

Western University

From the Selected Works of Amresh Srivastava

Winter February 7, 2011

SIS-MAP; Suicide Risk assessment Scale

Amresh Srivastava, *University of Western Ontario*

Casebook#: _____

Scale for Impact of Suicidality - Management, Assessment and Planning of Care (SIS-MAP)

NAME: _____

A. Srivastava, M.D. & C. Nelson, Ph.D. (2008) *

DATE: _____

1. Demographics

Age in years: _____	Score 1 for ages 15-25 or 70+ years →	_____
Gender: _____	Score 1 for male →	_____
Marital status: _____	Score 1 for recent widow/widower →	_____
Number of children living with you: _____	Score 1 for single parenting →	_____
Inpatient or outpatient (circle)	Score 1 for inpatient →	_____

Subtotal for Demographics section 1: _____

2. Psychological Domain

Item Scores (right column = 1)

Ideation:

	0	1
I. Do you feel that life isn't worth living?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Do you think you would be better off dead?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Do you get ideas to hurt yourself?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Are you facing any 'situation' in which you might hurt yourself?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Do you feel you are vulnerable to hurting yourself?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Have you been thinking of hurting yourself recently?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Currently, do you think that dying might be a better option?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Have you recently attempted to hurt yourself? (i.e. within last 7 days)	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Do you often hurt yourself by cutting or overdose of pills?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Do you get suicidal ideas?	No <input type="checkbox"/>	Yes <input type="checkbox"/>

Subtotal for section 2I:
(right column = 1)

Management of ideation:

M. How often do you get these thoughts?	Score 1 for rarely, 2 for occasionally →	_____
How intense are these thoughts?	Score 1 for low, 2 moderate, 3 high →	_____
Can you control these thoughts?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Can you cope with distressing thoughts of suicide?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you wish to be killed?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Do you wish to die?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Do you fear losing control and attempting suicide?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Are you uncertain about the nature of your suicidal thoughts?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Do you believe in communicating about your suicidal thoughts to others?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Do you believe in seeking help for suicidal thoughts?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Subtotal for section 2M:
(right column = 1)

* Assessment of current state of suicidality (consider current thought processes and/or recent attempt)

A. Do you currently feel suicidal?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Do you feel hopeless?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Do you feel helpless?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Do you feel worthless?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Do you feel sad or depressed?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Do you feel any guilt?	No <input type="checkbox"/>	Yes <input type="checkbox"/>

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Psychological Domain, continued

Have you attempted to kill yourself?	<i>If no, skip to question P...</i>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Did you want to die ¹ ?		No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Were you certain that you wanted to die?		No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Did you want attention from someone?		No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
At the time of your attempt, were you depressed?		No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
At the time of your attempt, were you angry with yourself?		No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Do you want to attempt again?		No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Was the method damaging to your body? (<i>specify</i>) _____		No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Do you regret it?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Did you speak to someone before making the attempt?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Did you inform anyone afterwards?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Did you leave a suicide note?		No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Are you still stressed about it?		No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Are you feeling relieved?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Are you feeling safe in the hospital? (if applicable)		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you feel safe in your house?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you feel guilt or shame?		No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Was your attempt because of your mental illness?		No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Is it because of your social situation or due to psychological distress?		No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Who do you hold responsible for the attempt?	<i>Score 1 if client mentions family; score 1 if client says self; score 2 if client mentions both</i>				<input type="checkbox"/>
Do you still have suicidal ideas?		No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Do you want to seek help?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you think you can deal with it yourself?		Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Subtotal for section 2A: _____
(right column = 1)

Planning for subsequent attempt:

P. Do you think you will get suicidal ideas in the future?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Will you be able to cope with these thoughts?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you think you will attempt suicide in the future?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Do you think you need treatment and help?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you think your illness needs treatment?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Subtotal for section 2P: _____
(right column = 1)

Subtotal of all Psychological Domain sections (2I, 2M, 2A, 2P): _____

3. Comorbidities (check all that apply)

Alcohol abuse or dependence	<input type="checkbox"/>	History of	<input type="checkbox"/>	Current
Drug abuse	<input type="checkbox"/>	History of	<input type="checkbox"/>	Current
Sexual abuse	<input type="checkbox"/>	History of	<input type="checkbox"/>	Current
Physical abuse	<input type="checkbox"/>	History of	<input type="checkbox"/>	Current
Emotional abuse/exploitation	<input type="checkbox"/>	History of	<input type="checkbox"/>	Current

Subtotal for Comorbidities section (count all check marks): _____

¹ Client should be instructed to answer these questions with reference to the most recent attempt.

4. Family History (including siblings, parents, or grandparents)

Suicide attempt	(family member) _____	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Death due to suicide	(family member) _____	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Mental illness	(family member) _____	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Addictions or alcoholism	(family member) _____	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>

Subtotal for Family History (Score 1 for each Yes in this section):

5. Biological Domain

Do you currently have any psychiatric illness? (specify) _____	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Do you have any chronic medical illnesses? (specify) _____	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Do you suffer from frequent mood swings?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Do you think you are suffering from an 'undiagnosed psychological disorder' like anxiety, depression, psychosis, memory loss, lack of drive or motivation or getting easily stressed? if no, section is finished	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Do you think it is affecting your life in terms of functioning and day to day living?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>

Subtotal for this Biological Domain (Score 1 for each Yes in this section):

6. Protective factors for suicide risk

Do you benefit from community or outpatient support/counseling?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Is your family practically supportive of your problems and your recovery?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Does your faith or spirituality help you in dealing with your problems?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Do you have children that rely on you, and depend on your well-being?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Do you live in impoverished conditions? (difficulty paying for food and shelter)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you think you are worthy of living?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Do you have good self-esteem? (believe that you are a worthwhile person)	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Have you succeeded when faced with similar life challenges?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Is your home environment safe and stable?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Do you savour life's satisfying moments?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Do you have additional reasons for not committing suicide? (specify:)	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>

Subtotal for Protective factors:
(right column = 1)

7. Clinical ratings/observations

Does client lack insight?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Is there evidence of a personality disorder or issues related to personality?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Is there presence of psychosis?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Is there evidence of impulsivity? (i.e. behavioral dyscontrol)	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Would you consider client vulnerable due to any of the following?				
Personal crisis (i.e. extremely adverse situational event)	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
A dysfunctional or chaotic home environment	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Recent childbirth or abortion	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Existential issues (i.e. no meaning in life)	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>

For attempters only:

Was the method used capable of causing death?

No Yes

Was the attempt planned?

No Yes **Subtotal for Clinical ratings/observations (Score 1 for each Yes in this section):** **8. Psychosocial and Environmental Problems²****Score 1 for every problem named in this section***Check:*___ Problems with primary support group (*specify*): ________ Problems related to the social environment (*specify*): ________ Educational problems (*specify*): ________ Occupational problems (*specify*): ________ Housing problems (*specify*): ________ Economic problems (*specify*): ________ Problems with access to health care services (*specify*): ________ Problems related to interaction with the legal system/crime (*specify*): ________ Other psychosocial and environmental problems (*specify*): _____**Subtotal for Psychosocial/Environmental (count all check marks):**

² A psychosocial or environmental problem may be a negative life event, an environmental difficulty or deficiency, a familial or other interpersonal stress, an inadequacy of social support or personal resources, or other problem relating to the context in which a person's difficulties have developed. So-called positive stressors, such as job promotion, should be listed only if they constitute or lead to a problem, as when a person has difficulty adapting to the new situation. In addition to playing a role in the initiation or exacerbation of a mental disorder, psychosocial problems may also develop as a consequence of a person's psychopathology or may constitute problems that should be considered in the overall management plan.

When an individual has multiple psychosocial or environmental problems, the clinician may note as many as are judged to be relevant. In general, the clinician should note only those psychosocial and environmental problems that have been present during the year preceding the current evaluation. However, the clinician may choose to note psychosocial and environmental problems occurring prior to the previous year if these clearly contribute to the mental disorder or have become a focus of treatment—for example, previous combat experiences leading to Posttraumatic Stress Disorder. For convenience, the problems are grouped together in the following categories:





- **Problems with primary support group**—e.g., death of a family member; health problems in family; disruption of family by separation, divorce, or estrangement; removal from the home; remarriage of parent; sexual or physical abuse; parental overprotection; neglect of child; inadequate discipline; discord with siblings; birth of a sibling;
- **Problems related to the social environment**—e.g., death or loss of friend; inadequate social support; living alone; difficulty with acculturation; discrimination; adjustment to life-cycle transition (such as retirement)
- **Educational problems**—e.g., illiteracy; academic problems; discord with teachers or classmates; inadequate school environment
- **Occupational problems**—e.g., unemployment; threat of job loss; stressful work schedule; difficult work conditions; job dissatisfaction; job change; discord with boss or co-workers
- **Housing problems**—e.g., homelessness; inadequate housing; unsafe neighborhood; discord with neighbors or landlord
- **Economic problems**—e.g., extreme poverty; inadequate finances; insufficient welfare support
- **Problems with access to health care services**—e.g., inadequate health care services; transportation to health care facilities unavailable; inadequate health insurance
- **Problems related to interaction with the legal system/crime**—e.g. criminal charges; probation or parole.
- **Other psychosocial and environmental problems**—e.g., exposure to disasters, war, other hostilities; discord with nonfamily caregivers such as counselor, social worker, or physician; unavailability of social service agencies








The clinician should identify the relevant categories of psychosocial and environmental problems and indicate the specific factors involved.



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SIS-MAP Clinical Profile:

I-MAP subscales

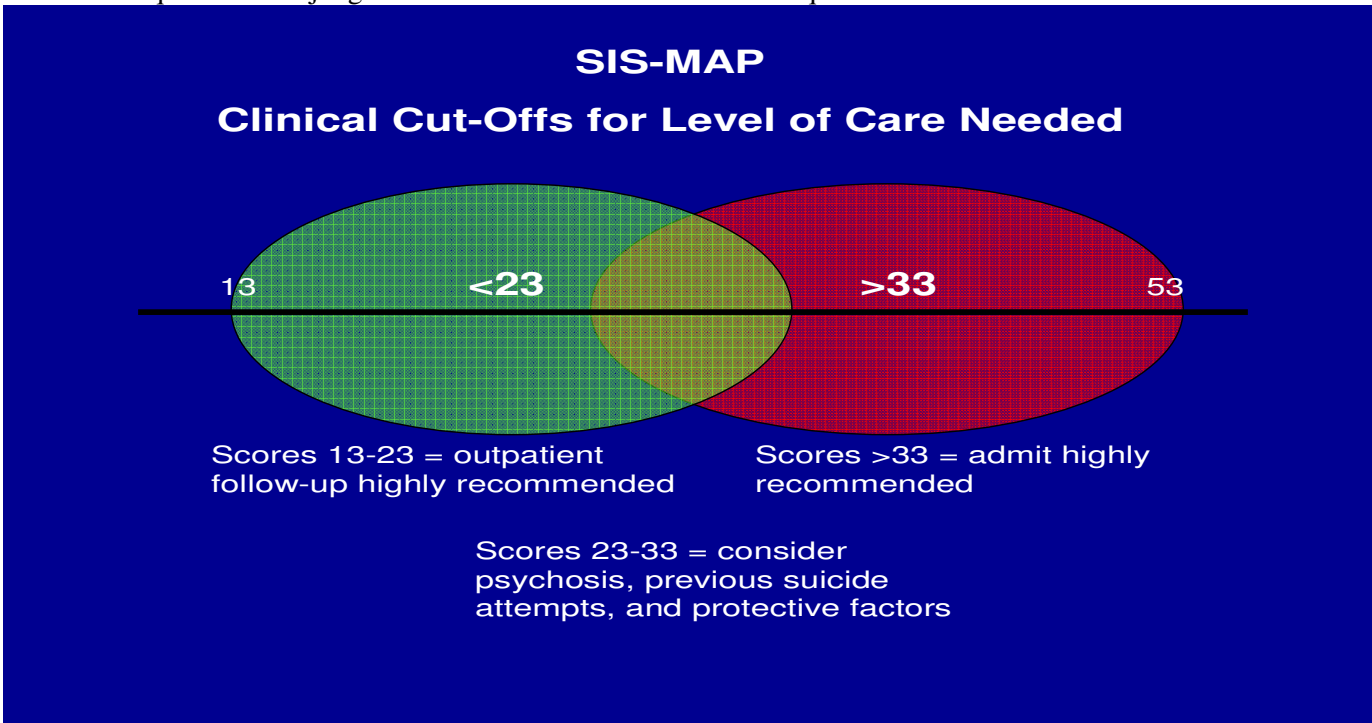
2I- Ideation: 
2M- Management 
2A- Assessment 
2P- Planning 

Demographics: 
Psychological Domain: 
Comorbidities: 
Family History: 
Biological Domain: 
Clinical ratings/observations: 
Psychosocial/Environmental: 

Total of all above sections: 
Protective Factors: (subtract): - 

SIS-MAP Risk Index:  ³

³ The mean total scores on the SIS-MAP for individuals who were admitted ($M = 23, SD = 9$) vs. not admitted ($M = 33, SD = 14$) and their respective standard deviations were used to establish clinical cut-offs. Thus, it was determined that scores falling between 13 and 23 represent individuals who require outpatient follow-up but do not require admission (individuals who score less than 13 likely require no follow-up). Individuals who score above 33 on the SIS-MAP are at a serious risk of suicide and should be admitted to a psychiatric facility. Scores between 23 and 33 require clinical judgment to determine the level of care required.



Casebook#: _____

**Scale for Impact of Suicidality Management,
Assessment and Planning of Care (SIS-MAP)**

NAME: _____

A. Srivastava, M.D. & C. Nelson, Ph.D. (2008) *

DATE: _____

Clinical Disposition

Urgent Care:

- | | | | | |
|--|----|--------------------------|-----|--------------------------|
| Consultation with admitting physician? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Client medically cleared? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Client admitted to Assessment Unit? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Client certified (specify form)? _____ | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |

Follow-up/Specialized Resources:

- | | | | | |
|---|----|--------------------------|-----|--------------------------|
| Crisis plan developed? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Client referred to outpatient or Crisis unit follow-up? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Client referred to specialized addictions' service? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Client referred to Woman's Shelter? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Client referred to Safe Bed? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Client's family notified? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| A.C.T. or CMHA notified? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Family physician notified? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |

Resource Utilization (if known):

- | | | | | |
|---|----|--------------------------|-----|--------------------------|
| Length of stay (specify number of inpatient days) _____ | | | | |
| Readmission within 6 months? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Subsequent suicide attempt within 6 months? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Use of seclusion? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Use of restraint? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Client transferred to Tertiary Care Unit? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |

Operational Stress Injury (O.S.I.) Clinic Information:

- | | | | | |
|--|----|--------------------------|-----|--------------------------|
| Does the client have an O.S.I.? (specify _____) | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Has the client been previously deployed? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| If deployed, how many tours? (specify _____) | | | | |
| Client's rank and military role? (specify _____) | | | | |
| Does the client receive a pension for an O.S.I.? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Is the client aware of peers' committing/attempting suicide? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| Does the client participate in OSISS (Social Support)? | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |

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