Ontario Common Assessment of Need (OCAN)

Community Mental Health Common Assessment Project

Core + Self OCAN 3.0

CCIM Community Care Information Management

OCAN Consumer Self-Assessment

Have your own voice heard

This organization uses OCAN to understand your needs. We invite you to complete this brief self-assessment that captures areas of your life where you need support and where things are going well. Completing the self-assessment helps us to focus on services that support the needs you have identified.

You decide what you would like to share

The self-assessment is optional. When completing the self-assessment, you can chose not to respond to questions you're not comfortable with. Your decision on whether or not to complete all or parts of the self-assessment will not change the services you're accessing.

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Why we encourage you to complete the Self-Assessment:

- Gives you a voice by capturing your perspective
- Services and supports are directed to areas that are most important to you
- Only respond to questions that you feel comfortable discussing

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

INSTRUCTIONS:

The self-assessment covers 24 life domains or areas of your life. The following steps will help guide you to complete the assessment. Let your worker know if you need help.

1. Read the first life domain in the assessment e.g. (Accommodation) and consider your needs in that area of your life.
2. The questions just beneath the domain are there to help you think about whether this is a problem (area of need) and whether you're getting the help you need.
3. Check off one of the four boxes identifying your need rating in that domain using the definitions below. **Notice that one of the boxes you can tick off is "*I don't want to answer*". Feel free to tick this box off for any domains you don't feel comfortable answering.**
4. You are encouraged to provide comments so your worker can better understand your situation.
5. Following the 24 domains, there are 5 questions. Responding to these questions will capture what's important to you, your strengths and your recovery goals.

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
I Don't Want to Answer = I prefer not to respond

		No Need	**Met Need**	**Unmet Need**	**I Don't Want to Answer**
1.	**Accommodation**	☐	☐	☐	☐
	Are you happy with the place you live in or has it been a problem (an area of need)? Are you getting the help you need? **Comments**				
2.	**Food**	☐	☐	☐	☐
	Has getting food that suits your dietary needs been a problem (an area of need)? Are you getting the help you need? **Comments**				

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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					
I Don't Want to Answer = I prefer not to respond					
		No Need	**Met Need**	**Unmet Need**	**I Don't Want to Answer**
3.	**Looking After the Home**	☐	☐	☐	☐
	Has keeping your home tidy been a problem (an area of need)? This could include cleaning and laundry. Are you getting the help you need? **Comments**				
4.	**Self-Care**	☐	☐	☐	☐
	Has maintaining your personal hygiene been a problem (an area of need)? This could include challenges accessing or using products/facilities. Are you getting the help you need? **Comments**				
5.	**Daytime Activities**	☐	☐	☐	☐
	Have daytime activities been a problem (an area of need)? This could include work, education or leisure activities. Are you getting the help you need? **Comments**				
6.	**Physical Health**	☐	☐	☐	☐
	Has your physical health been a problem (an area of need)? Are you getting the help you need? **Comments**				
7.	**Psychotic Symptoms**	☐	☐	☐	☐
	Have symptoms of psychosis been a problem (an area of need)? These could include feeling like you're being watched or hearing voices that interfere with your daily life? Are you getting the help you need? **Comments**				
8.	**Information on Condition and Treatment**	☐	☐	☐	☐
	Has understanding your mental health condition and recommended services/treatments been a problem (an area of need)? Are you getting the information you need? **Comments**				
9.	**Psychological Distress**	☐	☐	☐	☐
	Have symptoms of depression or anxiety been a problem (an area of need)? These could include feelings of sadness or worry that interfere with your daily life. Are you getting the help you need? **Comments**				
10.	**Safety to Self**	☐	☐	☐	☐
	Have thoughts and/or acts of harming yourself been a problem area (an area of need)? Are you getting the help you need? **Comments**				

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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					
I Don't Want to Answer = I prefer not to respond					
		No Need	**Met Need**	**Unmet Need**	**I Don't Want to Answer**
11.	**Safety to Others**	☐	☐	☐	☐
	Have thoughts and/or acts of harming others been a problem area (an area of need)? Are you getting the help you need? **Comments**				
12.	**Alcohol**	☐	☐	☐	☐
	Has alcohol use been a problem (an area of need)? Are you getting the help you need? **Comments**				
13.	**Drugs**	☐	☐	☐	☐
	Has drug use been a problem (an area of need)? This could include illicit drugs or misuse of prescription drugs? Are you getting the help you need? **Comments**				
14.	**Other Addictions**	☐	☐	☐	☐
	Have other addictions been a problem (an area of need)? Other addictions could include gambling, overuse of electronic devices or smoking. Are you getting the help you need? **Comments**				
15.	**Company**	☐	☐	☐	☐
	Has your social life been a problem (an area of need)? Are you getting the help you need? **Comments**				
16.	**Intimate Relationships**	☐	☐	☐	☐
	Have close personal relationships been a problem (an area of need)? Are you getting the help you need? **Comments**				
17.	**Sexual Expression**	☐	☐	☐	☐
	Have your sex life and sexual health been a problem (an area of need)? Are you getting the help you need? **Comments**				
18.	**Child Care**	☐	☐	☐	☐
	Has looking after your children been a problem (area of need)? This could include access to childcare or parenting. Are you getting the help you need? **Comments**				

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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					
I Don't Want to Answer = I prefer not to respond					
		No Need	**Met Need**	**Unmet Need**	**I Don't Want to Answer**
19.	**Other Dependents**	☐	☐	☐	☐
	Has looking after other dependents been a problem (an area of need)? Other dependents could include elderly parents and pets. Are you getting the help you need? **Comments**				
20.	**Basic Education**	☐	☐	☐	☐
	Has reading, writing or basic math been a problem (an area of need)? Are you getting the help you need? **Comments**				
21.	**Communication**	☐	☐	☐	☐
	Has accessing or using a phone or computer been a problem (an area of need)? Are you getting the help you need? **Comments**				
22.	**Transport**	☐	☐	☐	☐
	Has transportation been a problem (an area of need)? This could include getting to and from appointments and daily activities. Are you getting the help you need? **Comments**				
23.	**Money**	☐	☐	☐	☐
	Has managing your money been a problem (an area of need)? Are you getting the help you need? **Comments**				
24.	**Benefits**	☐	☐	☐	☐
	Has accessing the benefits/money you're entitled to been a problem (an area of need)? This could include Ontario Works, Disability Support Program and Drug Benefit. Are you getting the help you need? **Comments**				

Please write a few sentences to answer the following questions:

What are your strengths and skills?

What are your hopes and goals for the future?

What do you need to accomplish your hopes and goals?

Is spirituality an important part of your life? Please explain.

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

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 Mental Health Functional Centre 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 ☐ (Prior to) Discharge

☐ Reassessment ☐ Significant change (please specify) _____

3. Consumer Information

First Name:

Middle Initial:

Last Name:

Preferred Name:

Address:

City:

Province:

Postal Code:

Phone Number: Ext:

Date of Birth (YYYY-MM-DD):* ☐ Estimate ☐ Do not know

Health Card Number:

Version Code:

Issuing Territory:

Service Recipient Location (county, district, municipality):*

LHIN Consumer Resides in:*

Email Address:

3b. What is your gender? (select one)* ☐ Male ☐ Female ☐ Intersex ☐ Trans-Female to Male ☐ Trans-Male to Female ☐ Prefer not to answer ☐ Do not know ☐ Other (please specify) _____

3c. Marital Status (select one)*

☐ Single ☐ Partner or significant other ☐ Separated ☐ Prefer not to answer

☐ Married or in common-law relationship ☐ Widowed ☐ Divorced ☐ Do not know

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:**
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:**

**** Mandatory fields***

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 ☐ Prefer not to answer ☐ Do not know

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

Last seen:

6. Psychiatrist Information

☐ Yes ☐ No ☐ None available ☐ Prefer not to answer ☐ Do not know

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

Last seen:

7. Other Contact

☐ Yes ☐ No ☐ Prefer not to answer ☐ Do not know

Contact Type:

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

Last seen:

**** Mandatory fields***

Other Contact

☐ Yes ☐ No ☐ Prefer not to answer ☐ Do not know

Contact Type:

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

Last seen:

8. Other Agency

☐ Yes ☐ No ☐ Prefer not to answer ☐ Do not know

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 ☐ Prefer not to answer ☐ Do not know

Power of Attorney or SDM Name:

Address:

Phone Number: Ext:

9b. Power of Attorney for Property ☐ Yes ☐ No ☐ Prefer not to answer ☐ Do not know

Power of Attorney:

Address:

Phone Number: Ext:

9c. Guardian ☐ Yes ☐ No ☐ Prefer not to answer ☐ Do not know

Name:

Address:

Phone Number: Ext:

9d. Areas of concern

Finance/property: ☐ Yes ☐ No ☐ Do not know

Treatment decisions: ☐ Yes ☐ No ☐ Do not know

10. Age in years for onset of mental illness:	☐ Estimate	☐ Prefer not to answer	☐ Do not know	☐ N/A
11. Age of first psychiatric hospitalization:	☐ Estimate	☐ Prefer not to answer	☐ Do not know	☐ N/A
12. Most recent date consumer entered your organization (YYYY-MM):	☐ Estimate	☐ Prefer not to answer	☐ Do not know	☐ N/A

**** Mandatory fields***

13. Which of the following best describes your racial or ethnic group? (select one)*

☐ Asian - East (e.g. Chinese, Japanese, Korean)
☐ Asian - South (e.g. Indian, Pakistani, Sri Lankan)
☐ Asian - South East (e.g. Malaysian, Filipino, Vietnamese)
☐ Black - African (e.g. Ghanaian, Kenyan, Somali)
☐ Black - Caribbean (e.g. Barbadian, Jamaican)
☐ Black - North American (e.g. Canadian, American)
☐ First Nations
☐ Indian - Caribbean (e.g. Guyanese with origins in India)
☐ Indigenous/Aboriginal - not included elsewhere
☐ Inuit
☐ Latin American (e.g. Argentinean, Chilean, Salvadoran)
☐ Metis
☐ Middle Eastern (e.g. Egyptian, Iranian, Lebanese)
☐ White - European (e.g. English, Italian, Portuguese, Russian)
☐ White - North American (e.g. Canadian, American)
☐ Mixed heritage (e.g. Black - African & White – North American)
Please specify: _____
☐ Other _____
☐ Prefer not to answer
☐ Do not know

14. What is your Sexual Orientation? (Select One)*

☐ Bisexual ☐ Gay ☐ Heterosexual ☐ Lesbian ☐ Queer ☐ Two-Spirit ☐ Prefer not to answer

☐ Do not know ☐ Other (please specify): _____

15. Citizenship Status (select one)

☐ Canadian citizen ☐ Temporary resident ☐ Prefer not to answer
☐ Permanent resident ☐ Refugee ☐ Do not know

16. Were you born in Canada?* ☐ Yes ☐ No ☐ Prefer not to answer ☐ Do not know

If No, what year did you arrive in Canada? _____

17. What language would you feel most comfortable speaking in with your health care provider? (select one)*

18. Language of service provision*

19. What is your mother tongue? (select one)*

20. If your mother tongue is neither French nor English, in which of Canada's official languages are you most comfortable?*

☐ English ☐ French

21. Do you currently have any legal issues? (select all that apply)*

☐ Civil ☐ Criminal ☐ None ☐ Prefer not to answer ☐ Do not know

22. Comment on legal issues:

23. 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

Outcomes

☐ Charges withdrawn
☐ Stay of proceedings
☐ Awaiting sentence
☐ NCR
☐ Conditional discharge
☐ Conditional sentence
☐ Restraining order
☐ Peace bond
☐ Suspended sentence
☐ Incarceration

**** Mandatory fields***

Custody Status	***Other***
☐ ORB detained – community access	☐ No legal problem *(includes absolute discharge and time served – end of custody)*
☐ ORB conditional discharge	☐ Prefer not to answer
☐ On parole	☐ Do not know
☐ On probation	

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

☐ Approved homes & homes for special care	☐ Private non-profit housing
☐ Correctional/probation facility	☐ Private house/Apt. – SR owned/market rent
☐ Domicillary hostel	☐ Private house/Apt. – other/subsidized
☐ General hospital	☐ Retirement home/senior's residence
☐ Psychiatric hospital	☐ Rooming/boarding house
☐ Other specialty hospital	☐ Supportive housing – congregate living
☐ No fixed address	☐ Supportive housing – assisted living
☐ Hostel/shelter	☐ Other _____
☐ Long term care facility/nursing home	☐ Prefer not to answer
☐ Municipal non-profit housing	☐ Do not know

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

☐ Independent	☐ Supervised non-facility	☐ Prefer not to answer
☐ Assisted/supported	☐ Supervised facility	☐ Do not know

26. Do you live with anyone? (select all that apply)*

☐ No-on my own	☐ Children	☐ Non-relatives
☐ Spouse/partner	☐ Parents	☐ Relatives
☐ Other	☐ Prefer not to answer	☐ Do not know

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

☐ Independent/competitive	☐ Non-paid work experience	☐ Prefer not to answer
☐ Assisted/supportive	☐ No employment – other activity	☐ Do not know
☐ Alternative businesses	☐ Casual/sporadic	
☐ Sheltered workshop	☐ No employment – of any kind	

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

☐ Not in school	☐ Vocational/training centre	☐ Other_____
☐ Elementary/junior high school	☐ Adult education	☐ Prefer not to answer
☐ Secondary/high school	☐ Community college	☐ Do not know
☐ Trade school	☐ University	

29. Psychiatric History

29a. Have you been hospitalized due to your mental health? (select one)*

If Initial OCAN, during the past two years OR if Reassessment, since the last OCAN

☐ Yes ☐ No ☐ Prefer not to answer ☐ Do not know

29b. 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

**** Mandatory fields***

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

☐ None ☐ 2 - 5 ☐ Prefer not to answer

☐ 1 ☐ >6 ☐ Do not know

31. Community Treatment Orders:*

☐ Issued CTO ☐ No CTO ☐ Prefer not to answer ☐ Do not know

32. Diagnostic Categories (select all that apply)* **Source of Diagnosis (select one):**

☐ Neurodevelopmental Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Schizophrenia Spectrum and Other Psychotic Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Bipolar and Related Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Depressive Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Anxiety Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Obsessive-Compulsive and Related Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Trauma- and Stressor-Related Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Dissociative Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Somatic Symptom and Related Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Feeding and Eating Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Elimination Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Sleep-Wake Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Sexual Dysfunctions	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Gender Dysphoria	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Disruptive, Impulse-Control, and Conduct Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Substance-Related and Addictive Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Neurocognitive Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Personality Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Paraphilic Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Other Mental Disorders	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both
☐ Medication-Induced Movement Disorders and Other Adverse Effects of Medication	☐ Self-reported	☐ Diagnosing Practitioner	☐ Both

☐ Not Applicable

☐ Prefer not to answer

☐ Do not know

33. Do you have any of the following disabilities? (select all that apply)*

☐ Chronic Illness

☐ Drug or Alcohol Dependence

☐ Mental Illness

☐ Sensory Disability (i.e. hearing or vision loss)

☐ Prefer not to answer

☐ Do not know

☐ Development Disability

☐ Learning Disability

☐ Physical Disability

☐ None

☐ Other (Please specify): _____

**** Mandatory fields***

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

☐ No formal schooling
☐ Some elementary/junior high school
☐ Elementary/junior high school
☐ Some secondary/high school
☐ Secondary/high school
☐ Some college/university
☐ College/university
☐ Prefer not to answer
☐ Do not know

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

☐ Employment
☐ Employment insurance
☐ Pension
☐ ODSP
☐ Social assistance
☐ Disability assistance
☐ Family
☐ No source of income
☐ Other _____
☐ Prefer not to answer
☐ Do not know

36. What is your total family income before taxes last year? (Select One)*

☐ $0 – $19,999
☐ $20,000 – $29,999
☐ $30,000 - $59,999
☐ $60,000 - $ 89,999
☐ $90,000 - $119,999
☐ $120,000 - $149,999
☐ $150,000 or more
☐ Prefer not to answer
☐ Do not know

37. How many people does this income support?*

_____ **person(s)** ☐ Prefer not to answer ☐ Do not know

38. Presenting Issues (select all that apply)*

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

39. General Comments:

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

**** Mandatory fields***