The Oxford Monitoring System for Self-harm

Clinical Research Update Newsletter #3

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Summary of selected editorials and commentaries

Fazel, S. Improving suicide prevention in men. *PLoS Med.* **23**, e1005169 (2026).

Summary: This editorial addresses why suicide rates among men remain persistently high despite population-level prevention strategies, arguing that greater attention is needed for targeted, specialist interventions for identifiable high-risk groups of men, alongside broader universal approaches.

The author highlights that many men at highest risk are already known to services, frequently presenting with combinations of psychiatric disorder, substance misuse, self-harm, physical illness, or criminal justice contact, yet often receive fragmented and poorly coordinated care. Alcohol misuse and gambling-related harm are identified as under-recognised contributors to suicide risk in men that are often treated as separate from suicide prevention frameworks rather than integrated into them. Older men with a history of self-harm and men who move repeatedly through the criminal justice system are highlighted as particularly high-risk groups whose needs are often poorly met by generic, streamlined care pathways.

The author argues that diagnostic clarity, continuity of care, and sustained multidisciplinary support remain essential for engaging men whose needs are complex, and that scalable risk assessment tools informed by contemporary evidence could support more precise identification of risk alongside these efforts.

Hawton, K. & Pirkis, J. Preventing suicide: a call to action. *Lancet Public Health* **9**, e825–e830 (2024).

Summary: This paper is part of a series argues for a fundamental shift in how suicide prevention is approached, moving beyond a predominantly clinical model toward a whole-of-government public health strategy.

Using an iceberg analogy, the authors describe how indicated (clinical) interventions reach only the smaller group of people already experiencing suicidal thoughts or behaviour, while universal interventions are needed to address the much larger group of people who may become at risk due to social determinants such as financial hardship, alcohol and gambling-related harm, and domestic abuse. Drawing on specific examples, including means restriction, alcohol policy, poverty-reduction programmes, and responsible media reporting, the authors demonstrate that upstream, population-level interventions can meaningfully reduce suicide rates, sometimes substantially.

The paper sets out a detailed call to action across four domains: policy, practice, research and evaluation, and advocacy, emphasising that many of the most effective levers sit outside the health sector and require sustained political commitment and cross-sectoral coordination. The authors also stress the importance of genuinely involving people with lived experience of suicide throughout these efforts, and note ongoing challenges in evaluating population-level interventions due to data quality gaps and the difficulty of applying randomised designs to broad social and policy changes.

Nguyen, J., Dwyer, D. B., Nelson, B. & Schmaal, L. From Static to Dynamic Prediction of Suicide Risk. *JAMA Psychiatry* **82**, 1061–1062 (2025).

Summary: This viewpoint argues that suicide risk prediction models have not kept pace with clinical practice, which has moved away from static, categorical risk assessment toward dynamic formulation approaches that treat risk as fluctuating over time and focus on modifiable drivers.

The authors identify two key limitations of existing models: most rely on psychosocial information collected at a single time point (e.g., hospital intake) and so miss subsequent changes in mental state or circumstances, and many reduce risk to a binary or categorical output that offers limited insight into what is driving an individual's risk or whether targeting specific factors would reduce it.

They outline promising methods for building more dynamic, actionable models, including statistical approaches that recalculate risk at each clinical contact using time-varying data, and deep learning methods that capture temporal patterns but face interpretability challenges requiring explainability techniques. They also highlight the potential of causal inference to estimate how modifiable events (e.g., relationship breakdown, sleep disturbance) might change risk, and of real-time monitoring to enable just-in-time interventions. The authors call for rigorous evaluation of such tools (including via trials against usual care), strong governance and privacy safeguards, and co-design with people with lived experience.

Hart, J., Lignou, S. & Fazel, S. Health justice, resource allocation and age in suicide risk assessment. *Nat. Ment. Health* **4**, 707–714 (2026).

Summary: This perspective article reconsiders the NICE recommendation against using suicide risk assessment tools through the lens of health justice and resource allocation, arguing that the guidance overlooks important equity considerations.

The authors contend that, given finite mental health resources, some form of patient prioritisation is unavoidable, and that risk assessment tools should be evaluated not only on their predictive accuracy but on whether they support fairer priority-setting than clinical judgement alone. They highlight substantial age-related disparities in suicide risk following self-harm – with mortality up to 17 times higher in older adults compared with younger groups – and argue that NICE's guidance, by not addressing how such disparities should inform prioritisation, risks amounting to indirect discrimination against older patients, drawing a parallel with a prior legal case (Eisai vs NICE) on this point.

The authors also address common criticisms of risk prediction tools, arguing that concerns about low predictive accuracy and arbitrary risk thresholds do not, on close examination, undermine the case for their use, particularly when tools use probability scores rather than crude categories and are used to inform rather than replace clinical judgement. They conclude that categorical exclusion of these tools is premature, and call for further research into their comparative effectiveness, feasibility, and impact on inequalities in care.

Seyedsalehi, A. & Fazel, S. Clinical guidelines on self-harm and suicide prevention: taking uncertainty into account in the evidence base. *BMJ Ment. Health* **29**, 1–3 (2026).

Summary: This perspective article critically examines the process by which the 2022 NICE self-harm guideline arrived at its recommendation against using risk assessment tools and scales to predict repeat self-harm or suicide, or to guide treatment and discharge decisions.

The authors highlight that the evidence review underpinning this recommendation included only two studies, both of which assessed the predictive accuracy of clinical risk categorisation rather than comparing the impact of using structured tools against usual care. Given the very limited evidence base, the guideline committee's strong conclusions about the poor predictive performance and potential harms of risk assessment tools were, by the committee's own account, based largely on their collective expertise and experience rather than on empirical data. The authors also raise concern that NHS England's 2025 "Staying safe from suicide" guidance has since extended these recommendations to a much broader population of mental health service users, without an updated evidence review.

The authors argue that while premature implementation of unvalidated prediction tools should be avoided, there is a substantial and growing body of evidence on model performance that was excluded from the NICE review's narrow scope, and that well-validated tools have the potential to support clinical decision-making. They call for future guideline updates to draw on more comprehensive evidence, including emerging research on model impact, feasibility, and acceptability in routine care.

Clinical and public health implications

1. Suicide prevention for men should combine population-level strategies with better-coordinated, sustained specialist care for high-risk groups, including older men and those with criminal justice involvement.
2. Effective suicide prevention requires action beyond clinical services, including upstream, cross-sectoral interventions that address social determinants such as poverty, alcohol and gambling harms, and domestic abuse.
3. The dynamic nature of suicide risk requires careful monitoring and follow-up in at-risk populations.
4. Age-related disparities in suicide risk after self-harm should be explicitly considered in resource allocation and priority-setting decisions, not left to clinical judgement alone.
5. The date of clinical guidelines and their scope should considered as part of any critical appraisal of evidence. NICE's 2022 recommendation against using suicide risk assessment tools for people who self-harm was based on a very limited evidence review and relied on committee expertise, and has since been extended to broader populations without updating the evidence base. New research should examine whether risk assessment tools, when complementing clinical assessment, can support fairer, more consistent clinical decision-making.

Further information

Further information about the Multicentre Study of Self-harm in England and the Centre for Suicide Research is available on our website:

https://www.psych.ox.ac.uk/research/csr

https://www.psych.ox.ac.uk/research/csr/ahoj

https://www.psych.ox.ac.uk/research/csr/research-projects-1/the-oxford-monitoring-system-for-self-harm