Invictus Games Radio Podcast: Episode One – Colonel Rakesh Jetly

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**PJ:** Welcome to Invictus Games Radio. I'm PJ Kwong.

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**PJ:** On today's episode, a fellow of the Royal College of Physicians and Surgeons of Canada and of the American Psychiatric Association. He is currently the head of the Center of Excellence on Mental Health, directorate of mental health and an associate professor of psychiatry at Dalhousie University, Queens University and the University of Ottawa. He's published numerous articles and speaks nationally and internationally on topics such as post-traumatic stress disorder, which is what I'm going to talk to him about today. I'm delighted to welcome Colonel Rakesh Jetly.

**Colonel Rakesh Jetly:** It's a pleasure to be here.

**PJ:** You are wonderful to do this. Okay I want to know first of all, tell me about your interest in psychiatry. Where does it come from?

**Colonel Rakesh Jetly:** Ah, that's an interesting question. I'm a UofT grad…

**PJ:** Me too!

**Colonel Rakesh Jetly:** … and I finished medicine but I joined the Canadian Armed Forces while I was in medical school. So like a lot of us, we started off as… So I was always sort of interested in psychiatry during medical school, but the way the military program works, we are general duty medical officers or GPs**,** your family docs, whatever you want to call it. I became a flight surgeon as well… Which so, during my four years of doing that, just sort of north of Toronto on a base called Borden, I got a chance to deploy a couple of times. I went to Israel for about six to seven months and I went to Rwanda in 1994 and really saw a lot of the trauma and stress and the humanitarian crisis that was Rwanda and in fact, applied for the post-grad training while we're in Rwanda. There was a competition and so, always kind of had an interest and then I think Rwanda helped peak that interest in stress and trauma and so your 96 came back and did four years of

post-grad here in Toronto and become a psychiatrist and since 2000 I've been a psychiatrist with the Canadian Forces.

**PJ:** And when you're dealing with/when you're talking about post-traumatic stress disorder, it has its roots in shell shock. Am I correct?

**Colonel Rakesh Jetly:** Yeah I mean, I think, I mean, it's really interesting. You know, you never want to do a disservice as, you know, there's lots of trauma out there, a lot of the research on sort of, you know, horrific things like sexual trauma, rape, childhood trauma. There's also a motor vehicle accidents. You know, Canada with through the large immigrant and refugee population, people have been exposed to horrific things. That's sort of the one side of it. The other face of it and one that's sort of been a driver for the last 100 years as the anniversary of World War One really has been from war, the exposure that people have had, you know, whether its shell shock, battle-fatigue, you know, all of these different kinds of disorders and really 1980 was when the PTSD, post-traumatic stress disorder, was first coined by the American Psychiatric Association, largely to explain the phenomena that was occurring in the post-Vietnam troops. So you had a lot of these lot of these young men and women coming back that were behaving strangely, you know, people thought some of them had schizophrenia, they were psychotic because they were seeing things and hearing things with their flashbacks. So it wasn't quite explained by depression, wasn't quite explained by substance use, wasn't quite explained by anxiety, so putting together this disorder that involves, sort of overwhelming trauma, than the consistently re-experiencing of that trauma, whether it's nightmares, flashbacks, those types of things, the avoidance, the I don't want to be reminded of it, so I'm not going to watch TV, I'm not going to see people that remind me and then that hyper vigilance and that arousal that we see. So really it was the DSM-III, the American Psychiatric Association, that coined the term with a few revisions, there have been revisions. The DSM-5 just came out a year or so ago. So really has been the military trauma that's been driving a lot of it and really, you know, the western world has come out of ten years of pretty significant war in Iraq and Iran and, sorry Iraq and Afghanistan, was certainly understanding more and more have more questions about this whole PTSD phenomenon.

**PJ:** And as we're seeing it in the military, there's been a huge spike in cases or incidences of post-traumatic stress disorder and is it just because the diagnosis, being able to diagnose it has become better? Or is it…

**Colonel Rakesh Jetly** : Well, you know, I think I mean I think we've got pretty good science that shows, you know, we're lucky in Canada because we, in 2002 we did a very, very nice and rigorous study of PTSD, sorry of all mental conditions, of all mental illness in our forces, and then we did a similar study in 2013. So we basically had a study, two studies, that looked at PTSD, depression, all of these conditions, sort of pre-post- the war, but also at a time when a great deal of renewal and interest, stigma reduction, this kind of thing occurred. So we have found fairly reliably a doubling of our PTSD rate. You know, so the past year PTSD rates gone from, you know, about two-and-a-half just over five, so roughly doubling of the rate and that really is accounted for by the war, accounted for by the exposure, particularly of people sort of outside the wire, in direct combat, so we're seeing differential rates of people that were, depending on the trauma that was exposed, we're understanding more and more that it's not just about deployment, it's about what happened during the deployment, where you are, what you're doing, how much you're seeing. So I think there's a genuine increase in the rate of the illness. The good news is, there's also increase in help-seeking. Canadian Forces members are seeking care more than ever. We are understanding the illness a little bit more, so treatments are getting better with continuing to innovate. So in many ways, you know, war is a driver of enhancements in medicine, just like World War I plastic surgery, World War II antibiotics, so I think, you know, our understanding of sort of serious psychological stress is really going to be accelerated by what's occurred in the last decade.

**PJ:** As you talk about what people are exposed to and the types of different traumas, is it also a little bit dependant on the kind of person? Coming as a psychiatrist, are you looking at different personality types that are more prone to this?

**Colonel Rakesh Jetly:** It is. That's a great question. We have certain risk factors that increase your relative risk right, but there's nothing that's so strong and powerful that we would say you shouldn't go. So, I mean, for example, being female puts you at slightly higher risk…

**PJ:** Ok.

**Colonel Rakesh Jetly** : But most females that deploy won't develop PTSD. So the overall rate of the 40,000 or so troops that, in some way or another went in support of this mission, is about 8% of the four year mark. So the majority of them aren't going to get ill but, you know, poor coping skills, prior mental illness, family history of

mental illness… There's four or five of these risk factors but we don't have one that kind of says, "Hey kid, you know, we need to give you this extra training or you need to watch out for this." So that's part of the search as well, to try to predict and longitudinal studies, sort of studies done over time but will give us some of that. So the Americans are doing some studies, the Dutch are doing some studies, Australians are doing pre- post- and we might be able to find sort of either a genetic or disposition that puts people at higher risk. Not to exclude them from going, but just to identify the risk and give them, perhaps, further resiliency and mental health coping training.

**PJ**: Is there also, I think is the people the superior officers, is there kind of a willingness to sort of look at who they're managing to try and figure out what to do with people?

**Colonel Rakesh Jetly:** Well there is and so what we've what we've done right now is, I think, the messaging that we've done, like emphasizing the PTSD, you know, to some extent, is kind of wrong. But we need to switch that a little bit and just really talk about mental health in the workplace. Right, it's not about PTSD or depression, you know, after trauma, PTSD, depression, substance use can all occur, so the one-on-one sort of correlation PTSD. So really we should be thinking about, you know, we have a workplace like every other workplace, sometimes our office's in Kandahar, sometimes our office's in downtown Toronto.

**PJ:** Yeah.

**Colonel Rakesh Jetly:** But, so developing a mental health strategy for mental health in the workplace will take care of the PTSD problem, but developing PTSD strategy isn't going to take care of the mental health in the workplace thing, so we think about it overall. So what we've done is, we recognized how prevalent mental illness is in the Canadian Forces it's, you know, slightly higher than the regular population or depression rates are higher, you know, adverse childhood events are about 30 something percent in society there are about 50% of people that join the military.

**PJ:** Really.

**Colonel Rakesh Jetly:** So we recognize that, you know, there's a population at risk like every population, like at the University of Toronto. So what we do is, because we can't necessarily, you know, with confidence identify people at high risk, what we're

doing is we're doing sort of general mental health training. Teaching people using sports psychology, you know, positive psychologies, of, you know, visualization, self-talk, goal-setting. We're teaching that right in basic training. We're enhancing people's psychological strength and also giving people sort of permission to, hey if this doesn't work, seek help and then as you advance in your career, you know, so this is again the leadership point is that that precious time during basic training, when you ask this the leadership, "hey, can we take time during basic training?" Absolutely. Then we have, as people advance in their careers, you remind them how to look after themselves, but how to look after other people. So again, that's inserted in all the career courses before deployment, during deployment, after deployment. There's mental health training and education as well. So we've taken to the population-based approach to enhance the skills of self-care, other care, peer care, in our folks. We have specific leadership training as well, to give leaders the right tools and how to manage sort of mental health care issues in the workplace kind of ideas. So we've done absolutely what we can to try to make that cultural change occur, but not just change the culture, but actually give people the tools to deal with it and then of course the care itself.
Really making sure that the treatment, the evidence-based care is there. Then we're going to cell was looking at research itself, which is part of the cell that I'm in charge in Ottawa as well. So I think we've taken sort of a multi-faceted approach and the key is a population-based approach because the entire population is at risk. You know, just like we talked about suicide, if you started to say suicide is about gay teens or it's about bullying, I mean you're missing the mark because over 4,000 Canadians kill themselves every year.

**PJ:** Wow.

**Colonel Rakesh Jetly:** So we know we need to have an approach for suicide. Period. And then somewhere in there we could have approaches for different populations in the same way we're trying to cover everybody.

**PJ:** I've had the chance to speak to a couple of veterans by this point who tell me that in coping with PTSD, before they realize that's what it was, they were trying to white-knuckle their way through you what they were doing. They were trying to live up to an image of themselves that they thought of tough and indestructible and all this. There's a point at which they just kind of collapsed.

**Colonel Rakesh Jetly:** Yeah.

**PJ:** How does that collapse manifest itself?

**Colonel Rakesh Jetly**: Well that's an excellent point. I think, you know, a really good analogy with soldiers, you know, sort of with athletes right. So an athlete hurts their knee or they hurt, you know, we've had that whole issued concussion in sports, something. So the idea, whether it's denial, whether it's, you know, like, Canadian soldiers have a have a no-fail kind of approach to things. Like nobody gives anybody a task and says, "See what you can do."

**PJ**: Goodluck.

**Colonel Rakesh Jetly:** Yeah, goodluck. The idea is, let's take that hill, hold that hill forever. Let's go there. So we never go in with the idea of let's give it our best, it's actually let's do it. And so that kind of… And that's actually what you want in soldiers. You want, you know, you want to win wars, you want to sort of rescue people in earthquakes, you want to be able to keep, you know, keep Canadian safe. But there comes a point… So one of the things that kind of happens is it works out in different ways. You know, a big number of people… it's when it starts to really take a toll on the family.

**PJ:** Okay.

**Colonel Rakesh Jetly:** Right, so quite often it will be, you know, you'll do something that will scare your own kids or, you know, your spouse will say, "Okay that's enough." I mean either get help or with them in this kind of idea. So that's a big group. I think that's a wake-up call, because, you know, soldiers I mean, it's one thing you have that tough-tough stereotype but all you need to do is go to a Walmart near base and you'll see there's 6'3 guy being led around by his three-year-old. Right? So it's… Families are extremely important. I think that's a piece. I think the other pieces sometimes they'll see their work performance, like the matter how much they try, it's not working. So it's the family realizes it sometimes, but he's in the workplace and sometimes it's yourself. So I think its various ways. What we've tried to do is, we've tried to create in our mental readiness, our mental health training and education, we try to create this mental health continuum so people have a better way and not self-diagnosis, I mean, I think that's a mistake that we've all done in the past by giving people symptoms and signs of a disease. Rather, you know, we've got a green, yellow, orange, red zone am I in, you know, how am I behaving, how my sleeping, how my interacting, how's my sense of humor and see if and do a quick self-check of how you're doing. So I think we're seeing that more and more. What's really nice is, you know, when I

was in Afghanistan a few years ago, you know, a senior leader brought in his troops and said, “Hey doc, you know, I think, you know, a lot of my guys are in the orange and we've tried doing all that stuff. It's not working.” So right in the middle of the row three hospital during a war, you know, he brings in his guys and the mental health team checks them out, right. So the kind of, they’re kind of understanding that, you know, you can have good days and bad days and you start to have more bad than good or, you know, bad starts to get to worse get help, right. And so we're seeing an increase in help-seeking just based on people understanding that, you know, the what's going on isn't right and they need to get care.

**PJ:** The whole brothers-in-arms, brothers and sisters-in-arms, does that create an environment of support? Or one of contagious, contagion?

**Colonel Rakesh Jetly:** Well yeah, I think the contagion is fantastic because it can go both ways.

**PJ:** Okay.

**Colonel Rakesh Jetly:** Right, so if momentum starts going like, you know, “suck it up,” if you have that kind of tone, then it's positively harmful, but if you have real, honest discussions, which we teach our people to do and our good leaders will do that. We want, you know, junior leaders, you know, after a combat, you know, to sit around look people in the eye and say, “Hey, you know, what first time I ever did that, I nearly pissed my pants too. That was so frickin’ scary. So wonderful some of you young guys are you feeling the same thing I felt 15 years ago.” Right, so that there's an apprentice kind of model as well, so leaders can model that behavior and we've been so fortunate. I mean we've got, you know, Admiral Norman who's our Vice EDS was the head of the Navy has talked about his own mental health issues and seeking care and his career’s advance. So the more and more we destigmatize and normalize it and then model that behavior and so for leaders to kind of say, “Hey, you know, I had a bad time,” to “Hey, I went for care.” And we're getting more and more of that kind of thing. So I think I think be the brotherhood… There's evidence as well that is helpful, like for example, you know, I mentioned that, you know, our men and women that joined the military have a higher rate of adverse childhood events and that sometimes things to suicidality.

**PJ:** Okay.

**Colonel Rakesh Jetly:** But that's the strength of the link to suicidality in the military is weaker than civilian link.

**PJ:** Really.

**Colonel Rakesh Jetly:** So that may be something protective about, so we'll take more people that have the sort of vulnerable childhood… But there's something protective about being in an organization where you belong and you have purpose and all those kinds of things. So I think from the determinants of health point of view, is military if you're employed, you have insurance, your training, you have a sense of belonging, hopefully challenges this kind of idea. So I think that we can… We have opportunities that a civilian workplace wouldn't have so we need to leverage those and basically enhance the support that people have.

**PJ:** You know, it's so interesting. One of the things that I'd love to understand more, you're in a war situation, you see something terrible that's truly traumatic and for some reason you're able to get all the way through the rest of your tour, you're able to get home and it does not hit for some time later. Can you please explain?

**Colonel Rakesh Jetly:** That it's not something that's easily explainable. In fact, that very phenomenon has led to change in the diagnostic criteria like from DSM-IV to the DSM-5. In DSM-5, you know, to have PTSD, you had to have the trauma occur, the A1 trauma, which is something horrific overwhelming and then you have to have that horror, helplessness, shock happen.

**PJ:** Okay.

**Colonel Rakesh Jetly:** To have PTSD. If you didn't have that, you couldn't have PTSD. Which certainly makes sense if a woman being raped or something.

**PJ:** Sure.

**Colonel Rakesh Jetly:** Of course she's having it. What happens with soldiers and maybe the training kicks in but, you know, the, you know, an IED attack occurs. Right, your best friend sitting across from you dies right. But immediately, you know, you secure the perimeter, you make sure that the enemy is going to attack, that you repel them. You take care of the wounded, you look after other people first, you clear landing zone for the helicopter if it has to take away the wounded. So you immediately… So I think part of what happens is training kicks in and that

training… Part of training, whether you're in elite athlete or a soldier of Allah or surgeon for that matter, is the idea of compartmentalizing, right. So I think a lot of people are able to compartmentalize things. Compartmentalizing is a good short-term coping, it's not good long-term coping and I think that once the stress of the war and the purpose of the war is gone, then you might sort of, open up that compartment a little bit and then then try to understand what it all meant and it might be grieving your fallen comrade, it may be wondering should I, could I, or just simply not being will turn off so. You know, our colleague, Charles Hoge, whose one of the preeminent psychiatrist, retired colonel from the States wrote a book Once a Warrior and he talks about the PTSD-type symptoms perhaps being protective in a war zone. Being hyper aroused and, you know, really experiencing something is how you learn. By not making the mistakes and, you know, you're avoiding the dangerous things is helpful. So you think about the caveman days, I mean, you don't want to sort of peek around the corner when you hear a rustling and then suddenly realize it's an animal. So there's a bit of that adaptive piece to it so it might have been there in theory, but it may not have seen so odd and when you're home, it may be. So I think the whole bunch of different, sort of, theories about it, but you you will see everything from like somebody from the moment it happens, they freeze and they're done. To people that sort of are impacted but sort of carry on and to people that really appear not to be impacted but then it's months to years later. So you can actually see this this whole idea of things that I just think it's a matter of how that individual brain processes that doesn't process them. Keeping in mind, the vast majority of people, you know, don't get the disease.

**PJ:** Right.

**Colonel Rakesh Jetly:** Right, that's the other part, because we're talking about it. Now, my belief really is that a 100% of people that deploy have a life-changing experience. As it's pretty hard to go to war zone or to a massive humanitarian crisis like Rwanda or Haiti and not come back seen the world a little bit different. But that's the same as, you know, in some ways of when you have a child. I mean these are life changing experiences and they're not necessarily for the worse, it might actually be, you know, might have overcome challenges that you never imagined, you know, growing up in your small town that you'd lead 200 people across the battlefield and have them all come home alive. This kind of idea. So that's the important, to keep in mind, some people… I mean everybody's impacted to some extent, it's a life-changing experience, you know, a minority, but a significant minority, get this disease called post-traumatic stress disorder. Some people develop sort of a depression and you have to depression after trauma,

you have substance use, you can have any kind, which is why we kind of coined the term OSI, operational stress injury, kind of our paradigm to sort of capture, you know, a multitude of psychological things that can happen after deployment.

**PJ:** You know, it's so interesting because in reading up but before talking to you, one of the things that struck me is the fact that treatment, as unique as it is to have people stricken with PTSD, the strategies for helping somebody cope with are as unique as the people. So it seems that it's not like, you know, antibiotics, everybody would you get strep throat you get X, it seems like… I was interested in the program, two programs, one of the (hold on) EMDR and the other one had to do with the walking.

**Colonel Rakesh Jetly**: Three MBR. Well yeah, treatment so, you know, the treatments are, in some ways, they appear varied, but really, you know, what it's about is, it's about having the person connect the emotion to the experience and then to expose themselves to it until they're desensitized and habituate to it right. So which comes a little bit from the anxiety disorders paradigm. So if you think about, you know, if I asked you to watch the scariest movie you've ever seen before you've got to watch with one eye closed and then if you watched the 10 days in a row, by definition the tenth day would be less scary the first day.

**PJ**: Okay.

**Colonel Rakesh Jetly**: It might not be about not scary, but it's going to be less right. So the idea… So prolonged exposure, those kind of treatment, they're hard treatments, lot of people drop out because it's, you know, if you're trying to avoid it but we're going to go through it. There's a piece of getting meaning to it. It's not just a simple as exposure, if you're afraid of mice or something like that, but the principles are from there.

So EMDR is a way of exposing yourself by having a person think about the trauma, think about the event, you don't have to share it verbally, but you just go there. Then I'll ask you sort of where do you feel it in your body and what moods come and then you sort of move your eyes back and forth tracking my fingers across from each other. And the idea, I mean, so it's not hypnosis, it's not… But really what it is, in a way, what it is, it's helping you to process the trauma and the eye movement keeps you grounded. Without getting lost completely in the memory and so the idea really is to think about the trauma, think about the feelings, and it's understanding the fact that this whole mind-

body duality is probably wrong right. Like so if you're thinking about something and you feel it in your belly, your belly gets sore… Or let's think about your belly as well, then let's connect to hold the whole body. So Three MDR is this kind of interesting therapy that, you know, the Dutch and us sort of put together where we're combining… We're using the big virtual reality, kind of a cave with a treadmill and what we're asking people to do is bring in their own music, bring their own pictures of the war, so not traumatic ones, but reminders and then as they're walking, again because, you know [name omitted], my Dutch colleague and I, whenever we meet we go for run together, we enjoy… We both believe in activity and we think about there's no more active people in the world than soldiers, but traditional therapy is always sitting down, lying down, or people being still and so many of our patients 20 minutes into a meeting, they stand up and start walking around. So this treadmill… They're walking around, you know, four and a half, five kilometers an hour, so good pace, gets the heart going a little bit and then they're… As they walk through this paradigm their image, their reminder of the war comes up and then there sort of literally and figuratively walking towards their trauma. So it's a sense of control, a sense of walking towards it and when they get there, we do the same EMDR type of protocol: what is this picture of, what does it remind you of, how do you feel when you see it. Then they do the eye movements, we try to process it through. So to using a bit of virtual technology, using a little bit of sort of a modern thing, and the idea really is that… So far as we've got a small pilot the Dutch have done some, it seems to be helping people, especially helping people that traditional therapies haven't worked for and so part of what we need to do is, we need to continue to innovate and come up with new ways because the traditional therapies, while they work, you know, there's no treatments in mental health at work a 100% of time for 100% of people. So we need to continue to look at sort of better ways using technology and better ways of doing things that and if it's therapy is appealing, even if it's not more effective than the traditional therapy, maybe less people will drop out, more people will be interested in doing it so.

**PJ:** You said something that just interested me right now, which is where I'm headed next, which was about activity. So tell me how sport and how participation Invictus Games how that can help a person.

**Colonel Rakesh Jetly**: Well I think, you know, I mean, jeeze, there's so many different ways and first of all, you know, as a physician, I mean I have now been… I've been in the military longer than half my life kind of idea, I've been a position for a large part of that, I've never told a patient to exercise less. ***[Laughs]*** Right? So really, I mean our surgeon general sense, you know, if you can change behaviour, if we could get

people to exercise more, eat better and sleep better, you know, over half the diseases would be gone right now. So the benefit of exercise are without question there and I think, you know, it's true for everybody and for ill and the injured, is probably maybe even more important as part of recovery. I think injury, from a psychological perspective, symbolizes a loss, right? And with loss comes grieving and with loss and grieving sometimes come negative cognitions of: I'm not whole anymore, I'm not competent anymore, and if you lose your competence, you lose your confidence, this kind of idea. So I think, you know, giving yourself a challenge and then meeting that challenge, perhaps overcoming the obstacle, probably gives you that confidence and confidence back right and helps you to realize that, you know, I'm a guy with one leg missing, or I'm a guy with an eye missing, or I'm a guy with a with a mental illness, but I'm still me. I'm still capable of doing lots of things and, you know, we look at many, many inspirational people, you know, we look at, you know, like Gandhi, Martin Luther King, you know, many, many… You know, Abraham Lincoln, many people that did, you know, well… Nelson Mandela… You know, many people that had mental illness, did exceedingly well. Right? So the idea of having an injury or a mental illness and competence and ability, they're not mutually exclusive, right? So I think, you know, these guys and gals are going to really represent the idea of, you know, just because I've been injured doesn't mean, I know, I'm conquered, I'm defeated. I can actually, you know, overcome and succeed. I think, you know, we're here at CAMH and just talking to some of the colleagues of how, you know, this can actually be inspirational for all the patients, the thousands of patients they see here every year, if you had addiction problems, depression problems, you know, sign up for a 5k run, you know, for breast cancer, achieve and do that in the sense of challenge and accomplishment. So I think it's just the human element of reminding people of as humans, we like challenges, we like to overcome, this kind of idea and I think the idea here is that it's pretty hard for there to be zero competition, but the idea really here is to compete and to achieve and to challenge yourself. So I mean, there's no question that that's positive for people's health.

**PJ**: There's no downside.

**Colonel Rakesh Jetly**: There's no downside, there's no downside. And so it's on the plus side, I mean it reminds… It's a poignant reminder to our society of sacrifice and I think you know a city like Toronto that's, you know, the largest city in the country and there but there really isn't a solid military presence here. So I think it's, you know, there's places like Halifax, the Navy's there then, you know, there's lots of places in the city where military plays a bigger roll. I think, you know, for it, for

the Canadians and the people of Toronto in particular, to see, you know, that the reminders of what war does and the sacrifice that people make in order to keep us safe, I think there's a piece of that. Wow. I think but instead of it being a negative story can, it can also be a transformational story of positive achievement and things. So I think there's no downside.

**PJ**: Two very quick final questions. One is, if somebody is listening to this podcast and they're not feeling well, what should they do?

**Colonel Rakesh Jetly**: Well I think, you know, I think, talk about it. I think the idea, you know, we have as our sort of our suicide, you know, platform our strategy, we talk about three things. We talk about, you know, excellence in mental health care, we talk about the role of leadership, but the third pillar is the individual themselves, because you could have the best system in place, but if people don't, you know, don't reach out for help. So I think, you know, I mean if it's an emergency of course 911, the nearest emergency room. If you're a military member, we've got our sift map, you know, our 1-800 number for our EAP program, completely confidential. You can walk into any one of our clinics and a mental health professional will see the same day if you're a veteran. Veterans Affairs has great programs in place as well and I just think, you know, I think that the really unfortunate thing about people that suffer is that, whether it's suicide, whether it's mental illnesses, that it's not necessary like, you know, putting up your hand which is which is difficult, I've acknowledge that, but there's many, many professionals that are willing to help you. So reaching out, do your share, take a step forward and the other people, the caring people to take it from there, but you have to identify.

**PJ**: Well and the other the final question that I have is for ordinary people walking in the world. If you if you see somebody struggling, what should you do?

**Colonel Rakesh Jetly**: Well I think what we need to do… I think Canada, I think we're really at a great point where, I mean, the rest of the world just loves us where we are in terms of this with things like Bell Let's Talk and all this stuff. So, I mean, the idea is in a non-judgmental way approach people. Be empathic, think about what you would want if you're in the same boat, and we all have good days and bad days, now we, you know, we use, one thing we use to train our people is The ACE which is the Ask, Care, Escort. Like, "Hey, are you doing okay, is there anything I can do for you, you know, is there somewhere you like me to go with you?" This kind of idea. I think just the empathic way. Let's not diagnose people, let's not become their therapist…

**PJ**: No.

**Colonel Rakesh Jetly**: …but just let's just be aware of the resources that are out there, especially if you're responsible for a workplace or for kids or something like that, know what's there and I think the real key is that we just need to talk about it. We need to normalized this because, you know, if you're feeling sad, if you're struggling every day, you know, the unburdening of sharing it with somebody, especially if that person has the right sensibility to do the right thing with information, like, that's the step towards getting better and feeling better.

**PJ:** Colonel Rakesh Jetly, it's been a true privilege to talk to you. Thank you so much.

**Colonel Rakesh Jetly**: Thank you.

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**PJ:** Thanks for listening to Invictus Games Radio for more information visit: www.invictusgames2017.com.