

# **Activities for Core OCAN Training Session**

**ONTARIO COMMON ASSESSMENT OF NEED  
(OCAN)**

These educational materials and the information contained herein are protected by the Copyright Act and are owned by the Ministry of Health and Long Term Care (MOHLTC). CCIM has obtained consent to use, copy and distribute these materials.

These educational materials are proprietary to MOHLTC and may only be copied or distributed without MOHLTC's permission solely for educational and implementation purposes, provided that: (i) this notice is reproduced on all copies, (ii) these materials are not modified in any way or republished, (iii) these materials are not provided nor distributed alone or in conjunction with any other materials, (iv) these materials are not used in a commercial manner and/or distributed for money or other consideration, and (v) these materials are not posted or transmitted on any website. Reproduction of multiple copies of these educational materials, in whole or in part for the purposes of commercial distribution is prohibited.

These educational materials are designed solely for use with the education and implementation support program provided by CMHCAP. These materials alone are not sufficient for a successful and complete OCAN implementation.

The recipient of these materials, by its/their retention and use, agrees to protect these educational materials from any loss, theft or compromise.

Under no circumstances including, but not limited to, negligence shall MOHLTC be liable for any direct, indirect, special, punitive, incidental, or consequential

# Table of Contents

<b>Activities for Core OCAN Training Session .....</b>	<b>4</b>
<b>a) Community Introductions .....</b>	<b>4</b>
Community Introductions Worksheet.....	5
<b>b) Getting to Know You Bingo .....</b>	<b>6</b>
Getting to Know You Bingo .....	7
<b>c) Introduce Your Partner .....</b>	<b>8</b>
<b>Activity #1 Mental Health Functional Centre Use .....</b>	<b>9</b>
Scenario 1: Hospital ACT Team .....	10
<b>Activity #2 Housing definition.....</b>	<b>11</b>
<b>Activity #3 Develop an understanding of consumer’s situation using Core OCAN.....</b>	<b>12</b>
CORE OCAN.....	13

## Activities for Core OCAN Training Session

Icebreakers	Title	Duration	Group Size	Optional
a)	Community Introductions	30 minutes	12 or less participants	Yes
b)	Getting to know you Bingo	20 minutes	15-30 participants	Yes
c)	Community Introductions	20+ minutes	any size	Yes

Activities	Title	Duration	Group Size	Optional
1)	Mental Health Functional Centre Use	30 minutes	Small groups of 2 -4 or one large group working together	No
2)	Housing Definition	10-15 minutes	Small groups of 2 -4 or one large group working together	No
3)	Develop an understanding of a consumer's situation using Core OCAN	60 minutes including debrief	Small groups of 2 -4	No

### a) Community Introductions

<b>Intent</b>	Community introductions are intended to involve the entire group of participants in the introduction of their classroom colleagues. People will learn many things about their group members depending on the type of question they ask. This is a great activity to debrief around questioning styles.
<b>Duration</b>	30 minutes
<b>Group size</b>	Due to the rather long debrief for this activity, it's recommended for group sizes up to 12 participants.
<b>Materials</b>	Community Introductions Worksheet (see next page) Participants will need paper / pens to record answers Name tags will help for participants who do not know each other
<b>How to facilitate</b>	Participants will ask questions of each of their colleagues, and there are three rules: <ol style="list-style-type: none"> <li>1. participants cannot answer a question they've already answered</li> <li>2. participants cannot give more information than is asked in the question</li> <li>3. questions must be open-ended, not yes/no questions</li> </ol>
<b>Debrief</b>	What were some of the challenges of this exercise? What were some of the benefits of this exercise?



## b) Getting to Know You Bingo

<b>Intent</b>	Get to know you Bingo is a game designed to introduce you to other workshop participants in a fun way. It works well even when you may already know the participants because you'll get to learn something new about your colleagues.
<b>Duration</b>	Allow the participants 10-15 minutes to get the information or until someone yells "Bingo." Debrief, if used, can take 5 minutes.
<b>Group size</b>	The best group size for Get to know you Bingo is 15 – 30 participants.
<b>Materials</b>	Bingo sheets (see next page) Pens, markers or pencils Room to move around & mingle
<b>How to play</b>	Each participant receives a bingo sheet. At the start of the game, participants get up and walk around the room introducing themselves to others and finding out whether people fit into the categories on the bingo form. Winning the game is at the discretion of the facilitator. For smaller groups winning can be just one completed line, horizontal, vertical or diagonal. Or, you can allow participants to record a person's name more than once. For larger groups, filling the whole sheet will allow participants to meet more in the group. Consider not allowing participants to record a name more than once. The winner yells "Bingo" and will read back their winning results. The group will verify if the results are correct. Consider offering a token prize for the winner.
<b>Debrief</b>	What were some of the challenges of this exercise? What were some of the benefits of this exercise?

## Getting to Know You Bingo

_____ had cereal for breakfast this morning	_____ traveled out of the country this past summer	_____ likes to watch television	_____ enjoys math	_____ rides a bike for exercise
_____ can speak more than 2 languages	_____ likes to play board games	_____ has an older sister	_____ is a really good cook	_____ likes the rain
_____ is afraid of spiders	_____ has a birthday in December	_____ would like to win one million dollars	_____ likes to play soccer	_____ can drive a motorcycle
_____ does not like candy	_____ can tap dance	_____ has been married for more than 2 years	_____ can play the piano	_____ has read all of the Harry Potter books
_____ would like to travel to France	_____ owns a pet bird	_____ does not like shopping	_____ can juggle	_____ is wearing something purple

## c) Introduce Your Partner

<b>Intent</b>	Introduce your partner is an ideal activity for a group with even or odd numbers of participants. The intent is to get to know some key information about one or two people in close proximity to you. This icebreaker works best when the participants don't know each other or they come from different HSPs.
<b>Duration</b>	Depending on the group size and debrief, this activity can take 20 minutes or longer.
<b>Group size</b>	Any size of group is fine. Debrief can be time consuming depending on the amount of information to be presented or the size of the group. If it is a particularly large group, choose one interesting fact to introduce your partner.
<b>Materials</b>	Flipchart / markers (optional)
<b>How to facilitate</b>	<p>Ask the participants to break into pairs. If there is an odd number in your group, there may be one group of 3 participants. Depending on the information that's important to gather, consider having participants answer the following questions from their partner:</p> <ul style="list-style-type: none"> <li>- person's name</li> <li>- HSP or department / program name</li> <li>- length of time with the HSP</li> <li>- most memorable moment at work</li> <li>- most memorable moment not at work</li> <li>- something unique about the person</li> <li>- background / experience with training others</li> </ul> <p>To assist with memory, you may write these questions on a flipchart or whiteboard. The facilitator will ask the partners to introduce each other.</p>
<b>Debrief</b>	<p>What were some of the considerations in sharing the information about your partner with the larger group?</p> <p>What were some of the challenges of this exercise?</p> <p>What were some of the benefits of this exercise?</p>



## Activity #1 Mental Health Functional Centre Use

<b>Intent</b>	To give learners the opportunity to practice completing Part 5 of the Core OCAN, “Mental Health Functional Centre Use (for the last 6 months)” with information collected from a fictional scenario.
<b>Duration</b>	30 minutes
<b>Group size</b>	This activity can be conducted with small break-out groups of 2 to 4, or as a bigger group working together.
<b>Materials</b>	Copy of scenario for each learner and partially completed Mental Health Functional Centre Use form (see next page)
<b>How to facilitate</b>	<p>Explain the instructions for the activity to the group</p> <p>Set the time for completion</p> <p>Read the scenario out loud to the entire group</p> <p>Walk around the groups, if you’ve broken out into smaller work groups, provide assistance where necessary</p> <p>Provide correct answers and debrief with the larger group</p>
<b>Scenario 1</b>	<p><b>Hospital ACT Team</b></p> <p>You are a program coordinator for an ACT team at a local hospital where your main role is determining who may qualify for the program. You have just received a referral from a family physician at The University of Degrossi’s Student Health Services referring Natasha J. to your program on February 11, 2009. You are swamped with work today and put the referral in the “To Do” pile for the next day.</p> <p>After carefully reviewing Natasha’s referral, you accept her into your program and set up her first appointment for March 3, 2009 at 0900hrs.</p>

## Scenario 1: Hospital ACT Team

You are a program coordinator for an ACT team at a local hospital where your main role is determining who is suitable for the program. You have just received a referral from a family physician at The University of Degross's Student Health Services referring Natasha J. to your program on February 11, 2009. You are swamped with work today and put the referral in the "To Do" pile for the next day.

After carefully reviewing Natasha's referral, you accept her into your program and set up her first appointment for March 3, 2009 at 0900hrs.

Mental Health Functional Centre 1	
OCAN Lead:*	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Staff Worker Name:*	
Staff Worker Phone Number:*	Ext:
Organization LHIN:*	6
Organization Name:*	New City Hospital
Organization Number:*	000
Program Name:*	New City ACT Team
Program Number:*	1111
Functional Centre Name:*	Clinic/Program - MH Assertive Community Treatment Teams
Functional Centre Number:	715 10 76 20
Service Delivery LHIN:*	6
Referral Source:*	Family Physician
Request for Service Date (YYYY-MM-DD):	2009-02-11
Service Decision Date (YYYY-MM-DD):	2009-02-12
Accepted:	Yes
Service Initiation Date (YYYY-MM-DD):	2009-03-03
Exit Date (YYYY-MM-DD):	(don't know at this time)
Exit Disposition:	(don't know at this time)

Notes:

---

---

---

## Activity #2 Housing definition

<b>Intent</b>	To give learners the opportunity to practice referencing the user manual for definitions to complete item #23 of the Core OCAN.
<b>Duration</b>	10-15 minutes
<b>Group size</b>	This activity can be conducted with small break-out groups of 2 to 4, or one large group working together
<b>Materials</b>	User manual for each learner Copy of scenarios to complete for each learner Copy of User Reference Guide
<b>How to facilitate</b>	Explain the instructions for the activity to the group Have the large group break out into smaller groups of 2-4 Read the scenario out loud to the group Direct learners to the user manual to complete the activity while referencing the User Reference Guide Stress why its important to be familiar with standardized definitions in the User Reference Guide
<b>Instructions</b>	Refer to the User Reference Guide to identify the housing type in each of the following scenarios
<b>Scenario 1</b>	Joe is new to your HSP and you learn about various parts of his life. Among the details you hear, Joe tells you that he lives with his parents in their home and does not pay rent.  <i>What is the Housing Type in this situation?</i>
<b>Answer Key</b>	Accommodation – Private House/Apt. – Other/Subsidized
<b>Scenario 2</b>	Susan has been in your HSP for several years. You are now completing a Core OCAN in your HSP. Susan Lives in Valley View Adult Care facility which is funded by the municipality and privately owned and operated  <i>What is the Housing Type in this situation?</i>
<b>Answer Key</b>	Domiciliary Hostel – Municipal funded, privately owned and operated accommodation providing room and board.  Note: while this may not be common, this provides the participants an opportunity to look up definitions.

## Activity #3 Develop an understanding of consumer's situation using Core OCAN

<b>Intent</b>	To give learners the opportunity to interpret Core OCANs they might receive and to gain a better understanding of the importance of completing Core OCAN accurately.
<b>Duration</b>	60 minutes including debrief
<b>Group size</b>	This activity can be conducted with small break-out groups of 2 to 4, debrief in a larger group.
<b>Materials</b>	Copy of complete Core OCAN Paper to record notes
<b>How to facilitate</b>	Explain the instructions for the activity to the group Have the large group break out into smaller groups of 2-4 Set time limit Move about room to provide assistance if needed Read the instructions out loud to the entire group
<b>Instructions</b>	Review the completed Core OCAN provided in a small group. Discuss the information and what the client profile might be. Report back to the large group your understanding of the consumer's situation.
<b>Answer key</b>	<p>The scenario points us to the following assumptions:</p> <p>Tiffany is a young woman of mixed racial background. She does not feel comfortable in giving a great deal of information. We estimate her age to be in the early thirties. She presents to the sandy Hill Community Mental Health Center asking for assistance in getting off the streets. She is from Northern Canada (Yukon), having come to Ottawa about a year ago. She has an elderly grandmother in Ottawa.</p> <p>She does not have a family doctor, and does not share any information about a psychiatrist. She does not mention having connection with any other services in Ottawa at this time.</p> <p>She does not have a Power of Attorney, and indicated she has no concerns about her own capacity to manage her own affairs.</p> <p>Tiffany does share that she has had 'problems' with drugs for about 10 years, she does not want to tell any details of this and came to this HSP asking specifically to get help with finding a place to live and any other help that she would be able to get from the service.</p> <p>She has family in the Yukon, and her mother's family is aboriginal.</p>

## **CORE OCAN**

### **Using CORE OCAN**

This agency is using the Core OCAN which comprises only the Consumer Information Summary and Service Use and not the Consumer Self-Assessment or Staff Assessment parts of OCAN. The Core OCAN captures the information that this agency reports as a community mental health service provider.

Start Date (YYYY-MM-DD)\*: 2010-09-13

### Consumer Information Summary

#### 1. OCAN Lead Assessment

OCAN completed by OCAN Lead?\*  Yes  No

#### 2. Reason for OCAN (select one)\*

- Initial OCAN  Review  
 Reassessment  Re-key  
 (Prior to) Discharge  Other (e.g., consumer request) \_\_\_\_\_  
 Significant change

#### 3. Consumer Information

First Name: \_\_\_\_\_ Date of Birth (YYYY-MM-DD):\*1981-06-19  Estimate  
Middle Initial: \_\_\_\_\_  Unknown  
Last Name: \_\_\_\_\_ Health Card Number: 234-567-890  
Preferred Name: **Tiffany** Version Code: **RL**  
Address: \_\_\_\_\_ Issuing Territory: **Yukon**  
City: \_\_\_\_\_ Service Recipient Location (county, district, municipality):\***Ottawa**  
Province: \_\_\_\_\_ LHIN Consumer Resides in: \* **Champlain**  
Postal Code: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Ext: \_\_\_\_\_  
Email Address: \_\_\_\_\_

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

#### 3c. Marital Status (select one)

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

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

##### Mental Health Functional Centre 1

OCAN Lead:\*  Yes  No  
Staff Worker Name:\* Susan Smith  
Staff Worker Phone Number:\* 613-777-1111 Ext: 1237  
Organization LHIN:\* Champlain  
Organization Name:\* Sandy Hill Community Health Centre  
Organization Number:\* 00000  
Program Name:\* Peer Support  
Program Number:\* 01234  
Functional Centre Name:\*  
Functional Centre Number:\*  
Service Delivery LHIN:\* Champlain

##### Mental Health Functional Centre 2

OCAN Lead:\*  Yes  No  
Staff Worker Name:\*  
Staff Worker Phone Number:\* Ext:  
Organization LHIN:\*  
Organization Name:\*  
Organization Number:\*  
Program Name:\*  
Program Number:\*  
Functional Centre Name:\*  
Functional Centre Number:\*  
Service Delivery LHIN:\*

<b>Referral Source:* Self</b> <b>Request for Service Date (YYYY-MM-DD): 2010-09-13</b> <b>Service Decision Date (YYYY-MM-DD): 2010-09-13</b> <b>Accepted:</b> <b>Service Initiation Date (YYYY-MM-DD): 2010-09-13</b> <b>Exit Date (YYYY-MM-DD):</b> <b>Exit Disposition:</b>	<b>Referral Source:*</b> <b>Request for Service Date (YYYY-MM-DD):</b> <b>Service Decision Date (YYYY-MM-DD):</b> <b>Accepted:</b> <b>Service Initiation Date (YYYY-MM-DD):</b> <b>Exit Date (YYYY-MM-DD):</b> <b>Exit Disposition:</b>
<b>Mental Health Functional Centre 3</b>	<b>Mental Health Functional Centre 4</b>
<b>OCAN Lead:*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Staff Worker Name:*</b> <b>Staff Worker Phone Number:*</b> <b>Ext:</b> <b>Organization LHIN:*</b> <b>Organization Name:*</b> <b>Organization Number:*</b> <b>Program Name:*</b> <b>Program Number:*</b> <b>Functional Centre Name:*</b> <b>Functional Centre Number:*</b> <b>Service Delivery LHIN:*</b> <b>Referral Source:*</b> <b>Request for Service Date (YYYY-MM-DD):</b> <b>Service Decision Date (YYYY-MM-DD):</b> <b>Accepted:</b> <b>Service Initiation Date (YYYY-MM-DD):</b> <b>Exit Date (YYYY-MM-DD):</b> <b>Exit Disposition:</b>	<b>OCAN Lead:*</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Staff Worker Name:*</b> <b>Staff Worker Phone Number:*</b> <b>Ext:</b> <b>Organization LHIN:*</b> <b>Organization Name:*</b> <b>Organization Number:*</b> <b>Program Name:*</b> <b>Program Number:*</b> <b>Functional Centre Name:*</b> <b>Functional Centre Number:*</b> <b>Service Delivery LHIN:*</b> <b>Referral Source:*</b> <b>Request for Service Date (YYYY-MM-DD):</b> <b>Service Decision Date (YYYY-MM-DD):</b> <b>Accepted:</b> <b>Service Initiation Date (YYYY-MM-DD):</b> <b>Exit Date (YYYY-MM-DD):</b> <b>Exit Disposition:</b>
<b>5. Family Doctor Information</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> None available <input type="checkbox"/> Consumer declined to answer <input type="checkbox"/> Unknown	
Name:	Address:
Phone Number:	City:
Ext:	Province:
Email Address:	Postal Code:
Last seen:	
<b>6. Psychiatrist Information</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> None available <input checked="" type="checkbox"/> Consumer declined to answer <input type="checkbox"/> 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: Significant Other

Name: **Genevieve Kentillia (grandmother)**

Address: **Thorwood Place Retirement**

Phone Number: **613-555-1111**

City: **Ottawa**

Ext:

Province: **Ontario**

Email Address:

Postal Code:

Last seen: **2009-12-25**

**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	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Consumer declined to answer	<input type="checkbox"/> Unknown
Name:				
Address:				
Phone Number:		Ext:		
9d. Areas of concern				
Finance/property:	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Unknown	
Treatment decisions:	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	<input type="checkbox"/> Unknown	
10. Age in years for onset of mental illness: 10	<input checked="" type="checkbox"/> Estimate	<input type="checkbox"/> Consumer declined to answer	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A
11. Age of first psychiatric hospitalization:	<input type="checkbox"/> Estimate	<input checked="" type="checkbox"/> Consumer declined to answer	<input type="checkbox"/> Unknown	<input type="checkbox"/> N/A
12. Date when consumer first entered your organization (YYYY-MM): 2010-09-10	<input type="checkbox"/> Estimate	<input type="checkbox"/> Consumer declined to answer	<input checked="" type="checkbox"/> Unknown	<input type="checkbox"/> N/A
13. What culture do you (consumer) identify with? Mixed ethnic group				
14. Aboriginal Origin (select one)* <input checked="" type="checkbox"/> Aboriginal <input type="checkbox"/> Non-aboriginal <input type="checkbox"/> Consumer declined to answer <input type="checkbox"/> Unknown				
15. Citizenship Status (select one) <input checked="" type="checkbox"/> Canadian citizen <input type="checkbox"/> Temporary resident <input type="checkbox"/> Consumer declined to answer <input type="checkbox"/> Permanent resident <input type="checkbox"/> Refugee <input type="checkbox"/> Unknown				
16. Length of time lived in Canada (number of years/months): 29 years				
17. Service recipient preferred language:* English				
18. Language of service provision:* English				
19. Do you currently have any legal issues? (select one)* <input type="checkbox"/> Civil <input type="checkbox"/> Criminal <input type="checkbox"/> None <input checked="" type="checkbox"/> Consumer declined to answer <input type="checkbox"/> Unknown				
20. Current Legal Status (select all that apply)				
<b>Pre-Charge</b>		<b>Outcomes</b>		
<input type="checkbox"/> Pre-charge diversion		<input type="checkbox"/> Charges withdrawn		
<input type="checkbox"/> Court diversion program		<input type="checkbox"/> Stay of proceedings		
<b>Pre-Trial</b>		<input type="checkbox"/> Awaiting sentence		
<input type="checkbox"/> Awaiting fitness assessment		<input type="checkbox"/> NCR		
<input type="checkbox"/> Awaiting trial (with or without bail)		<input type="checkbox"/> Conditional discharge		
<input type="checkbox"/> Awaiting criminal responsibility assessment (ncr)		<input type="checkbox"/> Conditional sentence		
<input type="checkbox"/> In community on own recognizance		<input type="checkbox"/> Restraining order		
<input type="checkbox"/> Unfit to stand trial		<input type="checkbox"/> Peace bond		
		<input type="checkbox"/> Suspended sentence		
<b>Custody Status</b>		<b>Other</b>		
<input type="checkbox"/> ORB detained – community access		<input type="checkbox"/> No legal problem (includes absolute discharge and time served – end of custody)		
<input type="checkbox"/> ORB conditional discharge				

<input type="checkbox"/> On parole <input type="checkbox"/> On probation	<input checked="" type="checkbox"/> Consumer declined to answer <input type="checkbox"/> Unknown
<b>21. Where do you live? (select one)*</b>	
<input type="checkbox"/> Approved homes & homes for special care <input type="checkbox"/> Correctional/probation facility <input type="checkbox"/> Domicillary hostel <input type="checkbox"/> General hospital <input type="checkbox"/> Psychiatric hospital <input type="checkbox"/> Other specialty hospital <input checked="" type="checkbox"/> No fixed address <input type="checkbox"/> Hostel/shelter <input type="checkbox"/> Long term care facility/nursing home <input type="checkbox"/> Municipal non-profit housing	<input type="checkbox"/> Private non-profit housing <input type="checkbox"/> Private house/Apt. – SR owned/market rent <input type="checkbox"/> Private house/Apt. – other/subsidized <input type="checkbox"/> Retirement home/senior's residence <input type="checkbox"/> Rooming/boarded house <input type="checkbox"/> Supportive housing – congregate living <input type="checkbox"/> Supportive housing – assisted living <input type="checkbox"/> Other _____ <input type="checkbox"/> Consumer declined to answer <input type="checkbox"/> Unknown
<b>22. Do you receive any support? (select one)*</b>	
<input type="checkbox"/> Independent <input type="checkbox"/> Assisted/supported	<input type="checkbox"/> Supervised non-facility <input type="checkbox"/> Supervised facility <input checked="" type="checkbox"/> Unknown
<b>23. Do you live with anyone? (select one)*</b>	
<input type="checkbox"/> Self <input type="checkbox"/> Spouse/partner <input type="checkbox"/> Spouse/partner and others	<input type="checkbox"/> Children <input type="checkbox"/> Parents <input type="checkbox"/> Relatives <input checked="" type="checkbox"/> Unknown
<b>24. What is your current employment status? (select one)*</b>	
<input type="checkbox"/> Independent/competitive <input type="checkbox"/> Assisted/supportive <input type="checkbox"/> Alternative businesses <input type="checkbox"/> Sheltered workshop	<input type="checkbox"/> Non-paid work experience <input type="checkbox"/> No employment – other activity <input checked="" type="checkbox"/> Casual/sporadic <input type="checkbox"/> No employment of any kind <input type="checkbox"/> Consumer declined to answer <input type="checkbox"/> Unknown
<b>25. Are you currently in school? (select one)*</b>	
<input checked="" type="checkbox"/> Not in school <input type="checkbox"/> Elementary/junior high school <input type="checkbox"/> Secondary/high school <input type="checkbox"/> Trade school	<input type="checkbox"/> Vocational/training centre <input type="checkbox"/> Adult education <input type="checkbox"/> Community college <input type="checkbox"/> University <input type="checkbox"/> Other _____ <input type="checkbox"/> Consumer declined to answer <input type="checkbox"/> Unknown
<b>26. Psychiatric History</b>	
<b>26a. Have you been hospitalized due to your mental health during the past two years? (select one)*</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Consumer declined to answer <input type="checkbox"/> Unknown
<b>26b. If Yes,</b>	
<b>Total number of admissions for mental health reasons:</b>	
<i>If <u>Initial OCAN</u>, list hospital admissions for the past 2 years OR if <u>Reassessment</u>, list hospital admissions since last OCAN</i>	

**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*

**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?\***

- |                               |   |  |
|-------------------------------|---|--|
| <input type="checkbox"/> None | <input checked="" type="checkbox"/> 2 - 5 | <input type="checkbox"/> Consumer declined to answer |
| <input type="checkbox"/> 1    | <input type="checkbox"/> > 6              | <input type="checkbox"/> Unknown                     |

**28. Community Treatment Order:\***

- |                                     |  |  |                                  |
|-------------------------------------|--|--|----------------------------------|
| <input type="checkbox"/> Issued CTO | <input checked="" type="checkbox"/> No CTO | <input type="checkbox"/> Consumer declined to answer | <input type="checkbox"/> 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.*

- |  |  |
|--|--|
| <input type="checkbox"/> Adjustment disorders                                    | <input checked="" type="checkbox"/> Mood disorder                    |
| <input type="checkbox"/> Anxiety disorder  | <input type="checkbox"/> Personality disorders                       |
| <input type="checkbox"/> Delirium, dementia, and amnesic and cognitive disorders | <input type="checkbox"/> Schizophrenia and other psychotic disorders |
| <input type="checkbox"/> Developmental handicap                                  | <input type="checkbox"/> Sexual and gender identity disorders        |
| <input type="checkbox"/> Disorder of childhood/adolescence                       | <input checked="" type="checkbox"/> Sleep disorders                  |
| <input type="checkbox"/> Dissociative disorders                                  | <input type="checkbox"/> Somatoform disorders                        |
| <input type="checkbox"/> Eating disorders  | <input checked="" type="checkbox"/> Substance related disorders      |
| <input type="checkbox"/> Factitious disorders                                    | <input type="checkbox"/> Intellectual disability or impairment       |
| <input type="checkbox"/> Impulse control disorders not elsewhere classified      | <input type="checkbox"/> Consumer declined to answer                 |
| <input type="checkbox"/> Mental disorders due to general medical conditions      | <input type="checkbox"/> Unknown                                     |

**30. Other Illness Information (select all that apply)**

- |  |   |
|--|---|
| <input type="checkbox"/> Concurrent disorder (substance abuse)     | <input checked="" type="checkbox"/> Other chronic illnesses |
| <input type="checkbox"/> Dual diagnosis (developmental disability) | <input type="checkbox"/> Other physical disabilities        |

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

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> No formal schooling                | <input checked="" type="checkbox"/> Some secondary/high school | <input type="checkbox"/> College/university          |
| <input type="checkbox"/> Some elementary/junior high school | <input type="checkbox"/> Secondary/high school                 | <input type="checkbox"/> Consumer declined to answer |

<input type="checkbox"/> Elementary/junior high school	<input type="checkbox"/> Some college/university	<input type="checkbox"/> Unknown
<b>32. What is your primary source of income? (select one)*</b>		
<input type="checkbox"/> Employment	<input checked="" type="checkbox"/> Social assistance	<input type="checkbox"/> Other _____
<input type="checkbox"/> Employment insurance	<input type="checkbox"/> Disability assistance	<input type="checkbox"/> Consumer declined to answer
<input type="checkbox"/> Pension	<input type="checkbox"/> Family	<input type="checkbox"/> Unknown
<input type="checkbox"/> ODSP	<input type="checkbox"/> No source of income	
<b>33. Presenting Issues*</b>		
<input type="checkbox"/> Activities of daily living	<input type="checkbox"/> Problems with addictions	
<input type="checkbox"/> Attempted suicide	<input type="checkbox"/> Problems with relationships	
<input type="checkbox"/> Educational	<input checked="" type="checkbox"/> Problems with substance abuse	
<input type="checkbox"/> Financial	<input checked="" type="checkbox"/> Sexual abuse	
<input checked="" type="checkbox"/> Housing	<input type="checkbox"/> Specific symptom of serious mental illness	
<input type="checkbox"/> Legal	<input type="checkbox"/> Threat to others	
<input type="checkbox"/> Occupational/employment/vocational	<input checked="" type="checkbox"/> Threat to self	
<input type="checkbox"/> Physical abuse	<input type="checkbox"/> Other _____	
<b>34. Comments: Tiffany was not comfortable talking about many issues. We will help her to find housing, supply her with clothing from the clothing room and we have invited her to attend the lunch program.</b>		

Completion Date (YYYY-MM-DD)\*: 2010-09-13