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“We’re not just patients”: A qualitative examination of public safety service users’ experiences with staff at an inpatient mental health treatment facility in Canada

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ABSTRACT

Posttraumatic stress disorder and substance use disorder (SUD) are highly prevalent among public safety professionals (PSP), including first responders and active/retired military members, due to the trauma-laden nature of their work and associated challenges. This interview study explores the perspectives of 30 PSP who received inpatient treatment at a trauma and SUD recovery facility in Ontario, Canada, analyzing interactions with staff and the impact on their journey to recovery. We employed a semi-structured approach to interviewing and a qualitative approach to content analysis. Findings revealed three themes: (1) “professionals treating professionals,” highlighting the importance of staff treating PSP with respect and recognizing their professional identities; (2) “controlled freedom,” emphasizing the value of flexibility and trust in fostering autonomy; and (3) “kindness goes a long way,” illustrating how care and empathy from staff contributed to emotional safety and healing. By incorporating service user perspectives into inpatient care practices and beyond, facilities can optimize therapeutic outcomes, create environments conducive to psychological healing, and foster a strong therapeutic alliance. This study underscores the necessity of trauma-informed, person-centred care tailored to the unique needs of PSP and offers healthcare providers guidance on how to operationalize the therapeutic alliance in this occupational population.

Key Words Public safety professionals; military; veterans; inpatient treatment; qualitative research.

INTRODUCTION

Posttraumatic stress disorder (PTSD) and substance use disorder (SUD) are prevalent among first responders and active/retired military members (both referred to as public safety professionals (PSP) in the current article) due to the high-stress, trauma-laden nature of their work (Ricciardelli et al., 2024a, 2025a; Richardson et al., 2019; Sommer et al., 2022), as well as experiences with moral injury and difficulties with emotion regulation (Protopopescu et al., 2021; Ricciardelli et al., 2024b, 2025b). Frequent exposure to critical incidents, including life-threatening situations and human suffering, and a history of child abuse have been found to place these individuals at heightened risk for psychological distress and maladaptive coping mechanisms, such as substance misuse (Taillieu et al., 2020, 2025) or self-medication (Seager et al., 2024). While evidence-based psychotherapy provided within inpatient mental healthcare facilities provides a crucial environment for addressing these challenges, the *quality of treatment* provided by staff – as perceived by service users – plays an invaluable role in shaping the recovery outcomes of these individuals (Johnson et al., 2018), which the current study seeks to explore qualitatively from the perspective of PSP service users (n = 30) who received treatment at a recovery facility located in Ontario, Canada.

Understanding how PSP wish to be treated by staff during their inpatient care is vital for several reasons. First, PSP often face unique barriers to seeking mental health treatment, including (internalized) stigma (especially among men), fear of judgment, and concerns about being misunderstood by healthcare providers (Regehr & Bober, 2005; Ricciardelli et al., 2021). Research specific to the law enforce-

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ment sector has shown how officers encounter pressures to present as resilient, stoic, and self-sufficient consistently to their peers, or even conceal mental health struggles (Pasciak & Kelley, 2013), findings that only serve to negatively impact their willingness to seek care, support, or treatment for mental health needs (Park, 2022). Fearing career implications if mental health concerns ever become known in a public safety organization has also led to a widespread distrust of mental health practitioners among many PSP, driven in part by a lack of resources or skepticism and questions in clinicians' ability to effectively treat *them*, not necessarily the communities and people they serve (Gavin & Porter, 2025; Haecker, 2017).

In light of the stigma still prevailing in many PSP work settings, creating a supportive and validating therapeutic environment tailored to PSP needs has been found to mitigate these barriers by fostering trust, empathy, and engagement in the recovery process (Topor et al., 2018). Second, how staff interact with service users has been shown to influence treatment adherence, therapeutic alliance, and overall satisfaction with care – factors that are critical in achieving successful treatment and recovery outcomes (Horvath et al., 2011). The dual challenges of PTSD and SUD necessitate a nuanced, trauma-informed, compassionate-centred approach to care. Many PSP may struggle with feelings of guilt, shame, or inadequacy stemming from their conditions or organizational practices and cultures (Ricciardelli et al., 2024b, 2025b), factors which certainly can be exacerbated during treatment by unintentional insensitivity or miscommunication practices from staff. Conversely, when staff exhibit empathy, respect, and a deep understanding of the unique experiences of PSP, they can create an environment conducive to emotional safety and psychological healing (Herman, 1992; Substance Abuse and Mental Health Services Administration, 2014) – a framework service users in the general population have described as conducive and often necessary to recovery (Johnston, 2020).

Incorporating service user perspectives into mental healthcare is crucial for developing effective and responsive services as well as providing service users with a stronger sense of dignity, autonomy, and person-centred care (Johnston, 2019; Kirmayer, 2000; Kirmayer et al., 2015) and may be required in some jurisdictions (Ministry of Health and Long Term Care, 2015). Earlier research shows how service user involvement in treatment and recovery design may lead to more person-centred care, increased satisfaction, and improved health outcomes (Doyle et al., 2013). The critical disability studies praxis, while tending to operate in tension with some aspects of the more hierarchal medical model (Rashed, 2019), holds that when individuals with lived experience meaningfully contribute to shaping mental health services, interventions become more relevant, accessible, and tailored to real-world needs (LeFrançois et al., 2013; Voronka, 2017). By actively integrating service user voices into decision-making, mental health systems can create services that are both effective and empowering, ultimately fostering a more compassionate and sustainable approach to care.

The relationship between the service user and therapist is referred to as a therapeutic alliance in diverse scholarship and linked to treatment outcomes (Bonta & Andrews, 2016; Horvath & Luborsky, 1993; Martin et al., 2000). For any treatment to be effective, the relationship between the service user and therapist must be rooted in mutual trust, respect, and the ability to hear each other. The therapeutic alliance must be focused on meeting the service user's changing needs, as they progress through the recovery process. The alliance is founded on an ethos of care that can then underpin interpersonal growth. In the current article, we explore the perspectives of PSP (n = 30) regarding the treatment they received from inpatient mental health staff working at a recovery centre in Ontario, Canada, to examine how these interactions impacted service users' journey to recovery. Thus, we qualitatively account for how service users perceive the therapeutic alliance with staff and shed light on their preferences and priorities, to operationalize the therapeutic alliance between PSP and caregivers and practitioners and inform the development of trauma-informed care practices that optimize outcomes for PSP grappling with PTSD and SUDs.

METHODS

Research Design

To address the study objectives, we conducted semi-structured, in-depth qualitative interviews with participants (n = 30) as part of a larger study interested in exploring public safety service users' views of their entire inpatient treatment experience. In the current analysis, we focus on content related to their interactions with staff to elucidate the value of the therapeutic alliance in their journeys to recovery. Ethical approval for this study was obtained from the Research Ethics Board at Ontario Tech University (File #17761) of the lead author's institution prior to participant recruitment. The Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong et al., 2007) was used to guide the reporting of this study.

Setting

The study participants were service users at a private healthcare facility in Ontario, Canada, which specializes in treating trauma and SUDs exclusively for PSP. The facility has 28 beds and offers two treatment streams: trauma-focused care or trauma care combined with substance use treatment. The inpatient program typically spans 7–9 weeks and includes group cognitive processing therapy, individual psychotherapy, and supplementary activities such as therapeutic recreation, yoga, integrative restoration, art therapy, exposure therapy, and psychoeducational groups.

Participants

Qualitative data were gathered from 30 service users who received care at the facility under study between April 2024 and August 2024. A sample size of 30 was determined after the interviews began: the interviewer (K.M.) monitored responses to balance the need for diverse lived experiences with the depth required for meaningful qualitative interpretation and saturation. Rather than aiming for statistical representation, the goal was to explore recurring themes and outlier perspectives until conceptual patterns began to repeat – an indication of thematic sufficiency in qualitative inquiry. Furthermore, this number allowed for a broad range of voices while remaining small enough to support careful, case-oriented analysis. The average participant age was 45.7 years (standard deviation = 9.8) and most identified as male

(n = 24). Approximately half of the participants had first responder backgrounds (e.g., law enforcement, paramedicine, correctional services), while the remaining had military experience. Many were undergoing treatment for both trauma and SUDs. Individuals were not chosen based on which stream they were in, but both clinical streams were represented in the sample. We refrain from sharing any further demographic details of participants to protect confidentiality.

Procedure

In the last 1–2 weeks of their treatment and just before discharge, all service users were approached by the second author, who was not involved in their direct clinical care. During their free time and in private, the second author informed them about the study and invited them to participate. Interested individuals received a detailed explanation of the study and had an opportunity to ask questions for considering providing informed consent. Those who consented were assigned a participant number (e.g., participant 01) to maintain confidentiality and integrity of the data. Only one person declined to participate who was approached – no reason was given for this decision. Additionally, no participants chose to withdraw from the study once they had provided consent. Participants were not provided an incentive to join the study. As recruitment occurred, the person conducting the interviews monitored the participants' responses for content. She conferred with the recruiting research team member about the possibility of saturation and they agreed to continue recruiting consecutively until a sample size of 30 was reached. At this point, it was believed among research team members that saturation had been achieved, and no unique ideas were introduced.

Interviews were scheduled collaboratively to be completed with the first author and conducted either in-person in a private office at the facility or virtually via the secure healthcare version of Zoom. The principal investigator (PI), who was also not involved in the participants' clinical care, is a female clinical psychologist (PhD) with expertise in treating and working with PSP. She has been involved in research, including conducting qualitative interviews, for over 22 years. She began each session by reviewing the consent process and explaining her role at the facility that she provides clinical consultation to leadership and staff and is engaged in research initiatives. This research session was the first time the PI had met any of the participants. Participants were initially asked: "Has being at [facility name] helped your mental health?" Given that all participants answered in the affirmative, they were then asked, "What specifically about your treatment at [facility name] helped to improve your mental health?" Probing questions were used to clarify their responses or expand on their comments. Of note, participants were not asked directly about their relationships with the staff unless they introduced this topic when asked the above question. While they were asked if there were any factors that negatively impacted their recovery or if they had anything else they wanted to share that would help us support them better, none of the responses mentioned how they were treated by the staff. Interviews, lasting 20–75 minutes, were audio-recorded for accuracy and documentation but destroyed once transcription was complete.

Data Analysis

A qualitative content analysis approach was employed to interpret participant responses through a process of coding and identifying patterns or themes (Hsieh & Shannon, 2005). This analytical method explores explicit or implicit meanings, themes, and patterns within these data, enabling researchers to investigate social phenomena in a subjective and systematic manner (Shava et al., 2021). The analysis followed an inductive reasoning framework: data were meticulously reviewed, coded, and categorized, with themes emerging directly from the content. Qualitative content analysis began with transcription of the audio recordings to ensure a complete dataset. Thematic units, representing expressed ideas, served as the primary analytical focus, with even single words qualifying as thematic units (Zhang & Wildemuth, 2005). Initial coding categories were created as the first author (K.M.) analyzed the first three transcripts. The second author (E.V.) reviewed these transcripts independently to validate the coding scheme and propose additional categories, which were refined collaboratively with the third author (S.C.) to create a final coding manual. Subsequently, the second author coded the remaining transcripts using this manual, adjusting it as needed through regular discussions with the first author (K.M.). Once all transcripts were coded, the first and second authors worked together to analyze the categories, identify relationships, and discern patterns. Insights were reviewed with the remaining authors to refine the conclusions and deepen the analysis. Participants were discharged shortly after the interviews; as such, we did not have permission to sustain ongoing contact with them and were not able to have them review the transcripts or the results of the study.

RESULTS

All service users reported their mental health improved over time while receiving treatment at the inpatient facility. When asked what specifically had helped to improve their mental health, participants provided a wide range of responses, with all of them including something about how they were treated by the staff at the facility. When these specific responses were examined during analytical processes, three main themes were produced: (1) professionals treating professionals; (2) controlled freedom; (3) and kindness goes a long way. We structure the results around these themes and discuss their value in shaping future healthcare needs and treatment practices for PSP experiencing PTSD and SUD, as well as future research across more treatment settings, including both inpatient and community.

Professionals Treating Professionals

Several participants expressed feelings of shame and embarrassment with regard to their mental health status and noted that they experienced stigma from within their occupational groups and communities prior to attending the facility. They explained how they believed people saw them as "broken toys" and that some people had lost respect for them. These perceptions were especially difficult, given the high esteem many of them enjoyed, particularly as a person working in a highly regarded profession in public safety. Therefore, when they came to the inpatient program, participants explained how good it felt to be treated as *professionals* again. For example, participant 1 stated, "we're very devalued and ignored [in the community] so to come into an environment where we are recognized as first responders felt good." This was echoed by participant 12 who said, "I found it to be very respectful in terms of ... we're treated like we've been respectful pieces of the community, not just people with addictions or people with traumas, we're people who have been respected and have responsibility and intelligence and we're treated respectfully that way. And I really appreciate that coming here." Thus, being at this particular inpatient facility and treated as a professional helped the service user feel like a whole and valued person anew.

When probed to better understand participant 8's experience of feeling respected by the staff, they stated, "I think [this] relates to being professionals before we got here ... that we were respected and responsible people to begin with and I think that's pretty important." Put another way, participant 20 said they appreciated that they were "not infantilized" and that "it feels like we're all in this together here and I'm not like some patient that they're just kind of treating." This idea that they had regained some status and were treated as equals with the staff was echoed by participant 28 when they said, "It's really like a community of people who are just working together." Feelings of infantilization in inpatient mental health environments (i.e., through behaviour modification programs, punishment/reward systems) have been criticized in healthcare literature for having a role in removing dignity from service users (Holmes & Murray, 2012). At this treatment site, however, participants generally describe feeling supported and *respected* by the staff for their contributions and service to their communities, which, as an entry point into recovery, provided service users with motivation and encouragement to become healthier.

Controlled Freedom

Traditionally, inpatient programs – particularly those that treat SUDs – have strict rules, guidelines, and security in an attempt to support the abstinence goals of the service users and ensure that they maintain adherence to treatment. However, these service users were surprised to find that there were less rules and more flexibility than they had either previously experienced or had expected. In addition, their freedom was experienced as being trusted, which allowed them to regain an identity as someone who could be trusted – "it's having the freedom, the trust" that helped work toward their recovery goals (participant 3). This was evident when participant 22 shared that it helped to have,

> The freedom we have … the ability to do things on our own … it feels like we're *responsible people* instead of broken people I guess … Yeah, I expected it to be kind of more secure, hospitalized, you know, everywhere, watched all the time situation and it's just the freedom is a relief, the ability to go around and kind of do our own thing … You can walk in the woods or bounce a basketball or shoot a hockey stick or work out so it's that freedom to do that (emphasis added).

In the excerpt, participant 22 idealizes the freedoms and spatial permeability provided to service users by the staff insofar as the freedom empowered the participant to stay busy with activities and express their autonomy throughout the recovery process. Yet, some service users described experiencing the minimal rules as "controlled freedom" that allowed them (as a person seeking help for an SUD) to feel "safe, like there's no risks" (participant 11). The "tiered" freedom extended to the ability to make choices about which groups or activities they engaged in. Participant 25 noted that because of this flexibility, "you don't feel stressed out, like you're being pushed into anything – all our lives we've been pushed to do stuff because you had to do it." In this sense, the dispositions of the staff also allowed participants to break away from the normal structures and responsibilities of their working lives, which may have been a precipitating factor to experiences with compromised mental health.

Kindness Goes a Long Way

As service users continued to describe what facilitated their journey to recovery, the third theme we identified was the kindness they felt from staff. Participants noted how they felt welcomed and supported by the staff: "[they] are so caring and supportive and nice and friendly" (participant 4) and "every single person was so kind, so welcoming ... I just think like everybody was so welcoming, they knew us all by name" (participant 29). The participants stated they believed the connections were real, and this was unique to either the healthcare system or just in their lives. Participant 17's comment, for instance, demonstrated: "There's a unique set of qualities in the staff that exists at [facility name]. There's some very special people here with the ability to share and foster relationships ... who are able to relate with you on a level probably that nobody ever has and who are able to explain things to you in a way that you can understand." Similarly, participant 15 shared that "I haven't experienced that in a while, being around people like this." The unexpectedness of the level of care was also described by participant 9, "I honestly didn't expect as much support. Like I can speak to a counselor. Literally, they'll be in the kitchen and I can be like, can I talk to you for a quick sec and then they'll give me 30 minutes of their time ... Having that support is so incredible. That's something I did not expect at all." What is described here is a setting where the staff "go the extra mile" to relate and build interpersonal relationships with service users beyond the medical gaze, a humanitarian process which service users described as improving their recovery process.

Not only were the service users referring to the clinical staff, but they noted how the support was felt across all staff, "right down to the chefs, you know, they are family" (participant 9). This was echoed by participant 5 who said, "from the cleaning staff to the clinicians, [they] are genuinely interested in your well-being. You can tell that they care. And I think that really helps feeling comfortable enough to open up." As evident in this quote, participants strongly indicated that this friendly environment helped them feel more open, but perhaps more importantly, the interpersonal dynamics of the treatment settings helped them feel *worthy* of care. To close, a specific example of this mentioned was related to having concerns addressed: "having staff and management being receptive to actually reading suggestions and having weekly community meetings to not only voice it, like read the suggestions box, but also to keep the community apprised of what's going on, I think is phenomenal. And we appreciate it because we feel like we're cared for. We're not just patients" (participant 22).

DISCUSSION

Our study of service user experiences and relations with staff at an inpatient treatment centre in Ontario, Canada revealed three central themes, each we argue are integral to the establishment of a therapeutic alliance between staff and people in treatment. In truth, when professionals treat professionals, the experience can be humbling for the professional receiving treatment. Thus, the therapeutic alliance is foundational to helping the service user be open and trusting to receive the support offered (Horvath & Luborsky, 1993; Martin et al., 2000). Indeed, for support to help, the person must be open to the support; offering support in and of itself is not sufficient. Select participants were ashamed of requiring inpatient treatment and suffered from the stigma of mental health in their workplace (Johnston et al., 2024). They did not feel treated as a professional at work because of their compromised wellness and instead felt a relief in being treated as a professional by the care team, not a "broken toy," language which was internalized by some participants as a consequence of organizational stigma. Participants reported this "fresh" experience as validating, and it would appear to be integral to building the trust necessary for effective and meaningful treatment of PSP suffering from and grappling with a loss of professional identity and status due to illness.

The "tiered" freedom offered at the facility under study helped to solidify feelings of being trusted, despite being a service user, while also providing a sense of safety. Being trusted encourages trust to develop; as such, how can staff be trusted if the service user feels not trusted or unsafe? Mutual trust and reciprocity then, being key to effective treatment and the therapeutic alliance, seemed to benefit all participants and was, we learned, revealed in the practice of facility flexibility instead of rigid rules. Service users were empowered and able to organize their lives and live feeling safe, rather than feeling overly structured by the environment which can lead to feelings of infantilization (Holmes & Murray, 2012).

The kindness of staff, which was equated with genuine care, was invaluable for service users. They felt valued, despite their shame, and cared for, where staff showed each person how they were worth efforts toward recovery. This was especially appreciated, given that many of the participants were off work and had previously been transferred to units for, again, "broken toys," a derogatory term for PSP with mental illness. Such interpretations reveal a functioning therapeutic alliance that creates mutual trust, kindness, and ways forward that are effective, while combating mental health stigma among PSP that continues to jeopardize life and hinder help-seeking (Krakauer et al., 2020). Service users, in their interactions with staff, felt valued as professionals, and this appeared to remove some of the burden the participants felt, particularly around impacts on their families while struggling with illness and then recovering.

While the data represented in the current study are largely positive, even upon thematic saturation, we argue these findings should not be read as too surprising in relation to the extant and critical literature on mental health systems and relations within these institutions. It has long been argued how service users are often – both historically and in the present day – excluded from having a meaningful say in their treatment practices in Canadian mental health systems and beyond (Joseph, 2014; Rashed, 2019), despite their agency to comprehend their illness and recovery processes and therefore engage healthcare professionals in their care (Kirmayer et al., 2015). Critical literature has documented the discursive practices and disciplinary hegemony that can mark mental health treatment spaces and ultimately reduce service users' feelings of autonomy and control in these settings (Holmes et al., 2014). In the current study, we are presented with a different story from participants who felt more dignified, safe, and respected during mental health treatment and recovery *because* the staff/caregivers respected them and worked *alongside* them to build their autonomy and help empower them throughout their journeys to recovery. Our findings reiterate how the style of care provided to service users by staff really impacts their interpretations of the treatment setting – when service users feel they are being treated with kindness, compassion, and non-judgmental approaches to listening and engaging, service users will tend to praise clinicians (Johnston, 2019, 2020) – a finding important to vulnerable PSP populations who continue to work through cultures of mental health stigma in their profession and in broader society (Johnston et al., 2024).

LIMITATIONS AND FUTURE RESEARCH

Our study does have some limitations worth noting. Foremost, while we believe our sample represented a variety of voices, experiences, and occupations, the results are derived from a small sample of 30 people. In addition, 80% of the service users in our sample were men. As such, additional data collected from other samples could likely increase the generalizability, and efforts to target responses from more women participants are needed. Additionally, external factors such as variations in clinical presentations, treatment offerings, and milieu may have influenced the experience of the participants, thereby impacting our results and making it difficult to isolate the specific dynamics between staff and service users. Lastly, we did not directly ask the participants about their relationship with the staff members – instead we queried them about the factors they believed contributed to their recovery. While we believe this means we prevented leading participants to certain answers, it could also mean we are missing other important variables characterizing their relationship with the staff members. We emphasize our study is not a clinical evaluation of PSP recovery outcomes per se but rather an analysis of the social milieu and relations with the staff's underpinning treatment and the road to mental health recovery. We recommend future research, both qualitative and quantitative, to extrapolate these findings across other PSP inpatient treatment settings in Canada, as well as community and outpatient settings, and to shed further light on the importance of actualizing the social dimensions of mental health treatment and recovery that the service users have positioned in this study as intrinsic to their effective care.

CONCLUSION

It is well established in early literature that having a strong therapeutic alliance is critical to successful treatment outcomes (Horvath & Luborsky, 1993; Martin et al., 2000). We know that person-centred care is also important – meaning that interventions must be customized to meet the specific needs of each person. In the current study, we found participants emphasized the necessity of the dignity and autonomy components of treatment and recovery that have been documented as being vitally important to service users in other literature (Johnston, 2019, 2020; Kirmayer, 2000; Kirmayer et al., 2015) and that the staff were especially intrinsic in fulfilling these values during treatment. Given the unique occupational experiences of PSP, it is reasonable that these individuals would have different mental healthcare needs in a psychotherapeutic environment. The participants in this study provided an applied description of how clinicians can develop the therapeutic alliance specifically with PSP through the shared and reciprocal values of respect, trust, and kindness, which we argue, going forward, should be considered by PSP mental health and addictions treatment centres desiring a fresh and evidence-based approach to recovery.

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ETHICS APPROVAL AND INFORMED CONSENT

This study was approved by Ontario Tech University Research Ethics Board (#17761). All participants in this study provided written and verbal consent to participate.

CONFLICT OF INTEREST DISCLOSURES

Dr. Martin is a consultant for the facility where data were collected and received part-time salary for this work. Ms. Vester and Mr. Carter are both employed by the inpatient facility as well. The authors have no other potential conflicts of interest to declare.

AUTHOR CONTRIBUTIONS

All authors were involved in the development of the research idea and conceptualization of the project. K.M. and E.V. were responsible for data collection, input, and analysis. All authors contributed to data interpretation. K.M. and E.V. worked to produce the first draft of the manuscript, and all other authors were involved in reviewing and editing subsequent drafts.

DATA AVAILABILITY

The qualitative data used in this study are not available for public distribution due to ethical considerations regarding participant confidentiality.

DETAILS OF POSSIBLE PREVIOUS OR DUPLICATE PUBLICATION

None.

AUTHOR AFFILIATIONS

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