APPENDIX 7

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 Based on Questions and Observation	Findings	Points
1 Abdominal changes: Do you have any pains in your abdomen? Crampy abdominal pain, diarrhea, active bowel sounds.	No abdominal complaints, normal bowel sound. Reports waves of crampy abdominal pain.	0 1 2
2 Changes in temperature: Do you feel hot or cold? clammy to touch. Uncontrolled shivering.	None reported. Reports feeling cold, hands cold and	0 1 2
3 Nausea and vomiting: Do you feel sick in your stomach? Have you vomited?	No nausea or vomiting. Mild nausea; no retching or vomiting. Intermittent nausea with dry heaves. Constant nausea; frequent dry heaves and/or vomiting.	0 2 4 6
4 Muscle aches: Do you have any muscle cramps?	No muscle aching reported, arm and neck muscles soft at rest. Mild muscle pains. Reports severe muscle pains, muscles in legs, arms or neck in constant state of contraction.	0 1 3
Parameters based on Observation Alone	**Findings**	**Points**
5 Goose flesh	None visible. Occasional goose flesh but not elicited by touch; not permanent. Prominent goose flesh in waves and elicited by touch. Constant goose flesh over face and arms.	0 1 2 3
6 Nasal congestion	No nasal congestion or sniffling. Frequent sniffling. Constant sniffling, watery discharge.	0 1 2
7 Restlessness	Normal activity. Somewhat more than normal activity; moves legs up and down; shifts position occasionally. Moderately fidgety and restless; shifting position frequently. Gross movement most of the time or constantly thrashes about.	0 1 2 3
8 Tremor	None. Not visible but can be felt fingertip to fingertip. Moderate with patient's arm extended. Severe even if arms not extended.	0 1 2 3
9 Lacrimation	None. Eyes watering; tears at corners of eyes. Profuse tearing from eyes over face.	0 1 2
10 Sweating	No sweat visible. Barely perceptible sweating; palms moist. Beads of sweat obvious on fore-head. Drenching sweats over face and chest.	0 1 2 3
11 Yawning	None. Frequent yawning. Constant uncontrolled yawning.	0 1 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 = total score/31 x 100%.
Source: Adapted from Peachey JE, Lei H. Assessment of opioid dependence with naloxone. Br J Addict. 1988 Feb;83(2):193-201.

Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

Patient:_____ Date: _____ Time: _____ (24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute:_____ Blood pressure:_____

NAUSEA AND VOMITING -- Ask "Do you feel sick to your stomach? Have you vomited?" Observation.
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

TACTILE DISTURBANCES -- Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.
0 none
1 very 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

TREMOR -- Arms extended and fingers spread apart. Observation.
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

AUDITORY DISTURBANCES -- 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?" Observation.
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

PAROXYSMAL SWEATS -- Observation.
0 no sweat visible
1 barely perceptible sweating, palms moist
2
3
4 beads of sweat obvious on forehead
5
6
7 drenching sweats

VISUAL DISTURBANCES -- 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?" Observation.
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

ANXIETY -- Ask "Do you feel nervous?" Observation.
0 no anxiety, at ease
1 mild 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

HEADACHE, FULLNESS IN HEAD -- 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

AGITATION -- Observation.
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

ORIENTATION AND CLOUDING OF SENSORIUM -- 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/or person

Total **CIWA-Ar** Score _____
Rater's Initials _____
Maximum Possible Score 67

 This assessment for monitoring withdrawal symptoms requires approximately 5 minutes to administer. The maximum score is 67 (see instrument). Patients scoring less than 10 do not usually need additional medication for withdrawal.

Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (**CIWA-Ar**). *British Journal of Addiction* 84:1353-1357, 1989.

Clinical Institute Withdrawal Assessment Scale - Benzodiazepines

Guide to the Use of the Clinical Withdrawal Assessment Scale for Benzodiazepines

Person Report:

For each of the following items, circle the number that best describes how you feel.

Do you feel irritable?	0 Not at all	1	2	3	4 Very much so
Do you feel fatigued?	0 Not at all	1	2	3	4 Unable to function
Do you feel tense?	0 Not at all	1	2	3	4 Very much so
Do you have difficulties concentrating?	0 Not at all	1	2	3	4 Unable to concentrate
Do you have any loss of appetite?	0 Not at all	1	2	3	4 No appetite, unable to eat
Have you any numbness or burning on your face, hands or feet?	0 No numbness	1	2	3	4 Intense burning/numbness
Do you feel your heart racing? (palpitations)	0 No disturbance	1	2	3	4 Constant racing
Does your head feel full or achy?	0 Not at all	1	2	3	4 Severe headache

Do you feel muscle aches or stiffness?	0 Not at all	1	2	3	4 Severe stiffness or pain
Do you feel anxious, nervous or jittery?	0 Not at all	1	2	3	4 Very much so
Do you feel upset?	0 Not at all	1	2	3	4 Very much so
How restful was your sleep last night?	0 Very restful	1	2	3	4 Not at all
Do you feel weak?	0 Not at all	1	2	3	4 Very much so
Do you think you didn't have enough sleep last night?	0 Very much so	1	2	3	4 Not at all
Do you have any visual disturbances? (sensitivity to light, blurred vision)	0 Not at all	1	2	3	4 Very sensitive to light, blurred vision
Are you fearful?	0 Not at all	1	2	3	4 Very much so
Have you been worrying about possible misfortunes lately?	0 Not at all	1	2	3	4 Very much so

Clinician Observations

Observe behaviour for sweating, restlessness and agitation		Observe tremor		Observe feel palms	
0	None, normal activity	0	No tremor	0	No sweating visible
1		1	Not visible, can be felt in fingers	1	Barely perceptible sweating, palms moist
2	Restless	2	Visible but mild	2	Palms and forehead moist, reports armpit sweating
3		3	Moderate with arms extended	3	Beads of sweat on forehead
4	Paces back and forth, unable to sit still	4	Severe, with arms not extended	4	Severe drenching sweats

Total Score Items 1 – 20

1–20 = mild withdrawal

41–60 = severe withdrawal

21–40 =moderate withdrawal

61–80 = very severe withdrawal

Source: Adapted from Busto, U.E., Sykora, K. & Sellers, E.M. (1989). A clinical scale to assess benzodiazepine withdrawal. *Journal of Clinical Psychopharmacology*, 9 (6), 412–416.

Clinical Opiate Withdrawal Scale

Introduction

The Clinical Opiate Withdrawal Scale (COWS) is an 11-item scale designed to be administered by a clinician. This tool can be used in both inpatient and outpatient settings to reproducibly rate common signs and symptoms of opiate withdrawal and monitor these symptoms over time. The summed score for the complete scale can be used to help clinicians determine the stage or severity of opiate withdrawal and assess the level of physical dependence on opioids. Practitioners sometimes express concern about the objectivity of the items in the COWS; however, the symptoms of opioid withdrawal have been likened to a severe influenza infection (e.g., nausea, vomiting, sweating, joint aches, agitation, tremor), and patients should not exceed the lowest score in most categories without exhibiting some observable sign or symptom of withdrawal.

APPENDIX 1
Clinical Opiate Withdrawal Scale

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

Patient's Name:_____ Date and Time ____/____/____:_____

Reason for this assessment:_____

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset**: *over last* 1/2 *hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over past* 1/2 *hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessment* 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	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 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	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 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	**Gooseflesh skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 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; more than 36 = severe withdrawal

This version may be copied and used clinically.

Source: Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). *J Psychoactive Drugs,* 35(2), 253–9.