Alcohol Use Disorder Screening and Assessment Tools

The Alcohol Use Disorders Identification Test (AUDIT)[201]

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks". Place the corresponding answer number in the box at the right.

1. How often do you have a drink containing alcohol?

(0) Never [Skip to Qs 9-10]
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7, 8, or 9
(4) 10 or more

3. How often do you have six or more drinks on one occasion?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

Skip to Questions 9 and 10 if total score for Questions 2 and 3 = 0

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?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started? (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	**9. Have you or someone else been injured as a result of your drinking?** (0) No (2) Yes, but not in the last year (4) Yes, during the last year
5. How often during the last year have you been unable to do what was normally expected from you because of drinking?* (0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily	**10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?** (0) No (2) Yes, but not in the last year (4) Yes, during the last year
Interpretation: Scores of 8 or higher indicate hazardous or harmful use	**Total score:**

**Wording has been slightly modified from the original tool to avoid stigmatizing language.*

The AUDIT-Consumption (AUDIT-C) Tool[207]

1. How often do you have a drink containing alcohol?

(0) Never
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week

2. How many units of alcohol do you drink on a typical day when you are drinking?

(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7, 8, or 9
(4) 10 or more

3. How often do you have six or more drinks on one occasion?

(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

Interpretation: In men, a score of 4 or more is considered positive for hazardous drinking.

In women, a score of 3 or more is considered positive for hazardous drinking.

If score is positive, proceed to diagnosis and assessment for AUD.

Total score:

Severity of Alcohol Dependence Questionnaire (SADQ)[208]

Please recall a typical period of heavy drinking in the last 6 months. When was this? _____

Please select a number (either 0, 1, 2, or 3) to show how often each of the following statements applied to you during this time.

Questions	Almost never	Sometimes	Often	Nearly always
I woke up feeling sweaty.	0	1	2	3
My hands shook first thing in the morning.	0	1	2	3
My whole body shook violently first thing in the morning.	0	1	2	3
I woke up absolutely drenched in sweat.	0	1	2	3
I dreaded waking up in the morning.	0	1	2	3
I was frightened of meeting people first thing in the morning.	0	1	2	3
I felt at the edge of despair when I awoke.	0	1	2	3
I felt very frightened when I awoke.	0	1	2	3
I liked to have a morning drink.	0	1	2	3
I always gulped my first few morning drinks down as quickly as possible.	0	1	2	3
I drank in the morning to get rid of the shakes.	0	1	2	3
I had a very strong craving for drink when I awoke.	0	1	2	3
I drank more than 1/4 bottle of spirits a day (or 4 pints of beer/1 bottles of wine).	0	1	2	3
I drank more than 1/2 bottle of spirits a day (or 8 pints of beer/2 bottles of wine).	0	1	2	3
I drank more than 1 bottle of spirits a day (or 15 pints of beer/3 bottles of wine).	0	1	2	3
I drank more than 2 bottles of spirits a day (or 30 pints of beer/4 bottles of wine).	0	1	2	3

Imagine the following situation: (a) You have been completely off drink for a few weeks. (b) You then drink very heavily for two days. How would you feel the morning after those two days of heavy drinking?

Symptom	No	Slight	Moderate	A lot
I would start to sweat.	0	1	2	3
My hands would shake.	0	1	2	3
My body would shake.	0	1	2	3
I would be craving for a drink.	0	1	2	3

TOTAL SADQ SCORE = _____

Interpretation:

Score	8-15	16-30	31-60
Indication	Mild dependence	Moderate dependence	Severe dependence

Prediction of Alcohol Withdrawal Severity Scale (PAWSS)[36]

PART A: THRESHOLD CRITERIA – Yes or No, no point	
	Have you consumed any amount of alcohol (i.e., been drinking) within the last 30 days? OR Did the patient have a positive (+) blood alcohol level (BAL) on admission?
	If the answer to either is *YES*, proceed to next questions.
PART B: BASED ON PATIENT INTERVIEW – 1 point each	
1.	**Have you been recently intoxicated/drunk, within the last 30 days?**
2.	**Have you ever undergone alcohol use disorder rehabilitation treatment or treatment for alcohol use disorder?* (i.e., in-patient or out-patient treatment programs or AA attendance)**
3.	**Have you ever experienced any previous episodes of alcohol withdrawal, regardless of severity?**
4.	**Have you ever experienced blackouts?**
5.	**Have you ever experienced alcohol withdrawal seizures?**
6.	**Have you ever experienced delirium tremens or DTs?**
7.	**Have you combined alcohol with other "downers" like benzodiazepines or barbiturates, during the last 90 days?**
8.	**Have you combined alcohol with any other substances, during the last 90 days?***
PART C: BASED ON CLINICAL EVIDENCE – 1 point each	
9.	Was the patient's blood alcohol level (BAL) greater than 200mg/dL? (SI units 43.5 mmol/L) OR **Have you consumed any alcohol in the past 24 hours?****
10.	Is there any evidence of increased autonomic activity? e.g., heart rate >120 bpm, tremor, agitation, sweating, nausea
Interpretation: Maximum score = 10. This instrument is intended as a SCREENING TOOL. The greater the number of positive findings, the higher the risk for the development of alcohol withdrawal syndrome (AWS). A score of ≥4 suggests *HIGH RISK* for moderate to severe (complicated) AWS; prophylaxis and/or inpatient treatment are indicated.	

**Slight language modifications have been made to avoid stigmatizing terminology*
*** The committee has added this modification due to the common absence of a BAL. Please see next page.*

An online version of the original (unmodified) PAWSS can be found at: https://www.mdcalc.com/prediction-alcohol-withdrawal-severity-scale.

Remarks and Cautions

The PAWSS has not been validated in outpatient care settings, or in youth or pregnant individuals. While this guidance document endorses the usefulness of the PAWSS for risk assessment in all settings and populations, it emphasizes that when making clinical decisions, **this tool should be used in conjunction with best clinical judgment based on a comprehensive assessment of a patient's medical history, current circumstances, needs, and preferences.**

Modifications

Question 9 – Blood Alcohol Level (BAL):

The vast majority of outpatient care settings will not be equipped to assess BAL at the point-of-care. As an alternative, the PAWSS administrator may ask patients:

- Have you consumed any alcohol in the past 24 hours?

Based on rates of alcohol metabolism and elimination in humans,[209] it is very unlikely that a patient who has not consumed alcohol in the past 24 hours would have a BAL greater than 200mg/dL. While any alcohol consumption in the past 24 hours is a conservative measure of BAL>200mg/dL (i.e., this low threshold may over-identify those at risk), it is the consensus of the committee that the benefits of identifying individuals at risk of severe complications outweigh the risk of false negatives for this questionnaire item.

Alternatively, if a portable breath alcohol concentration device (i.e., a "breathalyzer") is available, breath alcohol concentration can be used in place of BAL. Research indicates that breath alcohol concentration is strongly correlated with and an accurate proxy measure of BAL.[210,211]

Qualifiers

The following questionnaire items should be clearly understood by the PAWSS administrator and defined for the patient to maximize the accuracy of results.

Question 4 – Blackouts:

Blackouts are transient episodes of retrograde amnesia typically **without loss of consciousness that accompany various degrees of alcohol intoxication.**[36] Blackouts can be an indicator of severe intoxication or long-term alcohol use, as a considerable degree of alcohol tolerance is required to ingest the amount of alcohol that could trigger a subsequent episode of amnesia without loss of consciousness.[36] The PAWSS administrator should clearly distinguish between alcohol-related blackouts and loss of consciousness (i.e., "passing out") as they pose the question to the patient.

Question 5 – Withdrawal Seizures:

Withdrawal seizures are typically generalized and brief tonic-clonic seizures that occur 6-48 hours after reduction or discontinuation of alcohol use.[212] Patients may mistake other experiences, such as tremor, for a seizure, so it is important to define what is meant by a withdrawal seizure and differentiate from other withdrawal symptoms. Patients with AUD are at increased risk of idiopathic epilepsy or seizure for other reasons,[213,214] so the PAWSS administrator should clearly define as seizures that occur within 1-2 days of ceasing or greatly reducing alcohol use.

Question 6 – Delirium Tremens (DTs):

Delirium tremens is a severe consequence of alcohol withdrawal that requires immediate hospitalization and management; if left untreated, the risk of death is approximately 3-5%.[215] Symptoms include profound disorientation, confusion and agitation, accompanied by severe autonomic hyperactivity.[215] In colloquial language, delirium tremens or "DTs" has come to loosely represent general symptoms of alcohol withdrawal. The PAWSS administrator should clearly distinguish delirium tremens from other withdrawal symptoms to avoid false positive results.

The Clinical Institute Withdrawal Assessment of Alcohol Scale, revised (CIWA-Ar)[203]

Patient: _____ Date: _____ Time: _____

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

NAUSEA AND VOMITING— Ask "Do you feel sick to yourstomach? Have you vomited?" Observation.

0 no nausea and no vomiting
1
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 andneedles 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 youknow 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 arenot 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 notrate for dizziness or light-headedness. 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: _____

Maximum Possible Score: 67

Rater's Initials: _____

The **CIWA-Ar** is not copyrighted and may be reproduced freely. The 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 JT, Sykora K, Schneiderman J, Naranjo CA & Sellers EM. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol Scale CIWA-Ar. *Br J Addict*. 1989;84:1353-1357.

Interpretation:

Score	Severity
0-9	Very mild withdrawal
10-15	Mild withdrawal
16-20	Moderate withdrawal
>20	Severe withdrawal

Notes:

- Training is required to administer this tool accurately; a regular audit and feedback process is recommended to ensure intra- and inter-rater variability is within an acceptable range.[216,217]
- This tool should be used in conjunction with best clinical judgment when making decisions on appropriate medication protocols, schedules, and dosages.
- Due to the need for a clinical interview, the CIWA-Ar is not appropriate where there is a language barrier or if the patient is cognitively impaired, delirious, or displaying a decreased level of consciousness.[218]