IMH@Home: Pioneering Psychiatric Mobile Inpatient Care in Singapore

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Aim / Objectives

IMH@Home aims to evaluate the suitability, safety, and effectiveness of delivering acute psychiatric care in the home setting, as an alternative inpatient care delivery model to address bed occupancy challenges.

In addition, it also seeks to develop operational frameworks and clinical governance pathways to support the scalable and sustainable adoption of home-based psychiatric inpatient care.

Background

Psychiatric inpatient care traditionally requires hospital admission, which can be stigmatising and disruptive for patients and families. In addition, inpatient environments may not always be perceived as conducive to recovery.

Sustained demand for inpatient services and limited bed capacity may place pressure on inpatient care, with patients requiring readmission following discharge to home or step-down facilities such as nursing homes, further contributing to the strain on inpatient capacity.

In this context, alternative models that enable the delivery of acute care outside of the hospital setting have emerged as a potential approach. Hospital-at-Home models have been successfully implemented in general medicine (e.g., MIC@Home), demonstrating that hospital-level care can be delivered safely in the community.

Building on this model, IMH@Home is Singapore's first psychiatric mobile inpatient care service, designed to provide hospital-level acute psychiatric care in the home setting through multidisciplinary support and comprehensive monitoring protocols, while maintaining clinical safety and treatment efficacy.

Interventions / Implementation

A pre-pilot was conducted from November 2024 to May 2025. Patients were recruited from general acute wards based on the following inclusion criteria:

1. Aged at least 18 years old
2. Requires acute admission
3. Medically stable
4. Residing in safe and private home environment
5. Suitable diagnostic and risk profile for home-based care

Patients received hospital-level psychiatric care at home delivered by a multidisciplinary team through a combination of scheduled home visits and virtual consultations, with regular psychiatrist and nurse reviews and allied health support based on individual patient needs. This was supplemented by remote monitoring using wearable devices to enable ongoing assessment and timely intervention.

Results & Outcomes/ Discussion

A total of 150 inpatients were screened for suitability, of which 11 were recruited with diagnoses such as depression, anxiety, psychosis, adjustment disorder, and bipolar disorder. All 11 patients completed IMH@Home pre-pilot without escalation back to the hospital. There were also no reported incidents of suicide attempts, serious self-harm, harm to others, or abscondment.

Clinical outcomes: 91% of patients achieved a Clinical Global Impression (CGI-I) score of 3 or below at discharge, comparable to an average of 95% in patients discharged from Regional (General Adult Psychiatry) wards. The 30-day readmission rate was 9%, lower than 13% in acute physical wards. Average total length of stay (ALOS) was shorter at 22.6 days, with 7.5 days delivered through IMH@Home, compared to 31 days in acute physical wards. Refer to Table 1 below.

Table 1: Clinical outcomes in comparison with IMH inpatient

Indicators	IMH@Home	Physical Ward	Inpatient ward KPI
% of patients with discharge CGI-I score of 3 and below	91%*	95%	95%
Readmission within 30 days	9%	13%	14%
Average Length of Stay	22.6^	31	29

** 10 out of 11 patients*
^ This is the ALOS for the whole admission episode (physical ward + IMH@Home)
IMH@Home-only LOS is 7.5 days

Patient feedback: Feedback was positive, with 70% reporting high satisfaction, 20% moderate satisfaction, and 10% neutral; none reported low satisfaction. Patients appreciated the dedicated care teams, noting staff's consistent check-ins and prompt responses. Teams were described as empathetic, non-judgmental, and attentive to both patients and caregivers. Patients specifically valued receiving treatment in the comfort of their homes with loved ones present, the added convenience for caregivers, and the opportunity to learn coping strategies at home during the inpatient phase, which significantly improved reintegration after discharge.

Conclusion

The pre-pilot for IMH@Home demonstrates that acute psychiatric care can be safely and effectively delivered outside the hospital through innovative care models, digital health solutions, and robust safety protocols. Majority of the psychiatric interventions without procedures can be effectively delivered via IMH@Home. Clinical outcomes were comparable to inpatient care, with potential to reduce reliance on hospital-based services while improving patient experience.

Recruitment during the pre-pilot followed a conservative approach, with eligibility limited to selected diagnostic profiles. However, findings suggest that suitability for IMH@Home is influenced more by patients' risk profile and caregiver support rather than diagnostic group, indicating potential for expanding eligibility beyond current inclusion criteria.