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STARS

Systematic Tailored Assessment for Responding to Suicidality 2018 Edition

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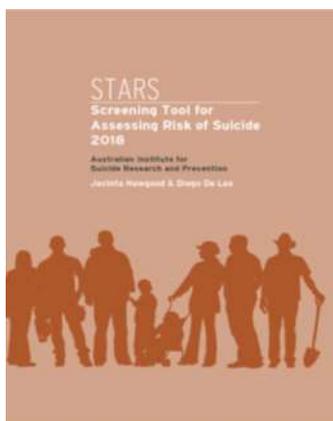
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Overview of STARS - Systematic Tailored Assessment for Responding to Suicidality

(Hawgood & De Leo, 2018).

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Introduction

The STARS protocol was developed in recognition of the centrality of psychache (referring to intolerable psychological pain; see Shneidman, 1993) and contextual experiences associated with the suicidal status, and in recognition of its unique and changing state over time (Hawgood & De Leo, 2015). It includes example clinician probes or questions to facilitate exploration of suicidal status (and contextual, situational, relational risk and protective indicators) to reduce clinician anxiety that often accompanies approaching this domain of assessment. It also has a 'traditional' categorical severity-rating system against individual assessment indicators of the tool to guide clinician response to those most important to the client; as opposed to provision of a global risk rating or categorical classification. Finally, the tool provides for documentation of client needs and suicidal status, and commensurate actions proposed or undertaken by the clinician for demonstration of standard of care.

Purpose of STARS

The purpose of STARS is to assist and guide clinicians² on ways to elicit some of the essential empirically based risk and protective factor information, short-term indicators of suicide risk (or warning signs), and current and past suicidality (from the client's perspective). STARS is not a comprehensive suicide assessment method; rather STARS was developed to provide a very initial insight into the complex world of a suicidal client to inform immediate clinician action and client care, including further examination of client suicidal status as necessary.

Administration

STARS is designed for collaborative administration beginning with the client's own narrative. Each section of STARS includes questioning probes against specific items pertaining to several domains of enquiry which fall under three separate sections: Part A – Suicidal Behaviour Enquiry (Critical questions asked first in a crisis situation); Part B – Risk Factor Enquiry (Enquiry may start here with less intrusive questioning in cases where risk is not imminent); Part C – Protective Factors Enquiry (Enquiry may start here with less intrusive questioning in cases where risk is not imminent). Despite author recommendations on the ordering of enquiry based on presentation of client acuity, the clinician should remain cognisant of the need to accommodate the pace and presentation of the client's narrative. Thus three sections of enquiry are neither prescriptive nor linear and may be covered in any particular order. Probes were designed simply as examples to facilitate access to client experiences which are often difficult to label and disclose (such as suicidal status, feelings about self, burdensomeness, shame). In general, the tool provides a pathway to enquiry into specific and broader areas of an individual's life known to impact on the inner psychological state.

¹ The reader is advised to access and peruse the recently published article by Hawgood and De Leo (2016) appearing in *InPsych Bulletin* (February Volume, 2016), entitled *Reconceptualising suicide risk assessment: A person-centred approach to needs-based exploration of current suicidality* for a background on suicide risk assessment which presents the context for making of STARS.

² We have used the term 'clinicians' because of the original target audience of intended users of STARS which included mental health workers in the field of suicide prevention. However, we believe that STARS is well suited for use by all workers in suicide prevention including youth workers, clergy, guidance officers and other human service workers. We strongly recommend however that users have received training and acquired experience in suicide risk assessment prior to administration of this tool.

Construction

STARS is based on the combined theoretical works of Edwin Shneidman (1988), Aaron Beck (Beck, Rush, Shaw & Emery, 1979), Roy Baumeister (1990), Marsha Linehan (1993), David Jobes (1995; 2005), Shawn Christopher Shea (1999) and David Rudd, Thomas Joiner and Hasan Rajab (2000). It is beyond the scope of this summary paper to expand further into theory underpinning specific domains of enquiry and items, however, it can be surmised that accumulating empirical evidence for chronic and acute suicidality derived from the works of these and other researchers in the field guided our selection of STARS items. We gained further support and endorsement for the items based on our own clinical experience and understandings acquired from years of clinical interviews with suicidal clients. Lived experience of suicidal clients informed inclusion of several relational, contextual and situational items, and protective factors. We have not conducted any psychometric testing of our tool, since our interest is not in deriving an overall score or standardised categorisation system for predicting any suicidal state. Instead, our interest is in utilising data on the client's suicidal status for informing immediate care or management in line with client needs. The outcome is a 'snap shot' examination of a client's suicidal status at one point in time. We intend however to undertake quantitative and qualitative evaluations of client and clinician useability, as well as cultural and developmental adaptations and comparisons of STARS³.

The meaning of the items assessed by STARS will be unique to each individual and as such an opportunity exists for the clinician to report on each item/factor separately (rather than synthesised into a total score). The item-based client rating within Parts A and B, of 'no concern', 'some concern' and 'severe concern' is for reporting of the client's perspective on the intensity of the item's contribution towards suicidality. There is no scoring of these responses, just a need for some determination of current experience of the item for informing care. STARS allows for documentation of the client's perspective at the conclusion in direct association with documentation of a commensurate level of care plan or response. Therefore, STARS represents an opportunity for clinicians to gather data to inform further assessment, treatment, management and recovery plans for clients in line with (at least) the 'community standard of care' requirements.

Need for collateral data

We believe that the data obtained from use of STARS is not sufficiently accurate when obtained from the client alone, despite our support of the client as the best author of his or her story. We know from years of research that suicidal persons rarely share their true intent, and that even in the most therapeutic of clinical engagements, the actual intent to die may not be revealed. Several reasons for this are well documented (Jobes, 2006; Shea, 2011). Convergent information from other family members, including next of kin, partner, peer, and sibling is therefore required and recommended for more systematic suicide risk formulation, and for more confident

Unique Attributes of STARS

- Addresses enquiry domains associated with chronic (long term) and acute (short term/warning signs) factors
- Allows clinicians to determine administration point of enquiry or the priority assessment areas based on presenting acuity – Enquiry may begin at either Part A, B or C
- Includes protective factor enquiry (not often sought with suicide risk tools) including client relatedness, interpersonal and intrapersonal elements, norms, spirituality, coping and problem solving, esteem and cultural identity
- Differentiates Non-Suicidal Self Injury (NSSI) from Suicidal Behaviour
- Seeks clinician confidence ratings against commentary aligned with specific items or status of suicidality
- Provides example probe questions, with potential meaning or indicators of response
- Past and present data is explored – to allow for clinician compiled timeline of experiences as well as trajectory or pathway of suicidality (e.g. fluctuating experiences associated with specific events/crises or overall mental health/illness can be understood in context)

³ Further empirical work is required to test useability, applicability and generalisability across different cultures and developmental groups of the lifespan

documentation. The STARS data recording form requires clinician's to source this information, where possible. While seemingly time-consuming such serious commitment may not only prevent fallible or sub-optimal management responses but may save a client's life. Higher clinician confidence ratings gained from more comprehensive information (as required from Parts A and B of STARS) can result in more accurate documentation of client needs, including a clear rationale and purposeful management and caring of the client.

Confidence rating

Confidence ratings are requested so that the clinician is a) encouraged to reflect upon his/her decisions rather than merely 'accepting' first impression inferences, b) considers acuity and changeability of the suicidal state (including influences on client capacity to engage), and c) able to indicate to colleagues and others level of certainty associated with item responses. Uncovering the client's suicidality (suicide intent) is central to the clinician confidence in the overall assessment of current suicide status (STARS Parts A and B).

Limitations

STARS is not yet contextualised to all age groups of the lifespan such as youth or older person, nor is it culturally adaptable to other populations or subgroups of clients. Given that STARS is a practical tool or framework for identifying immediate or momentary suicidality, it does not include all possible areas of phenomenological experience of suicidality, and as indicated earlier, it does not replace nor supplement a comprehensive, systematic suicide risk enquiry and formulation.

Conclusion

STARS provides an opportunity for collaboratively and compassionately engaging a person in discussion about some of the most hidden or least communicated experiences of his/her life. It offers the clinician a timely opportunity to access information on a range of risk, protective and momentary elements known to contribute to suicidality, in order to delicately explore important areas perceived by the person that may require further support and management.

STARS can inform immediate response to presenting needs of the client and the need for more comprehensive risk assessment which might include comparison between 'baseline' suicidality versus the obtained data from STARS on subsequent evaluations of suicidality. We hope that clinician anxiety may reduce, while more reliable and meaningful documentation, and effective client care may increase from use of this tool. In essence, if use of STARS allows access to the individual suicidal expressions and needs, it may be possible to provide the much needed individual care in line with the required solutions to these problems.

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Unique Attributes of STARS

- Allows rating of client concern regarding a *specific item* (e.g. no concern, some concern and severe concern) rather than overall risk rating; to allow for importance of each item to be indicated according to the unique concerns of the client (e.g. something of significance as a risk factor in the literature may not necessarily be experienced by the client as such, and vice versa)
- Documentation requires written verbatim of the clients response which can be collated in the 'specify' column of all Parts A, B and C
- The lack of requirement to make an overall risk rating or categorical allocation of risk for commensurate planning is viewed positively rather than as a weakness of STARS, since it reflects the need for unique understanding of the inner distress of the client rather than a categorical measurement of this overall state.