



California Access to Recovery Effort 3

(CARE 3)

Revised December 2011

CARE PROGRAM SCREENING TOOL FOR MILITARY CLIENTS

Name: _____ Address: _____
 SSN: _____ DOB: _____

PART A (Ask the potential client these questions)

During the past 30 days, did you:

Drink any alcohol? No Yes - frequency: _____

Smoke any marijuana or hashish? No Yes - frequency _____

Use anything else to get high? (illegal drugs, over-the-counter prescription drugs, and things that you sniff or "huff") No Yes - specify substance(s) and frequency: _____

If the individual answers "yes" to any question, skip to Part C.

PART B (For assessor to complete)

Is the individual receiving substance abuse treatment services (paid for by another fund source) and wants to choose activities that will support his/her treatment and recovery? Yes No

Is the individual in early recovery (six months or less since last substance use) and needs recovery support services to help sustain recovery? Yes No

If the answer to one of the questions is yes, client is eligible for recovery support services only. Skip to next page.

PART C (Ask the potential client these questions—CRAFT Screening)

Have you ridden in a car driven by someone (including yourself) who was high or had been using alcohol or drugs? Yes No

Do you ever use alcohol or drugs to relax, feel better about yourself, or to fit in? Yes No

Do you ever use alcohol or drugs while you are by yourself alone? Yes No

Do you ever forget things you did while using alcohol or drugs? Yes No

Do your family or friends ever tell you that you should cut down on your drinking or drug use? Yes No

Have you ever gotten into trouble while you were using alcohol or drugs? Yes No

If the individual answers "yes" to three or more questions in Part C, STOP. He/she is not eligible for CARE. Assessor must refer individual to another program for additional assessment and referral to treatment. Otherwise, continue on next page.



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CARE PROGRAM ASSESSMENT TOOL

Medical and Mental Health/Safety Issues

Are you homeless or have unstable housing? No Yes

During the past few weeks, have you often felt sad or down as though you have nothing to look forward to?
 No Yes

Are you taking any medication prescribed for you by a physician for any emotional or mental health problems? No Yes

Have you ever seriously thought about killing yourself, made a plan, or actually tried to kill yourself?
 No Yes

Do you have any health issues that need attention? No Yes

Do you have any immediate legal issues? No Yes

Do you need assistance accessing veteran's benefits? No Yes

"Yes" answers to these questions require further clarification and may require immediate action.

Recommended/Action Taken:

Emergency/transitional housing referral

Mental health evaluation referral

Medical treatment referral

Assistance accessing veterans benefits

Other: _____

Strengths and Abilities

What do you think are your greatest strengths and abilities?

Substance Use Issues

At what age did you first try alcohol or drugs? _____

Have you ever been treated in an alcohol or drug program? No Yes - when and for how long: _____

Would anything hold you back from participating in treatment or recovery?

- No
- Lack of transportation
- Scheduling
- Attending groups w/non-military clients
- Having to take drug tests
- Drinking or drug-using friends
- Other: _____

Would you like to learn more about recovery groups, the different types of group available, or how to locate a group in your area? No Yes

Do you smoke cigarettes (or other tobacco product)? No Yes

Recommended:

- Relapse prevention therapy*
- Bus passes or tokens*
- Smoking cessation*
- Substance abuse education*
- 12-Step group*

Family/Peer Relationships

Do you have any children? No Yes

Do you have family support to help you transition to civilian life? No Yes NA

Do any of your family members have problems with alcohol or drugs? No Yes

Do you socialize with any non-veterans friends? No Yes

Who do you feel is important to be involved in your counseling or recovery services? _____

Recommended:

- Family counseling*
- Domestic violence prevention*
- Interpersonal communication*
- Child care*
- Other: _____*
- Parenting skills*
- Stress management*
- Al Anon*

School Issues

Do you have a high school diploma or a GED? No Yes NA

Do you need assistance returning to school? No Yes NA

Are you interested in preparing for college? No Yes

If in school, would you like to find veterans support on campus? No Yes

If in school, do you need assistance with school or homework? No Yes NA

Recommended:

- GED prep*
 - Academic counseling or tutoring*
 - Assistance with finding or applying for schooling*
 - Aptitude and achievement testing*
 - Other:* _____
-

Employment Issues

Are you employed? No Yes

Do you need help finding a job or getting a different job? No Yes

Do you need training to help prepare you for the type of job you would like? No Yes

Recommended:

- | | |
|---|--|
| <input type="checkbox"/> <i>Vocational assessment</i> | <input type="checkbox"/> <i>Technical or vocational training</i> |
| <input type="checkbox"/> <i>Help finding or maintaining employment</i> | <input type="checkbox"/> <i>Developing a resume</i> |
| <input type="checkbox"/> <i>Arranging job interviews</i> | <input type="checkbox"/> <i>Interviewing skills</i> |
| <input type="checkbox"/> <i>Getting a promotion, better job or skills</i> | |
| <input type="checkbox"/> <i>Other:</i> _____ | |
-

Daily Living Needs

Do you eat a balanced diet that includes fruits and vegetables daily? No Yes

Do you have opportunities for regular exercise and physical recreation? No Yes

Do you have difficulty planning ahead and making choices? No Yes

Is budgeting or managing money a problem for you? No Yes

Do you have difficulty resolving conflicts nonviolently? No Yes

Recommended:

- | | |
|--|---|
| <input type="checkbox"/> <i>Budgeting or financial counseling</i> | <input type="checkbox"/> <i>Time management</i> |
| <input type="checkbox"/> <i>Anger management/conflict resolution</i> | <input type="checkbox"/> <i>Household management</i> |
| <input type="checkbox"/> <i>Nutritional counseling</i> | <input type="checkbox"/> <i>Stress management/relaxation techniques</i> |
| <input type="checkbox"/> <i>Recreational activities</i> | <input type="checkbox"/> <i>Health/wellness education</i> |
| <input type="checkbox"/> <i>Other:</i> _____ | |
-

Social Support Issues

Do you have at least one caring, supportive person in your life that you can talk to when you need help?
 No Yes

Do you feel disconnected from others around you, or misunderstood? No Yes

Do you have difficulty communicating with others who are not fellow military? No Yes

Do you wish you had more opportunities for participating in groups, clubs, hobbies, social gatherings?
 No Yes

Would you like to have a fellow veteran help you through the VA system? No Yes

Would you like to meet other veterans to whom you can relate and get support? No Yes

Recommended:

Peer support

Sports

Other: _____

Spiritual/Cultural Issues

Are spiritual or religious activities important to you? No Yes

Do you wish you had someone to listen to you or speak to you about spiritual needs? No Yes

Are you interested in learning more about your culture or participating in cultural activities? No Yes

Are there any cultural, gender or sexual orientation issues that would make participating in treatment or recovery support difficult for you? No Yes - explain: _____

Recommended:

Spiritual coaching

Cultural enrichment activities

Yoga

Other: _____

Bible study

Meditation

Notes: _____
