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Treating suicidal patients in an acute psychiatric day hospital: A challenge to assumptions about risk and overnight care

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Abstract

Background: It is widely assumed that suicidal patients need to be treated in an overnight facility.
Aim: To test this assumption using quantitative and qualitative findings from a study of suicidal patients treated in a day hospital versus overnight care.
Method: Patients admitted to psychiatric wards were randomly allocated to a day hospital (141 patient) or conventional inpatient treatment (65 patients). Analysis of co-variance was used to test the hypothesis that patients with high suicidal ideation, particularly when living alone, would have less reduction in symptoms at the end of treatment period and following discharge, and higher readmission rates when treated in a day hospital as compared to an inpatient ward. In addition, descriptive case-by-case data were explored.
Results: Patients with high level of suicidal ideation, regardless of whether they lived alone, showed greater symptom reduction during a day hospital treatment. However this effect did not persist 3 or 12 months following discharge. However there was no significant difference in terms of days spent in readmissions after discharge. Two suicides occurred within the study period, one from each treatment group.
Conclusion: Our findings challenge the assumptions that overnight care is necessarily the best treatment option for acutely suicidal patients.

Keywords: *Mental health, risk, suicide, inpatient wards, day hospital*

Introduction

How should acutely mentally ill patients with suicidal ideation be treated? Despite recent critical reports on the safety and pleasantness of acute psychiatric inpatient wards (Kings Fund, 2003; Mind, 2004), there is an enduring assumption that the environment of an overnight ward is the best way to protect and monitor highly suicidal patients. This assumption is reflected in the recommendations of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (Department of Health, 2001). Their recommendations for reducing the number of inpatient suicides (which represent 16% of the suicides by people in contact with mental health services) included removing ligature points, ensuring there are no gaps in one-to-one observation and more careful consideration of whether to give high-risk patients time off the ward. These recommendations are focused on increasing ''safety'' of the physical environment but do not question the general concept of the inpatient ward itself as an appropriate treatment option.

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The defining feature of a psychiatric inpatient ward is that patients stay overnight. The act of staying overnight is pervasively associated with safety and enclosure. A statement by the mental health charity Mind epitomizes this position. Whilst pointing out that hospital can be distressing, Mind also states: ''Hospital can provide a place of 'asylum' which offers shelter and protection'' (Mind, 2004). There are two different aspects of providing ''shelter and protection'' from suicidal thoughts in a clinical setting. One is about providing physical safety whilst the other one is about providing emotional containment by intense therapeutic input. This paper will use evidence from a study of suicidal patients treated in two different acute settings, a psychiatric day hospital and an inpatient ward, to argue that these two aspects of ''shelter and protection'' in treatment of acutely suicidal patients can become confused, with one being taken as synonymous with the other.

Day hospitals as an alternative to inpatient care

Sometimes psychiatric patients who would otherwise be treated in an inpatient ward are offered treatment in an acute psychiatric day hospital. A survey found around 73 acute psychiatric day hospitals in England offering this kind of service (Briscoe et al., 2004). A number of randomized controlled trials have tested the efficacy of acute day hospital care (e.g., Creed et al., 1990; Schene et al., 1993; Sledge et al., 1996). Combined findings suggest that day hospitals are generally as effective as inpatient care for psychiatric patients.

Day hospitals and suicidal ideation

Despite the positive findings on acute psychiatric day hospitals in general, there is still significant doubt as to whether acute psychiatric day hospitals are an appropriate treatment milieu for suicidal patients. Currently, 30% of the acute psychiatric day hospitals set up to be an alternative to inpatient care in England will not officially take patients with acute suicidal ideation (Briscoe et al., 2004). Even when this is not an official exclusion criterion there may be a high level of caution amongst staff responsible for referring patients to a day hospital. The level of caution may be even greater when patients live alone. The National Confidential Inquiry seems to share the view that a day hospital might be inappropriate for patients with acute suicidal ideation, *especially if they live alone* advocating greater caution in allowing leave soon after admission for suicidal inpatients living alone (Department of Health, 2001). This group is prioritised by the inquiry for suicide prevention and monitoring practices. Interestingly the quality of the relationships the patient has with people s/he is living with is not taken into account. It seems as if presence of another person at home is considered important primarily in terms of physical safety.

There is some evidence to support the idea that living with others, as part of the more general bundle of factors under the heading ''social support'', has a protective effect on suicide. Marriage, for example, has been shown to have a buffering effect on socio-economic inequalities in suicide (Lorant et al., 2005). Thinking about these findings in terms of day hospital treatment, ''intuitively'' it seems that sending suicidal patients back to an empty home in the evening could be detrimental.

However, there is very tentative evidence from previous research to suggest that, in fact, acute day hospital treatment for suicidal patients, particularly those living alone, may operate ''counter-intuitively''. It is practically impossible to statistically analyse actual suicide rates as an outcome criterion of a randomized controlled trial because the event is so rare. Therefore, proxy measures such as psychopathology ratings, number of crisis situations and self-reports of feelings are most often used. A comparative study of psychiatric day hospital treatment and

inpatient treatment in the Netherlands investigated the number of ''crisis situations'' occurring during admission. (Schene et al., 1993). The authors concluded that day hospital treatment carried no extra suicide risks for patients. In fact the number of patients engaging in ''self-mutilation'' was higher in the inpatient group. In terms of living alone, a Canadian study of a short-term psychiatric day hospital program (for patients who would otherwise require inpatient care) showed no difference in terms of symptom reduction between day hospital patients living alone and those living with others (Potvin Kent et al., 2000). Apart from Schene et al.'s (1993) exploration of ''crisis situations'' occurring during day hospital admissions, none of the previous day hospital trials have specifically reported on suicidal patients (although this does not mean there were no suicidal patients in their samples).

The randomized controlled trial of an acute psychiatric day hospital versus an inpatient ward found a significant result on symptom reduction in favour of the day hospital at discharge and greater treatment satisfaction at discharge and three months after discharge, also in favour of the day hospital (Priebe et al., 2006). In this paper we report findings from the same trial focusing on patients with acute suicidal ideation. By tracking what happened to these patients, and using both quantitative and qualitative methods, we test assumptions about the treatment of suicidal patients, especially those living alone, and about the role of inpatient wards in this respect. Our method involves delving beneath the usual outputs of randomized controlled trials by compiling data drawn from a variety of sources and exploring individual cases as well as outcomes on group level.

Method

The full methodology of this trial is reported elsewhere (Priebe et al., 2006), so the method will only be presented in brief here.

Overall sample

Voluntary patients admitted to three adult psychiatric wards in an inner city area in London (1999 – 2002) were randomly allocated to either day hospital treatment or inpatient treatment within 24 hours of admission. Patients had a wide range of diagnoses and symptoms, including suicidal thoughts. As described in a previously published paper from this study (Priebe et al., 2006), one of the exclusion criteria was homelessness.

Treatment settings

The inpatient wards in this study provided conventional psychiatric care. A limited programme of optional daily activities was sometimes available at these wards.

The day hospital exclusively treated patients as an alternative to inpatient care, with an emphasis on providing acute rather than long term care. Patients were expected to attend Monday to Friday from 9.30 – 4.30pm and at weekends there was an optional drop in service.

The day hospital was organized around an intensive group based programme which comprised the following categories: work based group activity, creative activities and art therapy, psychoeducation, cognitively-orientated problem solving groups and psycho-dynamically-oriented talking groups. Patients were encouraged to learn from each other and take an active role in their treatment. There was a strong emphasis on fostering a good therapeutic alliance and mutual respect between staff and patients. With this in mind, there were daily and weekly community meetings in which patients were able to feed back practical and emotional aspects of their experience of the day hospital.

Data collection

Quantitative ratings of psychiatric symptoms and of suicidality. Patients were interviewed on admission, discharge, three months after discharge and 12 months after discharge by researchers. Psychopathological symptoms were assessed at each of these points using the 24-item version of the Brief Psychiatric Ratings Scale (BPRS) (Ventura et al., 1993). As well as obtaining an overall rating of symptoms (measured as the mean score on the full 24 items of the BPRS), the rating for suicidality was singled out for particular attention.

Patients' ratings at admission on this dimension were coded into two main categories: ''high level of suicidality at admission'' (4 or more on the BPRS ratings scale) and ''low level of suicidality at admission'' (a score of less than 4). We chose this cut-off point because ratings of 4 or above represent a clinically appreciable risk of actual suicide occurring, in terms of the frequency of suicidal thoughts and intent. Table I provides a description of the criteria of the BPRS ratings and our coding.

Readmissions. Medical records were used to collect data on patients' readmissions to either day hospital or inpatient treatment in the twelve months after their discharge from the index treatment.

The qualitative effect of treatment setting on suicidal thoughts – Open question. In addition to a battery of questionnaires administered to all patients at discharge and in the follow-ups (Priebe et al., 2006), patients in the ''high level of suicidality at admission'' group were asked in a form of open question if anything during their stay at the day hospital or ward had helped their suicidal thoughts. The answers were recorded by researchers, coded into categories (more than one category per answer if necessary), and checked for inter-rater reliability by two researchers.

Table I. Ratings on the Brief Psychiatric Ratings Scale (Ventura et al., 1993) and categorization used in this study.

1. Not present		
2. Occasional feelings of being tired of living. No overt suicidal thoughts	Low level of suicidality at admission	
3. Occasional suicidal thoughts without intent or specific plan. OR he/she feels they would be better off dead.		
4. Suicidal thoughts frequent without plan or intent		
5. Many fantasies of suicide by various methods. May seriously consider making an attempt with specific time and plan OR impulsive suicide attempt using non-lethal method or in full view of potential saviours.		
6. Clearly wants to kill self. Searches for appropriate means and times. OR potentially serious suicide attempt with patient knowledge of possible rescue.	High level of suicidality at admission	
7. Specific suicidal plan and latent (e.g. ''as soon as _____I will do it by doing x''). OR suicide attempt characterized by plan patient thought was lethal or attempt in secluded environment.		Very high level of suicidality at admission

Looking beneath the statistics – Transfers, Suicides and Tracking highly suicidal patients. Recognizing that statistical tests can obscure individual cases, we choose to explore the actual practicalities of randomizing patients with high level of suicidality to the day hospital. We first looked at those patients with high level of suicidality who were transferred from the day hospital to the ward during their index treatment period. Drawing on medical notes, patient interviews and discharge summaries we collected data on number, length and reason for transfers. We also used medical records to ascertain whether any participants had committed suicide during admission or within twelve months of discharge. Case notes were collected for suicides, including GP summaries, coroners' notes and the original discharge summaries, to try to build a picture of the circumstances leading up to the suicide. Finally we ''tracked'' those patients at the top end of the ''high level of suicidality at admission'' group (see Table I) who were perceived as being particularly at risk.

We classified these patients as a subgroup of the ''high level of suicidality'' group, which we called the ''very high level of suicidality'' group. We looked at the individual circumstances of their admission and discharge (using discharge summaries), the length of their admission, readmissions, whether they lived alone, and their suicidality scores at each time point.

Analysis

This sub-study within a main randomized controlled trial was designed to explore whether patients with high level of suicidality could be successfully treated in an acute psychiatric day hospital. To this end we wanted to produce both a measure of their outcome and descriptive data about clinical and practical realities of randomizing highly suicidal people to day hospital treatment, which may have otherwise been lost behind this outcome measure. Our analyses and presentation of findings reflect these aims.

An outcome measure for day hospital treatment of patients with high level of suicidality – Psychopathology. We used SPSS to conduct one-way analyses of co-variance on symptom scores (i.e., mean BPRS scores) at discharge, three months after discharge and 12 months after discharge. Our independent variables were treatment setting (day hospital or ward), suicidality (coded into two groups: ''high level of suicidality at admission'' and ''low level of suicidality at admission''), and living alone or not. We were interested in the individual effects of each variable on outcome symptoms but also in possible interaction effects between the variables. We controlled symptom scores at admission by entering them as a co-variate. We also entered length of stay (in days) as a covariate to control for differing lengths of stay. Considering that in our main trial day hospital treatment had proved more efficacious than ward treatment (Priebe et al., 2006) we wanted to test the following hypothesis: ''Day Hospital treatment is more effective than ward treatment only for patients who have low level of suicidality. For patients with high level of suicidality it may be worse in particular if they live alone''.

An outcome measure for day hospital treatment of patients with high level of suicidality – Readmissions. We conducted a one way analysis of variance on the number of days spent in readmission in the 12 months after discharge, testing for the effect of setting, living alone or not, suicidality status, and interactions between these variables.

Descriptive data

The rest of the data collected (open question about how treatment had helped with suicidal thoughts, details of transfers, suicides and trajectories of highly suicidal patients), was used to contextualize the results of the ANOVA. It is presented in this paper as exploratory, and anecdotal, evidence that can be used to shed light on the realities, issues and assumptions involved in the treatment of acutely suicidal patients in hospital settings.

Results

Sample composition

During the study period, 791 voluntary admissions were screened for eligibility for randomization. Although acute suicidal ideation was not one of our formal exclusion criteria, participants had to be approved by the on-duty consultant. The on-duty consultant excluded 55 admissions (7%) because they were deemed too much of a suicide risk to go to the day hospital. Therefore no outcome data for these patients are available. After exclusions 206 patients were entered into the study with 141 being randomized to the day hospital and 65 to the ward (randomization was weighted in favour of the day hospital to ensure it had enough patients to remain in operation). Of the 141 patients randomized to the day hospital, 55% (76/139 – for 2 patients suicidality ratings were missing) were coded as ''high level of suicidality at admission''; 12% of these day hospital patients could be further classified as ''very high level of suicidality'' (BRPS suicidality score of 6 = 12 patients, BPRS suicidality of 7 = 5 patients). This composition was comparable to those patients randomized to the ward, 59% (38/65) of whom were ''high level of suicidality at admission'', and 17% of whom were ''very high level of suicidality''.

The mean length of admission for patients randomized to the day hospital was 55.7 days (SD = 46.0, range 0 – 198) with 30.5 days (SD = 35.6, range 2 – 175) for the ward group. Baseline socio-demographic information is presented in Table II.

A CONSORT diagram is available in a previously published paper from this study (Priebe et al., 2006).

Suicidality, treatment setting and living alone

Results of the ANCOVA on psychopathology. There was a significant three-way interaction effect between suicidality, treatment setting and living alone on symptom scores at discharge ($n = 105$ (day hospital = 75, ward = 30), $F = 6.18$, $df = 1$, $p = 0.015$, 95% confidence intervals = 0.204 – 1.823). Although the numbers are small the test is robust. In the ''high level of suicidality at admission'' group, patients randomized to the day hospital showed greater symptom reduction than those randomized to ward, regardless of whether they lived alone or not. In contrast in the ''low level of suicidality at admission'' group, patients randomized to the day hospital showed greater symptom reduction than those randomized to the ward, but only if they lived with others. However, patients with ''low level of suicidality'' living alone showed greater symptom reduction if they were randomized to the ward, rather than the day hospital (see Table III).

This three-way interaction effect did not persist at either three months or twelve months after discharge.

Table II. Socio demographic information for patients with "high" and "very high" level of suicidality at admission.

	Day Hospital Patients		Ward Patients	
	"High level of suicidality at admission" (BPRS ≥ 4) $n=76$	"Very high level of suicidality at admission" (BPRS ≥ 6) $n=17$	"High level of suicidality at admission" (BPRS ≥ 4) $n=38$	"Very high level of suicidality at admission" (BPRS ≥ 6) $n=11$
Living situation				
Living alone	26	3	15	6
Living with others	50	14	22	5
Gender				
Male	33	9	20	6
Female	43	8	18	5
Occupational status				
Paid employment	14	7	3	2
Unemployed	52	8	33	9
Other	7	2	2	0
Diagnosis				
Anxiety and Depressive disorders	37	11	22	6
Bipolar Affective disorders	7	2	1	0
Personality disorder	8	3	5	2
Psychotic disorders	12	0	7	2
Other	2	0	1	1
Unknown	10	1	2	0
Mean age (years)	37.5	36.5	37.7	40.1
Mean Length of admission (in days)	53.1	40.8	28.1	48.0

Results of the ANOVA on readmission. Unlike the results on symptom severity, there were no significant main effect of, or interactions between setting, living alone and suicidality status on the number of days spent in readmissions in the 12 months after discharge. Therefore, there were no statistically significant differences in readmissions between day hospital and ward patients, regardless of whether they were suicidal or lived alone. However, there was a trend suggesting that overall patients randomized to the day hospital spent longer in readmission, although this was not statistically significant, and living situation and suicidality were not mediating factors on readmissions ($F=3.86$, $p=0.051$, 95% confidence intervals $=-57.565-11.085$).

Subjective accounts of how treatment settings helped with suicidal thoughts

Thirty-four patients in total (9 ward, 25 day hospital patients) agreed to answer a question on how treatment had helped with their suicidal thoughts. This represented 30% of the "high level of suicidality at admission" group. Originally we wanted to compare their answers at discharge, three months after discharge and 12 months after discharge. However, the number of patients was very small at each time point. Therefore in order to get a big enough sample we took answers gained at any time point and considered them together. Numbers were still small, so rather than statistically comparing the coded answers of the day hospital patients versus the ward patients, we analysed the findings qualitatively looking particularly at the aspects day hospital patients mentioned that ward patients didn't. The two main aspects mentioned the most by patients randomized to the

Table III. Outcomes of treatment – psychopathology and readmissions by setting, suicidality and living status.

	n	BPRS Mean Score at discharge (Controlling for BPRS mean at admission, length of stay in an ANCOVA, lower scores represent less symptoms)	Standard error	Mean no. of days spent in readmissions	Standard error
High level of suicidality at admission					
Day Hospital Patients					
Living alone	14	1.83	0.11	27	64
Living with others	26	1.52	0.08	20	46
Ward Patients					
Living alone	5	2.37	0.12	17	52
Living with others	14	1.77	0.19	9	28
Low level of suicidality at admission					
Day Hospital Patients					
Living alone	9	1.17	0.14	24	43
Living with others	26	1.59	0.09	28	57
Ward Patients					
Living alone	5	1.44	0.20	8	20
Living with others	6	2.04	0.18	12	35

day hospital were ''Able to talk/be listened to'' (17 patients, e.g., ''They talked to me a lot and listened and I didn't feel like they were judging me. Even the patients were really good to me. You don't get that on the ward''.) and ''Learning they were not alone, others in the same/worse situation'' (10 patients, e.g., ''Others going through the same situation helped as you felt that you weren't alone''.). ''Developing coping strategies/understanding my illness'' (e.g., ''They helped me deal with anxiety, helped me find ways of dealing with it''.), ''Being occupied'' (e.g., ''Because I wasn't isolated during the day, I had people to talk to and I was kept busy so I couldn't dwell''.), ''Talking groups'', ''Not being isolated/making friendships'' and ''Support'' were aspects also mentioned. Among the ward patients ''Able to talk/be listened to'' was also frequently mentioned (4 patients). But they also mentioned ''Being observed'' (4 patients, e.g., ''I still had the thoughts but the staff watched me all the time. Then the thoughts went away. The staff stopped me harming myself''.), and ''Feeling safe'' (3 patients, e.g., ''Felt safe. I am here and I am safe''.).

What was *not* mentioned in the different treatment settings was particularly interesting. Ward patients did not mention the categories ''Being occupied'', ''Not being isolated/making friendships'', ''Developing coping strategies/understanding illness'' or ''Support''. These were categories prevalent in the day hospital patients' responses.

In terms of what was mentioned by ward patients but not by day hospital patients, day hospital patients did mention the categories ''Being safe'' and ''Being observed'' but only twice, which was comparatively little considering the frequency of other answers.

Transfers to the ward – is the Day Hospital enough on its own?

Table IV gives details of the seven patients randomized to the Day Hospital who were transferred to the ward at some point for reasons related to risk to self.

Table IV. Details of day hospital patients transferred to the ward for reasons related to risk to self.

BPRS Suicidality rating at admission	Living alone	Transfer details	Why
1	No	Randomized but almost immediately transferred to the ward for 2 and half months. Returned to the day hospital for 3 months	Reported not feeling safe at home
4	No	5 days after admission transferred to ward for 12 days. Returned to day hospital for 29 days	Said would commit suicide if not allowed to go to ward. During time on ward remained in close contact with day hospital
4	No	1 month after admission transferred for 2 days. After being back at the day hospital for 2 months patient was again transferred to ward. Remained there for 1 and half months until discharge.	Threatened to take an overdose on several occasions and took the overdose twice. The second time was permanently transferred as not felt to be ''containable'' in the day hospital.
4	Yes	25 days after admission transferred to the ward for 49 days until discharge.	Felt afraid to go back home, reported feeling very paranoid and unsafe. Made ''threats'' to self harm if needs not met at both day hospital and ward.
4	No	6 days after admission transferred to the ward for 35 days. 1 month after return to day hospital, patient was transferred again to the ward for 14 days. One month after returning to the day hospital patient transferred for the third time, this time for 12 days. Returned to day hospital for 5 weeks.	(1) self reported risk to self and family, (2) family not able to cope with patient at home, and (3) overdose.
5	No	18 days after admission, transferred for 35 days. Returned to the day hospital for 5 days	Transferred for a short time during admission to a general hospital for physical health problems but left before treatment was complete. Assessed as neglecting medication for physical health problems as a way of trying to commit suicide. Transferred to the ward compulsory in order to monitor suicidal risk and insure physical health needs met.
5	No	1 and half months after admission. Transferred for 6 days	Transferred after conflict with the family at home leading to an overdose

With the exception of patient 1, all transferred patients were in the ''high level of suicidality at admission'' group. Therefore 6 out of the 76 ''high level of suicidality at admission'' patients at the day hospital were transferred at some point. None of the patients in the ''very high level of suicidality'' group were transferred. Transfers ranged from 2 days to 49 days, with two of the transferred patients not returning to the day hospital and remaining at the ward until discharge. Only one transferred patient was living alone. Most of these transfers occurred at the patient's request. These patients either reported feeling unsafe at home or, in three cases, made or actually carried out suicide ''threats''. Family was also an issue. One patient was transferred once

because of a self-reported risk to their family and once because the family had difficulty coping with the patient at home. Another patient required a short transfer as a break from a family conflict that had led to an overdose. Finally, transfer was required to manage physical health needs of one patient neglecting a potentially life threatening condition.

Tracking the group with very high level of suicidality

Of the 17 ''very high level of suicidality at admission'' patients randomized to the day hospital, 13 (76%) could be classified as treated successfully. They were not transferred and spent an average of 48 days at the day hospital. Out of these 13 patients 10 were discharged with a ''not present'' rating for suicidality (BPRS = 1), which persisted in the follow-ups. The remaining three were not able to be interviewed at discharge, but all three had ratings of suicidality ''not present'' three months after discharge.

For four patients with very high level of suicidality at admission however, treatment at the day hospital appeared to be less successful. The first patient was discharged from the day hospital after 31 days with suicidality rating only decreased from 6 to 5 (see TableI for rating details). Three months after discharge the rating was 4. We were unable to obtain discharge or follow-up data for the second of these patients (who died of natural causes within 12 months of discharge). The third patient could not be successful contained in the day hospital as s/he absconded from the day hospital the same day s/he was admitted. We have no follow-up data, although there was no record of compulsory detention or suicide in the proceeding twelve months. The fourth patient committed suicide one month after randomization to the day hospital and the case will be discussed below.

Suicides

There were two suicides by patients in this study within 12 months of discharge from treatment.

Case 1. Case 1 was randomized to the ward. On admission s/he had a suicidality rating of 3, and therefore was not in ''high level of suicidality at admission'' group. The patient spent 22 days at the ward and was discharged with the same suicidality rating. When interviewed three months after discharge, suicidality had increased to 6. Seven months after discharge, having not been readmitted in this time, s/he committed suicide by overdose.

Case 2. Case 2 was randomized to the day hospital. The score on suicidality on the admission was 7 (''very high level of suicidality'' group). One hour after admission to the day hospital the patient changed his/hers mind about the admission claiming s/he felt better and wanted to return to work. S/he left the day hospital and did not return but presented to the inpatient ward with suicidal ideas and a possible suicidal plan three weeks later. S/he was put on level 2 observations (every 15 mins). The following day, s/he requested to go on leave but was persuaded to stay on the ward and observations were increased to level 3 (constant). Later on that day, appearing much calmer and reporting no suicidal ideation, the patient asked to go home to pick up some belongings, planning to return to the ward in the evening. S/he did not return and committed suicide that evening.

Discussion

Can severe suicidal ideation be successfully managed in an acute psychiatric day hospital?

Our study presents an attempt to use descriptive and exploratory findings to address this question. The small numbers involved are an obvious limitation. We subsequently use the findings as a starting point to consider the appropriate treatment of suicidality, rather than represent a definitive treatise on the subject. Other significant limitation is using BPRS rating as a single measure of suicidality.

The findings offer a challenge to current thinking on suicidality and overnight care, the assumptions which suggest severely suicidal patients should not be treated in an acute day hospital. Patients who had high level of suicidality randomized to the day hospital in our study fared no worse, in terms of symptom reduction and readmissions, than their ward counterparts, even if they lived alone. Symptom findings at discharge suggest that in fact the day hospital is the preferable place to send suicidal patients (the only time the ward was preferable was for patients with ''low level of suicidality'' who are living with others).

These results emphasize a need for a more flexible approach to a risk assessment which often determines the type of acute mental health care offered to a suicidal patient. The risk assessment usually consists of a cumulative score of ''tick boxes'' which represent risk factors. Living alone is considered one of the risk factors for suicide, however our results show that it should not be taken as a risk factor when deciding on whether to treat patient in an overnight facility or in a day hospital. When considering a patient's living situation, it may be more appropriate to explore the quality of the relationships the patient has at home rather than considering other people at the patient's home primarily with respect to their capacity to observe the patient.

In an ambiguous situation psychiatrists' decision to treat suicidal patient in an overnight facility is often influenced by ''primum non nocere'' (primarily not harm) philosophy. This study shows that treating suicidal patients in an overnight facility as opposed to a day hospital may actually imply denying them more effective form of treatment for suicidality.

Nevertheless, the situation regarding treating suicidality in a day hospital is not as clearcut as the statistical analysis might suggest. None of the patients in the ''very high level of suicidality'' group were transferred to the ward during their stay. However, some patients in the ''high level of suicidality group'' were transferred. More importantly they were transferred for severe suicidal ideation, including overdoses. Here the ward was being considered by day hospital staff as a more appropriate treatment milieu for the suicidal ideation manifested in these patients, confirming, perhaps the assumptions about risk and overnight care discussed at the outset of this paper. In addition, on some of these occasions, it was not the staff who felt that ward treatment was needed. Some patients felt very strongly that the day hospital was not providing the right level of security.

As Wilkinson (2004) points out ''risk is a slippery term''. This is particularly evident in the case of the transfers. Considered on an individual case-by-case basis, they bring up issues about staff perception of risk, patient perception of risk, and, in the case of one of the transferred patients who was neglecting his physical health, what counts as suicidal (and therefore treatable in this context) behaviour. One cannot predict what would have happened if transfer to the ward had not been available. The transfers, and particularly the fact that most of these patients were able to return to the day hospital after the ''crisis'' or ''break'', suggest a need for day hospital care as one of a range of acute treatment options that could be used in an integrated manner by particular patients according to needs. For some highly suicidal patients day hospital treatment may be an entirely inappropriate alternative.

The fact that the majority of patients who had ''high level of suicidality'' and, particularly, almost all patients with ''very high level of suicidality'' were successfully treated in the day hospital without need for transfer indicates that foreseeing who will attempt/commit suicide is not straightforwardly predictable. Suicide Case 1 is a clear demonstration of this. The fact remains that a number of day hospital patients with imminent plans of committing suicide were not only ''protected'' from doing so, but also left the day hospital with a clear improvement in suicidal thoughts and feelings. This last point raises an important issue about what hospital treatments are set up to achieve. In a risk-based society (Beck, 1999), it seems that the priority has been placed solely on protecting people from being able to harm themselves. The Department of Health (2001) document ''Safety First'' is a testament to this, with its focus on ligature points, observation and caution in allowing home leave for inpatients. It focuses on increasing physical safety of inpatient wards overlooking possibility of increasing ''emotional safety'' of the ward through containment of suicidal thoughts provided in a therapeutic relationship. The acute psychiatric day hospital in this study was specifically designed to empower patients, inform them about their illness and create an environment of support, both between staff and patients and between patients themselves. These aims are reflected in the anecdotal evidence collected on how the treatment settings helped with patients' suicidal thoughts and feelings. ''Learning they were not alone'' and ''Developing coping strategies/understanding illness'' in the answers of day hospital patients hints that these aims might have been instrumental in producing a greater reduction in symptoms than in the ward. The ward, at least in our study, did not provide the same programme as the day hospital. It may be that the defining comparative features of the two treatment settings is not ''going home in the evening'' versus overnight care, but rather the presence or absence of supportive and confidence building activities.

It is important to mention that topography of mental health services in the UK has changed with the introduction of Home Treatment Teams (HTT) since the original study was undertaken. Although both HTT and acute day hospital are acute mental health services offering an alternative to inpatient treatment, therapeutic approach differs significantly between the two. Further research needs to explore effectiveness of HTT in treating suicidal patients. However this diversity of services further reinforces a conclusion from this paper – that one setting is not simply better than another one but rather different. One might conclude that generalized statements about risk assessment and services, including generalized ''intuitive'' assumptions, are less appropriate than a specific analysis in every single patient about what treatment is most appropriate in the given situation and considering the potential of the patient to benefit from interactions with staff and other patients.

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