Ontario Common Assessment of Need (OCAN)

Community Mental Health Common Assessment Project

Core + Self OCAN 2.0

Revision 2.0.5

CCIM Community Care Information Management

ACCESS TO INFORMATION

OCAN Consumer Self-Assessment

Welcome to this opportunity to speak with your own voice

This agency is providing you the opportunity to complete the OCAN Consumer Self-assessment. This formal process is becoming standard across the province to ensure consumers' views about their needs are heard.

Why we would like you to take this opportunity:

- You can choose to bring this information to other agencies to reduce the number of times you have to answer questions. These questions are becoming common to all community mental health agencies.
- Agencies can work with you to better find the right help the first time because it asks a broad set of questions to cover all your needs.
- You can fully discuss your needs. The answers you give will help determine what services you will receive, and how to prioritize your goals.
- You can record your comments in every section, as well as your hopes, dreams and goals so that a plan can be developed to help you get there.

You decide how many of the questions you answer and the amount of time you need to complete it. You can decide whether or not you want some help, and choose this help from a number of options including a peer support worker, other trusted worker, family, friends, etc. You also have the option to answer some or all of the questions.

Name:	
Date of Birth (YYYY-MM-DD):	
Start Date (YYYY-MM-DD):	**Completion Date (YYYY-MM-DD):**

INSTRUCTIONS:

When you have completed this assessment, your worker will have a conversation with you about your needs.

- Please let your worker know if you have completed a Common Assessment in the last six months.
- Please read the pamphlet provided on how your information will be used.
- Please ask about any questions you don't understand.

Please ✓ tick one box in each row (24 in total) using the following key:

No Need = this area is not a serious problem for me at all

Met Need = this area is not a serious problem for me because of the help I am given

Unmet Need = this area remains a serious problem for me despite any help I am given

		No Need	Met Need	Unmet Need	I Don't Want to Answer
1.	**Accommodation**	☐	☐	☐	☐
	What kind of place do you live in? **Comments**				
2.	**Food**	☐	☐	☐	☐
	Do you get enough to eat? **Comments**				
3.	**Looking After the Home**	☐	☐	☐	☐
	Are you able to look after your home? **Comments**				
4.	**Self-Care**	☐	☐	☐	☐
	Do you have problems keeping clean and tidy? **Comments**				
5.	**Daytime Activities**	☐	☐	☐	☐
	How do you spend your day? **Comments**				
6.	**Physical Health**	☐	☐	☐	☐
	How well do you feel physically? **Comments**				

No Need = this area is not a serious problem for me at all
Met Need = this area is not a serious problem for me because of the help I am given
Unmet Need = this area remains a serious problem for me despite any help I am given

		No Need	Met Need	Unmet Need	I Don't Want to Answer
7.	**Psychotic Symptoms**	☐	☐	☐	☐
	Do you ever hear voices or have problems with your thoughts? **Comments**				
8.	**Information on Condition and Treatment**	☐	☐	☐	☐
	Have you been given clear information about your medication? **Comments**				
9.	**Psychological Distress**	☐	☐	☐	☐
	Have you recently felt very sad or low? **Comments**				
10.	**Safety to Self**	☐	☐	☐	☐
	Do you ever have thoughts of harming yourself? **Comments**				
11.	**Safety to Others**	☐	☐	☐	☐
	Do you think you could be a danger to other people's safety? **Comments**				
12.	**Alcohol**	☐	☐	☐	☐
	Does drinking cause you any problems? **Comments**				
13.	**Drugs**	☐	☐	☐	☐
	Do you take any drugs that aren't prescribed? **Comments**				
14.	**Other Addictions**	☐	☐	☐	☐
	Do you have any other addictions – such as gambling? **Comments**				
15.	**Company**	☐	☐	☐	☐
	Are you happy with your social life? **Comments**				

No Need = this area is not a serious problem for me at all

Met Need = this area is not a serious problem for me because of the help I am given

Unmet Need = this area remains a serious problem for me despite any help I am given

		No Need	Met Need	Unmet Need	I Don't Want to Answer
16.	**Intimate Relationships**	☐	☐	☐	☐
	Do you have a partner? **Comments**				
17.	**Sexual Expression**	☐	☐	☐	☐
	How is your sex life? **Comments**				
18.	**Child Care**	☐	☐	☐	☐
	Do you have any children under 18? **Comments**				
19.	**Other Dependents**	☐	☐	☐	☐
	Do you have any dependents other than children under 18, such as an elderly parent or beloved pet? **Comments**				
20.	**Basic Education**	☐	☐	☐	☐
	Any difficulty in reading, writing or understanding English? **Comments**				
21.	**Telephone**	☐	☐	☐	☐
	Do you know how to use a telephone? **Comments**				
22.	**Transport**	☐	☐	☐	☐
	How do you find using the bus, streetcar or train? **Comments**				
23.	**Money**	☐	☐	☐	☐
	How do you find budgeting your money? **Comments**				
24.	**Benefits**	☐	☐	☐	☐
	Are you getting all the money you are entitled to? **Comments**				

Please write a few sentences to answer the following questions:

What are your hopes for the future?

What do you think you need in order to get there?

How do you view your mental health?

Is spirituality an important part of your life?

Is culture (heritage) an important part of your life?

CORE + Self OCAN

Using CORE + Self OCAN

This agency is using the CORE + Self OCAN which provides consumers the opportunity to complete the OCAN Consumer Self-assessment to ensure consumers' views about their needs are heard. It also includes the Consumer Information Summary and Service Use sections of OCAN which capture the information that this agency reports as a community mental health service provider.

Start Date (YYYY-MM-DD)*: _____

Consumer Information Summary

1. OCAN Lead Assessment

OCAN completed by OCAN Lead?* ☐ Yes ☐ No

2. Reason for OCAN (select one)*

☐ Initial OCAN
☐ Reassessment
☐ (Prior to) Discharge
☐ Significant change
☐ Review
☐ Re-key
☐ Other (e.g., consumer request)
Please specify _____

3. Consumer Information

First Name:
Middle Initial:
Last Name:
Preferred Name:
Address:
City:
Province:
Postal Code:
Phone Number: Ext:
Email Address:

Date of Birth (YYYY-MM-DD):* ☐ Estimate ☐ Unknown
Health Card Number:
Version Code:
Issuing Territory:
Service Recipient Location (county, district, municipality):*
LHIN Consumer Resides in:*

3b. Gender (select one)* ☐ Male ☐ Female ☐ Other ☐ Consumer declined to answer ☐ Unknown

3c. Marital Status (select one)

☐ Single
☐ Married or in common-law relationship
☐ Partner or significant other
☐ Widowed
☐ Separated
☐ Divorced
☐ Consumer declined to answer
☐ Unknown

4. Mental Health Functional Centre Use (for the last 6 months)

Mental Health Functional Centre 1	Mental Health Functional Centre 2
OCAN Lead:* ☐ Yes ☐ No	**OCAN Lead:*** ☐ Yes ☐ No
Staff Worker Name:*	**Staff Worker Name:***
Staff Worker Phone Number:* **Ext:**	**Staff Worker Phone Number:*** **Ext:**
Organization LHIN:*	**Organization LHIN:***
Organization Name:*	**Organization Name:***
Organization Number:*	**Organization Number:***
Program Name:*	**Program Name:***
Program Number:*	**Program Number:***
Functional Centre Name:*	**Functional Centre Name:***
Functional Centre Number:*	**Functional Centre Number:***
Service Delivery LHIN:*	**Service Delivery LHIN:***
Referral Source:*	**Referral Source:***
Request for Service Date (YYYY-MM-DD):	**Request for Service Date (YYYY-MM-DD):**
Service Decision Date (YYYY-MM-DD):	**Service Decision Date (YYYY-MM-DD):**
Accepted:	**Accepted:**

**** Mandatory fields***

Service Initiation Date (YYYY-MM-DD):	**Service Initiation Date (YYYY-MM-DD):**
Exit Date (YYYY-MM-DD):	**Exit Date (YYYY-MM-DD):**
Exit Disposition:	**Exit Disposition:**

Mental Health Functional Centre 3			**Mental Health Functional Centre 4**		
OCAN Lead:*	☐ Yes	☐ No	**OCAN Lead:***	☐ Yes	☐ No
Staff Worker Name:*			**Staff Worker Name:***		
Staff Worker Phone Number:*	**Ext:**		**Staff Worker Phone Number:***	**Ext:**	
Organization LHIN:*			**Organization LHIN:***		
Organization Name:*			**Organization Name:***		
Organization Number:*			**Organization Number:***		
Program Name:*			**Program Name:***		
Program Number:*			**Program Number:***		
Functional Centre Name:*			**Functional Centre Name:***		
Functional Centre Number:*			**Functional Centre Number:***		
Service Delivery LHIN:*			**Service Delivery LHIN:***		
Referral Source:*			**Referral Source:***		
Request for Service Date (YYYY-MM-DD):			**Request for Service Date (YYYY-MM-DD):**		
Service Decision Date (YYYY-MM-DD):			**Service Decision Date (YYYY-MM-DD):**		
Accepted:			**Accepted:**		
Service Initiation Date (YYYY-MM-DD):			**Service Initiation Date (YYYY-MM-DD):**		
Exit Date (YYYY-MM-DD):			**Exit Date (YYYY-MM-DD):**		
Exit Disposition:			**Exit Disposition:**		

5. Family Doctor Information

☐ Yes ☐ No ☐ None available ☐ Consumer declined to answer ☐ Unknown

Name:	Address:
Phone Number:	City:
Ext:	Province:
Email Address:	Postal Code:
Last seen:	

6. Psychiatrist Information

☐ Yes ☐ No ☐ None available ☐ Consumer declined to answer ☐ Unknown

Name:	Address:
Phone Number:	City:
Ext:	Province:
Email Address:	Postal Code:
Last seen:	

7. Other Contact

☐ Yes ☐ No ☐ Consumer declined to answer ☐ Unknown

Contact Type:

Name:	Address:
Phone Number:	City:
Ext:	Province:

**** Mandatory fields***

Email Address:		Postal Code:	
Last seen:			
Other Contact			
☐ Yes	☐ No	☐ Consumer declined to answer	☐ Unknown
Contact Type:			
Name:		Address:	
Phone Number:		City:	
Ext:		Province:	
Email Address:		Postal Code:	
Last seen:			
8. Other Agency			
☐ Yes	☐ No	☐ Consumer declined to answer	☐ Unknown
Name:		Address:	
Phone Number:		City:	
Ext:		Province:	
Email Address:		Postal Code:	
Last seen:			

9. Consumer Capacity (select all that apply)

9a. Power of Attorney for Personal Care:	☐ Yes	☐ No	☐ Consumer declined to answer	☐ Unknown
Power of Attorney or SDM Name:				
Address:				
Phone Number: Ext:				
9b. Power of Attorney for Property	☐ Yes	☐ No	☐ Consumer declined to answer	☐ Unknown
Power of Attorney:				
Address:				
Phone Number: Ext:				
9c. Guardian	☐ Yes	☐ No	☐ Consumer declined to answer	☐ Unknown
Name:				
Address:				
Phone Number: Ext:				
9d. Areas of concern				
Finance/property:	☐ Yes	☐ No	☐ Unknown	
Treatment decisions:	☐ Yes	☐ No	☐ Unknown	

10. Age in years for onset of mental illness:	☐ Estimate	☐ Consumer declined to answer	☐ Unknown	☐ N/A
11. Age of first psychiatric hospitalization:	☐ Estimate	☐ Consumer declined to answer	☐ Unknown	☐ N/A
12. Date when consumer first entered your organization (YYYY-MM):	☐ Estimate	☐ Consumer declined to answer	☐ Unknown	☐ N/A

13. What culture do you (consumer) identify with?

14. Aboriginal Origin (select one)*

☐ Aboriginal ☐ Non-aboriginal ☐ Consumer declined to answer ☐ Unknown

15. Citizenship Status (select one)

☐ Canadian citizen ☐ Temporary resident ☐ Consumer declined to answer

**** Mandatory fields***

☐ Permanent resident ☐ Refugee ☐ Unknown

16. Length of time lived in Canada (number of years/months):

17. Service recipient preferred language:*

18. Language of service provision:*

19. Do you currently have any legal issues? (select one)*

☐ Civil ☐ Criminal ☐ None ☐ Consumer declined to answer ☐ Unknown

20. Current Legal Status (select all that apply)

Pre-Charge

☐ Pre-charge diversion

☐ Court diversion program

Pre-Trial

☐ Awaiting fitness assessment

☐ Awaiting trial *(with or without bail)*

☐ Awaiting criminal responsibility assessment (ncr)

☐ In community on own recognizance

☐ Unfit to stand trial

Custody Status

☐ ORB detained – community access

☐ ORB conditional discharge

☐ On parole

☐ On probation

Outcomes

☐ Charges withdrawn

☐ Stay of proceedings

☐ Awaiting sentence

☐ NCR

☐ Conditional discharge

☐ Conditional sentence

☐ Restraining order

☐ Peace bond

☐ Suspended sentence

Other

☐ No legal problem *(includes absolute discharge and time served – end of custody)*

☐ Consumer declined to answer

☐ Unknown

21. Where do you live? (select one)*

☐ Approved homes & homes for special care

☐ Correctional/probation facility

☐ Domicillary hostel

☐ General hospital

☐ Psychiatric hospital

☐ Other specialty hospital

☐ No fixed address

☐ Hostel/shelter

☐ Long term care facility/nursing home

☐ Municipal non-profit housing

☐ Private non-profit housing

☐ Private house/Apt. – SR owned/market rent

☐ Private house/Apt. – other/subsidized

☐ Retirement home/senior's residence

☐ Rooming/boarding house

☐ Supportive housing – congregate living

☐ Supportive housing – assisted living

☐ Other _____

☐ Consumer declined to answer

☐ Unknown

22. Do you receive any support? (select one)*

☐ Independent ☐ Supervised non-facility ☐ Consumer declined to answer

☐ Assisted/supported ☐ Supervised facility ☐ Unknown

23. Do you live with anyone? (select one)*

☐ Self ☐ Children ☐ Non-relatives

☐ Spouse/partner ☐ Parents ☐ Consumer declined to answer

☐ Spouse/partner and others ☐ Relatives ☐ Unknown

24. What is your current employment status? (select one)*

☐ Independent/competitive ☐ Non-paid work experience ☐ Consumer declined to answer

☐ Assisted/supportive ☐ No employment – other activity ☐ Unknown

**** Mandatory fields***

☐ Alternative businesses ☐ Casual/sporadic

☐ Sheltered workshop ☐ No employment of any kind

25. Are you currently in school? (select one)*

☐ Not in school ☐ Vocational/training centre ☐ Other_____

☐ Elementary/junior high school ☐ Adult education ☐ Consumer declined to answer

☐ Secondary/high school ☐ Community college ☐ Unknown

☐ Trade school ☐ University

26. Psychiatric History

26a. Have you been hospitalized due to your mental health during the past two years? (select one)*

☐ Yes ☐ No ☐ Consumer declined to answer ☐ Unknown

26b. If Yes,

Total number of admissions for mental health reasons:

If Initial OCAN, list hospital admissions for the past 2 years OR if Reassessment, list hospital admissions since last OCAN

Total number of hospitalization days for mental health reasons:

If Initial OCAN, list total number of days spent in hospital for the past 2 years OR If Reassessment, list total number of days spent in hospital since last OCAN

27. How many times did you visit an Emergency Department in the last 6 months for mental health reasons?*

☐ None ☐ 2 - 5 ☐ Consumer declined to answer

☐ 1 ☐ > 6 ☐ Unknown

28. Community Treatment Order:*

☐ Issued CTO ☐ No CTO ☐ Consumer declined to answer ☐ Unknown

29. Diagnostic Categories (select all that apply)*
This information is collected from a variety of sources, including self-report, and should not be used for diagnosis without being confirmed by a qualified diagnosing practitioner.

☐ Adjustment disorders ☐ Mood disorder

☐ Anxiety disorder ☐ Personality disorders

☐ Delirium, dementia, and amnestic and cognitive disorders ☐ Schizophrenia and other psychotic disorders

☐ Developmental handicap ☐ Sexual and gender identity disorders

☐ Disorder of childhood/adolescence ☐ Sleep disorders

☐ Dissociative disorders ☐ Somatoform disorders

☐ Eating disorders ☐ Substance related disorders

☐ Factitious disorders ☐ Intellectual disability or impairment

☐ Impulse control disorders not elsewhere classified ☐ Consumer declined to answer

☐ Mental disorders due to general medical conditions ☐ Unknown

30. Other Illness Information (select all that apply)

☐ Concurrent disorder (substance abuse) ☐ Other chronic illnesses

☐ Dual diagnosis (developmental disability) ☐ Other physical disabilities

31. What is your highest level of education? (select one)*

☐ No formal schooling ☐ Some secondary/high school ☐ College/university

☐ Some elementary/junior high school ☐ Secondary/high school ☐ Consumer declined to answer

☐ Elementary/junior high school ☐ Some college/university ☐ Unknown

32. What is your primary source of income? (select one)*

**** Mandatory fields***

☐ Employment	☐ Social assistance	☐ Other _____
☐ Employment insurance	☐ Disability assistance	☐ Consumer declined to answer
☐ Pension	☐ Family	☐ Unknown
☐ ODSP	☐ No source of income	

33. Presenting Issues*

☐ Activities of daily living	☐ Problems with addictions
☐ Attempted suicide	☐ Problems with relationships
☐ Educational	☐ Problems with substance abuse
☐ Financial	☐ Sexual abuse
☐ Housing	☐ Specific symptom of serious mental illness
☐ Legal	☐ Threat to others
☐ Occupational/employment/vocational	☐ Threat to self
☐ Physical abuse	☐ Other _____

34. Comments:

Completion Date (YYYY-MM-DD)*: _____

**** Mandatory fields***