RETURN TO SPORT

MENTAL HEALTH DISORDER GUIDELINE

GAME PLAN
PLAN DE MATCH

WHAT IS THIS GUIDELINE?

This guideline is to provide a tool to assist in the stepwise return to the competitive and daily training environment following a mental health condition identified in the team environment or disclosed to team support members by the athlete. The safety and well-being of the athlete remain paramount. The guideline must remain flexible according to the athlete's progress and feedback. Each step must be individualized and managed on a case-by-case basis according to medical recommendations.

As a general rule, the plan and progression are communicated to coaches and/or support staff by the team physician with the athlete's consent. The coach and support staff should contact the team physician for any questions about the process. For legal liability, a physician is the only person who may remove an athlete from sport or provide medical clearance for an athlete to return to sport - this should be done in consultation with the Athlete and their support team. If a team physician is unavailable, the athlete's family physician or treating physician (i.e., psychiatrist) will be responsible for clearance. If the mental performance consultant and licensed mental health provider for a team are the same person (i.e., dually credentialled) it is critical to ensure the roles are delineated and separate when considering a return to sport. Yielding to the higher duty of care is required.

The first step is recognizing an athlete's deteriorating mental health status (moving from green to orange or red on the mental health continuum—see next page). This recognition could be by the athlete themselves or any team member (e.g., teammate, staff, etc.), who should then alert the team physician. The aim is early recognition to maintain the athlete in the environment if appropriate.

TERMS

Activities of Daily Living (ADLs): A term used to collectively describe fundamental skills required to independently care for oneself, such as mobility, eating, dressing, personal hygiene, continence, bathing, and toileting.

Mental Resilience: The role of mental processes and behaviour in promoting personal assets and protecting an individual from the potential negative effect of stressors[1].

Competitive Environment: Where athletes compete; refers to the settings and conditions under which sports competitions take place.

Integrated Support Team: The members of the integrated support team (IST) that are actively involved in returning the athlete to performance, which can include the athlete's treating team as well as their physiotherapist or athletic therapist, massage therapist, strength and conditioning personnel, and mental performance consultant.

Psychological Safety: A climate where individuals feel safe to take interpersonal risks, be their authentic selves, and express themselves freely without fear of repercussions[2,3].

Recovery: The process of returning to a normal or healthy state (mentally, physically and physiologically).

REDs: Relative Energy Deficiency in Sport

Regular Field of Play: The normal competition environment and competition conditions.

Sport Performance Environment: The high-performance training and competition environment.

Team Environment: This includes the training space (gym and sport specific), change room, and team-sanctioned events.

Treating Team or Medical Team: The members of the health care team that are actively involved in treating the *mental health injury* which can include the athlete's physician (either team physician, external sport medicine physician, and/or family physician), psychologist, psychiatrist or other licensed mental health provider. These may also be members of the IST.

[1] Fletcher D., Sarkar M. (2012). A grounded theory of psychological resilience in Olympic champions. *Psychology of Sport and Exercise, 13,* 669–678.

[2] Kahn, W. A. (1990). Psychological conditions of personal engagement and disengagement at work. *Academy of management journal, 33(4),* 692-724.

[3] Edmondson, A. (2011). Psychological Safety, Trust, and Learning in Organizations: A Group-level Lens. *Trust and Distrust in Organizations: Dilemmas and Approaches.*

CONTINUUM OF MENTAL HEALTH INDICATORS AND RESOURCES

	HEALTHY	REACTING	INJURED	ILL
INDICATORS	• Normal fluctuations in mood • Normal sleep patterns • Full of energy • Consistent performance • Normal social activity • Limited or no alcohol use or gambling	• Nervousness, irritability sadness • Trouble sleeping, nightmares • Intrusive thoughts • Tired or low energy • Procrastination • Decreased social activity • Regular but controlled use of alcohol or gambling	• Anxiety, anger, pervasive sadness, hopelessness • Restless or disturbed sleep, recurrent nightmares • Low or no energy • Decreased performance, presenteeism • Social avoidance or withdrawal • Increased alcohol use, substance use, or gambling	• Excessive anxiety • Depression • Self harm, suicidal thoughts and intentions • Unable to fall or stay asleep • No energy • Unable to perform duties, absenteeism • Isolation, avoiding social events • Frequent alcohol use, substance use, or gambling
ACTIONS TO TAKE	• Focus on task at hand • Break problems into manageable chunks • Identify and nurture support systems • Maintain healthy lifestyle	• Recognize limits • Get adequate rest and nutrition • Engage in healthy coping strategies • Identify and minimize stressors	• Identify and understand your own signs of distress • Talk with someone • Seek help • Seek social support	• Seek professional help • Follow healthcare provider recommendations • Regain physical and mental health
WHO CAN HELP	• Your **Game Plan Advisor** • Mental Performance Consultant (MPC)	• Mental Performance Consultant (MPC) • Counsellor • Psychotherapist • Your **Game Plan Advisor** • Your COPSIN Mental Health Lead	• Team, Family, or Treating Physician • Clinical or Registered Psychologist • Counsellor • Psychotherapist • Social Worker • Your COPSIN Mental Health Lead	• Team, Family, or Treating Physician • Clinical or Registered Psychologist • Counsellor • Psychotherapist • Social Worker • Your COPSIN Mental Health Lead
RESOURCES AVAILABLE	**WorkLife Services** Follow **this link** and enter the credentials below: • Username: TeamCanada • Password: lifeworks Qualified mental health service providers and self-directed resources offer support with mental, financial and emotional wellbeing.	**EAP Services** Care Access Centre - Professional EAP Counselling Services Available 24/7, 365 days a year. • Call 1.844.240.2990 Clinical Services are delivered through various modalities such as Face-to-Face, Telephone, Video, Chat/Instant Messaging, Online Group Counselling, or Self-Directed. **Book services online.** **AbilitiCBT App**	**Connect with a mental health practitioner who knows sport:** Email the Mental Health Coordinator: **mentalhealth@mygameplan.ca** • Confidential • Secure • $2,500 of coverage / year **What to expect**	**If it's an emergency:** **Crisis Services Canada** 24-hour line: • Call: 1-833-456-4566 • Text: 45645 • 9-1-1 **If it's not an emergency:** Email the Mental Health Coordinator: **mentalhealth@mygameplan.ca** • Confidential • Secure • $2,500 of coverage / year

IT IS IMPORTANT TO NOTE:

1. "Recovery" often has an up-and-down (relapsing-remitting) course in individuals with mental health disorders.
2. Stigma and shame can play a significant role and thus athletes might not want their health status disclosed in the team environment.
3. Individuals may lack insight into their mental health concerns, which can add complexity to the recognition and awareness of one's mental status.

GENERAL INSTRUCTIONS

This guideline is a guide for a gradual return to the competitive environment following mental health symptoms that interfere with functioning, ranging from inability to cope with psychosocial stressors to more severe emotional dysregulation or any diagnosed mental health disorder. It must remain flexible according to the athlete's progress and feedback. Each stage must consider the principles of "Safety, Stability, and Function," and be individualised and managed on a case-by-case basis by the lead indicated (Edwards, 2023). This guideline is not for use in athletes with eating disorders or severe REDs.

The team physician (or treating physician where no team physician is available) will liase and communicate with the treating team and will communicate the information in the plan to the stakeholders(s) and/or coach(es). The coach is to liaise directly with the team physician (or treating physician) with any questions regarding the process.

At each stage, the medical team develops an individualized return plan (Appendix 2). It is strongly recommended that regular follow-up/feedback meetings between the team physician (or treating physician) and coach(es) be established to re-adjust the plan as needed.

The medical team at the heart of guideline management consists of the team physician (or treating physician) and others in the athlete's circle of care, including licensed mental health providers. The medical team can adjust the plan as the athlete progresses. While respecting the bounds of confidentiality, close collaboration and ongoing communication are essential between the team (or treating) physician, athlete, licensed mental health providers, and any external healthcare providers.

The duration of each step varies from one week to several weeks, depending on the athlete's mental status and improvement. To move to the next stage, athletes must meet the "Progression Criteria" from the previous stage.

The exact duration of this guideline *cannot be predicted*. Regular medical team follow-up is compulsory throughout this progression.

It is possible for the athlete to experience anxiety during progression. Given the variety of factors that can impact one's mental health, it is expected that athletes might regress to a previous stage after meeting the Progression Criteria. If there is a sustained change from green to orange or red on the mental health continuum, the return to sport plan must be revisited (and potentially altered) with the team or treating physician. Information gathered from the athlete regarding where they are on the mental health continuum can be used to modify and optimize the return to sport plan. High recurrence rates can be seen within three months post-hospitalization in athletes with bipolar disorder and/or in athletes with a history of maltreatment, post-treatment residual symptoms, or a history of previous recurrence after RTP. Athletes with these histories might need a more gradual return to sport plan.

STEP 1

Step one, through mental health observation, is the recognition of mental status change or distress by the athlete, coach, staff, or team (the athlete may enter the guideline in the orange or red zone). Assessment of the athlete by team physician and/or external treating physician, as indicated.

STEP 2

Step two represents managing the current situation, supporting the athlete in finding their bearings and assuring a safe environment. This step emphasizes the safety and well-being of the athlete in their living environment.

STEPS 3 & 4

Steps three and four enable the athlete to resume physical activity, focusing primarily on well-being, mental health recovery and routine(s) within the performance environment. This step emphasizes a gradual return to team-based training and resuming contact with the team while maintaining a psychologically safe environment that promotes mental wellness.

The plan will consider several training elements/variables such as (but not limited to)

- Number of training sessions per day and week.
- Duration of training sessions.
- Type of training.
- Training time (AM, PM).
- Presence of stressors.

The athlete and their medical team identify stressors and facilitators for mental health. Subsequently, in this phase, the individuals responsible for coaching or support staff might differ from those before removal from the team environment.

Training may take place outside the performance training area.

Any adjustments to the plan requested by the coach or support staff [*i.e. mental performance consultant (MPC), strength and conditioning coach (S&C) Coach]* must be approved by the team or treating physician.

STEP 5

Step five involves a return to the sport performance environment and the regular field of play, with the integration of IST team members and regular coaches.

The plan will consider several training elements and variables such as (but not limited to):

- Number of training sessions per day and per week.
- Duration of training sessions.
- Type of training.
- Training time (AM, PM).
- Presence or absence of stressors.

The integrated support team (IST) will oversee the training on the field of play while maintaining a psychologically safe environment that promotes mental wellness.

At this stage, the coach becomes more involved in planning. The coach may guide the daily routine and determine the training plan. **However, the team physician (or treating physician) remains the lead.**

The team or treating physician must approve any requested adjustments to the plan. Regular communication between the coach responsible for the athlete, the support staff, and the team physician is critical.

Given the increased load of stressors, the athlete must maintain medical follow-up (every one to two weeks) to ensure continued recovery and detection of any deterioration in mental status.

STEP 6

Step six starts when the athlete can return to the competition environment without restrictions. Despite recovery, medical and/or psychotherapeutic support may still be required.

To reach step six, an athlete must have completed all the previous steps, maintained their mental health status, and tolerated the stressors of the competitive environment.

GUIDELINE

An athlete can enter into the recommended guideline at different steps. It is vital to remember that the IST, coaches, or other staff may not know about critical cases due to confidentiality and the potential lack of services available within the team. It is also possible that, at the clinical discretion of the athlete's treating physician, not all steps will be required for each athlete.

STEP 1 MEDICAL AND PSYCHOLOGICAL ASSESSMENT

Disclosure by athletes of a mental health status change and/or distress and/or team recognition of mental health status change and/or distress through regular Mental Health Surveillance.

- Objective assessment of mental health status via the SMHAT.
- Determination of the severity of the athlete's level of distress.
- Determination of UCCMS or safe-sport issues contributing to athlete distress.
- Decision on remaining in or removing from the training environment based on safety, stability, and function.

STEP 2 SPORT REMOVAL (SEE REMOVAL FROM SPORT GUIDELINE)

Lead: Team or treating physician.
Engaged parties: The athlete, team physician, and the athlete's medical circle of care, including any licensed mental health provider.
Duration: Minimum two to four weeks.
Frequency of medical follow-up: Once a week.

2-A Acute crisis period. Management will depend on specific signs and symptoms. Once the team or treating physician deems no acute safety concerns, the athlete may enter stage 2-B.

2-B Return to activities of daily living (ADL), including exercise outside the training/team environment.

Progression Criteria from Step 2 to Step 3:

- There are no safety issues preventing a return to the team environment.
- There are no safe-sport restrictions on returning to the team environment.
- Athlete is stable and able to manage ADLs consistently without significant deterioration of mental status.
- Athlete feels ready to manage the stressors of the team environment.
- The team or treating physician has provided written medical clearance to progress based on safety, stability and function. Some key considerations for RTP planning can be found in Appendix 3.

STEP 3 GRADUAL RETURN TO TRAINING

Lead: Team or treating physician.
Engaged parties: The athlete, team physician, licensed mental health provider, strength and conditioning coach, team coach.
Duration: Variable; allow several weeks, depending on the condition and progress of the athlete.
Frequency of medical follow-up: Once a week; may require two to three times per week if stressors are in the training environment.

- Gradual return to training and contact with the team in a psychologically safe environment.
- In certain cases where the stressor for the athlete is the training or competition environment, exposure to return to training via desensitization (grounding and self-regulation) techniques (e.g. graduated exposures to adverse weather conditions – fog, rough water, etc. – similar to those that caused PTSD or contributed to an injury) may be medically indicated.

Depending on the severity of the athlete's distress and its causes, a non-IST staff member may carry out this step. The team or treating physician will determine this in collaboration with the coach.

Progression Criteria from Step 3 to Step 4:

- The athlete has been able to maintain their mental health status in the team environment.
- The athlete feels ready to start performance-guided training again with the team and can manage the team environment's stressors.
- The team or treating physician has provided medical clearance to enter performance, team-based training based on safety, stability and function.

STEP 4 RETURN TO SUPERVISED TRAINING

Lead: Team physician*.
Engaged parties: The athlete, coach(es)**, S&C coach, nutritionist, mental performance consultant, and licensed team mental health provider.
Duration: Allow several weeks, depending on the condition and progress of the athlete.
Frequency of medical follow-up: Minimum, once a week or as indicated by the team or treating physician and/or licensed mental health provider.

- Gradual return to training in the performance environment with team members while maintaining psychological support to build mental resilience.
- Gradual return to the field of play and return to performance-driven team training with close IST support and monitoring.

Medical restrictions may still apply at this stage, and t**hey must be respected without exception.** The athlete may only proceed to this step after obtaining medical clearance (via the Appendix 1 form).

The coach becomes more involved. With input from the team physician, the coach may guide the daily routine and determine the training plan according to the athlete's physical abilities and mental status.* ***The team or treating physician remains the lead.*

***In step 4-A, due to scheduling or identified stressors, the coach present during training may not be the one normally assigned to the athlete and/or training group (to be determined by the team or treating physician with coach and athlete input).*

4-A Return to progressive training supervised by support team members in a high-performance environment.

- Progressive return to the field of play.

4-B Progression to standard team-based performance-focused training.

- Sport-specific training with the team's coaches.
- Medical constraints or limitations may persist at this stage, but the team or treating physician and athlete will determine them and communicate them to the coaching team.

Progression Criteria from Step 4 to Step 5:

- The athlete has maintained their mental health status in the team environment.
- The athlete feels ready to manage the stressors of the competitive training environment (potentially to include travel).
- Medical clearance has been provided by the team or treating physician, supported by the team or treating licensed mental health provider based on safety, stability and function.

STEP 5 RETURN TO FULL TRAINING

Lead: Coach.
Engaged parties: The athlete, licensed mental health provider, team or treating physician and regular team IST.
Duration: Variable; allow several weeks, depending on the condition and progress of the athlete.
Frequency of medical follow-up: every two weeks or as clinically indicated by the team physician (or treating physician and/or licensed mental health provider) **(mandatory).**

- No restrictions except for official competitions
- The athlete is back to normal training.
- Unless an exception is made, there should be no further limitation.

Progression Criteria from Step 5 to 6:

- The athlete has maintained a consistent high-intensity training schedule with the team.
- The athlete has been able to manage fluctuations in their mental health status in the high-performance team environment.
- The athlete feels ready to manage the stressors of the competitive environment (potentially to include travel).
- Medical clearance has been provided by the team or treating physician based on safety, stability and function.

STEP 6 RETURN TO COMPETITION

Lead: Coach.
Engaged parties: The athlete, licensed mental health provider, team or treating physician and regular team IST.
Duration: No duration, based on the annual training plan.
Suggested frequency of medical follow-up: every two to four weeks or as clinically indicated by the team physician (or treating physician).

- The athlete must receive medical clearance* before returning to official competitions.

*Medical Clearance Form - Appendix 1

The athlete can only proceed to this stage after obtaining medical clearance. The athlete must have reached the level of sport-specific performance to participate in competitions safely. The athlete's mental health status must be compatible with a return to performance. This stage can include competition simulations.

APPENDIX 1

MEDICAL CLEARANCE FORM

DATE: **PATIENT ID:**

INTERIM SUMMARY:

- athlete remains on XXX medication
- licensed mental health provider is happy with progress and no concerns about returning to performance environment
- athlete feels prepared to return to performance environment

MENTAL STATUS EXAMINATION

Behaviour & Appearance: appropriate and cooperative

Mood & Affect: euthymic

Thought Content: no suicidal or homicidal ideation , intent or plan

Insight & Judgment: good insight and judgment

CLINICAL IMPRESSION[1]

SEVERITY OF ILLNESS

1 = Normal—not at all ill, symptoms of disorder not present past seven days

2 = Mildly mentally ill—subtle or suspected pathology OR clearly established symptoms with minimal, if any, distress or difficulty in social and occupational function

3 = Moderately or markedly ill—overt symptoms causing noticeable, but modest, functional impairment or distress; symptom level may warrant medication OR intrusive symptoms that distinctly impair social/occupational function or cause intrusive levels of distress

4 = Severely ill—disruptive pathology, behavior and function are frequently influenced by symptoms, may require assistance from others

5 = Among the most extremely ill patients—pathology drastically interferes in many life functions; may be hospitalized

MEASURE OF IMPROVEMENT

1 = Very much improved—nearly all better; good level of functioning; minimal symptoms; represents a very substantial change

2 = Much improved—notably better with significant reduction of symptoms; increase in the level of functioning but some symptoms remain

3 = Minimally improved—slightly better with little or no clinically meaningful reduction of symptoms. Represents very little change in basic clinical status, level of care, or functional capacity

4 = No change—symptoms remain essentially unchanged

5 = Minimally worse—slightly worse but may not be clinically meaningful; may represent very little change in basic clinical status or functional capacity

6 = Much worse—clinically significant increase in symptoms and diminished functioning

7 = Very much worse—severe exacerbation of symptoms and loss of functioning

ASSESSMENT

Clinical assessment and collateral information support a progression to the next stage in the Return to Sport framework.

SIGNATURE

1. Busner, J., & Targum, S. D. (2007). The clinical global impressions scale: applying a research tool in clinical practice. *Psychiatry (Edgmont (Pa.: Township))*, 4(7), 28–37.

APPENDIX 2

RETURN TO SPORT PLAN (FOR MENTAL HEALTH DISORDER)

Athlete:

Sport:

Date:

Stage of Return:

FACILITATING FACTORS: Identify elements that can be applied to facilitate the return-to-training process.

STRESSORS: Identify the variables that may impact mental stress during return.

TYPE OF TRAINING

TRAINING GROUP

NUMBER OF TRAINING SESSIONS PER DAY/WEEK:

DATE FOR NEXT REVIEW AND FOLLOW UP:

SIGNATURE OF PHYSICIAN

SMHAT-1

The International Olympic Committee Sport Mental Health Assessment Tool 1

DEVELOPED BY THE IOC MENTAL HEALTH WORKING GROUP

Athlete's name: _____ Athlete's ID number: _____

What is the SMHAT-1

The International Olympic Committee (IOC) Sport Mental Health Assessment Tool 1 (SMHAT-1) is a standardized assessment tool aiming to identify at an early stage elite athletes (defined as professional, Olympic, Paralympic and collegiate level; 16 and older) potentially at risk for or already experiencing mental health symptoms and disorders, in order to facilitate timely referral of those in need to adequate support and/or treatment.

Who should use the SMHAT-1

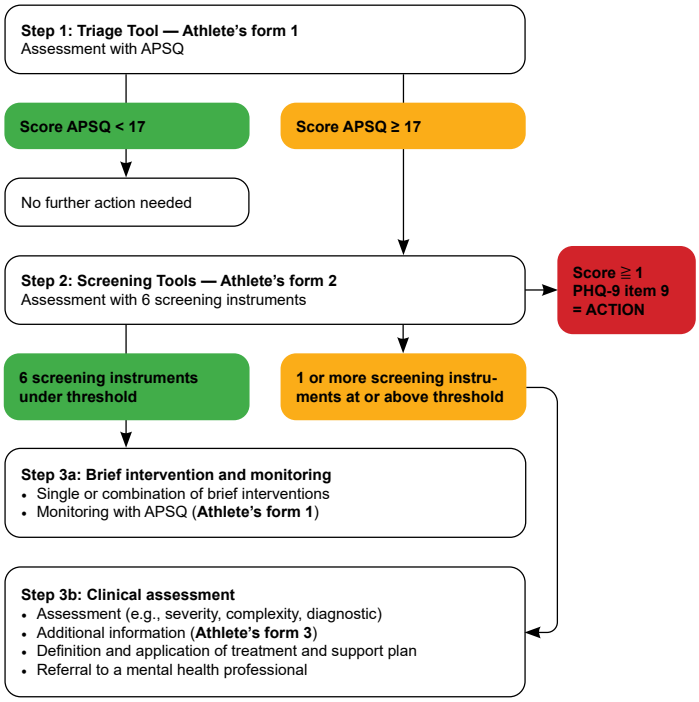
The SMHAT-1 can be used by sports medicine physicians and other licensed/registered health professionals, but the clinical assessment (and related management) within the SMHAT-1 (see step 3b) should be conducted by sports medicine physicians and/or licensed/registered mental health professionals. If you are not a sports medicine physician or other licensed/registered health professional, please use the IOC Sport Mental Health Recognition Tool 1 (SMHRT-1). Physical therapists or athletic trainers working with a sports medicine physician can use the SMHAT-1 but any guidance or intervention should remain the responsibility of their sports medicine physician.

Why use the SMHAT-1

Mental health symptoms and disorders are prevalent among active and former elite athletes. Mental health disorders are typically defined as conditions causing clinically significant distress or impairment that meet certain diagnostic criteria, such as in the Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5) or the International Classification of Diseases 10th revision (ICD-10), whereas mental health symptoms are self-reported, may be significant but do not occur in a pattern meeting specific diagnostic criteria and do not necessarily cause significant distress or functional impairment.

When to use the SMHAT-1

The SMHAT-1 should be ideally embedded within the pre-competition period (i.e., a few weeks after the start of sport training), as well as within the mid- and end-season period. The SMHAT-1 should also ideally be used when any significant event for athletes occurs such as injury, illness, surgery, unexplained performance concern, after a major competition, end of competitive cycle, suspected harassment/abuse, adverse life event and transitioning out of sport.



1

Step 1. Triage tool for mental health symptoms and disorders

ACTION: For this step, you need to refer to the Athlete's form 1. Complete the following.

Calculate the total score by summing up the answers on the 10 items — Total Score

Total score 10 – 16 **>>>** No further action needed
Total score 17 – 50 **>>>** The athlete should complete the Athlete's form 2. Once the Athlete's form 2 is completed, proceed to step 2

2

Step 2. Screening tools for mental health symptoms and disorders

ACTION: For this step, you need to refer to the Athlete's form 2. Complete the following.

Screening 1 (anxiety)

Calculate the total score by summing up the answers on the 7 items — Total Score

Screening 2 (depression)

Calculate the total score by summing up the answers on the 9 items — Total Score

Note the score ('0', '1', '2' or '3') of the athlete on item 9 — Score

Screening 3 (sleep disturbance)

Calculate the total score by summing up the answers on the 5 items. — Total Score

Screening 4 (alcohol misuse)

Calculate the total score by summing up the answers on the 3 items — Total Score

Screening 5 (drug(s) use)

Calculate the total score by summing up the answers on the 4 items — Total Score

Note which drug(s) caused concerns or problems for the athlete — Drug(s)

Screening 6 (disordered eating)

Calculate the total score by summing up the answers on the first 6 items — Total Score

Summary table about step 2 (screening)

ACTION: Refer to all scores previously calculated and complete the summary table; note the screening scores and tick the appropriate box

	Total score	Under threshold	At or above threshold
Anxiety (screening 1)		0-9 ☐	≧10 ☐
Depression (screening 2)		0-9 ☐	≧10 ☐
Depression item 9 (screening 2)		0 ☐	≥1 ☐
Sleep disturbance (screening 3)		0-7 ☐	≧8 ☐
Alcohol misuse (screening 4)		Men 0-3; ☐ Women 0-2 ☐	Men ≧4; ☐ Women ≧3 ☐
Drug(s) misuse (screening 5)		0-1 ☐	≧2 ☐
Disordered eating (screening 6)		0-3 ☐	≧4 ☐

Anxiety: score 5-9 = mild; score 10-14 = moderate; score ≧15 = severe

Depression: score 5-9 = mild; score 10-14 = moderate; score 15-19 = moderately severe; score ≧20 = severe

Sleep disturbance: score 5-7 = mild; score 8-10 = moderate; score ≧11 = severe

Box ticked for depression item 9 **>>>** Take immediate action to ensure safety of the athlete.
All screening scores under threshold **>>>** Proceed to step 3a
One or more screening scores at or above threshold **>>>** Proceed to step 3b

Step 3a. Brief intervention and monitoring

ACTION: Refer the athlete to a single intervention or combination of brief interventions such as psychoeducation, mindfulness, meditation, mental skills training, or stress control.

ACTION: After the completion of brief intervention(s), the athlete should be re-assessed with the triage tool (Athlete's form 1), and further action taken as follows:

Total score 0 – 16 **>>>** No further action needed
Total score 17 – 50 **>>>** The athlete must proceed into step 3b

Step 3b. Clinical assessment and management

This step should be completed by a sport medicine physician or a licensed/registered mental health professional. The objective of this step is to conduct a comprehensive clinical assessment in order to identify important problems/diagnoses and create a management/intervention plan.

ACTION: Review and interpret the triage and screening scores and conduct a clinical assessment in order to obtain additional information. Inquire about a history of and/or current presence of harassment/abuse within or outside of sports.

ACTION: Your comprehensive assessment should consider the following:

Severity

Severity refers to the likelihood of an identified clinical problem significantly compromising the athlete's health and wellbeing, for instance, by causing severe functional impairments, markedly disturbed behaviors and/or risk to self or others (e.g., suicidal/homicidal intent, significant self-neglect, or electrolyte abnormalities in eating disorders would be considered high severity).

Complexity

Complexity refers to comorbid mental health and other medical conditions (e.g., alcohol use disorder and anxiety, depression and diabetes mellitus, or any mental health disorder and significant musculoskeletal injury) and/or significant sport (e.g., performance concerns, career dissatisfaction) or non-sport (e.g., relationship or financial problems, bereavement) stressors. Note that being successful can also be a major life event leading to unexpected stresses.

Diagnostic uncertainty

Diagnostic uncertainty refers to any doubt about diagnosis. Examples include differentiating a high level of sport-related physical activity from over-activity found in hypomania and ADHD, functional performance-related eating from eating disorders, or depression from bipolar disorder.

Treatment non-response

Treatment non-response refers to when the initial treating clinician has implemented one or two treatment cycles with no response or a partial response.

ACTION: Note the most significant problem(s) of the athlete in the following table (column 'problem') and complete the table by ticking the appropriate box(es) if applicable.

Problem	Severity	Complexity	Diagnostic uncertainty	Treatment non-response
Problem 1				
Problem 2				
Problem 3				

In cases that are neither severe, complex, diagnostically uncertain nor non-responsive to treatment **>>>** Treatment/support can be provided by a sports medicine / primary care physician, referring then to the International Olympic Committee consensus statement on mental health in elite athletes for guidance
In cases of diagnostic uncertainty or when further information might be useful **>>>** Consider whether one or more additional screening tools should be completed by the athlete. If relevant, use the Athlete's form 3: screening 7 for attention-deficit hyperactivity disorder, screening 8 for bipolar disorder, screening 9 for post-traumatic stress disorder, screening 10 for gambling, screening 11 for psychosis. For the calculation of total score(s) and related interpretation, please refer to the last section of this form.
In cases that are severe, complex, diagnostically uncertain even after any appropriate additional screening and/or non-responsive to treatment **>>>** Athletes should be referred to a mental health professional (e.g., clinical psychologist or psychiatrist).

Additional screening tools for mental health symptoms and disorders

ACTION: For this, you need to refer to the Athlete's form 3. Complete the following.

Screening 7 (attention-deficit/hyperactivity disorder)

Calculate the total score by summing up the answers on the 6 items — Total Score

Score ≧4 = symptoms highly consistent with ADHD

Screening 8 (bipolar disorder)

Calculate the total score by summing up the answers on item 1 — Total score

Note the score of item 2 — Score

Note the score of item 3 — Score

Possible bipolar disorder if total score ≧7 AND item 2 = 1 AND item 3 = 1

Screening 9 (post-traumatic stress disorder)

Calculate the total score by summing up the answers on the 5 items — Total Score

Cut-off of 3 = sensitivity of 0.95 & specificity of 0.85; cut-off of 4 = sensitivity of 0.83 & specificity of 0.91

Screening 10 (gambling)

Calculate the total score by summing up the answers on the 9 items — Total Score

Score 0 = non-problem gambling; score 1-2 = low level of problems with few or no identified negative consequences; score 3-7 = moderate level of problems leading to some negative consequences; score ≧8 = problem gambling with negative consequences and a possible loss of control

Screening 11 (psychosis)

Calculate the total score by summing up the answers on the 16 items — Total Score

Score ≧6 = at risk for psychosis

APPENDIX 4

OTHER SCREENING QUESTIONNAIRES FOR CONSIDERATION

SYMPTOMS	QUESTIONNAIRE	AUTHOR(S)
Burnout	Athlete Burnout Questionnaire (ABQ) - 15 items	Raedeke & Smith, 2001
Demographics	Adapted from CADDRA ADHD Assessment Form and SEWP Lab intake form; includes SCAT-5 history questions	CanadiWn ADHD Resource Alliance (CADDRA), 2011; Durand-Bush, n.d.
Eating Disorder	Eating Attitudes Test (EAT-26) - 26-items	Garner, Olmsted, Bohr, & Garfinkel, 1982
Mental Health	Mental Health Continuum (Short Form) - 14 items	Keyes, 2022; Keyes et al., 2008
Mental Performance	Mental Performance Checklist - 23 items	Durand-Bush, 2020
OCD	Florida Obsessive Compulsive Inventory (FOCI) - 5 items and YALE-BROWN OBSESSIVE COMPULSIVE SCALE (Y-BOCS)	American Academy of Family Physicians, 2009; Storch et al., 2007 Goodman et al Arch Gen Psychiatry, 1989 Nov
Panic Disorder	Panic Disorder Self Report Scale	Shear, M.K. et al, (1997). American Journal of Psychiatry
PTSD	PTSD checklist (PCL-5) - 20 items	Blevins et al., 2015
Substance abuse	Drug Abuse Screening Test (DAST-10) - 10 items	Skinner, 1989
Suicidality	Columbia-Suicide Severity Rating Scale (C-SSRS) -	Posner et al., 2008

APPENDIX 5

FRAMEWORK OF KEY CONSIDERATIONS FOR RETURN TO SPORT PLANNING

Table 3. Framework of key considerations for RTP planning

Elements	General assessment	Safety considerations	Stability considerations	Functional considerations
Situation	• Did the team, coach, or environment contribute to the challenge? • How were the team, coach, or environment affected by the mental health episode?	• Is the athlete safe to return to the environment? • Is the environment safe for the athlete to return to?	• Is the environment stable and predictable?	• Can the athlete presently function in the athletic environment (consider training and/or competition)
Symptoms	• Presence or ongoing or residual symptoms • Impact on thoughts or behavior during the episode • Whether the symptoms were witness or experienced by others • Degree of insight • Attitude towards treatment. • Predominantly internal (i.e., affects the self) vs. external (i.e., affects others)	• The nature of the symptoms may place the individual or others at risk for physical harm (i.e., agitation, anger, aggression, suicidal or homicidal thoughts)	• Are the symptoms stable and remitting, or labile and relapsing? • Do increased stimulation, demands and stress make symptoms worse?	• Are symptoms resulting in functional impairment?
Safety	• Influence of active symptoms on current risk appraisal • Consideration of prognostic risk factors • Consideration of recent hospitalization • Past history of self harm, suicidal behavior, or violence • Is the athlete taking medications that may result in adverse effects or drug interactions?	• Are there active thoughts or intentions of self harm, suicide, or homicide? • Presence of disorganized behavior, paranoia, psychotic features • Active self injurious behavior • Safety should be considered both at home and in the context of travelling.	• Emotional or behavioral stability • Ability to maintain personal safety despite increased stress or adversity • Ability to adhere to a safety plan • Adherence to treatment and follow up.	• Is there preoccupation with thoughts of suicide, harming oneself, or harming someone else? • Has self-harm behavior led to impaired ability to function? (i.e., through injury, compromised health)
Sport-specific circumstances	• Individual vs. team sport • Role (i.e., starter vs. support player) • Timing in the season • Proximity to major events • Potential impact on career • Suitability to develop gradual RTP • Consider how the athlete's return would potentially impact the group (if applicable)	• Are there symptoms that can place the athlete at risk in the sport setting (i.e., cognitive fogginess, poor concentration, emotional lability, impulsivity) ? • Risk of post-competition "crash" (low mood)	• Are there sport-specific elements that may compromise stability? (i.e., presence of hostile spectators, high pressure role) • Are there sport-specific factors that may support stability? (i.e., supportive team, confidence and success with role)	• Certain sports may require higher levels of recovery before return can be considered (i.e., returning to a collision sport while recovering from anorexia nervosa)
Systems	• Supports, including family, friends, formal mental health supports, other sport-based supports, organizational supports. • Consider who should be aware of key details to ensure appropriate monitoring and provision of safety. • *Consider*: supports at home as well as while traveling. • The process of developing the support system should begin prior to return, and its effectiveness should regularly be reviewed.	• Mental health supports are essential • Frequent monitoring and symptom review after hospitalization • Crisis plan with identification of available crisis services	• Consider developing a Mental Health Action Plan. • Plan for supporting the athlete if they relapse or encounter difficulty	• Appropriate supports should be established according to the level of impairment the athlete has experienced • Supports and monitoring should be continued throughout the recovery phase
Risk of Return	• Consider how the athlete would react to poor performance, peer conflict, pressure situations, feedback (including criticism), hostility on social media or from fans. • *Consider*: navigating these factors at home as well as while traveling. This needs to be addressed **prior to return** and should guide the timeline of return.	• Consider the potential for panic attacks, suicidal ideation, further emotional disturbance.	• Consider the potential that exposure to sport-specific adversity, pressure or stress related to sport will destabilize the athlete's condition.	• A difficult or unsuccessful return could lead to withdrawal and deterioration; while successful reintegration could mitigate the risks of return. • The ability of the athlete to manage the load of return to sport concurrently with daily functional activities should be monitored.

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APPENDIX 6

ACKNOWLEDGEMENTS

The Return to Sport Task Force would like to thank Dr. Alexis Gagnon-Dolbec (sports psychologist), Dr. Gabrielle Ostiguy (sports physician), and INS for allowing the use of their original protocol (RESET) to develop this document. The original RESET document also had input from IST members from Speed Skating Canada. The INS Mental Health Task Force revised the RESET protocol for wider use, which the Return to Sport Task Force used to inform the new PIRS Protocol.

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