

## Appendix B Assessment and Screening Instruments

Several of the following drug and alcohol assessment and screening instruments are available online at: <http://www.niaaa.nih.gov/publications/instable.htm>.

### General

- Addiction Severity Index (ASI) (McLellan et al. 1980) (<http://www.tresearch.org> and <http://www.niaaa.nih.gov/publications/asi.htm>)
- Substance Use Disorders Diagnostic Schedule (SUDDS-IV) (Hoffmann and Harrison 2002) ([http://www.evinceassessment.com/product\\_sudds.html](http://www.evinceassessment.com/product_sudds.html))

### Readiness to Change

See appendix G.

### Screening Instruments

#### Drug Abuse Screening Test (DAST-10), Drug Use Questionnaire

The following questions concern information about your possible involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is “Yes” or “No.” Then circle the appropriate response beside the question.

# DRAFT

In the following statements “drug abuse” refers to

- The use of prescribed or over-the-counter drugs in excess of the directions, and
- Any nonmedical use of drugs.
- The various classes of drugs may include cannabis (e.g., marijuana, hashish), solvents (e.g., paint thinner), tranquilizers

(e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., lysergic acid diethylamide [LSD]), or narcotics (e.g., heroin). Remember that the questions do not include alcoholic beverages.

Please answer every question. If you have difficulty with a question, then choose the response that is mostly right.

These Questions Refer to the Past 12 Months			
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you always able to stop using drugs when you want to?	Yes	No
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)?	Yes	No

Interpretation (Each “Yes” response = 1)

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No Problems Reported	None At This Time
1–2	Low Level	Monitor, Reassess At A Later Date
3–5	Moderate Level	Further Investigation
6–8	Substantial Level	Intensive Assessment

Source: Adapted from Addictive Behaviors, 7(4), Skinner, H.A. The drug abuse screening test, 363–371, copyright 1982, with permission from Elsevier.

Available online at <http://www.drugabuse.gov/Diagnosis-Treatment/DAST10.html>.

## Skinner Trauma History

Since your 18th birthday, have you

- Had any fractures or dislocations to your bones or joints?
- Been injured in a road traffic accident?
- Injured your head?
- Been injured in an assault or fight (excluding injuries during sports)?
- Been injured after drinking?

A score of two or more positive responses to the five questions has been shown to indicate a high probability of excessive drinking or alcohol abuse.

*Source:* Skinner et al. 1984, reprinted with permission from American College of Physicians–American Society of Internal Medicine (ACP–ASIM).

## CAGE Questionnaire

- Have you ever felt you ought to **C**ut down on your drinking?
- Have people **A**nnoyed you by criticizing your drinking?
- Have you ever felt bad or **G**uilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (**E**ye-opener)?

One or more “yes” responses constitute a positive screening test. Note, however, that due to language barriers, individual interpretation of the questions, or other confounding factors, individuals answering “no” to all CAGE questions may still be at risk due to elevated drinking levels.

*Source:* Maisto et al. 2003.

## CAGE-AID: The CAGE Questions Adapted To Include Drugs

- Have you felt you ought to **C**ut down on your drinking or drug use?
- Have people **A**nnoyed you by criticizing your drinking or drug use?
- Have you felt bad or **G**uilty about your drinking or drug use?
- Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (**E**ye-opener)?

One or more “yes” responses constitute a positive screening test. Note, however, that due to language barriers, individual interpretation of the questions, or other confounding factors, individuals answering “no” to all CAGE-AID questions may still be at risk due to elevated drinking or drug use levels.

*Source:* Brown and Rounds 1995.

## The TWEAK Questionnaire

**Tolerance:** (a) How many drinks can you hold, or (b) How many drinks does it take before you begin to feel the first effects of the alcohol?

**Worried:** Have close friends or relatives worried or complained about your drinking in the past year?

**Eye openers:** Do you sometimes take a drink in the morning when you first get up?

**Amnesia:** Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?

**Kut down:** Do you sometimes feel the need to cut down on your drinking?

The TWEAK questionnaire was originally developed to screen for risk drinking during pregnancy (Russell et al. 1991). It can also be used to screen for harmful drinking in the general population (Chan et al. 1993).

*Scoring:* A 7-point scale is used to score the test. The Tolerance question scores 2 points if (a) the patient reports he or she can hold more than five drinks without falling asleep or passing out, or (b) if it is reported that three or more drinks are needed to feel high. A positive response to the Worry question scores 2 points. A positive response to the last three questions scores 1 point each.

A total score of 3 or 4 usually indicates harmful drinking. In an obstetric patient, a total score of 2 or more indicates the likelihood of harmful drinking.

*Source:* The National Institute on Alcohol Abuse and Addiction Web site at <http://www.niaaa.nih.gov/publications/tweak.htm>

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## The Alcohol Use Disorders Identification Test (AUDIT): Interview Version

1. How often do you have a drink\* containing alcohol?  
 Never (0) [Skip to Questions 9–10]  
 Monthly or less (1)  
 2 to 4 times a month (2)  
 2 to 3 times a week (3)  
 4 or more times a week (4)
  2. How many drinks containing alcohol do you have on a typical day when you are drinking?  
 1 or 2 (0)  
 3 or 4 (1)  
 5 or 6 (2)  
 7, 8, or 9 (3)  
 10 or more (4)
  3. How often do you have six or more drinks on one occasion?  
 Never (0)  
 Less than monthly (1)  
 Monthly (2)  
 Weekly (3)  
 Daily or almost daily (4)
- [Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0]
4. How often during the last year have you found that you were unable to stop drinking once you had started?  
 Never (0)  
 Less than monthly (1)  
 Monthly (2)  
 Weekly (3)  
 Daily or almost daily (4)
  5. How often during the last year have you failed to do what was normally expected of you because of drinking?  
 Never (0)  
 Less than monthly (1)  
 Monthly (2)  
 Weekly (3)  
 Daily or almost daily (4)
  6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?  
 Never (0)  
 Less than monthly (1)  
 Monthly (2)  
 Weekly (3)  
 Daily or almost daily (4)

# DRAFT

7. How often during the last year have you had a feeling of guilt or remorse after drinking?  
 Never (0)  
 Less than monthly (1)  
 Monthly (2)  
 Weekly (3)  
 Daily or almost daily (4)
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?  
 Never (0)  
 Less than monthly (1)  
 Monthly (2)  
 Weekly (3)  
 Daily or almost daily (4)
9. Have you or someone else been injured as the result of your drinking?  
 No (0)  
 Yes, but not in the last year (1)  
 Yes, during the last year (2)
10. Has a relative, friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?  
 No (0)  
 Yes, but not in the last year (1)  
 Yes, in the last year (2)

Record the total of the specific items. [ ]

\*In determining the response categories it has been assumed that one drink contains 10 g alcohol. In countries where the alcohol content of a standard drink differs by more than 25 percent from 10 g, the response category should be modified accordingly.

Source: Babor et al. 2001. Available at [http://www.who.int/substance\\_abuse/pubs\\_alcohol.htm](http://www.who.int/substance_abuse/pubs_alcohol.htm)

[http://www.who.int/substance\\_abuse/PDFfiles/auditbro.pdf](http://www.who.int/substance_abuse/PDFfiles/auditbro.pdf)

A self-report version of the AUDIT is also available in Babor et al. 2001.

## **Scoring and Interpretation of the AUDIT**

The minimum score (for nondrinkers) is 0 and the maximum possible score is 40. A score of 8 is indicative of hazardous and harmful alcohol use, and possibly of alcohol dependence. Scores of 8–15 indicate a medium level and scores of 16 and above a high level of alcohol problems. Babor et al. (2001) recommend a cutoff score of 7 for women and individuals over 65 years of age; Bradley et al. (1998) recommended an even lower cutoff score of 4 points for women. For patients who are resistant, uncooperative, or noncommunicative, a clinical screening procedure (described by Babor et al. 2001) may be necessary.

# DRAFT

## Michigan Alcoholism Screening Test (MAST)

- |   |            |           |
|---|------------|-----------|
| 0. Do you enjoy a drink now and then?   | <b>YES</b> | <b>NO</b> |
| (2) 1. *Do you feel you are a normal drinker? (By normal we mean you drink less than or as much as most other people)   | <b>YES</b> | <b>NO</b> |
| (2) 2. Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?   | <b>YES</b> | <b>NO</b> |
| (1) 3. Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking?  | <b>YES</b> | <b>NO</b> |
| (2) 4. *Can you stop drinking without a struggle after one or two drinks?   | <b>YES</b> | <b>NO</b> |
| (1) 5. Do you ever feel guilty about your drinking?   | <b>YES</b> | <b>NO</b> |
| (2) 6. *Do friends or relatives think you are a normal drinker?   | <b>YES</b> | <b>NO</b> |
| (2) 7. *Are you able to stop drinking when you want to?   | <b>YES</b> | <b>NO</b> |
| (5) 8. Have you ever attended a meeting of Alcoholics Anonymous (AA)?   | <b>YES</b> | <b>NO</b> |
| (1) 9. Have you gotten into physical fights when drinking?  | <b>YES</b> | <b>NO</b> |
| (2) 10. Has your drinking ever created problems between you and your wife, husband, a parent, or other relative?  | <b>YES</b> | <b>NO</b> |
| (2) 11. Has your wife, husband (or other family member) ever gone to anyone for help about your drinking?   | <b>YES</b> | <b>NO</b> |
| (2) 12. Have you ever lost friends because of your drinking?  | <b>YES</b> | <b>NO</b> |
| (2) 13. Have you ever gotten into trouble at work or school because of drinking?  | <b>YES</b> | <b>NO</b> |
| (2) 14. Have you ever lost a job because of drinking?   | <b>YES</b> | <b>NO</b> |
| (2) 15. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?  | <b>YES</b> | <b>NO</b> |
| (1) 16. Do you drink before noon fairly often?  | <b>YES</b> | <b>NO</b> |
| (2) 17. Have you ever been told you have liver trouble? Cirrhosis?  | <b>YES</b> | <b>NO</b> |
| (2) 18. **After heavy drinking have you ever had delirium tremens (DTs) or severe shaking or heard voices or seen things that really weren't there?   | <b>YES</b> | <b>NO</b> |
| (5) 19. Have you ever gone to anyone for help about your drinking?  | <b>YES</b> | <b>NO</b> |
| (5) 20. Have you ever been in a hospital because of drinking?   | <b>YES</b> | <b>NO</b> |
| (2) 21. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem that resulted in hospitalization?                  | <b>YES</b> | <b>NO</b> |
| (2) 22. Have you ever been seen at a psychiatric or mental health clinic or gone to any doctor, social worker, or clergyman for help with any emotional problem where drinking was part of the problem? | <b>YES</b> | <b>NO</b> |
| (2) 23. ***Have you ever been arrested for drunk driving, driving while intoxicated, or driving under the influence of alcoholic beverages? If YES, how many times? _____                               | <b>YES</b> | <b>NO</b> |
| (2) 24. Have you ever been arrested, or taken into custody, even for a few hours, because of other drunk behavior? If YES, how many times? _____  | <b>YES</b> | <b>NO</b> |

\* Alcoholic Response is negative

\*\* 5 points for each DT

\*\*\* 2 points for each arrest

### MAST Scoring System

In general, five points or more would place the subject in alcoholic category. Four points would be suggestive of alcoholism, and three points or fewer would indicate the subject is not alcoholic (Selzer 1971).

Source: *American Journal of Psychiatry*, 127, 1653–1658 (1971). Copyright (1971). The American Psychiatric Association, <http://ajp.psychiatryonline.org>. Reprinted by permission. See <http://www.niaaa.nih.gov/publications/mast.htm>.

# DRAFT

## Self-Administered Short Michigan Alcoholism Screening Test (SMAST)

**Patient Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Date of Administration:** \_\_\_\_\_

- |  |            |           |
|--|------------|-----------|
| 1. Do you feel you are a normal drinker? (By normal we mean you drink less than or as much as most other people.)                      | <b>YES</b> | <b>NO</b> |
| 2. Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking?                               | <b>YES</b> | <b>NO</b> |
| 3. Do you ever feel guilty about your drinking?  | <b>YES</b> | <b>NO</b> |
| 4. Do friends or relatives think you are a normal drinker?   | <b>YES</b> | <b>NO</b> |
| 5. Are you able to stop drinking when you want to?   | <b>YES</b> | <b>NO</b> |
| 6. Have you ever attended a meeting of Alcoholics Anonymous?   | <b>YES</b> | <b>NO</b> |
| 7. Has drinking ever created problems between you and your wife, husband, a parent, or other near relative?                            | <b>YES</b> | <b>NO</b> |
| 8. Have you ever gotten into trouble at work or school because of drinking?  | <b>YES</b> | <b>NO</b> |
| 9. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?        | <b>YES</b> | <b>NO</b> |
| 10. Have you ever gone to anyone for help about your drinking?   | <b>YES</b> | <b>NO</b> |
| 11. Have you ever been in a hospital because of drinking?  | <b>YES</b> | <b>NO</b> |
| 12. Have you ever been arrested for drunken driving, driving while intoxicated, or driving under the influence of alcoholic beverages? | <b>YES</b> | <b>NO</b> |
| 13. Have you ever been arrested, even for a few hours, because of other drunken behavior?  | <b>YES</b> | <b>NO</b> |

Source: Adapted from Selzer et al. 1975. Reprinted with permission from the *Journal of Studies on Alcohol*.

### **SMAST Scoring System**

Each of the 13 items on the Short MAST is scored 1 (one) or 0 (zero), with questions 1, 4, and 5 scored 1 for each "no" answer, and the other items scored 1 for each "yes" answer. A score of 2 indicates possible alcoholism; a score of 3 or greater indicates probable alcoholism.

## Withdrawal Assessments

### Narcotic Withdrawal Scale

Fultz and Senay (1975); (Table 1 page 816) used a grading scheme for hospitalized patients undergoing opiate withdrawal, to determine initial methadone therapy as follows:

Grade	Physical Findings	Initial Dose of Methadone
1	Lacrimation and/or rhinorrhea Diaphoresis Yawning Restlessness Insomnia	5 mg
2	Dilated pupils Piloerection Muscle twitching and/or myalgia Arthralgias Abdominal pain	10 mg
3	Tachycardia Hypertension Tachypnea Fever Anorexia or nausea Extreme restlessness	15 mg
4	Diarrhea and/or vomiting Dehydration Hyperglycemia Hypotension Curled-up position	20 mg

Source: Fultz and Senay 1975, reprinted with permission from American College of Physicians–American Society of Internal Medicine (ACP–ASIM).

# DRAFT

## The Clinical Institute Narcotic Assessment (CINA) Scale for Withdrawal Symptoms

The Clinical Institute Narcotic Assessment (CINA) Scale measures 11 signs and symptoms commonly seen in patients during narcotic withdrawal. This can help to gauge the severity of the symptoms and to monitor changes in the clinical status over time.

PARAMETERS	FINDINGS	POINTS
<b>Parameters based on Questions and Observation:</b>		
(1) abdominal changes: Do you have any pains in your abdomen?	No abdominal complaints; normal bowel sounds	0
	Reports waves of crampy abdominal pain	1
	Crampy abdominal pain; diarrhea; active bowel sounds	2
(2) changes in temperature: Do you feel hot or cold?	None reported	0
	Reports feeling cold; hands cold and clammy to touch	1
	Uncontrolled shivering	2
(3) nausea and vomiting: Do you feel sick in your stomach? Have you vomited?	No nausea or vomiting	0
	Mild nausea; no retching or vomiting	2
	Intermittent nausea with dry heaves	4
	Constant nausea; frequent dry heaves and/or vomiting	6
(4) muscle aches: Do you have any muscle cramps?	No muscle aching reported; arm and neck muscles soft at rest	0
	Mild muscle pains	1
	Reports severe muscle pains; muscles in legs arms or neck in constant state of contraction	3
<b>Parameters based on Observation Alone:</b>		
(5) goose flesh	None visible	0
	Occasional goose flesh but not elicited by touch; not permanent	1
	Prominent goose flesh in waves and elicited by touch	2
	Constant goose flesh over face and arms	3
(6) nasal congestion	No nasal congestion or sniffing	0
	Frequent sniffing	1
	Constant sniffing watery discharge	2
(7) restlessness	Normal activity	0
	Somewhat more than normal activity; moves legs up and down; shifts position occasionally	1
	Moderately fidgety and restless; shifting position frequently	2
	Gross movement most of the time or constantly thrashes about	3
(8) tremor	None	0
	Not visible but can be felt fingertip to fingertip	1
	Moderate with patient's arm extended	2
	Severe even if arms not extended	3
(9) lacrimation	None	0
	Eyes watering; tears at corners of eyes	1
	Profuse tearing from eyes over face	2
(10) sweating	No sweat visible	0
	Barely perceptible sweating; palms moist	1
	Beads of sweat obvious on forehead	2
	Drenching sweats over face and chest	3
(11) yawning	None	0
	Frequent yawning	1
	Constant uncontrolled yawning	2
TOTAL SCORE	[Sum of points for all 11 parameters]	
Minimum score=0, Maximum score=31. The higher the score, the more severe the withdrawal syndrome. Percent of maximal withdrawal symptoms= $((\text{total score})/31) \times 100\%$ . Source: Adapted from Peachey, J.E., and Lei, H. Assessment of opioid dependence with naloxone. <i>British Journal of Addiction</i> 83(2):193-201, 1988. Reprinted with permission from Blackwell Publishing, Ltd.		

# DRAFT

## Clinical Opiate Withdrawal Scale (COWS)

For each item, circle the number that best describes the patient's signs or symptoms. Rate just on the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increased pulse rate would not add to the score.

<b>Patient Name:</b>	<b>Date:</b>	<b>Time:</b>
<b>Reason for this assessment:</b>		
<b>1. Resting pulse rate: _____ beats/minute</b> <i>Measured after the patient is sitting or lying for one minute.</i> 0 Pulse rate 80 or below 1 Pulse rate 81–100 2 Pulse rate 101–120 4 Pulse rate greater than 120	<b>7. GI upset: over last half hour</b> 0 No GI symptoms 1 Stomach cramps 2 Nausea or loose stool 3 Vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting	
<b>2. Sweating: over past half hour not accounted for by room temperature of patient activity</b> 0 No reports of chills or flushing 1 Subjective reports of chills or flushing 2 Flushed or observable moisture on face 3 Beads of sweat on brow or face 4 Sweat streaming off face	<b>8. Tremor: observation of outstretched hands</b> 0 No tremor 1 Tremor can be felt, but not observed 2 Slight tremor observable 4 Gross tremor or muscle twitching	
<b>3. Restlessness: observation during assessment</b> 0 Able to sit still 1 Reports difficulty sitting still, but is able to do so 3 Frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds	<b>9. Yawning: observation during assessment</b> 0 No yawning 1 Yawning once or twice during assessment 2 Yawning three or more times during assessment 4 Yawning several times/minute	
<b>4. Pupil size</b> 0 Pupils pinned or normal size for room light 1 Pupils possibly larger than normal for room light  2 Pupils moderately dilated 5 Pupils so dilated that only the rim of the iris is visible	<b>10. Anxiety or irritability</b> 0 None 1 Patient reports increasing irritability or anxiousness 2 Patient obviously irritable, anxious 4 Patient so irritable or anxious that participation in the assessment is difficult	
<b>5. Bone or joint aches: if patient was having pain previously, only the additional component attributed to opiate withdrawal is scored.</b> 0 Not present 1 Mild diffuse discomfort  2 Patient reports severe diffuse aching of joints/muscles 4 Patient is rubbing joints or muscles and is unable to sit still because of discomfort	<b>11. Gooseflesh skin</b> 0 Skin is smooth 3 Piloerection of skin can be felt or hairs standing up on arms 5 Prominent piloerection	
<b>6. Runny nose or tearing: not accounted for by cold symptoms or allergies</b> 0 Not present 1 Nasal stuffiness or unusually moist eyes 2 Nose running or tearing 4 Nose constantly running or tears streaming down cheeks	Total Score: _____  [The total score is the sum of all 11 items.] Initials of person completing assessment: ____	

**Score: 5–12=Mild; 13–24=Moderate; 25–36=Moderately severe; >36=Severe withdrawal**

**Source: Adapted from Wesson et al. 1999. Reprinted with permission.**

# DRAFT

## Objective Opiate Withdrawal Scale (OOWS)

Instructions: Rate the patient on the basis of what you observe during a timed 10-minute period.

Item		Score 1 Point For Each Item If:	Points
1	Yawning (3 or more yawns in 10 minutes)	Present	
2	Rhinorrhea	Present	
3	Piloerection (observe the patient's arm or chest)	Present	
4	Perspiration	Present	
5	Lacrimation	Present	
6	Mydriasis	Present	
7	Tremors (hands)	Present	
8	Hot and cold flashes (shivering or huddling for warmth)	Present	
9	Restlessness (frequent shifts of position)	Present	
10	Vomiting	Present	
11	Muscle twitches	Present	
12	Abdominal cramps (holding stomach)	Present	
13	Anxiety (observable manifestations: finger tapping, fidgeting, agitation)	Present	
TOTAL OOWS score (Sum items 1–13)			

The Objective Opiate Withdrawal Scale (OOWS) is completed by an observer who notes the presence of 13 physically observable signs. The total score is the sum of the number of signs present during a 10-minute observation period.

Source: Reprinted from Handelsman et al. 1987, p. 297, by courtesy of Marcel Dekker, Inc.

# DRAFT

## Subjective Opiate Withdrawal Scale (SOWS)

Instructions: Answer the following statements as accurately as you can. Circle the answer that best fits the way you feel now.

0=not at all

1=a little

2=moderately

3=quite a bit

4=extremely

		Not at all	A little	Moderately	Quite a bit	Extremely
1	I feel anxious.	0	1	2	3	4
2	I feel like yawning.	0	1	2	3	4
3	I'm perspiring.	0	1	2	3	4
4	My eyes are tearing.	0	1	2	3	4
5	My nose is running.	0	1	2	3	4
6	I have goose flesh.	0	1	2	3	4
7	I am shaking.	0	1	2	3	4
8	I have hot flashes.	0	1	2	3	4
9	I have cold flashes.	0	1	2	3	4
10	My bones and muscles ache.	0	1	2	3	4
11	I feel restless.	0	1	2	3	4
12	I feel nauseous.	0	1	2	3	4
13	I feel like vomiting.	0	1	2	3	4
14	My muscles twitch.	0	1	2	3	4
15	I have cramps in my stomach.	0	1	2	3	4
16	I feel like shooting up now.	0	1	2	3	4

The Subjective Opiate Withdrawal Scale (SOWS) consist of 16 symptoms rated in intensity by patients on a 5-point scale of intensity as follows: 0=not at all, 1=a little, 2=moderately, 3=quite a bit, 4=extremely. The total score is a sum of item ratings, and ranges from 0 to 64.

Source: Reprinted from Handelsman et al. 1987, p. 296, by courtesy of Marcel Dekker, Inc.

Other Sources: Gossop 1990; Bradley 1987.

# DRAFT

## Addiction Research Foundation Clinical Institute for Withdrawal Assessment (CIWA-Ar)

Patient:	Date:	Time: (24 hour clock, midnight = 00:00)
<p><b>NAUSEA AND VOMITING</b>—Ask “Do you feel sick to your stomach? Have you vomited?” <i>Observation.</i> 0 no nausea and no vomiting 1 mild nausea with no vomiting 2 3 4 intermittent nausea with dry heaves 5 6 7 constant nausea, frequent dry heaves and vomiting</p>	<p><b>TACTILE DISTURBANCES</b>—Ask “Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?” <i>Observation.</i> 0 none 1 mild itching, pins and needles, burning or numbness 2 mild itching, pins and needles, burning or numbness 3 moderate itching, pins and needles, burning or numbness 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations</p>	
<p><b>TREMOR</b>—Arms extended and fingers spread apart. <i>Observation.</i> 0 no tremor 1 not visible, but can be felt fingertip to fingertip 2 3 4 moderate, with patient’s arms extended 5 6 7 severe, even with arms not extended</p>	<p><b>AUDITORY DISTURBANCES</b>—Ask “Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?” <i>Observation.</i> 0 not present 1 very mild harshness or ability to frighten 2 mild harshness or ability to frighten 3 moderate harshness or ability to frighten 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations.</p>	
<p><b>PAROSYSMAL SWEATS</b>—<i>Observation.</i> 0 no sweat visible 1 barely perceptible sweating, palms moist 2 3 4 beads of sweat obvious on forehead 5 6 7 drenching sweats</p>	<p><b>VISUAL DISTURBANCES</b>—Ask “Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?” <i>Observation.</i> 0 not present 1 very mild sensitivity 2 mild sensitivity 3 moderate sensitivity 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations</p>	
<p><b>ANXIETY</b>—Ask “Do you feel nervous?” <i>Observation.</i> 0 no anxiety, at ease 1 mildly anxious 2 3 4 moderately anxious, or guarded, so anxiety is inferred 5 6 7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions.</p>	<p><b>HEADACHE, FULLNESS IN HEAD</b>—Ask “Does your head feel different? Does it feel like there is a band around your head?” Do not rate for dizziness or lightheadedness. Otherwise, rate severity. 0 not present 1 very mild 2 mild 3 moderate 4 moderately severe 5 severe 6 very severe 7 extremely severe</p>	
<p><b>AGITATION</b>—<i>Observation.</i> 0 normal activity 1 somewhat more than normal activity 2 3 4 moderately fidgety and restless 5 6 7 paces back and forth during most of the interview, or constantly thrashes about</p>	<p><b>ORIENTATION AND CLOUDING OF SENSORIUM</b>—Ask “What day is this? Where are you? Who am I?” 0 oriented and can do serial additions 1 cannot do serial additions or is uncertain about date 2 disoriented for date by no more than 2 calendar days 3 disoriented for date by more than 2 calendar days 4 disoriented for place and/or person</p>	
	Total CIWA-Score _____ Rater’s Initials _____ Maximum Possible Score 67	
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Source: Sullivan et al. 1989.