Shooting Federation of Canada
Mental Health Strategy and Emergency Response Action Plan



Version Control:

Version	Date	Author	Change Description
V1	September 2020	Susan Cockle, Registered Psychologist	Initial Complete Version
V2	May 2025	Lauren McBride, Registered Psychologist	Updated
V3	August 2026	Zarina Giannone, Licensed Psychologist	General update; Emergency Response Team details

Purpose of this Document:

The MHEAP for Shooting Federation of Canada describes:

(1) Mental Health
(2) Who Mental Health Impacts
(3) Mental Health in the Canadian Sport System
(4) Mental Health Emergency situations
(5) How to differentiate between Urgent Mental Health Concerns and a Mental Health Emergency, with additional information included in Appendices A, B, and C.
(6) Steps to Address Mental Health Emergencies
(7) Suicide Prevention Plan, reviewed in more detail in Appendix D.
(8) Mental Health Emergency Response Team, with additional information in Appendix E
(9) Mental Health Pause-Play
(10) Return-to-Play protocols are reviewed with detailed information in Appendix F and Appendix G
(11) Steps to Mitigate Mental Health Emergencies, with supporting information in Appendix G, Mental Health Emergencies and Suicide Education Programs in Appendix H, and Critical Incident Response Plan and Psychological First Aid in Appendix I.
(12) Firearm Safety, including Firearm Risk Assessment and the Return to Sport Protocol following a firearm incident

This Mental Health document will serve as a resource for all SFC members: athletes, coaches, integrated support team, officials, and administrators.

The purpose is to support SFC to:

a. Effectively respond to mental health concerns and emergencies and how to differentiate between urgent concerns and emergencies.
b. Create a culture of mental health awareness, acceptance and support within SFC.
c. Maximize overall mental health and wellbeing, as well as mental performance, within our sport.

Anyone can experience a mental health emergency, including athletes, coaches, and staff. These guidelines may be applicable to anyone in the shooting community.

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1. What is Mental Health?

According to the World Health Organization (2022), mental health is:

"a state of well-being in which every individual realizes their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community. Therefore, if we look at mental health within the Canadian sport system, and more specifically, within the Shooting Federation of Canada (SFC), we are committed to ensuring that all members; athletes, coaches, integrated support staff, administrators and officials, have the necessary resources to support them to cope with the normal stresses of our sport, to work, train and perform productively and to make a contribution within our sport community and within the greater community in Canada.

2. Who Does Mental Health Impact?

Mental health impacts all of us regardless of age, education, income and culture. Just like physical health, we all have mental health, and it is important to consistently and systematically take care of our mental health, just as we do our physical health. Doing so can help prevent mental health stress, injury and manage mental health disorders.

The Canadian Mental Health Association reports that:

- *100% of Canadians are impacted by mental illness either directly or indirectly at some point in their lifetime.*
- *By age 40 years of age, 50% of the population in Canada will have or have had a mental illness, in any given year.*
- *1 in 5 Canadians will experience a mental health concern, in any given year.*

Those in the sport system are just as likely as the general population to experience mental health concerns. So, if a team has 5 members, we can anticipate that 5 members might experience mental health difficulties at any given point in time, within one calendar year.

3. Mental Health in Canadian Sport

Stress and pressure can impact emotions, behaviours, thoughts and ability to cope. When high-performance stakes are high, athletes, coaches, support staff or administrators may be less likely to come forward with their mental health concerns. This hesitance may be related to fear of being ostracized, stigmatized or deselected within the sport.

During a 2019 AthletesCan focus group, of approximately 90 Canadian National Team athletes, from various sports, several mental health concerns were highlighted, as well as the contributing factors within the national high-performance sport system. These contributing factors were described as:

Isolation
Loneliness
Self-worth attached to performance
Comparison to others
Injuries
Poor performance
Overthinking
Lack of control
Retirement
Loss of team or coach
Family/Personal tragedies
Moving to new locations
Lack of financial support
Change, chaos, uncertainty within sport
Team selection and de-selection
Team dynamics
Sport politics
High-performance pressure
Others' success
Inadequate mental health support
Lack of confidentiality

(Canadian Centre for Mental Health in Sport, 2019)

Due to the systemic pressures within the high-performance sport system, coaches, integrated support staff, officials and administrators may also experience some of these contributing factors and resulting mental health difficulties. If these factors, in combination with personality, hereditary and environmental factors, go unchecked and unsupported they may lead to mental health injury, breakdown or even emergency. Please see Appendix A for resources

4. Identification of Mental Health Emergency:

Mental health concerns vary in nature, from mental health challenges to urgent concerns and emergencies.

This variance can be attributed to factors such as the speed and severity of behavioural changes and the threat to the physical safety of self and others.

It is important to recognize extreme changes in mood, behaviour, or thought patterns, indications of suicidal ideation, disassociation, or violent behaviour.

In response, a **Mental Health Emergency Response Action Plan** can inform our process should such an event arise with any member(s) of the Shooting Federation of Canada.

Table 1. Characteristics of a Mental Health Emergency

Events that could trigger a mental health emergency (including, but not limited to)	• Severe injury to self or someone else • Unexpected death • Social media crisis • Underperformance at an important event • Sexual assault • Experience of threatening behaviour (e.g., stalking, threats of violence) • Unwanted/unplanned pregnancy • Crisis involving family or loved ones • Substance use
Examples of mental health emergencies	• Suicidal or homicidal thinking or behaviour • Acute psychosis, mania, paranoia, delirium, or confusion • Interpersonal violence against family, teammates, coaches, or staff • Acute intoxication or drug overdose

5. Urgent Mental Health Concern or Mental Health Emergency?

Sometimes it can be difficult to discern between an urgent mental health concern and a mental health emergency. See Appendix B for a description of a Continuum of Mental Health Indicators and Resources, including definitions of "mental health, mental health reactivity, mental health injury, or a mental illness," and Appendix C for the Canadian National Team Athlete Mental Health Resource Guide.

You can also use the questions below to help you decide if an event is an emergency. If the answer to any of these questions is YES, it is likely an emergency:

1. Is there an imminent risk that the individual may harm themselves?
2. Are you concerned that the individual may harm others?
3. Does the individual seem out of touch with reality?
4. Has the individual made threats? Do you feel that your or someone's safety is at risk?
5. Can the individual harm themselves or someone else if they leave the premises?

6. Mental Health Emergency Steps

If there is any chance that the person may hurt themself or others, take the immediate steps below. If someone is in imminent danger and is not able to keep themselves safe, call 911 or a local emergency number (e.g., European Union 112).

1. Stay calm.
2. Engage the person in a serious conversation about how they are feeling. Always make sure you are safe before engaging with the person.
3. Ask about suicide ("Are you thinking of harming yourself?" or "Are you having thoughts of suicide?") and homicidal thoughts ("Do you have thoughts about harming other people?")

4. Ask them who the emergency contact person of their choice is (do not assume it is a family member; it may be a friend).
5. Call 911 if the person is imminently at risk of attempting suicide or harm to others, you are concerned that their judgment is not intact and/or you cannot confirm they have a plan to stay safe.

See **Appendix D** for a Flowchart of Mental Health Non-Emergency and Emergency Response.

At-risk athletes, coaches, or staff should be reminded of the 9-8-8 Emergency Crisis Helpline (call or text), available 24 hours a day, seven days a week, bilingual service, trauma-informed, culturally appropriate, and available to anyone in Canada.

If athletes, coaches, or staff are in the US, they should be directed to use: 1-800-273-8255 or Lifeline (suicidepreventionlifeline.org).

7. Suicide Prevention Action Plan

Safety first. The trusted, support person (usually the individual who has recognized it is a Mental Health Emergency) stays with SFC member at risk and/or have member text *456-45 or Call 1 (833) 456-4566 Canadian Mental Health Association Emergency Services.*

This individual should immediately contact the Designated Team Lead. Depending on the circumstances, the **Designated Team Lead** may be different individuals. In most cases, this will be a coach or an SFC staff member who is present at the competition or training site and has been identified in advance.

The Designated Team Lead should notify the Emergency Response Team (ERT) Primary Responder to *inform them of the emergency situation, and to ensure a safety/well-being plan is made with the SFC member.*

The Designated Team Lead, with support from the ERT, will serve as the primary point of contact and will communicate directly with the member at risk.

The Designated Team Lead informs the member that they are very concerned about the members' safety/wellbeing, and they need to put steps in place to ensure they are safe. *Ask if they have a means or a plan to harm themself and if they are open to support.*

If the member at risk is at home, the Designated Team Lead, in collaboration with the ERT, will contact their identified family member or emergency contact number. *Let them know you are very concerned about the safety/wellbeing of the SFC members and need to put steps in place to ensure they are safe. Ask a support person to stay with the SFC member.*

The ERT, in collaboration with the Designated Team Lead will reduce the possible contagion of the emergency by providing basic information to others within SFC, if they are present and already aware of the emergency. *E.g. "there has been a critical situation, we are currently dealing with it, and we will give an appropriate update in time".* Confidentiality will be maintained, whenever possible.

The ERT will consult with the necessary professionals to stay up to date on situation and implement specific next steps.

The Designated Team Lead with the assistance of the ERT, will follow the steps below to continue to manage a mental health emergency or critical incident, if indicated.

Note: If training or competing needs to be suspended, as recommended by the Designated Team Lead, ERT member, or relevant healthcare provider, due to the severity of the emergency and subsequent compromise in psychological functioning, all measures will be put in place for successful return to sport.

When to call 911?

If member is actively suicidal, has unrelenting suicidal thinking, cannot keep themself safe, and/or has a plan to kill themself, or are otherwise at risk of harming self or others, this is a mental health emergency. If in doubt call 911.

Call 911 or have member go to nearest emergency room. State to 911 operator;

- *what is happening*
- *who is at risk*
- *how they are at risk (in possession of means to harm including access to a firearm)*
- *where the member is located*
- *how emergency services can contact and locate member*

Ask member to surrender any means* they may have to inflict immediate harm. ("sharps" – knives/razors, pills, drugs, firearms etc.)

** Firearms may be voluntarily and temporarily surrendered to a trusted person, provided that the individual receiving the firearms holds a valid firearms license, in accordance with the Firearms Act.*

Stay with the member until physical and psychological safety is restored.

When not to call 911?

If member is suicidal but agrees to keep themself safe, engages in a safety plan and is able to receive immediate support. Including, if they;

- are able to surrender plans and means of suicide *
- can de-escalate risk to self and others
- are open to receiving immediate support and connection from others.

** Firearms may be voluntarily and temporarily surrendered to a trusted person, provided that the individual receiving the firearms holds a valid firearms license, in accordance with the Firearms Act.*

In this case, establish a circle of support for the member that includes, at a minimum, the Designated Team Lead, a member of the ERT, and another trusted support person (e.g., a teammate or MPC). Focus on safety, containment and compassion. Have at least one person stay with the member until physical and psychological

safety is restored.

Maintain confidentiality and respect for the dignity of the member.

Emergency Response Team (ERT)
When contacting the SFC Mental Health Emergency Response Team (ERT) for guidance, begin with the Primary Responder. If you are unable to make contact, proceed to the Secondary Responder, followed by the Tertiary Responder.

SFC MENTAL HEALTH EMERGENCY RESPONSE TEAM		
ROLE	**NAME**	**CONTACT INFORMATION**
Primary Responder	High Performance (HP) Technical Director, SFC Susan Verdier	sverdier@sfc-ftc.ca
Secondary Responder	CEO, SFC Terry Dillon	ceo@sfc-ftc.ca
Tertiary Responder	Director of Sport Development, SFC Lisa Roddie	members@sfc-ftc.ca
Consultative (Clinical) Responder	Mental Health Lead, SFC Dr. Zarina Giannone, Licensed Psychologist (BC)	zarina@drzarinagiannone.com

The ERT can provide guidance on:

- Management of the situation
- Appropriate next steps and referrals
- Communication with relevant supports
- Follow-up care and monitoring
- Developing a plan for the member following the crisis

The role of an ERT is to lead the response to mental health emergencies. At a minimum, all ERT members should have completed the Mental Health First Aid Training. Specific training recommendations from the Mental Health Lead are forthcoming.

ERT members' roles and responsibilities:

1. Develop standardized procedures for responding to mental health emergencies.
   E.g., Support Designated Team Leads in creating a contact list with names, roles, and contact information for training, camps, and competitions (See **Appendix E** for Pre-Travel Mental Health Emergency Action Plan Form)
2. Respond to mental health emergencies by establishing clear roles, responsibilities, and communication protocols, while taking appropriate steps to safeguard the individual in crisis, those around them, and the organization (See **Appendix F** for De-escalation Guidelines).
3. Educate coaches, staff, and affiliates about mental health emergency procedures and their respective roles in responding to a crisis.

Key Considerations

The following questions are intended to guide ERT members in reflecting on key considerations. The italicized notes that follow were developed by ERT members on August 21, 2026, in response to these questions.

1. Who identifies and assesses the concern? *The individual who identified the emergency and/or the Designated Team Lead.*
2. Who activates the emergency protocol? *The individual who identified the emergency and/or the Designated Team Lead, in consultation with the ERT.*
3. Who contacts 911, if required? *The individual who identified the emergency and/or the Designated Team Lead, in consultation with the ERT.*
4. Who remains with the athlete? *The Designated Team Lead, or the circle of support put in place in Non-Emergency Situations (see above).*
5. Who contacts the athlete's emergency contact? *The Designated Team Lead, in consultation with the ERT's Primary and Secondary Responders.*
6. Who communicates with hospital/health-care providers? *The Designated Team Lead, in consultation with the ERT.*
7. Who notifies other stakeholders? *The ERT's Primary Responder, where appropriate.*
8. Who coordinates follow-up after discharge? *The ERT will convene to discuss the specifics of the situation and determine an appropriate response. Typically, the Primary Responder will assume the coordinating role, with the Mental Health Lead activated as a (clinical) Consultative Responder.*
9. Who develops the athlete's recovery plan? *The ERT, in collaboration with the Mental Health Lead, external healthcare providers, coaching staff, and any other relevant individual.*
10. Who determines readiness to return to training and/or competition? *The Mental Health Lead, where indicated, will work in collaboration with the ERT and in accordance with the Pause-Play and Return-to-Play protocols outlined below.*
11. What support is provided to teammates and staff? *To be determined on a case-by-case basis by the ERT.*
12. What documentation is required? *Each individual is responsible for maintaining their own records in accordance with their professional and ethical responsibilities and applicable standards. A general documentation template is provided below to support consistent and appropriate record-keeping.*

Mental Health Emergency Documentation Template

1. Basic Information

- Date of incident:
- Time incident began:
- Time incident concluded:
- Location:
- Name of individual involved:
- Name and role of person completing this record:
- Other individuals directly involved or present:

2. Initial Concern

- How was the concern identified or brought to your attention?
- What did you observe or what was reported to you?
  Record specific, observable facts rather than interpretations or assumptions.
- What, if anything, did the individual say about their immediate situation or needs?
  Where possible, document the individual's words accurately and briefly.

3. Immediate Response

- What actions were taken in response to the concern?
- Who was contacted or involved?
  - Designated Team Lead
  - ERT member
  - Coach/staff member
  - Trusted support person
  - Emergency services
  - Other: _____
- When were they contacted?
- What instructions or guidance were provided?
- What steps were taken to support the individual's immediate safety and the safety of others?

4. Outcome

- What happened following the immediate response?
- Was additional support or follow-up arranged?
- If applicable, was the individual transported elsewhere? By whom?

5. Notifications and Follow-Up

- Who was notified about the incident?
- Date/time of notification:
- What follow-up actions were recommended or agreed upon?
- Who is responsible for follow-up?

8. Mental Health “Pause-Play” Protocol

Any athlete unable to train or compete due to an MH emergency may need to inform (if appropriate) coach(es) and staff of their mental health status, with the timeline for communication being handled on a case-by-case basis.

Additionally, team members (athletes, coaches, staff) may be reassured that their teammate is under professional care and that other details will not be shared with them because of privacy and confidentiality. Athletes may be offered group or individual counselling upon request.

At all points, maintaining athletes' right to confidentiality will be respected and adhered to. Informed consent is dynamic in nature and, therefore, should be revisited if/when a pause-play protocol or a return-to-sport protocol is evoked.

9. MH Return-to-Sport Protocol

Game Plan has developed step-by-step resources to support NSO's to work with athletes who have experience a mental health challenge in their return to sport planning.

Return to Sport Guideline

Guideline 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.

Return to Sport Flowchart

Step-by-step flowchart to utilize when returning an athlete to sport after a leave of absence due to mental health.

During the return-to-sport protocol, meetings with key support members will be arranged to ensure that the athlete is involved in implementing any relevant protocols. A team physician and/or the treating MH practitioner will administer (and re-administer) appropriate standardized mental health assessment tools on a schedule deemed appropriate for the individual athlete to support them in their return to sport.

Follow-up and monitoring will depend, first, on the consent provided by the athlete. Athletes who do not feel safe sharing their information will likely keep their MH treatment to themselves. As we build trust in the system, the hope is that athletes will be willing to share key information on treatment progress with Shooting Federation of Canada's "point person" and Mental Health Lead

If the athlete decides not to return to sport, mental health support resources will be coordinated for continued care in the form of individual referrals. For example, athletes may be eligible for mental health support through a Game Plan for up to two years post-retirement.

HP Shooting Federation of Canada employees and HP coaches are eligible for mental health support under Game Plan (contact Game Plan regional advisor at https://www.mygameplan.ca/about/our-team)

Staff who are undergoing treatment following a mental health emergency will continue to follow and fall under the employee support services through Shooting Federation of Canada's Human Resources Policy.

If the coach or staff member decides to discontinue working with Shooting Federation of Canada, mental health support resources may be coordinated for continued care in the form of individual referrals.

Privacy and Confidentiality: The level of detail about the MH emergency remains in the athlete's control, which is key to building trust and assuring honest dialogue. Further, informed consent requires that both the benefits and consequences of *sharing* AND *not sharing* the information are discussed with the athlete. The athlete is encouraged to follow the treating provider(s)' recommendations and complete the relevant forms and assessments per their individualized return-to-sport protocol.

11. Strategies to Mitigate the Risk of a Mental Health Emergency

The following strategies could be used to prevent or mitigate the risk of a mental health emergency among Shooting Federation of Canada athletes, coaches, or staff:

1. Develop, implement, and disseminate a detailed Mental Health Strategy Plan for the sport.
2. Provide ongoing mental health literacy training for all members.
3. Administer a mental health screen as part of the annual intake process and mental health check-ins periodically throughout the YTP.
4. Encourage athletes, coaches, and staff to complete the Individual Mental Health Action Plan or Self Care Plan (see **Appendix G**).
5. Increase awareness of Mental Health Resources and mental wellness skills, including suicide prevention (see **Appendix H** for Mental Health Emergencies and Suicide Education Programs)
6. Review a Critical Incident Response Plan and Psychological First Aid (see **Appendix I**).
7. Create a culture of excellence, including psychological safety.
8. Facilitate early identification and intervention of mental health issues.
9. Improve communication between team members, athletes, and other connected professionals about mental health concerns.
10. Encourage athletes, coaches, and staff to regularly engage in mental support.

12. Firearm Safety

In preparation for a mental health emergency event in SFC that might involve a firearm, Shooting Federation of Canada may need to designate a person (e.g., a shooting coach or Mental Performance Consultant) for additional operational training. This training includes mental and ethical preparation and is crucial for managing firearm incidents. Pre- and post-event interventions should encompass risk assessment, psychological support, and reintegration (return-to-sport) steps.

Firearm Risk Assessment

If you are concerned about an athlete/coach/staff who is at risk of harming themselves/others, explain that you are worried that they are at risk. Advise that the safest option is not having access to a firearm until the situation improves. Acknowledge that not having access to the firearm might be temporarily difficult as it might affect their training or competition. Help them understand that risk sometimes escalates rapidly and unpredictably – for example, right after a stressful event. Not having a firearm quickly at hand is like keeping the keys to the car away from a person who has been drinking. It reduces potentially fatal outcomes in volatile situations.

Remove the firearm and other lethal means if the individual is at risk for suicide. Remove all firearms from the immediate vicinity. Enlist a support person to make the actual transfer if doing so would be risky for the individual. If the individual is at high risk and has not agreed to remove firearms, contact police and/or arrange for hospitalization if the individual is in acute danger and has not removed lethal

means or removing lethal means is not sufficient to keep them safe.

If the firearm was used with the intent to harm self or others, the firearm should be immediately removed from the individual and returned only upon the assessment by a psychiatrist and/or team physician. If an individual at risk reports suicidal thoughts but no plan to harm themselves/others and reports no serious risk factors (e.g., previous attempts), ask for permission to talk to a mental health professional to confirm your impressions. As a precaution, remove firearms or other lethal means from the individual at risk. If you have reason to doubt that the firearms or other potentially lethal means have been removed, involve the police.

Removal of firearms must be done respectfully. This is especially true if the removal is for public safety (self and others) and not due to any prior criminal activity/action. Explain that the removal of the firearms is for public safety (self and others) and that the firearms will be returned once the situation or crisis has been resolved (i.e., following an assessment, the individual is cleared by a physician or a psychiatrist). Encourage the individual's forward-thinking mindset, thinking about the future and that this should be a temporary precaution. Ensure that the individual knows that the firearm will be handled respectfully and will be cared for by a Shooting Federation of Canada Emergency Response Team member responsible for firearm safety. Also, ensure the individual/family members know how the firearm will be returned.

Once the initial investigative steps are completed on the day of the incident with a firearm, the individual who has been directly affected by the firearm incident should be assessed by a registered psychologist or a psychiatrist. All other affected individuals should be provided resources and seek professional help if needed. Once the treating professional has established that the individual is ready to return to sport, detailed steps of reintegration into sport should be communicated to the athlete/coach/administrators.

Return to Sport Following a Firearm Incident

These guidelines are based on the *Edmonton Police Service (EPS) Reintegration After Critical Incident and Long-Term Leave* programming. The EPS Reintegration Program, a proven and adaptable framework, can be applied to both preventative and reactive experiences that might occur in sports with access to firearms, such as SFC. It can be modified to be successfully applied to a sport context, both preventatively and reactively, to effectively reintegrate athletes/coaches/staff following a mental health emergency involving the use of a firearm. This adaptability should instill confidence in its effectiveness and applicability to sport (SFC) context.

- Preventative – reviewed annually.
- Current/active – in the active critical incident scenarios.
- Reactive – a major critical incident and/or long-term (or short-term) leave for an athlete/coach and their return to sport.

Proactive processes could be implemented as part of the annual sport policy review. These could be based on mock scenarios designed for training individuals who may assist in a crisis. This approach reassures the sport organization that if they encounter a similar, potentially serious scenario, the reintegration of an individual coping with a mental health emergency will be welcomed, not feared or seen as an unknown. A more comprehensive approach to returning to the sport may be necessary for active or significant critical incidents.

The short-term focus should be on assisting the athletes/coaches/staff involved in an incident with a firearm with immediate physical and mental health support. The long-term focus should be based on facilitating the process of returning to sport following the incident with a firearm, such as helping the individual(s) re-integrate into the sport following suicidal ideation, re-integrating a member with PTSD diagnosis, and managing the return of athlete/coach to their daily training and competitive environment. Short- and long-term steps of assisting members to return to sport environments should have substantial psychological oversight including regular individual meetings with a Registered Psychologist or a Mental Performance Consultant.

The primary goal of the short-term reintegration plan is to facilitate the return of the athlete/coach/staff who was directly/indirectly involved with the firearm incident shortly after a critical incident while diminishing the potential for long-term psychological injury. The return-to-sport program following an incident with a firearm should be facilitated by a qualified professional (a psychologist or a psychiatrist), acknowledging that the athlete/coach/staff has been through a potentially traumatic event and providing the opportunity to therapeutically work through and process any triggers that the event has created.

Short-term Plan

The case scenario below describes the seven stages of returning to sport, with the athlete as an individual directly involved in a firearm incident (with the intent of harming themselves) and the shooting coach as a helper assisting the athlete with the use of a firearm.

The athlete and the coach will be given control and self-efficacy over the pace and intensity of each portion of the return to sport. They will be encouraged to expect and accept initial potential discomfort, build resilience, and optimize psychological functioning and sport performance. The goal is to re-

regulate the central nervous system, rebuild confidence, regain focus, and minimize triggers. The athlete must be cleared to return to the daily training environment (DTE) and/or competition by a team physician, medical lead, and/or a psychologist or psychiatrist if training or competition was suspended due to the severity of the mental health crisis and resulting compromise in psychological functioning.

STAGE 1: Initial Meeting

This meeting establishes trust between the athlete and the shooting coach (and a psychologist). The initial return to the DTE can be coordinated to ensure that the psychologist/psychiatrist is present, if necessary, to ensure the management of potential anxiety and emotional triggers. The athlete is encouraged by a mental health professional to identify potential triggers in the daily training environment (people, objects, sounds, smells, movements). The meeting should not be near the range where sounds might trigger a reaction. At this meeting, the athlete is given an opportunity to tell his/her story, allowing the coach to normalize the reactions the athlete has been experiencing since the firearm incident. The initial meeting will also identify the areas the coach needs to pay attention to in later stages. All efforts must be made to protect the athlete and the integrity of the process (e.g., if there is an investigation or any court proceedings regarding the incident).

Before the meeting, the psychologist creates a graduated exposure plan with the athlete and communicates the plan to the coach to define self-regulation strategies to prevent over-triggering and overwhelming the athlete. Return to the range should be facilitated in a structured, step-by-step format, including collaboration with the coach, MPC, psychologist, and/or teammates. If possible, consider the athlete attending the range off-hours to afford privacy when returning to their DTE.

STAGE 2: Physical Dexterity of Firearm

Create discussion around any new limitations since the athlete last used a firearm (e.g., injury – psychological or physical that will change some of their activities on the range either temporarily or permanently). Problem-solve potential changes to handling a firearm before the firearm exposure to prevent disappointment or setbacks. This will help the athlete feel mentally prepared for the changes that might have occurred (e.g., a change in vision, clarity of focus, dexterity in the hands, or a change in ability to concentrate, etc.). This may include touching, dismantling an unloaded firearm, loading, or wearing eye and ear protection.

Guide the athlete through cleaning the firearm as an option for refamiliarization. Dry firing of a firearm with no ammunition is an important aspect of this stage to reconnect the athlete to the firearm. This stage may occur on the same day as the initial meeting or at a more suitable time. The speed of this part of the return to sport is driven by the athlete involved, with no pressure to complete anything he or she is uncomfortable with. If a firearm is removed by police, for safety reasons, the police will inform the Chief Firearms Officer in that particular jurisdiction. This may or may not result in a review of an individual's firearm license. It does not automatically mean a license will be taken away.

STAGE 3: Acclimation to Gunfire

The athlete is located away from the range, gradually moving towards the sound of gunfire. The athlete will be encouraged to get as close to the firearm as he or she feels is needed. A similar process can be used for other stimuli that may have been present during the critical incident.

STAGE 4: Live Fire

As the athlete begins to use the firearm, the coach introduces new drills as their confidence increases in handling the firearm.

STAGE 5: Athlete-Directed Training

Training can continue with easy, low-key sessions as the athlete regains confidence in using his or her firearm and feels in control. Once the athlete has indicated that he or she feels comfortable with the firearm and the coach (and other treating professionals) has no concerns, the athlete is cleared to return to sport.

STAGE 6: Reintroduction

The athlete returns to his or her DTE following a meeting with other athletes and coaches.

STAGE 7: Follow-up

The treating psychologist and coach should follow up periodically with the athlete to check progress and ensure support continuity. Other athletes, coaches, or staff who were at the scene of the shooting should also be advised to seek psychological assistance if needed.

Long-Term Plan

- For athletes/coaches/staff who have suffered a major injury related to the firearm incident

- For athletes/coaches/staff who have had suicidal ideations or attempt(s) that have resulted in the seizure of a firearm

- For athletes/coaches/staff who are returning to sport after a Post-Traumatic Stress Disorder diagnosis or other mental health injury/illness/disorder

Goals for the Long-Term Reintegration Plan

The goal is to assist athletes/coaches/staff who have been away from sport for an extended period to return to the normalcy of the sport environment by providing support and training that are outside the scope of what they have received from their healthcare providers (e.g., psychologist, psychiatrist, occupational therapist, etc.). Although the focus of this document is to assist the individual in crisis, other athletes'/teammates' opinions of their return to sport should be considered during the reintegration process. For example, if a teammate/coach/staff is concerned about his/her safety regarding the individual's return to DTE, their opinions should be included in the reintegration process, and the individual's return to DTE should be delayed until all athletes, coaches, and staff feel safe to interact with the individual.

The basic framework for sessions within the long-term program follows the short-term program. One key exception is that sessions are spread out and slowed down for athletes/coaches/staff within the long-term program.

Clinician Approval

Before reintegration sessions can start with an individual who has been suicidal in the past, the work

must be approved by the individual's psychologist and/or psychiatrist.

Skill Building

Strengthening an individual's mental and physical skills is important and relates to the individual's ability to return to sport confidently. These skills will aid the individual in feeling that he or she can return to the normalcy of daily training/coaching or other responsibilities. Strengthening the individual's skills should be viewed favourably by his or her teammates, coaches, or staff.

Exposure Therapy

At times, an individual's concerns center around specific sports-related conditions that the individual's psychologist or psychiatrist cannot access, such as shooting ranges. At these times, the person working with the individual on reintegration into sport (e.g., shooting coach) is integral to the successful return to sport.

Relationship Building

All individuals affected by a firearm incident should feel supported throughout the process and never judged. The individual working closely with the affected athlete or coach must build trust while always protecting confidentiality. Significant levels of cooperation and communication are required with the individual's other care providers. With the consent of the athlete/coach/staff, his or her entire care team can communicate about the treatment options and plans. This cooperation and communication are vital to the individual's success. If the individual is unwilling to communicate or to cooperate, the reintegration into the DTE should be delayed until communication and cooperation are established and all athletes/coaches/staff feel safe (e.g., with the help of a Mental Performance Consultant, Psychologist, or a third-party Mediator).

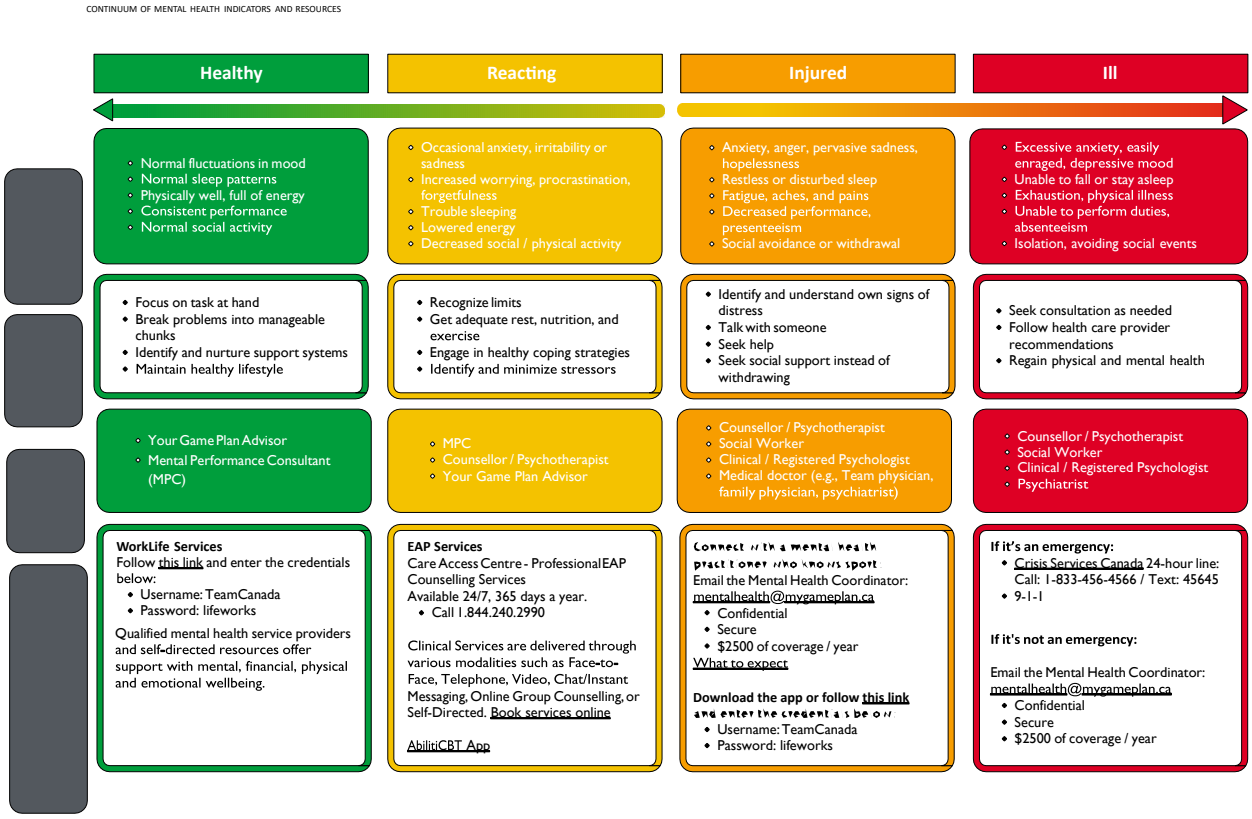
Additional Learning

Members of a team that is helping the individual who is affected by a firearm incident should familiarize themselves with the various psychological treatment options available to ensure a basic understanding of how the affected individual is being treated by professionals. These treatment approaches include but are not limited to Prolonged Exposure, Eye Movement Desensitization and Reprocessing, Exposure Therapy, Systemic Desensitization, and Cognitive Behavioural Therapy.

Appendix A Spectrum of Potential Mental Health Emergencies & Available Resources

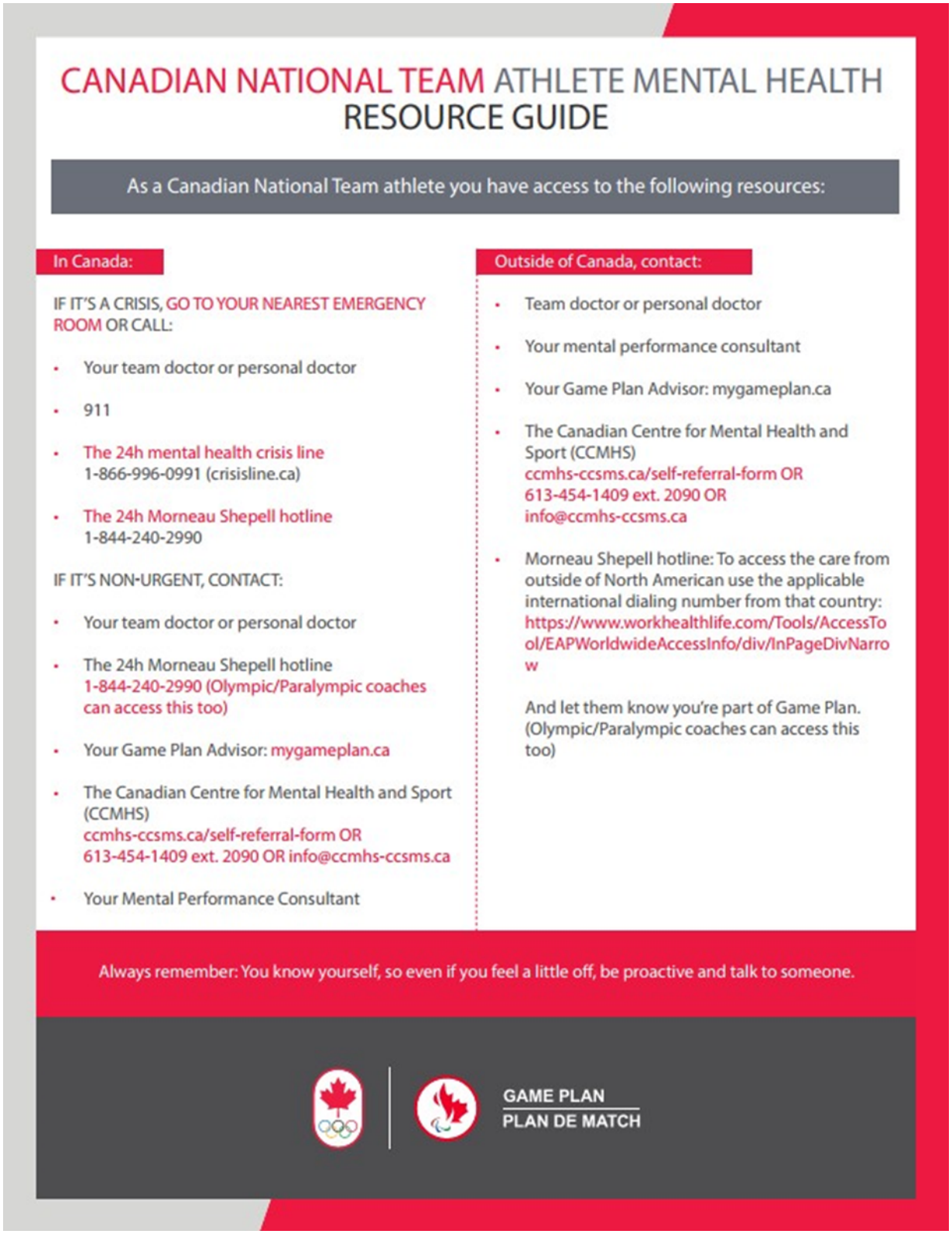
	MENTAL HEALTH CHALLENGE	URGENT CONCERN	MENTAL HEALTH EMERGENCY
DESCRIPTION	Warrants attention but does not involve any immediate risks and can be resolved with a standard referral for mental health support	Warrants immediate attention from mental health providers but does not involve an immediate safety threat to oneself or others	An acute disruption or breakdown in a person's usual pattern of functioning, often resulting in actual or potential harm to the individual or someone else
FOR EXAMPLE	· Overwhelming stress · Trouble managing symptoms of mental illness (e.g., anxiety, ADHD, OCD, eating disorder) · Interpersonal challenges with teammates, coaches, significant other, family · Challenges processing safe sport concerns	· Self-harm or maladaptive coping behaviours that are not life-threatening or causing significant property damage · Rapid mood swings · Panic attacks that are impacting functioning · Medication non-compliance · Substance use and/or abuse · Report of a sexual assault	· Suicidal or homicidal thinking or behaviour · Acute psychosis, mania, paranoia, delirium, or confusion · Interpersonal violence against family, teammates, coaches, or staff · Acute intoxication or drug overdose
ACTION	Make a standard referral	Connect with a mental health provider	Respond immediately, do not leave alone
RESOURCES	· **LifeWorks:** 1.833.456.4566 · **Sport-informed care**	· **LifeWorks:** 1.833.456.4566 · **Sport-informed care**	· 9-1-1 / Nearest ER · LifeWorks Crisis Line: 1.833.456.4566
RESPONSE TIME	Days or more	Today	Minutes
THREAT TO SAFETY	Low to moderate risk	High risk	Imminent Danger
BEHAVIOUR CHANGE	Gradual change	Noticible change	Dramatic and / or sudden
COPING OPTIONS & HOPE	Some ability to cope, some perceived hope	Limited ability to cope, some perceived hope	Limited ability to cope, little to no perceived hope

Appendix B Continuum of Mental Health Indicators and Resources



Not sure which services/resources are right for you? Connect with your Game Plan Advisor for help!

Appendix C Canadian National Team Athlete Mental Health Resource Guide



CANADIAN NATIONAL TEAM ATHLETE MENTAL HEALTH RESOURCE GUIDE

As a Canadian National Team athlete you have access to the following resources:

In Canada:

IF IT'S A CRISIS, GO TO YOUR NEAREST EMERGENCY ROOM OR CALL:

- Your team doctor or personal doctor
- 911
- The 24h mental health crisis line
  1-866-996-0991 (crisisline.ca)
- The 24h Morneau Shepell hotline
  1-844-240-2990

IF IT'S NON-URGENT, CONTACT:

- Your team doctor or personal doctor
- The 24h Morneau Shepell hotline
  1-844-240-2990 (Olympic/Paralympic coaches can access this too)
- Your Game Plan Advisor: mygameplan.ca
- The Canadian Centre for Mental Health and Sport (CCMHS)
  ccmhs-ccsms.ca/self-referral-form OR
  613-454-1409 ext. 2090 OR info@ccmhs-ccsms.ca
- Your Mental Performance Consultant

Outside of Canada, contact:

- Team doctor or personal doctor
- Your mental performance consultant
- Your Game Plan Advisor: mygameplan.ca
- The Canadian Centre for Mental Health and Sport (CCMHS)
  ccmhs-ccsms.ca/self-referral-form OR
  613-454-1409 ext. 2090 OR
  info@ccmhs-ccsms.ca
- Morneau Shepell hotline: To access the care from outside of North American use the applicable international dialing number from that country:
  https://www.workhealthlife.com/Tools/AccessTool/EAPWorldwideAccessInfo/div/InPageDivNarrow

  And let them know you're part of Game Plan. (Olympic/Paralympic coaches can access this too)

Always remember: You know yourself, so even if you feel a little off, be proactive and talk to someone.

GAME PLAN
PLAN DE MATCH

SELF-CARE RESOURCES

Walkalong – Resources to support your wellbeing, improve resilience, monitor progress, and record your thoughts

Anxiety Canada – Resources to manage anxiety including how to relax and strategies for managing unhelpful ways of thinking

Antidepressant Skills Workbook – Strategies to manage depression and change patterns that trigger depression

Centre for Clinical Interventions Modules: What? Me Worry!?! – Information & strategies to manage worrying and anxiety

Centre for Clinical Interventions Modules: Improving Self-Esteem- Information & strategies to manage low self esteem

Centre for Clinical Interventions Modules: Facing Your Feelings: Strategies to manage distressing feelings more effectively

Centre for Clinical Interventions Modules: Assert Yourself! -Information & strategies to develop assertiveness skills

Centre for Clinical Interventions Modules: Panic Stations- Information & strategies to manage panic attacks and anxiety

Centre for Clinical Interventions Modules: Perfectionism in Perspective- Strategies to manage perfectionism

Centre for Clinical Interventions Modules: Put Off Procrastinating! – Information & strategies to manage procrastination

Centre for Clinical Interventions Modules: Shy No Longer- Information & strategies to manage shyness and social anxiety

Centre for Clinical Interventions Modules: Back From the Bluez- Information and strategies for managing mood

Bounceback – Cognitive behavioural therapy self-help for depression; online program with phone coaching. Physician referral needed

Mindfulness Based Stress Reduction – Strategies and skills for coping with stress

Thrive RU Workbook – Workbook for self-care

Self-Compassion – Guided meditations and exercises

Calm app – Meditation and Sleep Stories

Headspace app – Anxiety management & mindfulness

Mindshift app – Anxiety management through anxietybc.com

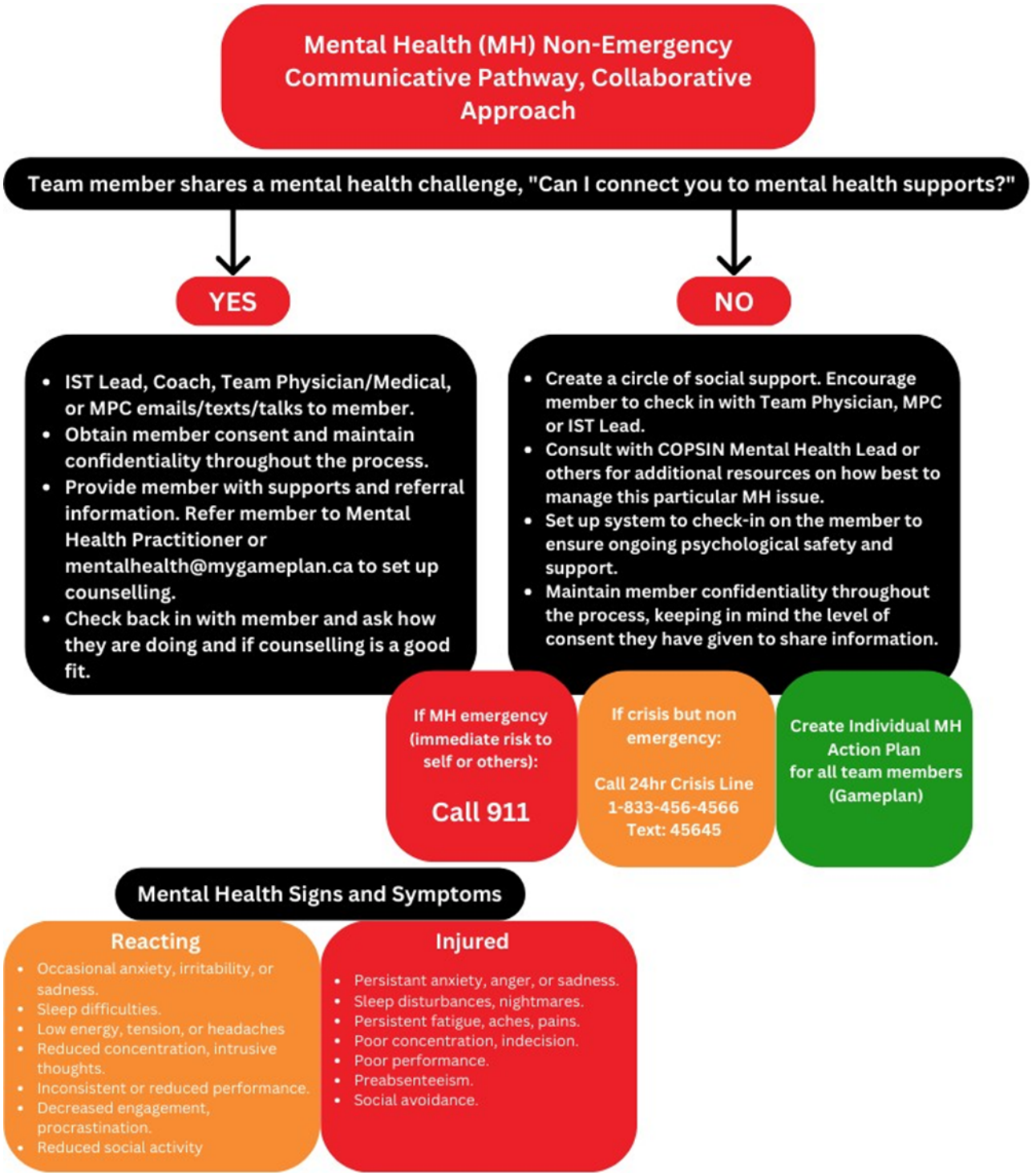
Stop, Breathe, Think: Meditation app – Mindfulness

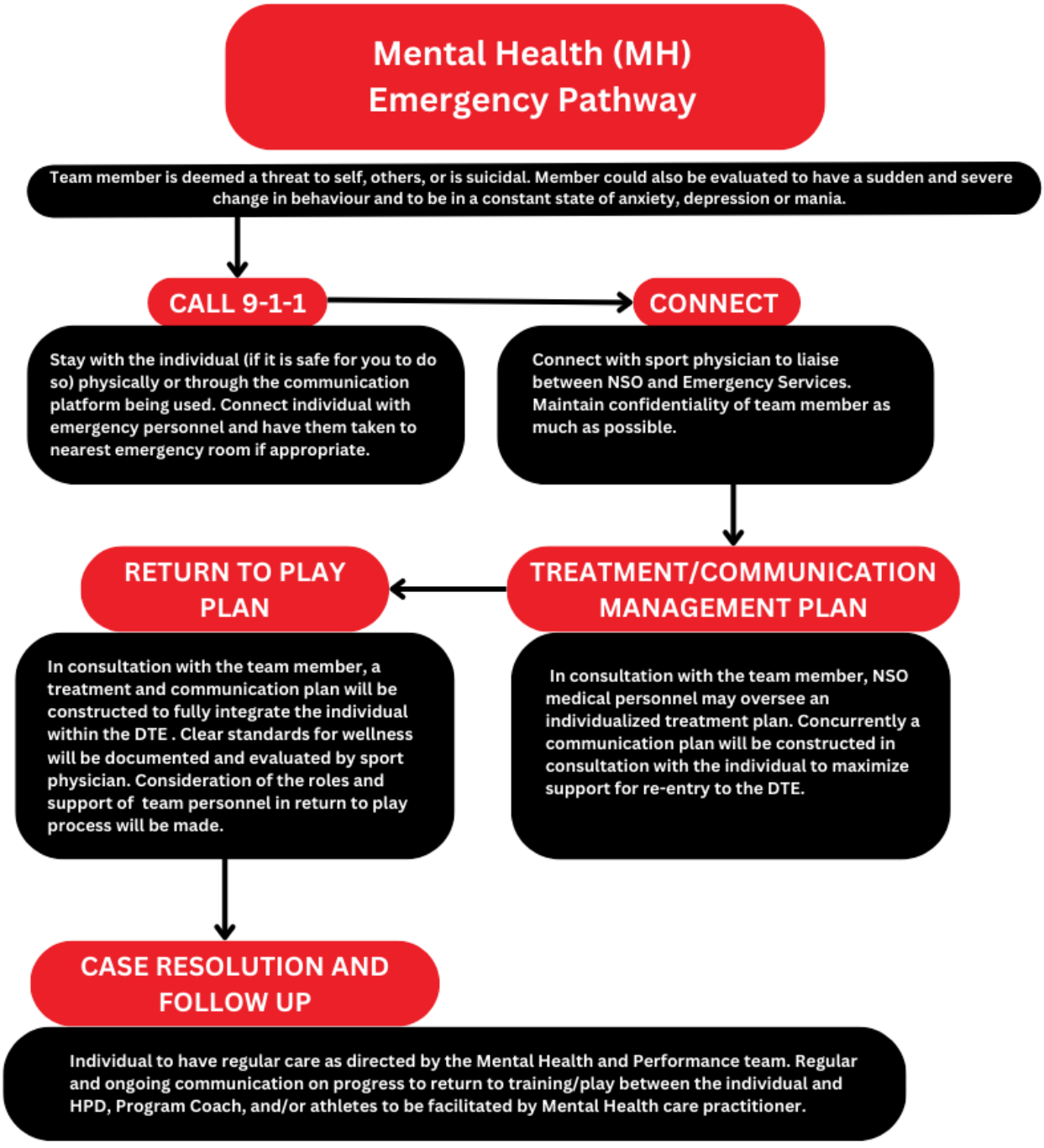
Boosterbuddy app – Self-care, time management/organization, cognitive strategies

Forest app – Focus & productivity

Bipolar Wellness Centre – Self-help website for people experiencing bipolar symptoms

Appendix D Flowchart of Mental Health Non-Emergency and Emergency Responses




Mental Health (MH) Emergency Pathway
Team member is deemed a threat to self, others, or is suicidal. Member could also be evaluated to have a sudden and severe change in behaviour and to be in a constant state of anxiety, depression or mania.
CALL 9-1-1
Stay with the individual (if it is safe for you to do so) physically or through the communication platform being used. Connect individual with emergency personnel and have them taken to nearest emergency room if appropriate.
CONNECT
Connect with sport physician to liaise between NSO and Emergency Services. Maintain confidentiality of team member as much as possible.
TREATMENT/COMMUNICATION MANAGEMENT PLAN
In consultation with the team member, NSO medical personnel may oversee an individualized treatment plan. Concurrently a communication plan will be constructed in consultation with the individual to maximize support for re-entry to the DTE.
RETURN TO PLAY PLAN
In consultation with the team member, a treatment and communication plan will be constructed to fully integrate the individual within the DTE . Clear standards for wellness will be documented and evaluated by sport physician. Consideration of the roles and support of team personnel in return to play process will be made.
CASE RESOLUTION AND FOLLOW UP
Individual to have regular care as directed by the Mental Health and Performance team. Regular and ongoing communication on progress to return to training/play between the individual and HPD, Program Coach, and/or athletes to be facilitated by Mental Health care practitioner.

Appendix E Pre-Travel Mental Health Emergency Action Plan Form

ROLE	NAME	CONTACT INFORMATION
Emergency Response Lead	Name of lead or designation/role for broader applicability (e.g., Athletic Therapist, Physiotherapist, Team Physician, Mental Health Practitioner, Mental Performance Consultant).	
Secondary Responder	Name/role of the individual who steps in if the lead person is unavailable.	
Tertiary Responder	Name/role of the individual who steps in if the secondary person is unavailable.	
WORK THROUGH THE FOLLOWING CONSIDERATIONS:		**NOTES**
Is a list of emergency contact numbers available for all Shooting Federation of Canada members on this trip?		
Are there any safety concerns at the local emergency care centers?		
Who will go with the individual in crisis to hospital and advocate on their behalf?		
Who will stay with them if hospitalization is not possible?		
Who will be the main point of contact for hospital care providers?		
Who will contact the individual's Emergency contacts?		
Who will follow up with the individual in crisis following discharge?		
Who will communicate with other Shooting Federation of Canada members about the care of the individual in crisis? (Remember confidentiality is key, share minimal information.)		
CONTINUITY OF CARE		**NOTES**
Who will be involved in coordinating the individual's care, recovery, and return-to-play plan?		
Does the individual in crisis have a mental health practitioner for support?		
If no support is available, what steps need to be taken to access a mental health practitioner through the national pathways?		
Who will facilitate this conversation if follow-up is needed with the individual in crisis?		
Name and Address of Local Hospital		

Appendix F What (Not) To Say or Do in Case of Emergency – Managing a Mental Health Crisis or Disaster

When providing support for a mental health crisis, it is important to follow established guidelines and principles. Each situation will be unique, and it is important to remain flexible and determine which steps best fit the particular incident.

The following recommendations have been adapted for Shooting Federation of Canada from resources from Psychological First Aid – Canadian Red Cross (Look, Listen, Link, Live), and the National Child Traumatic Stress Network (NCTSN-USA) & National Centre for PTSD, Critical Incident Stress Management (CISM), Critical Incident Defusing Protocols, the Canadian Foundation for Trauma Research and Education (CFTRE), and Crisis and Trauma Research Institute (CTRI). As well as many practical, evidence-based best practices.

Crisis Response Action Plan (4 Steps)

STEP 1: LOOK – CONTACT AND ENGAGEMENT

Aim to determine what has occurred. Who needs mental health support? Who will approach and talk to the person in need of support: teammate, coach, support staff, team psychologist, team physician, or administrator?

WHAT TO DO…	WHAT TO SAY…
1. Stay calm, open, and approachable. 2. Use self-regulation and grounding techniques for yourself. 3. Assess the situation – Listen! 4. Be confident, kind, and compassionate.	1. "*I'm here for you.*" 2. *"I want to make sure you are ok."* 3. *"Can you tell me what happened/is happening?"* 4. *"How are you doing?"* 5. *"I hear you."* 6. *"How is your mental health?"*
DON'T say *"I understand"* – no one can fully understand the lived experience of another. **DON'T** inhibit the conversation by trying to pump them up or give meaningless positives or platitudes such as "*Tomorrow is a new day*," "*There is nothing to worry about*," and "*Keep your chin up*." **DON'T** hijack the conversation by making it about your own experiences.	

STEP 2: LISTEN – SAFETY, COMFORT, STABILIZATION.

Aim to restore physical and psychological safety and provide emotional reassurance/comfort.

WHAT TO DO…	WHAT TO SAY…
1. Find a quiet, safe space to be and/or talk. 2. Give a choice of where to talk, if possible. 3. Be on the same eye level – sit if they are sitting, stand if they are standing. 4. Walking and talking works to regulate the nervous system. 5. Use the rule of two for backup support and Safe Sport protocols (another person in the background, aware of what is happening). 6. Do not be surprised if the individual can't talk about what is happening – the brain's speech center starts to power down in crisis. 7. Limit the impacts of further trauma by ensuring the environment is free from overwhelming images, sounds, and reminders – limit replaying on social media or news feeds. 8. Provide basic needs – water, warmth, snacks, shelter. 9. Actively listen. 10. Reinforce safety. 11. Have a designated support person stay in proximity. 12. Answer questions honestly with accurate and up-to-date information.	1. "*I am here for you*." 2. "*I've got your back*." 3. Give a limited choice: "*Do you want to be/talk here or go over there*?" 4. Reflect, paraphrase, and summarize what you hear: "*Sounds like you are saying that …*" 5. Use empathy – validate emotions: "*No wonder you are frustrated, upset, scared, worried…*" 6. Normalize: "*It's normal to react this way, in this kind of circumstance*." 7. Provide containment: "*I want to ensure you are emotionally safe*." 8. Reassure: "*Together, we are going to come up with the best possible plan for you". We care about you, and we want the best for you."*

13. State what to expect next, if known. 14. Continue to provide information updates.	
DON'T bombard with questions – "*Who? What? When? Why? Where*?" **DON'T** panic if what you hear is overwhelming – in fact, reflect that back to the individual – "*No wonder you feel overwhelmed right now*." **DO** let the individual know you will do your best to come up with a plan, with and for them.	

STEP 3: LINK TO IMMEDIATE RESOURCES

Aim to provide support so that individuals can feel safe and secure and can self-regulate and cope. Providing a sense of psychological "home" and comfort, or even physically going home, has been shown to reduce trauma effects.

WHAT TO DO…	WHAT TO SAY…
1. Encourage social connections with support people: family, friends, teammates, and community support. 2. Identify current specific needs. 3. Collaborate with the individual on an action plan. 4. Provide 2 or 3 helpful choices for the plan (e.g. "*Do you need to stay here or go back to the hotel*?") 5. Give info on typical signs and symptoms of crisis to normalize: a. Cognitive confusion b. Difficulty in decision-making c. Irritability, numbness, avoidance	1. "*Let's make a plan together; even though I know your brain might be a bit scattered right now, I can help you with that*." 2. "*Who is one of your best supports?" "Let's contact them."* 3. *"Where is the best place for you to be right now?"*
DON'T have the individual make significant decisions, especially, if they are shutting down or seem tired, confused, or overwhelmed.	

STEP 4: COPING STRATEGIES, RESILIENCE & HOPE.

Aim to reconnect the individual to their own internal coping resources, resilience, hope, and external adaptive strategies and supports.

WHAT TO DO…	
1. Suggest talking to others. 2. Encourage adequate rest and sleep, hydration, and recovery. 3. Suggest maintaining a normal schedule. 4. Ask which coping methods have worked for them in the past. Canadian 5. Suggest walking outdoors or being in nature. 6. Be patient, understanding and tolerant. 7. Encourage movement and music - stretching, yoga or dance. 8. Practice relaxation or mindfulness techniques.	9. Encourage breathing exercises. 10. Discourage drugs, alcohol, other Substances. 11. Discourage extreme avoidance. 12. Make a referral for counselling – local Resource, team psychologist or the Centre for Mental Health & Sport 13. Provide a list of resources (See Appendix C For Resource). 14. Use Graduated Return to Sport if necessary.

APPENDIX G Athlete Self-Care Plan

Click link for a fillable roadmap aimed to prevent mental health crises.

Appendix H Mental Health Emergencies and Suicide Education Programs		
PROGRAM	**DELIVERY**	**DESCRIPTION**
Mental Health First Aid **1.** Basic **2.** Persons who interact with youth **3.** First Nations **4.** Inuit	In-person or Virtual	Two-day workshop that teaches participants to engage confidently where a person may be a danger to themselves or others, provide help to prevent the mental health problem from developing into a more serious state, and promote recovery of good mental health. **Click for more Information**
Applied Suicide Intervention Skills Training (ASIST)	In-person	Two-day intensive, interactive, and practice-dominated course designed to help individuals recognize the risk of suicide and learn how to intervene to prevent the risk of suicidal thoughts from becoming suicidal behaviours. **Click for more Information**
Livingworks Start	Virtual	90-minute online intervention that teaches trainees to recognize when someone is thinking about suicide and connect them to help and support. **Click for more Information**
Livingworks Safe Talk	In-person	Four-hour face-to-face workshop that teaches participants how to prevent suicide by recognizing signs, engaging someone, and connecting them to an intervention resource for further support. **Click for more Information**
Lifeworks Understanding Suicide Workshop for Leaders	In-person or Virtual	Half-day instructor-led workshop that teaches leaders to recognize the risk factors and warning signs of suicide, better understand protective factors, and apply strategies to help colleagues/loved ones get professional help. **Click for more Information**

Lifeworks understanding suicide webinar	Virtual	1-hour instructor led online intervention that teaches participants to recognize key risk factors and warning signs of suicide, apply tips and strategies to assist colleagues in crisis and connect them with the available support. **Click for more Information**

Appendix I Critical Incident Response Plan and Psychological First Aid

Adapted from: Crisis intervention Approach for Sport developed by Dr. Karen MacNeill, Frank Van den Berg, and Roger Friesen (2013)

Psychological First Aid is an effective person-centered approach to assist people in the aftermath of a critical/traumatic incident, such as natural disaster, major accident, significant loss, or death, (threat of) violence/assault, being the first on scene. Consultation and education are designed to reduce the initial distress caused by critical incidents, foster short- and long- term adaptive functioning and coping, and facilitate return-to-sport/competition intentions.
Support resources and interventions are specifically tailored to the circumstances and needs of the people involved, following best practices and protocols for critical incident stress management.

Objectives:

- To bring people (team) together, and connect socially & purposefully following a crisis, major event and/or disruption to normal routine.
- To support each other and mitigate the impacts that major events may have on the group.
- To provide a safe environment in which people are able to share and vent their feelings, experiences, and concerns.
- To provide accurate and factual information (with discretion regarding sensitive or upsetting details- and should be informed by NSO)
- To acknowledge, confirm, and normalize people's reactions, whether similar in nature or different from each other.
- To offer strategies for reduction of cognitive, emotional, and/or physiological symptoms
- To assess individual and group needs that will inform future planning, support, and resourcing.

Ensure an experienced and qualified facilitator can assist the Emergency Response Team in the following process (abbreviated):

1. **Preparation**
    - Identify roles and responsibilities within the ERT. Who will lead if a critical incident should occur, who are the people you will deploy to the critical incident site?
    - Name individual (leaders, support staff) who will need to receive appropriate training (e.g., psychological first aid, skills for psychological recovery).
    - Develop a communication protocol.
    - Who needs to be informed of the situation, and who do they need to contact?
    - How will the lead communicate and provide updates?
    - Prepare a detailed contact information document.
    - What is the social media plan? What is the media plan?
    - Develop plan and share document/checklist.

2. Assessment and plan response

The assessment phase and response plan development will utilize the following structure:

- Gather information to understand context of critical incident: What happened? When and where did it take place? How many people are affected (directly and indirectly), and who are they? What is the severity of the incident and impacts?
- Needs and concerns: What are the current needs and concerns of team members? Are there any 'at risk' members that need special attention? What are the priorities?
- Supports and resources: Who is providing for basic needs like food, hydration, rest, and accommodation (may just be someone to provide reminders)? What support is currently available to those affected? How can they access this support (e.g., link with expert, provide phone for team to connect with family members)? What resources does the team, and its' members have (coping skills of elite athlete, strength of team, community, etc.)?
- Safety: assess both internal and external risk for personal and team safety.
    - External: What dangers may be in the environment? Are there areas to avoid entering because they are not secure or not allowed? Is the competition site safe to compete in?
    - Internal: Is anyone struggling to cope and take care of their basic needs? Is anyone hyper-agitated or unable to calm themselves? Is anyone demonstrating risky behaviors?
- Determine nature of support needed and how to implement (e.g., what interventions are needed, time, place, individual vs. group intervention).
- Designate roles and responsibilities: Identify who is the contact person of group impacted, identify who is in charge and get contact information, designate, and communicate roles of ERT.
- Revisit Communication Protocol and outline plan for communication/ updates given current logistics.
- Prior to implementing response plan have a formal briefing with ERT members that will be involved in response, key leads and associated members impacted by situation.
- Consult with peers and/or crisis intervention resource/expert regarding intended plan.
- Re-connect with contact person and key leadership personal as described above to provide update, confirm logistics and timelines.

3. Respond and reassess

- Implement communication protocol, contact/update key individuals, reaffirm roles/responsibilities. Know your limits and recognize when a trained professional is needed and reinforce the importance of self-care.
- Respond: implement key principles of crisis intervention as needed and planned.
- Safety – (both internal and external) bring people to a safe place, provide accurate and organized information to help manage inaccurate perceptions and feeling of threat,

encourage limit exposure to panicked discussion, news and media that can create misappraisal of traumatic events.

- Calming – Help individuals solve concerns, give updated and accurate information, provide psychoeducation on normal reactions to abnormal events, try to limit stimulus, and encourage use of relaxation activities.
- Resource and empower – identify and emphasize resources, skills, strengths, and capacity of individual members of team that they can use to get through this situation (e.g., What strengths do people have, how are people coping positively, what resources/ strengths does this team have as a collective)
- Connectedness – Help individuals to identify and link to sources of social support (loved ones, teammates, friends), encourage, and foster a sense of support, respect individual differences.
- Hope – Revisit strengths that they have as individuals and a team, identify opportunities that may exist in this situation.
- Consider what other interventions or referrals (current and post/ follow-up) are required, based on on-going assessment of needs, such as:
    - Psychoeducation to normalize reaction (validate, normalize, reframe- normal reaction to abnormal event)
    - Group meeting to equalize information- everyone has accurate facts and same story.
    - Psychological defusing (as per CISM protocol) to enhance normalized reaction, reframe, restore cognitive processes, equalize information,
    - Referral to psychologist- during event or after event in follow-up week/months post event.
- Implement media plan.

4. Reintegration in performance setting and follow-up

- Assess scenarios, demands and training/competitive schedule.
- Adjust and/or re-affirm performance goals/objectives.
- Adjust focus, performance, and distraction control plan.
- Assess increased risks resulting from event (risky behavior, lack of focus etc.) and determine if safe to proceed with competition.
- Identify what follow-up is needed post competition (e.g., monitoring, referral etc.)

Typical Response to Traumatic Events

There are a range of reactions that can emerge following a critical incident or traumatic event. This anxious or stress response is your body's physical and psychological response to anything you perceive as overwhelming. It is important to remember that trauma or stress reactions are normal reactions to abnormal situations. A typical reaction to a traumatic event may include the following symptoms:

Stress Warning Signs and Symptoms	
Cognitive Symptoms	**Emotional Symptoms**
▪ Memory problems and confusion ▪ Difficulty concentrating, intrusive thoughts ▪ Difficulty with decision-making, not able to think as quickly or easily as usual ▪ Seeing only the negative ▪ Anxious or racing thoughts ▪ Worry and rumination ▪ Disorientation ▪ Self-blame **Positive responses** ▪ Determination and resolve, sharper perceptions, courage, optimism, faith	▪ Heightened anxiety, fear, or shock ▪ Irritability, or short temper ▪ Feeling overwhelmed, sad ▪ Feeling numb or detached ▪ Sense of loneliness and isolation ▪ Depression or general unhappiness ▪ Moodiness, mood swings, or intense reactions ▪ 'Survivor guilt' or feelings of shame **Positive responses** ▪ Feeling involved, challenged, mobilized and Alive
Physiological Symptoms	**Behavioral/ Social Symptoms**
▪ Headaches, other aches, and pains ▪ Nausea, upset stomach, diarrhea ▪ Dizziness or fainting ▪ Chest pain, rapid heartbeat/breathing ▪ Fatigue ▪ Agitation, over-excitability, restlessness ▪ Exaggerated startle response ▪ Muscle tension **Positive responses** ▪ Alertness, readiness to response, increase Energy	▪ Loss of appetite, eating more or less ▪ Hyperactivity or less activity than usual ▪ Insomnia: inability to fall asleep or stay asleep, disrupted sleep, sleeping too much ▪ Extreme withdrawal, social isolation ▪ Procrastinating or neglecting responsibility ▪ Avoidance of activities or places ▪ Self-medication **Positive responses** ▪ Social connectedness, altruistic helping Behaviors

Common negative reactions that may continue over time include:

Intrusive reactions

- Distressing thoughts or images of the event while awake or dreaming.
- Upsetting emotional or physical reactions to reminders of the experience (exposure distress).
- Feeling like the experience is happening all over again (flashbacks).

Avoidance and withdrawal reactions

- Avoid talking, thinking, and having feelings about the traumatic event.
- Avoid reminders of the event (people or places connected to what has happened.
- Restricted emotions, feeling numb, feeling detachment from others.
- Loss of interest in usually pleasurable activities.

Physical arousal reactions

- Constantly being on the lookout for danger, startling easily, or being jumpy.
- Irritability of outbursts of anger, feeling 'on edge.'
- Difficulty falling or staying asleep, problems concentrating or paying attention.

Factors that can help and hinder the management of common reactions

What can HELP	What can HINDER
• Using calming strategies (breathing, mindfulness, soothing music) • Getting support or spending time with others • Engaging in positive distracting activities • Lots of rest and taking breaks • Healthy meals and hydration • Exercising in moderation • Keeping a journal • Seek counselling as needed • Self-monitoring- be aware of responses	• Using alcohol or drugs to cope • Extreme avoidance of thinking or talking about the event • Violence or conflict • Overeating or not eating • Extreme withdrawal from family or friends • Not taking care of yourself • Doing risky things • Withdrawing from pleasant activities • Excessive TV or computer games

Traumatic Stress Management Strategies

- **Self-monitoring and normalization**- be aware of physical responses, negative thoughts, emotional reactions and rushed behaviors. Normalize these reactions as part of common traumatic stress response.
- **Sleep-** Get adequate rest, take short power naps as needed, implement sleep hygiene strategies.
- **Calming strategies and relaxation**- Deep belly breathing, mindfulness, soothing music.
- **Practice helpful thinking**- Be aware of what you are saying about the traumatic event and identify and practice more helpful styles of thinking.
- **Social support**-Reach out for support and spend time with friends/ family that help to reduce sense of isolation.
- **Exercise**- go out for a walk to change the scenery and get the blood flowing.
- **Fun and meaningful activities**- Distract yourself from your reaction by engaging in hobbies, helping others, re-establishing routines, and/or taking part in satisfying activities.
- **Nutrition**- manage caffeine and alcohol intake, keep healthy snacks on hand.
- **Other**- use helping coping strategies that have worked for you in the past.

Resources

- Helpguide.org- information on post-traumatic stress responses, grief reactions, and sleep hygiene tactics
    - https://www.helpguide.org/articles/ptsd-trauma/ptsd-symptoms-self-help-treatment.htm
    - https://www.helpguide.org/articles/sleep/getting-better-sleep.htm
    - https://www.helpguide.org/articles/grief/coping-with-grief-and-loss.htm

(Stress resource prepared/reviewed by Dr. Karen MacNeill, Jeanne Leblanc, and Frank van den Berg)

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MHEAP Shooting Federation Canada

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