

Beyond the Surface: *Why Residential, Holistic, and Trauma-Focused Treatment is
Essential for First Responders and Veterans*

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Executive Summary

First responders and veterans experience disproportionately high rates of post-traumatic stress disorder (PTSD), depression, substance misuse, and suicide due to repeated exposure to traumatic events, moral injury, and occupational stress (Berger et al., 2012; Petrie et al., 2018). Despite this, many trauma programs do not meet their specific needs. This white paper asserts that residential, holistic, trauma-focused programs designed specifically for these groups deliver better outcomes than outpatient options (Marcantoni et al., 2024). By immersing participants in peer-supported environments and combining evidence-based therapies with complementary modalities such as mindfulness and yoga, these programs promote trust, cultural safety, and lasting recovery (Gallegos et al., 2017).

Introduction

First responders and veterans face higher rates of PTSD (14–30%), depression, substance misuse, and suicidality (Smith & Holmes, 2021; Stevelink et al., 2018). Their exposure to repeated critical incidents and moral injury is worsened by stigma, confidentiality concerns, and obstacles to culturally sensitive care (SAMHSA, 2018). This paper compares residential trauma-focused treatment with outpatient care, suggesting that immersive, peer-supported residential models designed for first responders and veterans produce better clinical outcomes (Marcantoni et al., 2024).

The Unique Needs of First Responders and Veterans

First responders and veterans encounter cumulative trauma, moral injury, and high-stakes decision-making inherent to their roles. PTSD rates are significantly higher in these groups (14–30%) compared to the general population (Petrie et al., 2018). Research shows that stigma, occupational culture, and hypervigilance experienced by this population create barriers to accessing care (Smith & Holmes, 2021).

Another study of Emergency Medical Services Personnel (EMS) showed PTSD rates between 8% and 30%, far higher than in the general population (SAMHSA, 2018). The reasons for this higher burden are complex. These individuals face cumulative trauma and moral injury from life-and-death decisions, as well as occupational stress within strict, stoic cultures that discourage showing emotion. Many first responders are hesitant to seek mental health care because of stigma, concerns over confidentiality, and fear of career impacts. For veterans, trauma often worsens due to combat stress, long deployments, military identity, and challenges with reintegration after service. (SAMHSA, 2018).

One of the unique challenges that police officers face involves postmortem reviews. Indeed, police officers are subjected to a broader range of public inquiry processes than those working in other emergency service professions; this puts them at

greater risk of harm because it undermines their professionalism and sense of control, causing extreme distress due to the possibility of facing criminal or civil charges in their cases (Regehr et al., 2005).

A notable minority of police officers also respond to extreme events or disasters. These incidents are usually marked by unpredictability, extended police involvement, and significant human injury, loss of life, property damage, or significant disruption of community services. Although the extent of loss and the nature of the disaster influence the impact, there is undeniable evidence that exposure can significantly affect mental health and well-being (Regehr et al., 2005).

Culturally Informed Care

Culturally aligned, trauma-informed environments rooted in peer support have been shown to enhance trust and retention, creating conditions necessary for meaningful therapeutic engagement (SAMHSA, 2018). Research consistently emphasizes the importance of trauma-informed, culturally aligned care tailored to these populations. Peer-based support, shared identity, and recognition of military or first-responder culture significantly enhance trust and engagement. Interventions that do not account for these dimensions (e.g. civilian-mixed outpatient groups) often fail to resonate. Instead, care environments that prioritize shared occupational narratives, address moral injury, and normalize trauma reactions within the peer group show higher therapeutic alliance and retention (SAMHSA, 2018).

To allocate effective interventions, mental health professionals require an appreciation of these distinctions:

- **Repeated, high-stakes exposure** leading to complex trauma presentations.
- **Occupational stigma** creates barriers to timely help-seeking.
- **Peer identity and culture** are critical for engagement and relatability.

- **Complex comorbidity**, including depression, substance misuse, and social dysfunction, requires holistic approaches alongside trauma therapy.

By addressing these unique needs explicitly, residential, trauma-specific treatment designed exclusively for first responders or veterans establishes an environment where trust, safety, and therapeutic impact are optimized.

Defining Treatment Programs

Residential clinics, sometimes called “inpatient” facilities, offer comprehensive treatment programs tailored to meet each individual's specific needs. These programs typically require residents to stay for 6 to 12 weeks, depending on the intensity and objectives. The exact treatment plans vary based on the clinic, the severity of symptoms, and each veteran's unique needs. By providing a highly structured environment, residential clinics help veterans manage comorbidities associated with PTSD and enhance their coping skills (Marcantoni et al., 2024).

Outpatient treatment programs generally provide psychotherapy sessions once a week for about 12 weeks. Patients visit the clinic solely for treatment. However, this seemingly less restrictive type of program presents challenges for active-duty military personnel and veterans, such as difficulties in scheduling appointments due to limited services in their area or challenges in taking time off work, the associated stigma of requesting or receiving services, the gap between available and desired services, and financial limitations.

Deficiencies of Day Trauma Programs for This Population

Traditional day treatment programs, whether standard outpatient or intensive outpatient programs (IOPs), present systemic limitations for first responder and veteran populations, particularly regarding engagement, retention, and cultural relevance (Marcantoni et al., 2024).

Limited immersion and fragmented support

Since patients return home each evening from outpatient programs, they remain exposed to external stressors such as family conflict, workplace triggers, or substance access. These stressors undermine therapeutic progress. By contrast, residential programs offer an immersive environment, free from daily life disruptions (Marcantoni et al., 2024).

High dropout and low completion rates

Standard outpatient models show dropout rates reaching up to 50%, a concern compounded among service members, where mandated participation reduces motivation. (Marcantoni et al., 2024).

Mandated Versus Voluntary

While this paper mainly discusses voluntary clients, it is also important to highlight specific outcomes related to workers who are mandated or funded through their respective Worker Compensation Boards in their provinces. When talking about mandated clients, such as those funded through Workers' Compensation Boards (like WorkSafe BC in British Columbia), there is limited public data available, at least in the author's local region of British Columbia. However, in Ontario, WSIB is the Workers' Compensation Board responsible for approving mental health claims in that province.

Talking specifically about their Mental Stress Injury program, an analysis of data from 2017 to 2021 for public safety personnel (PSP), including police, firefighters, corrections officers, paramedics, and communicators, showed that WSIB reported 54.5 percent of claimants were assigned to a return-to-work (RTW) program. Of these, 96.7 percent completed the programs and returned to work (Edgelow et al, 2025).

Although WSIB reports a high success rate for clients completing the RTW program and returning to work, qualitative research with injured workers highlights several challenges. These include difficulties navigating benefits, concerns about

workplace stigma, lack of accommodations, and trauma-informed RTW planning (Edgelow et al., 2023; Van Eerd, 2023; WSIB, 2025).

Reduced therapeutic advantage

In mixed civilian-first responder groups, individuals often struggle to bond and feel understood, leading to a weaker therapeutic alliance and reduced empathy. Peer cohesion is essential, and without it, participants may disengage. (Kirschman, 2023)

Superficial or insufficient cultural competence

While some outpatient programs claim to have trauma-focused interventions and supports, they often lack first responder/veteran-informed modalities or peer-support structures. This results in care that overlooks moral injury, hypervigilance culture, and occupational identity; key elements to effective engagement (Kirschman, 2023).

Less robust long-term outcomes

Although IOPs and residential programs both show PTSD symptom reductions by discharge, evidence suggests that therapeutic gains from outpatient care may dissipate over time without intensive follow-up support. In contrast, residential settings offer continuity and embedded relapse prevention planning (Grau et al., 2022).

In conclusion, outpatient and day programs may be more accessible, but they inadequately address the holistic, immersive, and identity-specific needs of first responders and veterans. This leads to lower retention, weaker therapeutic alliances, and less sustained recovery.

Benefits of Residential, Holistic, Trauma-Focused Treatment

Residential programs provide immersive, 24-hour therapeutic environments free from daily triggers, combining evidence-based trauma therapies (e.g., CPT, PE, EMDR) with holistic approaches such as yoga and mindfulness (Gallegos et al., 2017). Peer-support programs have become standard in many organizations for supporting staff facing high risks of potentially traumatic events, often to fulfill legal and moral obligations

to care for employees and overcome barriers to standard care like stigma, limited time, poor access to providers, lack of trust, and fears of job repercussions (Creamer et al., 2012). Completion rates in residential retreats exceed 90%, with ongoing reductions in PTSD and depression symptoms at follow-up (Reitav et al., 2022).

Residential treatment environments tailored for first responders and veterans offer significant therapeutic advantages over outpatient alternatives, especially for individuals with complex, prolonged trauma exposure. The advantages of this type of program will be discussed at length later in the paper.

Immersive Environment & Continuity of Care

Residential settings remove individuals from daily life stressors, which can include workplace triggers, family conflict, and substance access. This removal of stressors provides an uninterrupted, trauma-safe space conducive to deep therapeutic engagement. Veterans Affairs research residential programs achieved meaningful PTSD symptom reduction at discharge and maintained gains through 4-month follow-up, though trajectories varied across severity levels. Notably, residential treatments also allowed for flexible structures addressing comorbid challenges (Grau et al., 2022).

Effectiveness of Evidence-Based Trauma Therapies in Residential Context

In residential PTSD rehabilitation programs, guideline-recommended therapies that include Prolonged Exposure (PE) and Cognitive Processing Therapy (CPT) demonstrated large effect sizes for PTSD and depression maintained at 12-month follow-up among veteran cohorts, even those with severe comorbidity (Wiltsey, 2024). Notably, outcomes in residential settings appeared more robust than those typically reported in outpatient trials, where symptom severity often remained elevated post-treatment (Madigan et al., 2020)

Peer Cohort Cohesion and Cultural Alignment

Qualitative evidence from UK veteran programs highlights that cohort cohesion—shared identity and mutual support among veteran peers—serves as a key factor in achieving successful treatment completion and long-term improvement. Veterans expressed feeling “in the same boat,” which boosts motivation and safety during group therapy sessions (Madigan et al., 2020). Similarly, specialized retreats for first responders, such as the West Coast Post-Trauma Retreat, showcase the effectiveness of culturally appropriate methods. These programs achieved notable reductions in residents' symptoms through peer-led and trauma-sensitive approaches (Kamena et al., 2025).

Improved Retention and Engagement

Pilot data from veteran and first responder retreat programs show very high completion rates (e.g., 19 of 21 participants across a five-day residential trial completed the program), with clinically meaningful symptom reductions observed at one-month follow-up for most participants (Reitav et al., 2022). These retention rates stand in stark contrast to dropout rates often exceeding 40–50% in outpatient models.

Why First Responders and Veterans Should Not Be Mixed with the General Population

Research indicates poorer outcomes when military-affiliated individuals receive treatment in civilian-mixed settings (Schumm & Chard, 2012). Shared identity enhances trust, peer bonding, and therapeutic alliance (Project Trauma Support, 2024). Programs like the Warrior Care Network and First Responder Support Network show improved results through population-specific, peer-led care (Kamena et al., 2025). When first responders or veterans participate in trauma programs alongside civilians, the effectiveness of care is significantly reduced.

Lower Outcomes for Military-Affiliated Individuals in Civilian Settings

Studies comparing military-affiliated patients (including veterans and first responders) to civilians receiving the same trauma-focused therapies (e.g., CPT, PE) in community clinics reveal notably smaller treatment gains among the former group. Military-affiliated individuals achieved smaller effect sizes for depression, highlighting a diminished response when compared with civilian cohorts (Jacoby et al., 2022).

Inadequate Cultural Competency and Reduced Cohesion

Peer Cohort Bonding Improves Outcomes

Evidence from peer-support models indicates that shared lived experience fosters deeper emotional processing and post-traumatic growth (PTG) among first responders. Peer programs enhance disclosure, emotional safety, and relational bonds that support long-term recovery, benefits that are less accessible in mixed groups (Donovan, 2022).

Retention & Engagement Depend on Cultural Safety

Clinical literature indicates that trauma-exposed veterans and first responders have higher dropout rates and worse outcomes in general treatment settings. In civilian-mixed groups, participants often struggle with emotional suppression, stigma, and lack of shared language—barriers that are reduced in exclusive, culturally coherent environments (Jacoby et al., 2022).

Case Studies and Best Practice Models

Diversified Rehabilitation Group (Kelowna, BC)

Diversified Rehabilitation Group (DRG) is a Canadian organization based in the Okanagan region of BC. This group offers personalized programs for individuals who have experienced trauma or exhibit symptoms related to PTSD, anxiety, and depression. DRG employs a diverse team of mental health professionals, including psychologists, clinical counsellors, social workers, and mental health support workers, who deliver

trauma-informed clinical support and treatment to clients. They also work with registered dietitians, massage therapists, and yoga instructors, all of whom contribute to the holistic nature of the program. (Diversified Rehabilitation Group, 2021, pp. 1-16).

They offer a unique, holistic approach to treatment that utilizes a variety of approaches, emphasizing enhancement in all areas of the individual, otherwise known as a biopsychosocial approach to treatment. The programs are usually small, having no more than 8 participants, and they have separate cohorts for First responders and Veterans. They host the residential side of the program in a beautiful residence called Iremia, which consists of a 6500 square foot 8-bedroom residence and a 3500 square foot clinic, all located on a 3.8-acre property. This residence provides a calming, peaceful environment for participants to focus on the programming that is offered. (Diversified Rehabilitation Group, 2021, pp. 1-16).

The programming typically involves group work and individual clinical sessions and is highly structured. Proper nutrition, sleep hygiene, mindfulness, cognitive restructuring, and coping skills are all focused on and improved throughout the program. Treatment methods are also very diverse and include Cognitive Behavioural Therapy (CBT), Eye Movement Desensitization and Reprocessing (EMDR), Cognitive Processing Therapy (CPT), expressive art, prolonged exposure therapy, and many other approaches. (Diversified Rehabilitation Group, 2021, pp. 1-16).

Statistics collected in 2021 highlight the overall positive impact of the programs offered by DRG, with participants noting a reduction in symptoms related to PTSD, anxiety, and depression, based on self-reporting scales. They also discuss the participants' outcomes concerning their return to work. As of 2023, 82 percent of participants reported having returned to the same job, with many others in different situations related to returning to work. Participants were also generally very satisfied with the program, with DRG reporting that 37 percent of participants were satisfied and

another 53 percent were 'Very Satisfied'. (Diversified Rehabilitation Group, 2021, pp. 1-16).

Ultimately, the goal of DRG is for its participants to “overcome psychological and physical limitations in order to achieve a healthy and well-balanced lifestyle.” (Diversified Rehabilitation Group, 2025, p. 1).

Project Trauma Support (Perth, Ontario)

Project Trauma Support (PTS) provides a six-day residential retreat for veterans, military personnel, and first responders, based on a sanctuary or sanctuary-model therapeutic environment. Located on a 250-acre forested property, the experiential program includes trauma education, support for moral injury, narrative and schema therapy, EMDR, movement, yoga, meditation, equine experiences, and peer-led group reflection. (Project Trauma Support, 2024).

PTS highlights peer cohort bonding and clinician lived experience: all staff have backgrounds in emergency services or military settings, boosting occupational alignment and trust. Participant feedback shows significant personal transformation, often described as life-changing, with improved perception, purpose, and supportive bonds developed during the retreat. The program also supports alums peer-support groups across Canada (e.g., Kingston, Ottawa, Halifax) to help maintain post-retreat resilience. (Mood Disorders Society of Canada, 2021; Project Trauma Support, 2024).

Across these models, separation from the public, a focus on shared occupational identity, and the integration of peer-supported, trauma- and holistic-based programming consistently predict improved participant experience, retention, and clinical outcomes.

Policy and Practice Recommendations

Given the compelling evidence supporting residential, holistic, and population-specific trauma programs for first responders and veterans, several policy and practice initiatives are recommended. Policies should prioritize funding for specialized residential programs,

enforce population exclusivity in trauma care, develop standardized outcome measures, expand holistic modalities, provide clinician training in occupational trauma, and formalize post-discharge peer support systems.

Federal and provincial agencies (e.g., Veterans Affairs Canada, Public Safety Canada) should prioritize dedicated funding streams for population-specific residential trauma programs. Evidence from meta-analyses and pilot studies highlights that such programs achieve higher retention and symptom reduction compared to day programs. Stable funding would ensure consistent program delivery, enable scalability, and reduce reliance on charitable or private-sector contributions (Marcantoni et al., 2024).

Mixed-population trauma programs diminish outcomes for first responders and Veterans. Mental health policies must formalize occupational cohort separation in trauma treatment settings to improve peer trust, cultural safety, and therapeutic alliance (Schumm & Chard, 2012; US Department of Veteran Affairs, 2022).

Programs should be mandated to adopt standard evaluation metrics, including PTSD symptom reduction (e.g., PCL-5), depression, functional status, and reintegration success, to establish a comprehensive national dataset on treatment effectiveness. Such frameworks would enhance quality assurance and support continual clinical innovation.

Policies must acknowledge complementary practices (yoga, mindfulness, equine therapy, nature-based therapy) as essential adjuncts to evidence-based trauma therapies (PE, CPT, EMDR) in residential programs, due to their influence on emotional regulation, resilience, and managing comorbidity (Gallegos et al., 2017).

Professional training pathways should include cultural competency curricula tailored to military and first responder populations. Collaborations with professional associations (e.g., Canadian Association of Chiefs of Police, Canadian Armed Forces

Health Services) could help ensure clinicians are prepared to address moral injury, hypervigilance, and stigma-related avoidance behaviors.

Long-term peer networks such as alum groups, online support platforms, and regional meetups should be integrated into discharge planning to strengthen resilience, combat isolation, and uphold treatment gains (Project Trauma Support, 2024).

Policy reform must align mental health service delivery with the specific needs of trauma-exposed occupational groups. Public and private stakeholders, including Veterans Affairs Canada, IAFF, and provincial health authorities, should invest in evidence-based, population-specific residential trauma programs while establishing mechanisms for continuous outcome monitoring and peer-supported aftercare. These changes would modernize trauma services, reduce long-term disability, and improve reintegration among first responders and veterans.

Conclusion

First responders and veterans face unique, cumulative trauma exposures that require specialized, immersive, and culturally sensitive care. Evidence consistently shows that residential, holistic, and peer-supported trauma programs deliver better outcomes compared to outpatient or mixed-population day programs. The immersive nature of residential care—along with cultural alignment, dedicated peer groups, and the integration of complementary therapies—creates an environment where trust can grow, therapeutic engagement deepens, and lasting recovery becomes possible.

Conversely, outpatient and mixed-population models fail to adequately address the occupational identity, moral injury, and stigma-related barriers prevalent among these groups, often leading to poor retention and incomplete recovery. Case studies of programs such as Diversified Rehabilitation Group and Project Trauma Support (PTS) show how tailored residential care promotes post-traumatic growth, successful reintegration, and long-term symptom reduction.

To improve trauma care results for first responders and veterans, policymakers, clinicians, and funders should promote the development of dedicated residential facilities, ensure treatment environments tailored to specific populations, and adopt standardized assessment tools. These steps will shift trauma services from isolated, one-size-fits-all approaches to specialized, evidence-based care systems that recognize the unique needs and sacrifices of service members.

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