problems. Moreover, they need to identify and address issues in each community to improve the physical health of individuals with mental disorders.

Among the member countries of the Organization for Economic Cooperation and Development, Japan has the highest number of psychiatric hospital beds. However, there is little progress in transitioning medical care to the local community [9]. According to a 2020 national survey, approximately 60% of patients hospitalized in psychiatric beds for one year or longer

were aged 65 years or older [10]. In Japan, where hospitalized patients are aging, nearly 50% of long-term hospitalized patients (79,000) are estimated to die by 2040 [11]. To this end, end-of-life care, particularly in psychiatric hospitals, has gained considerable attention.

In the local community, individuals with SMI have different health issues than long-term hospitalized patients. According to a survey conducted by Sugai *et al.* [12], the percentage of obesity among individuals with mental disorders becomes high if they receive community-based care. Physical health problems in individuals with SMI have been gaining attention in Japan. Home-visit nursing services in Japan’s psychiatric field gained insurance coverage in 2012 and have continued to expand since then. The number of registered home-visit nursing stations providing psychiatric services reached approximately 6,600 facilities as of 2024, accounting for 38% of all home-visit nursing stations nationwide [10]. The calculation of psychiatric home visit nursing fees requires the presence of a nurse who has completed 20 hours of specialized training. However, it has been reported that home-visiting nurses face diverse patient needs and encounter numerous difficulties [13]. To support healthy community living and advance efforts to address physical illnesses, it is first necessary to clarify the problems currently affecting community nursing care.

This study aimed to examine the status of home-vis-

**Table 1** Interview guide

No.	Questions
1	Please outline a case of a patient with a mental illness who also has a physical condition (1) What aspects are you focusing on in terms of treatment and nursing support? (2) Please describe your interactions during visits (3) Have you encountered difficulties with physical care? How did you address them? (4) If you interact with the patient outside of visits, please describe the nature of this interaction
2	Do you encounter any particular challenges when providing home nursing services to patients with mental illness?
3	What resources or networks do you consider necessary to support patients with complex mental health and physical conditions within the community going forward?

iting health professionals and determine challenges in providing support to patients with physical and mental problems.

## MATERIALS AND METHODS

### Theoretical background and design

This study is based on social constructionism. According to Gergen [14], human behavior has meaning because of mutual acts of cooperation. This study followed a qualitative research design. The results of the focus group interviews were analyzed using thematic analysis.

### Recruitment and Data Collection

Reimbursement for home-visit nursing in Japan varies depending on whether the nurses have attended a training course. Questionnaires were sent to home-visit nursing stations which had participated in training sessions held by the Japan Psychiatric Nursing Association.

We employed purposive sampling to select the study sites. Initially, questionnaires regarding the actual status of nursing care for individuals with severe mental illness (SMI) were distributed to 806 stations that had participated in training sessions. A recruitment letter for focus group interviews was enclosed, specifically targeting stations with practical experience in this field.

Of the 806 stations, 166 responded to the initial survey, and 20 stations expressed interest in participating in the interviews. No specific exclusion criteria were applied. However, three stations subsequently withdrew due to internal reasons. Furthermore, while the interviews were conducted between October 2019 and January 2020, nine additional stations that had initially expressed interest were unable to finalize their schedules due to the onset of the COVID-19 pandemic and the subsequent restrictions. Consequently, eight home-visit nursing stations were ultimately included in the study. A total of 30 practitioners (nurses, public health nurses, occupational therapists, and administrative staff) participated. Written informed consent was obtained from all participants prior to the interviews. The participating stations were located in various regions across Japan to minimize regional bias. The authors were not related to the participants.

The study participants included nurses who worked primarily for home-visit nursing stations serving patients with SMI (defined as a diagnosis of schizophrenia or related conditions, bipolar disorder, or moderate to severe depression) with home-visit nursing services

in the community. The staff members should have worked with the patients, including over the phone.

In Japan, home-visit nursing stations operate under various organizational models and specialties. Specifically, previous reports indicate that facilities with a higher proportion of patients receiving psychiatric care demonstrate an increased rate of interprofessional collaboration, including occupational therapists and administrative staff, in implementing care [13]. Furthermore, multidisciplinary case discussions are often standard practice in these settings.

Consequently, to investigate the challenges of providing physical care to individuals with mental disorders in greater depth, occupational therapists and administrative staff were included in the focus group interviews as key interprofessional team members. However, because this study is focused on nursing practice, the subject matter is more inclined toward home-visiting nurses.

Focus group interviews were conducted with participants from each station between October 2019 and January 2020. All interviews were held face-to-face. The participants were interviewed about the difficulties they faced in providing physical healthcare for individuals with mental disorders.

The following items were included in the interview guide used for the focus groups: patient overview, team care description, difficulties encountered in the care setting, efforts to cope with difficulties, and social resources needed to provide care. All focus group interviews were recorded, and verbatim transcripts were created. All names and locations of the home-visit nursing stations were anonymized (Table 1).

### Analysis

The results of the focus group interviews were analyzed using thematic analysis, following the established methodology [15]. Two independent researchers (the coders) meticulously read the interview transcripts and generated unique initial codes. Subsequently, they systematically compared the initial codes, discussed any overlaps or discrepancies in detail, and deliberated until consensus was achieved on the definitions and application of each code. This process informed the development of the initial coding framework.

To ensure coding consistency, all transcripts were coded using this established framework. During the process, the coding framework was treated as iterative; categories were revised or added based on ongoing discussion among the researchers to accommodate new or emergent aspects of the data. All coding decisions and

**Table 2** Overview of the participants and facilities (n = 30 from 8 facilities)

No.	n	Age (years)	Members
1	3	63.3	Nurses
2	7	43.0	Nurses, OT, and administrative staff
3	5	59.0	Nurses
4	4	53.5	Nurses
5	2	48.5	Nurses
6	3	42.3	Nurses
7	4	34.0	Nurses and OT
8	2	30.0	Nurses
Total/Mean $\pm$ SD	30	47.3 $\pm$ 12.3	

Note. n = Number of participants; OT = occupational therapist. Nurses include public health nurses.

**Table 3** Theme and Subtheme

Theme	Subtheme
1. Difficulty related to social aspects	
Fragmentation of healthcare and isolation and adverse effects of long-term retention	(1) Poor cooperation with others due to a lack of supporters (2) A need for practices that are not covered by the current medical system
2. Difficulty related to clinical practice	
Background of patients that makes it difficult to participate in physical healthcare	(1) Limitation of nursing presence (2) Difficulty in understanding symptoms and treatment
3. Difficulty related to patients	
Loneliness of the patients concerned and lack of security in medical care	(1) Patients' distrust of medical care (2) Poor support from family

the rationale for modifications to the framework were rigorously documented to ensure an audit trail.

Upon completion of coding all interviews, the refined codes were consolidated into overarching research themes. The final themes and their corresponding data were reviewed under the supervision of an experienced psychiatric nurse specialist to confirm the interpretative validity of the findings. All analyses were conducted using the qualitative data analysis software NVivo 12.

### Ethical considerations

The study design was approved by the Institutional Review Board of Tokai University of Medicine (approval number: 18R-231). The objectives of this study and the protection of personal information were explained at the beginning of the interview. In addition, participants were guaranteed the right to withdraw from the study at any time without suffering any disadvantages for refusing to participate. Thereafter, written informed consent was obtained from the participants.

## RESULTS

Thirty participants (23 nurses, three public health nurses, three occupational therapists, and one administrative staff) from eight home-visit nursing stations were interviewed (Table 2). Of these, 24 were female and six were male. The mean age of participants was 47.3  $\pm$  12.3 years, the mean number of participants in each interview was 3.8  $\pm$  1.6, and the mean interview time was 61.1  $\pm$  4.5 min.

Through the interviews, the following three categories of difficulties were identified (Table 3): (1) "fragmentation of healthcare, isolation, and adverse effects

of long-term retention," arising from non-integrated medical care for individuals with mental disorders; (2) "background of patients that makes it difficult to participate in physical healthcare," stemming from mental symptoms or the patient's own perception; and (3) "loneliness of the patients concerned and lack of security in medical care."

### Difficulties related to social aspects: "fragmentation of healthcare, isolation, and adverse effects of long-term retention"

Patients with physical health problems need many community supporters. However, aside from home-visiting nurses, they have minimal contact with community members. Collaboration among specialists in Japan's community healthcare system is lacking, and resource shortages have increased the burden on visiting nursing services.

This theme focuses on the socio-structural challenges faced by home-visiting nurses, in which patient needs remain unmet due to a lack of support and the need for practices not covered by the current medical system. The system's fragmentation often leads to the isolation of both patients and nurses, with home-visiting nurses feeling limited in their ability to provide physical care to individuals with mental disorders (Table 3: Fragmentation of healthcare and isolation and adverse effects of long-term retention).

Patients with physical health problems often rely heavily on home-visiting nurses due to their limited social interaction and community support outside the nursing service. This isolated relationship is further reinforced by long-term relationships with the same nurse, posing a risk of falling into therapeutic stagna-

tion (so-called “routine patterns”) rather than serving as a factor promoting patient recovery and community participation.

Lack of supporters: *“Individuals with physical illnesses may feel bored if they routinely receive care from the same home-visiting nurse. Involving other medical professionals may be an opportunity to extend their interactions with others.”* (Institution 2)

This social isolation directly translates into a structural burden for home-visiting nurses, creating a critical dilemma regarding non-reimbursable care. Home-visiting nurses were frequently required to perform procedures for patients that fell outside the scope of current medical reimbursement (e.g., accompanying patients to examinations or transporting them by ambulance). This structural constraint forced home-visiting nurses into an ethical dilemma: provide essential care without compensation or abandon necessary support. Some nurses stated, *“I will offer care without compensation if needed.”* Others said, *“I will give up offering care because such efforts are not covered by medical remuneration.”*

Dilemma: *“I felt that the patient received a rude response from the hospital staff. Therefore, I took him to the hospital and explained his wishes to the staff. However, if I make such an effort, I would probably be exhausted from overworking. The patient suffers from a chronic disease, and there is no end to his care.”* (Institution 2)

System barrier: *“Actually, some patients could not participate in the examination. It would help them if the home-visiting nurse advised patients during the examination so they could complete the test smoothly. However, such a practice is not included in home-visiting nurses’ services. Accordingly, I am unable to attend to the patient’s medical consultation.”* (Institution 5)

Ultimately, whether home-visiting nurses take on care that is necessary but not covered by health insurance or comply with service restrictions, patients’ needs remain unmet. This creates a serious role conflict for visiting nurses. Furthermore, social isolation has obscured the difficulties home-visiting nurses faced.

### **Difficulty related to clinical practice: background of patients that makes it challenging to participate in physical healthcare**

Home-visiting nurses found this aspect very difficult, especially when patients were reluctant to seek treatment. The home-visiting nurses attempted to learn more about the patient’s complex background. These backgrounds included financial hardship, unsanitary living conditions, and patients’ unique beliefs and visions of life (Table 3: Backgrounds that make it difficult for patients to participate in physical healthcare).

Patients’ financial hardship impacted on their access to medical care, creating ethical dilemmas for home-visiting nurses. Many patients clinically required treatment, yet they found it unfair that only some patients qualified for medical fee reduction programs under the system.

Financial Inequity: *“Even if the patient is sick, the patient cannot go to the hospital because of financial problems. However, if patients receive public assistance, they can receive treatment without worrying about financial concerns. I think that this is unfair.”* (Institution 1)

*“I feel that the patient has given up on his life.”*

(Institution 5)

The patient’s economic and psychosocial determinants have complicated the role of home-visiting nurses, who have consequently often experienced professional resignation. Furthermore, when patients’ self-determined high-risk lifestyles conflicted with clinical guidance, home-visiting nurses encountered difficulties. This discord arises because patients perceive their chosen lifestyles as acceptable, while home-visiting nurses perceive these self-management behaviors as suboptimal, thereby contributing to therapeutic stagnation.

An unsuitable lifestyle: *“I am concerned about sudden changes in symptoms, particularly among patients who have difficulty making decisions. Repeated lifestyle guidance does not change patients’ unhealthy lives because they do not notice their worsening conditions. I have no choice but to provide care for my patients according to their lifestyles.”* (Institution 8)

Moreover, information regarding treatments and symptoms was either completely absent or fragmented when it was available, creating a confusing situation in nursing practice. The problem was that the patients themselves misunderstood severe physical symptoms, revealing a serious issue with health literacy regarding physical comorbidities.

Misunderstanding: *“The patient saw his health issues based on his point of view. Consequently, he was urgently hospitalized because of urine flow obstruction caused by a renal abscess. He falsely believed that his physical issue was associated with constipation. Such misunderstanding makes my care difficult.”* (Institution 2)

Although many problems were identified in clinical situations, home-visiting nurses were often forced to defer active intervention in favor of patients’ personal and complex backgrounds. Consequently, health concerns accumulated persistently.

### **Difficulty related to patients: loneliness of the patients concerned and lack of security in medical care**

The home-visiting nurses perceived patients’ refusal of hospitalization or treatment as stemming from a lack of security regarding medical care. This was rooted in traumatic past hospital experiences, which the home-visiting nurses interpreted historically (our past mistakes). Furthermore, the absence of close support and patients’ sense of isolation exacerbated this lack of security. (Table 3: Loneliness of the patients concerned and lack of security in medical care)

The experience of involuntary treatment created barriers in interactions with healthcare providers. The patients extended their refusal of care from psychiatric hospitals to general medical services.

Lack of security: *“Patients who have experienced involuntary hospitalization, especially those who were young, said that they no longer want to go to the hospital. Many patients reject hospital visits, not only to psychiatric hospitals but also to hospitals that provide internal medicine services.”* (Institution 3)

Some patients were sensitive to their treatments. Therefore, they could easily identify that medical professionals with insufficient knowledge of individuals with mental disorders were involved in their treatment. Consequently, these patients intentionally kept

a distance from medical care. They often positioned themselves as “unwelcome patients,” harboring a strong conviction that no one in the general hospital environment truly supported them.

Lack of security-2: *“Some patients insist on not going to the hospital anymore after they complete the examination. These patients may have anxiety or label themselves as unwelcome patients. I think that they feel nobody can support them if they go to the hospital. Because of such reasons, many patients hesitate to go to the hospital.”* (Institution 2)

When patients actually received medical care, further problems arose. Often, patients lacked family members who could provide strong support. This frequent lack of family support placed a practical and emotional burden on home-visiting nurses. Specifically, home-visiting nurses frequently had to undertake complex, non-covered intermediary tasks to secure essential support, such as obtaining family consent for treatment procedures.

Lack of family support: *“Physicians need to explain surgical procedures to families. Despite the fact that the work is not covered by insurance-based medical care, I was asked to contact a patient’s family member. However, the family member said that he ended his relationship with the patient after a previous distressing event. I asked him many times to come to the hospital until he finally visited the hospital.”* (Institution 2)

To address this patient’s lack of security and loneliness, the home-visiting nurses deliberately prioritized establishing themselves as familiar and trustworthy figures. They focused on building rapport through careful trust-building techniques before addressing sensitive health issues, aiming to alleviate feelings of isolation.

Nurse’s Therapeutic Response: *“Many of my patients live a solitary life. I tried to make them comfortable by engaging in small talk before asking them about a delicate matter.”* (Institution 1)

## DISCUSSION

### Participant background

This study involved eight home-visiting nurse teams. The average age of participants was  $47.3 \pm 12.3$  years, and 80% of participants were women. These demographics align with national trends, as most home-visiting nurses in Japan were in their 40s, and 90% of them were women. However, the composition of the nursing workforce cannot be statistically compared with that of the nursing population in psychiatric care because currently, there is no detailed statistical data on the nursing workforce engaged in psychiatric care.

In addition, the home-visit nursing stations are not subject to evident geographical bias. The only interview in this study wherein an occupational therapist and the administrative staff participated as team members was with an Assertive Community Treatment (ACT) team. In the present study, the primary objective for the occupational therapist’s participation was to collaborate with the visiting nurses to manage instances of violent or sexually explicit behavior that arose during the exacerbation of psychiatric symptoms. The occupational therapist reported no independent activities for addressing physical health issues or other distinct concerns. The ACT team actively collaborated across disciplines to establish a secure environment for both

the patient and the nursing staff.

### Fragmentation of healthcare, isolation, and adverse effects of long-term retention

Home-visiting nurses faced difficulties achieving effective interprofessional collaboration when working with primary care workers. They reported a lack of interprofessional collaboration in caring for mentally ill patients in the community and described the following divergent attitudes toward inadequate support for patients’ needs: *“I will offer care without compensation if needed”* and *“I will give up offering care because such efforts are not covered by medical remuneration.”* These conflicting opinions reflect the ethical and structural dilemmas that are frequently reported when patients receive primary care.

Notably, there is a conceptual conflict among nurses regarding the provision of care intended to address patients’ unmet needs, as such care is currently not reimbursed. This issue highlights the tension between patient advocacy and the limitations of the current reimbursement system.

According to previous studies, the depth of the therapeutic relationship and length of contact time positively supports long-term care [16, 17]. Furthermore, the presence of a patient advocate can improve access to healthcare [18]. This is because care from a health-care station that does not fully comprehend mental disorders can negatively impact patient outcomes [19]. Currently, the Ministry of Health, Labour and Welfare is investigating a Comprehensive Community Care System (CCCS); however, the physical healthcare system is not included in the present study [10]. In the practice of home-visit nursing, it is necessary to address and clarify the needs related to patients’ health-seeking behaviors [18, 20], which have not received sufficient attention until now. Addressing these barriers requires more than individual nursing efforts; it demands a systemic shift toward integrated community care. Specifically, it is essential to ensure that strategies for addressing low health literacy — which currently poses a significant challenge in home-visit nursing practice — are institutionally integrated into the existing public health infrastructure. For instance, developing community-wide health education protocols could alleviate the burden on individual nurses while ensuring equitable access to care.

### Background of patients that makes it challenging to participate in physical healthcare

Aside from comorbidities, many individuals with mental disorders also suffer from other socioeconomic vulnerability issues, including psychiatric symptoms, poverty, and isolation [18, 21]. Home-visiting nurses sought to explore and understand patients’ backgrounds and believed that their inability to tackle their comorbidities was because of other problems. Home-visiting nurses also noted that there is a need to address many issues and that addressing comorbidities is given a lower priority due to the acuity of psychosocial needs.

Patients’ cognitive impairment is a barrier to receiving physical care [18]. The patients had difficulty performing adequate self-assessment of their medical conditions [22], and home-visiting nurses spent more

time trying to motivate patients to receive physical care. However, these time-consuming strategies were associated with delays in addressing physical health problems. Furthermore, some nurses were concerned that health education and lifestyle interventions might exacerbate supportive relationships with patients who distrusted medical care. Although the practice of respecting patient decision-making is essential in psychiatry [23], it is time-consuming and creates difficulties that prevent nurses from practicing effectively.

### **Loneliness of the patients concerned and lack of security in medical care**

The interviews revealed that individuals with mental disorders who experienced long-term hospitalization in psychiatric hospitals felt a lack of security in medical care. The results of the present study suggest the pervasive nature of historical trauma and negative perceptions of healthcare among patients as a whole.

In Japan, where more than 86,000 patients are currently hospitalized for over five years [10], the tradition of large-scale institutional care and long-term hospitalization in psychiatry leads to the loss of the social fabric of mentally ill patients [24]. The issue of stigma, which affects medical practice, stems from social factors [25]. Consequently, patients experienced institutional oppression in social and medical settings and avoided contact with medical personnel because of exposure to prejudice [23]. Home-visiting nurses are well aware of this systemic problem. It is crucial for home-visiting nurses to implement care that specifically addresses a patient's trauma to establish patient safety and a therapeutic trusting relationship [26]. Furthermore, Trauma-Informed Care (TIC) has been noted to overcome barriers to accessing healthcare [27]. Consistent with these findings, the current study suggests that visiting nurses utilize trauma-specific care to address the challenges related to the patient's healthcare access. This approach is therefore indicated as an effective strategy in the practice of visiting nursing.

In addition, the home-visiting nurses in the present study focused on patients' sense of loneliness. Loneliness is an important factor because it has been reported to affect mental health status and comorbidities [28, 29]. Through a routine conversation with mentally ill patients who were living alone, a home-visiting nurse effectively cultivated a safe environment (therapeutic space), wherein they could easily seek medical support from the nurse if they experienced physical problems.

In Japanese psychiatry, professionals are concentrated in large psychiatric hospitals, and the social development of community care is insufficient [30]. Negative experiences cause insecurities among patients with regard to many aspects [31, 32]. Considering the challenges faced by home-visiting nurses, it is necessary to expand dialog with professionals and patients in the future to revise the pattern of mutual interaction and foster greater therapeutic alliance.

Based on this dialog, it is important to consider the CCCS implementation and gain patients' trust in psychiatric care. We must also improve the accessibility and equity of primary care for patients with comorbidities and build a network of professionals in the community to ensure that patients and visiting nurses

do not feel professionally or socially isolated.

Japan's mental health system is undergoing a unique transitional phase known as community-based care. The difficulties identified in this study, particularly barriers to physical medical care, align with international reports on health disparities among patients with severe mental illness. The specific challenges faced by visiting nurses discovered in this study provide a unique case study for other countries also struggling with the integration of physical and mental health services.

### **Limitations**

The current study has several limitations that necessitate careful interpretation of the findings. First, detailed information regarding the patients' backgrounds, including their specific psychiatric diagnoses and the status of any comorbid physical conditions, was not collected. Consequently, the holistic patient profile remains unclear. This lack of information limited the scope of the discussion regarding the specific challenges and necessary considerations employed by visiting nurses when providing individualized care tailored to the patients' characteristics (e.g., severity of illness, progression of pathology).

Second, the data on visiting nursing practice collected in this study included a wide variety of care instances, involving patients with diverse psychiatric disorders and across various stages of their illness. This variability in the collected data meant that in-depth interpretation of the visiting nurses' profound clinical insights and reflective narratives pertaining to specific contexts or issues was restricted, thereby limiting the scope for deeper theoretical consideration.

Third, data collection was limited to eight facilities, preventing comprehensive coverage of the issues. Consequently, generalizing the findings of this study is constrained. Therefore, future research is recommended to first clarify the medical needs of patients requiring physical care within psychiatric home visiting nursing. Subsequently, it is desired that researchers conduct in-depth explorations through case studies focused on specific diseases or illness stages to provide a more detailed and multifaceted description of the clinical difficulties encountered in visiting nursing practice.

### **CONCLUSION**

We attempted to identify the difficulties faced by home-visiting nurses when working with mentally ill patients with physical problems. The home-visit nursing system is inadequately responsive to patients' needs in Japan. Moreover, the complex socioeconomic problems, isolation, and loneliness of patients have prolonged their physical problems. Home-visiting nurses' voices could enhance the well-being of the patients and serve as a long-term link between healthcare and patients.

In conclusion, this study highlights that bridging the gap between mental health and primary care in home-visit nursing for individuals with comorbid mental and physical illnesses requires more than individual nursing skills. It necessitates the institutional integration of culturally sensitive, individualized care and health literacy support. This insight is essential for advancing Japan's psychiatric services from hospital-cen-

tered care toward a comprehensive, community-based healthcare system. Such a transformation will not only reduce the burden on home-visit nurses but also ensure a future where individuals with severe mental illness receive equitable and holistic care addressing both their mental and physical health needs.

#### ACKNOWLEDGMENTS

The authors would like to express their sincere gratitude to all the practitioners and home-visit nursing stations that participated in this study for their valuable time and cooperation. This work was supported by JSPS KAKENHI Grant Number 18K10327. We would also like to thank the professional English editing services for their support in the preparation of this manuscript.

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