Ambo, Int J Nurs Clin Pract 2025, 12: 420
https://doi.org/10.15344/2394-4978/2025/420

International Journal of Nursing & Clinical Practices

Case Report Open Access

A Nurse-Coordinated Community Mental Health Intervention Without Hospitalization: A Case Report from Rural Japan

Hiroaki Ambo

Department of Nursing, Yamagata Prefectural University of Health Sciences, Yamagata, 990-2212, Japan

Abstract

This qualitative case study explores the process and significance of multi-agency collaboration in community-based psychiatric crisis response in rural Japan. Drawing from five semi-structured interviews conducted between 2021 and 2023 with visiting psychiatric nurses and consultation support specialists, the study highlights a critical case involving a man in his 40s living alone under public assistance who experienced a sudden physical and psychiatric crisis. When traditional emergency medical services proved inaccessible due to systemic and institutional limitations, visiting nurses coordinated with care managers, municipal welfare officers, and an emergency relief facility (Facility C) to stabilize the client without hospitalization. Thematic content analysis revealed key mechanisms underpinning the success of the intervention: flexible role adaptation among providers, proactive engagement by care managers to reduce help-seeking avoidance, and the strategic use of social welfare infrastructure for non-medical stabilization. These findings underscore the urgent need to strengthen outreach-based mental health services in Japan and to institutionalize models of collaborative, community-based crisis care—particularly in rural areas where medical infrastructure is limited. This case contributes to the growing body of international evidence supporting integrated, rights-based approaches to mental health crisis intervention.

Publication History:

Received: June 18, 2025
Accepted: July 09, 2025
Published: July 11, 2025

Keywords:

Psychiatric visiting nursing, Multi-agency collaboration, Crisis intervention

Introduction

In recent decades, mental health care has undergone a substantial paradigm shift-from hospital-based treatment to community-based support systems. This shift, often referred to as "deinstitutionalization," has emphasized the importance of enabling individuals with mental illness to live safely and meaningfully within their communities, supported by integrated, multi-disciplinary networks of care [1,2].

In Japan, this transition has been particularly visible in the growing utilization of psychiatric home-visit nursing services (seishinka homon kango), which have expanded markedly in recent years. According to the Ministry of Health, Labour and Welfare, the number of psychiatric home visit nursing interventions has more than doubled over the past decade [3]. This trend reflects both a national policy direction toward community-based mental health and the emerging recognition of nurses as frontline actors in identifying, intervening, and coordinating care for individuals in psychiatric distress [4].

Internationally, community mental health care models have highlighted the critical importance of collaboration across medical, welfare, and social sectors in responding effectively to psychiatric emergencies, particularly for individuals who may be unwilling or unable to seek help proactively [5,6]. Yet, in Japan, despite progress in service development, effective multi-agency collaboration remains uneven and often reactive, particularly in rural areas where psychiatric beds remain limited, and access to coordinated emergency support can be fragmented [7].

This paper presents a case study selected from a larger qualitative research project involving five in-depth interviews conducted between August 2021 and October 2023. Across these interviews, eight distinct cases were described by psychiatric visiting nurses working in rural communities. Among them, the case of "Mr. B"-a man living alone under public assistance who experienced a sudden physical and psychiatric crisis-emerged as a particularly illustrative example of how inter-agency collaboration can enable timely, community-based intervention without hospitalization.

Through this case, we aim to examine the practical dynamics, challenges, and implications of emergency multi-agency coordination in community mental health care in Japan. The findings offer valuable insights for both clinical nursing practice and public mental health policy.

Methods

Study design

This qualitative case study was conducted to explore the dynamics of multi-agency collaboration in community mental health emergency care. The primary data source was semi-structured interviews with psychiatric visiting nurses involved in the care of clients in rural Japan.

Participants and data collection

The focal case (Mr. B) was initially identified through an interview with a primary visiting nurse who provided direct care during the crisis. To enrich and verify the case details, additional interviews were conducted with other professionals involved, including consultation support specialists (care managers) and secondary visiting nurses familiar with Mr. B's care trajectory.

A total of five interviews covering eight distinct cases were conducted between August 2021 and October 2023. The average duration of four interviews was approximately 68 minutes, with each lasting around 60 minutes. For this paper, data relevant to Mr. B's case were extracted and analyzed.

***Corresponding Author:** Prof. Hiroaki Ambo, Department of Nursing, Yamagata Prefectural University of Health Sciences, Yamagata, 990-2212, Japan

Citation: Ambo H (2025) A Nurse-Coordinated Community Mental Health Intervention Without Hospitalization: A Case Report from Rural Japan. Int J Nurs Clin Pract 12: 420. doi: https://doi.org/10.15344/2394-4978/2025/420

Interview procedure

Semi-structured interview guides were used to explore participants' experiences, roles, interprofessional collaboration, challenges faced, and perceptions of client outcomes. Interviews were audio-recorded and transcribed verbatim for analysis.

Data analysis

Data were analyzed using thematic content analysis without qualitative analysis software. Two researchers independently coded the transcripts and collaboratively discussed the emerging themes to ensure reliability and validity. Triangulation was achieved by comparing narratives from different professionals involved in the case.

Ethical considerations

This study was approved by the Ethical Committee of Yamagata Prefectural University of Health Sciences (Approval Number: 21–0702). All participants provided informed consent prior to participation. No financial incentives were provided. Confidentiality was strictly maintained by anonymizing all personal and location identifiers. No conflicts of interest were identified among individuals or organizations involved in this study.

Case Presentation

Mr. B was a man in his late 40s living alone in a public housing apartment in a semi-rural area of Yamagata Prefecture, Japan. He was receiving public assistance (seikatsu hogo) and had been diagnosed with depression by a local psychiatrist. Despite his mental health condition, Mr. B remained physically active and frequently used his bicycle for shopping and errands. He was not engaged in employment or structured social activities and had limited informal support networks.

In July 2023, psychiatric visiting nurse services were initiated at the request of his psychiatrist, mainly to support medication adherence and monitor his mental state. During the initial phase of visits, the nurse observed poor organization of medications, with blister packs scattered across his table, and irregular intake patterns. While Mr. B claimed to be taking his medication, it became evident that he lacked a structured routine, leading to concerns about self-management and potential side effects.

On December, 2023, Mr. B made an emergency phone call to his visiting nurse, saying, "I can't move. Please help me." This was highly uncharacteristic behavior, as he had never expressed such distress before. Upon visiting, the nurse found him unable to stand or walk independently. He reported extreme physical weakness and loss of muscle control, although he remained conscious and oriented. Supporting his body against a wall did not prevent him from sliding downward, suggesting a potential neuro-muscular complication.

Suspecting either medication-induced dysfunction or an acute neurological event, the nurse contacted Mr. B's primary psychiatrist, who advised seeking internal medicine consultation. However, attempts to arrange care through local general hospitals were unsuccessful, largely due to the lack of a referral letter and the patient's psychiatric history. Emergency departments refused direct intake, citing procedural limitations, thus revealing a gap in the local emergency response system for patients with mental illness.

In response, the visiting nurse coordinated with a local social welfare office and a community-based care manager. Through their joint efforts, Mr. B was accepted for temporary placement at a local relief facility (kyugo shisetsu) named Facility "C", which accommodates individuals on public assistance facing temporary crises. During his stay, he received IV fluids and nursing supervision. His physical condition gradually stabilized, suggesting that the episode may have been due to a combination of undernourishment, stress, and possible side effects from irregular medication intake.

Although the environment at Facility "C" was safe and structured, Mr. B soon expressed discomfort and a desire to return home, citing lack of privacy and autonomy. After a multi-agency meeting involving the facility staff, municipal officials, the care manager, and the visiting nurse, it was agreed that Mr. B would return to his apartment under enhanced monitoring. He was discharged in early January 2024 and transported home by taxi.

Upon returning, Mr. B resumed some level of independence, including shopping by bicycle. His visiting nurse introduced a medication calendar system to support adherence, and visit frequency was adjusted to ensure closer observation. At the time of writing, no recurrence of crisis has been reported, and Mr. B continues to live independently with regular community-based nursing support.

Multi-Agency Intervention

The response to Mr. B's crisis required rapid coordination among multiple sectors, as traditional emergency medical routes were inaccessible. The intervention process illustrates the essential role of community-based collaboration when formal systems fail to accommodate complex psychiatric needs in real time.

Initial triage and decision-making by the visiting nurse

Upon recognizing Mr. B's functional collapse, the visiting nurse immediately evaluated for life-threatening conditions and consulted his primary psychiatrist. When referral to an internal medicine facility proved unfeasible due to institutional limitations and stigma surrounding psychiatric patients, the nurse assumed a central coordinating role, functioning beyond conventional clinical responsibilities.

c officer and a care manager affiliated with the municipal government. Their involvement was pivotal in activating a short-term crisis housing solution: a public relief facility known as *Facility "C"*. These facilities are typically used to shelter individuals on public assistance during emergencies such as eviction, hospitalization of a caregiver, or abuse-but in this case, it was creatively adapted to serve a psychiatric health-related emergency.

The facility agreed to accept Mr. B without delay, recognizing both his vulnerability and the lack of alternative options. This decision reflects a flexible, human-centered application of local welfare resources in a region where psychiatric beds are limited and community support is often fragmented.

Collaborative risk management in the facility

During his temporary stay, Mr. B received intravenous hydration and continuous nursing observation, which stabilized his physical

symptoms. However, tension soon arose as he expressed resistance to the communal structure and voiced a desire to return home. At this point, multiple stakeholders-including *Facility* "C" staff, the visiting nurse, the municipal welfare division, and the care manager-convened to assess his condition, risks, and preferences.

Notably, the decision-making process remained inclusive and consensus-driven. While facility staff expressed concern about premature discharge, the nurse and care manager noted that Mr. B's condition had improved significantly and that ongoing community-based care could mitigate the risks of relapse. A discharge plan was developed that included frequent nursing visits and a structured medication adherence system using a pill calendar.

Challenges in role clarity and system gaps

This case highlighted several challenges in inter-agency collaboration. First, institutional ambiguity existed regarding who held ultimate responsibility for coordinating discharge and follow-up care. Although the visiting nurse initiated the crisis response, coordination efforts often depended on individual relationships rather than systematic protocols.

Second, gaps in emergency accessibility for psychiatric patients became evident. Emergency departments' unwillingness to accept Mr. B without referral underscores the persistent stigma and bureaucratic rigidity in Japan's emergency medical infrastructure.

Third, communication among stakeholders was sometimes delayed or inconsistent, particularly between non-medical facilities and clinical teams. Nonetheless, trust and long-standing collaboration between individual professionals ultimately enabled a successful transition back to the community.

The complexity of Mr. B's case required coordinated responses from multiple sectors, including medical, social welfare, and municipal services. Figure 1 illustrates the key roles and collaborative pathways among the agencies involved in the intervention.

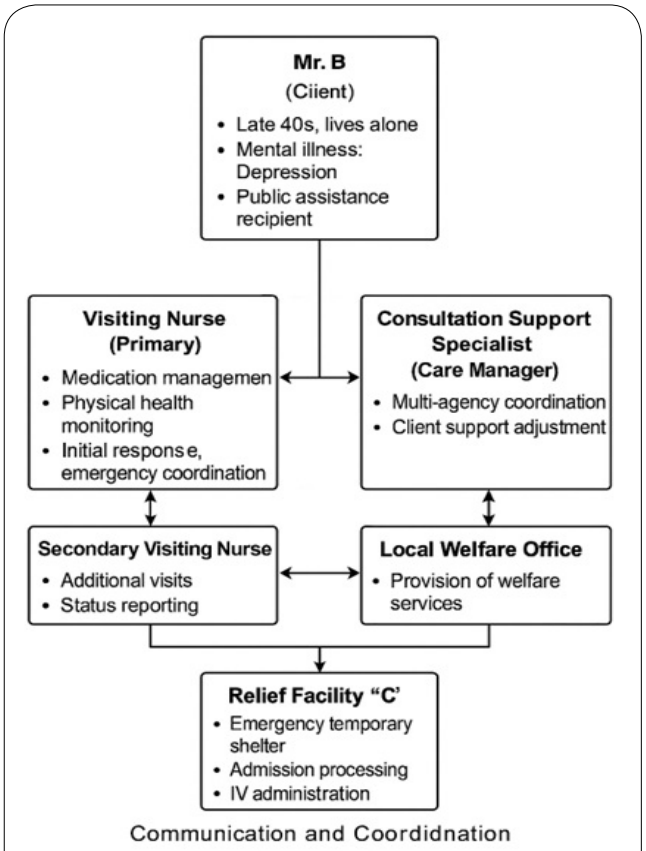

Figure 1: Multi-Agency Collaboration Model for Emergency Community Mental Health Support: Case of Mr. B
This flowchart illustrates the cooperative roles and communication pathways between the primary visiting nurse, consultation support specialist, local welfare office, secondary nurse, and the relief facility (C) involved in Mr. B's care.

Outcome and Follow-up

Following his temporary stay at the Facility "C" relief facility, Mr. B demonstrated gradual and sustained improvement in both his physical condition and emotional stability. Upon discharge in early January 2024, he was transported by taxi back to his apartment. Observations during the subsequent days revealed a marked return to independence; he was seen riding his bicycle to local shops and resumed basic self-care activities that had been compromised at the time of the emergency.

From a psychiatric nursing perspective, this recovery was particularly significant. It occurred without hospitalization, without pharmacological adjustment, and without any formal psychiatric crisis intervention, but instead through stabilization in a structured, non-medical environment and the careful engagement of a multi-agency support system.

To prevent recurrence and support Mr. B's continued recovery, several follow-up strategies were implemented:

Medication management and health monitoring

The visiting nurse introduced a medication calendar system that visually tracked daily medication intake. This approach helped compensate for Mr. B's previous disorganization and reduced the cognitive and emotional burden associated with self-administration. In each visit, the nurse would review medication compliance, check for side effects, and discuss any concerns related to physical symptoms or mood changes.

Adjusted visit frequency and relationship maintenance

Visit frequency was temporarily increased from once a week to two or three times per week during the first month following discharge. The nurse's consistent presence reinforced the therapeutic alliance and provided Mr. B with emotional security. These visits included health assessments, gentle guidance on maintaining a routine, and reinforcement of coping skills.

Coordination with local services

The nurse-maintained contact with the municipal welfare office and care manager to share updates on Mr. B's condition and ensure swift re-engagement should a future crisis emerge. This low-threshold, open-line communication among professionals served as a safety net, replacing the need for hospital-based follow-up.

Patient-centered evaluation of progress

Mr. B expressed appreciation for the support he received but also

indicated that he preferred to remain at home rather than engage in formal rehabilitation or day services. His autonomy in shaping the direction of care was respected, in line with person-centered care principles. Importantly, he maintained regular interaction with the visiting nurse and continued to adhere to medication and self-care routines as of the last follow-up.

Overall, Mr. B's case illustrates that even in the absence of psychiatric hospitalization, community-based multi-agency collaboration—anchored by skilled nursing care—can facilitate recovery from acute decompensation and promote functional reintegration into everyday life. His experience emphasizes the importance of flexibility, trust, and continuity in community mental health systems.

Discussion

Psychiatric home visiting and outreach services in Japan and international context

Psychiatric home visiting nursing in Japan has grown significantly over recent years. According to the Ministry of Health, Labour and Welfare, the number of psychiatric home visit nursing services more than doubled between 2010 and 2020, reflecting policy shifts toward deinstitutionalization and community-based mental health care [9]. Despite this growth, Japan still faces considerable challenges in establishing comprehensive outreach services similar to those seen in some European countries.

For example, in Italy, following Law 180 in 1978, a pioneering mental health reform initiated extensive community mental health services, including assertive community treatment (ACT) teams and multidisciplinary outreach that significantly reduced psychiatric hospitalization rates [9]. Similarly, Belgium has advanced community-based psychiatric services with well-integrated outreach teams facilitating continuity of care in community settings [10].

In contrast, Japan's system remains more hospital-centric, and while home visiting nursing is established, assertive outreach services for hard-to-engage individuals are less widespread and often fragmented. A national survey revealed that only approximately 20% of psychiatric patients receive regular outreach or assertive community treatment, highlighting gaps in service coverage [11]. This limits timely interventions for crisis situations, as seen in the case of Mr. B, where conventional emergency departments and hospitals were reluctant to provide acute care without referrals.

The role of consultation support specialists (Care Managers) in multi-agency collaboration

Japan's consultation support specialists—care managers dedicated to persons with disabilities—play a pivotal role beyond assessing care needs. They function as coordinators and facilitators who help bridge the gaps between service users, families, medical providers, and municipal offices [12]. Crucially, these specialists actively work to prevent assistance avoidance, which is a known issue among individuals with psychiatric disabilities, by creating trustful relationships and adjusting service delivery to align with the individual's preferences and circumstances [13].

In Mr. B's case, the consultation support specialist likely facilitated communication between the municipal government, the relief facility (Facility C), and Mr. B himself, enabling a smoother admission process despite the crisis situation. This form of tailored, person-centered coordination aligns with evidence showing that the involvement of care managers improves engagement, adherence, and overall outcomes in community mental health populations [14].

Implications for practice and policy

This case study exemplifies how multi-agency collaboration involving visiting nurses, consultation support specialists, welfare officers, and emergency relief facilities can provide effective community-based crisis intervention even in the absence of hospital admission.

To enhance such outcomes, Japan should consider adopting or expanding assertive community treatment models with multidisciplinary outreach teams, which have been shown in randomized controlled trials to reduce hospitalization rates, improve medication adherence, and enhance quality of life for people with severe mental illness [15,16].

Furthermore, strengthening the role of consultation support specialists through additional training and clearer mandates could enhance their capacity to manage complex coordination tasks and reduce the risk of service fragmentation. Policies supporting integrated data systems and inter-professional communication platforms will be necessary to overcome current barriers.

Finally, this case highlights the importance of flexible use of social welfare resources-such as relief facilities-in psychiatric emergency care, a strategy that could be systematized to bridge the gap where medical institutions are unable or unwilling to provide immediate care.

Conclusion

By illustrating the central roles played by psychiatric visiting nurses and consultation support specialists, this case reinforces the importance of interprofessional teamwork in managing psychiatric emergencies. The findings call for formalizing such collaborations within Japan's mental health care infrastructure.

Competing Interests

The authors declare that they have no competing interests.

References

1. Thornicroft G, Tansella M (2013) Community mental health: Putting policy into practice globally. Wiley-Blackwell.
2. World Health Organization (2021) Guidance on community mental health services: Promoting person-centred and rights-based approaches.
3. Ministry of Health, Labour and Welfare (Japan) (2023) Annual Report on Health, Labour and Welfare Statistics.
4. Nakanishi M, Endo K (2014) Coexisting trends in psychiatric services in Japan: Expansion of community-based care and persistence of hospital-based care. International Journal of Mental Health Systems 8: 1-7.
5. Slade M, Amering M, Farkas M, Hamilton B, O'Hagan M, et al. (2014) Whitley R. Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. World Psychiatry 13: 12-20.
6. Davidson L, Bellamy C, Guy K, Miller R (2012) Peer support among persons with severe mental illnesses: a review of evidence and experience. World Psychiatry 11: 123-128.

7. Tsutsui T (2017) Challenges and opportunities in the development of community-based integrated care system in Japan. International Journal of Integrated Care 17: 2.

8. Ministry of Health, Labour and Welfare, Japan (2020) Annual Report on Health, Labour and Welfare Statistics.

9. Tansella M (1986) Community psychiatry without mental hospitals--the Italian experience: a review. J R Soc Med 79: 664-669.

10. Van Audenhove C (2007) Community Mental Health Care in Belgium. International Journal of Mental Health 36: 5–17.

11. Takahashi S (2019) Status of Assertive Community Treatment in Japan: A Nationwide Survey. Psychiatry and Clinical Neurosciences 73: 525–532.

12. Nishio M, Ito J, Oshima I, Suzuki Y, Horiuchi K, et al. (2012) Preliminary outcome study on assertive community treatment in Japan. Psychiatry Clin Neurosci. 66: 383-389.

13. Yamamoto-Mitani N (2016) The Role of Care Managers in Community Mental Health in Japan. Journal of Psychiatric and Mental Health Nursing, 23: 540–549.

14. Woltmann E, Grogan-Kaylor A, Perron B, Georges H, Kilbourne AM, Bauer MS (2012) Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, specialty, and behavioral health care settings: systematic review and meta-analysis. Am J Psychiatry 169: 790-804.

15. Marshall M, Lockwood A (2000) Assertive community treatment for people with severe mental disorders. Cochrane Database Syst Rev 2000: CD001089.

16. Bond GR (2001) Assertive Community Treatment for People with Severe Mental Illness: Critical Ingredients and Impact on Patients. Clinical Psychology Review 21: 631–670.