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Veterans Justice Outreach Program, Risk of Recidivism, and Justice-Involved Veterans

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This is to certify that the doctoral dissertation by

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2024

Abstract

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by

Melody Weathers

MA, Walden University, 2018

BS, Columbia College, 2006

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Forensic Psychology

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August 2024

Abstract

To date, no study has examined whether the Veterans Justice Outreach (VJO) program influences recidivism once a justice-involved veteran (JIV) completes the program. Nor has a study examined the diagnoses and comorbidities between a JIV's propensity for recidivism following separation from the VJO. One of the VJO program's goals has been to end JIVs' contact with the criminal justice system. This study utilized a generic qualitative design that aimed to explore JIVs who received treatment from the VJO and whether there was an effect on their risk of recidivism. Additional elements for exploration included posttraumatic stress disorder, traumatic brain disorder, and mental health diagnosis, and how this phenomenon affects the risk of recidivism. Thematic information was derived from participants' accounts based on the semi-structured interview. All data were collected on SurveyMonkey. Once all five interviews were concluded, responses were analyzed together utilizing a thematic analysis approach. The results of this dissertation can contribute to positive social change by providing additional information to judges, lawyers, social workers, psychologists, and other legal, medical, and mental health professionals on justice involved veteran's recidivism. The forensic psychology and veteran community could benefit from this study. While some veterans found the program helpful, it is essential to remember that treatment is ongoing. Treatment may not end after the program, making it essential to repeat this study as a large-scale longitudinal study in the future.

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Dedication

This is dedicated to my family and friends who encouraged me throughout every stage of this study.

Acknowledgments

I want to thank my mom for being one of the smartest people I know and for her help and encouragement. I am not sure I would have made it this far without her help and the help of my friends, who cheered me on. Thank you, Amy, for being there from the first residency; you have been invaluable. Lastly, I want to thank Dr. Jessica Millimen for being my first chair and Dr. Jana Price-Sharps and Dr. Jerrod Brown for helping me cross the finish line.

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Chapter 1: Introduction to the Study

Introduction

This study focuses on the Veterans Justice Outreach (VJO) program and whether it affects the risk of recidivism. Justice-involved veterans (JIVs) comprise 10% of the incarcerated population; however, incarceration does not address crime's underlying causes (Blodgett et al., 2015). One of the VJO program goals is to eliminate or reduce recidivism and repeat contact with the justice system. VJO specialists connect veterans to treatment and supplementary services by working as liaisons between the Veteran Affairs (VA) and the Veterans Treatment Courts (VTC) to identify, assess, and link JIVs to the appropriate services (Finlay et al., 2016).

To date, no study has examined whether the VJO program influences recidivism once a JIV completes the program. Nor has a study examined the diagnoses and comorbidities between a JIV's propensity for recidivism following separation from the VJO (Johnson et al., 2015). My findings fill the gaps in research regarding the relationship between VJO treatment, JIVs, and the risk of recidivism. The forensic psychology and veteran community can benefit from this qualitative study, where a gap is addressed in research that directly relates to VJO treatment and the risk of recidivism. I explored whether the VJO ends JIVs' contact with the criminal justice system by reducing the risk of recidivism. In this dissertation, I provide a thematic analysis through explorational research with a generic qualitative research design to determine whether VJO treatment affects the risk of recidivism. If VJO treatment affects recidivism risk, I

will provide analytical evidence to favor the program and its goals, thus effecting positive social change within this population.

This chapter will continue with the background to introduce the study topic. The background section will include current research on the JIV population, veterans' treatment courts, meta-analyses on the topic, recidivism, and the VJO program. Then, I will describe the problem and purpose as to why this study is essential to social change and the forensic psychology field. I will then present a description of the research questions used in this study. The theoretical foundation will also be described in detail, followed by the nature of this study. After presenting the definitions of key terms, I will present the research assumptions, delimitations, and possible limitations in detail. Lastly, I will provide the significance of the study and its importance to social change.

Background

VTC, modeled after drug and mental health courts, was created to address the needs of JIVs (Yerramsetti et al., 2017). This rapidly growing specialty court has diverted qualified veterans from incarceration (Yerramsetti et al., 2017). The VA independently operates VTC and is strongly supported by the VJO program. The VJO's primary mission is to link JIVs to mental health and substance use treatment (Yerramsetti et al., 2017). JIVs comprise 10% of the incarcerated population (Blodgett et al., 2015). Ten percent is approximately 210,000 veterans, a reported vulnerable population that experiences higher rates of substance use disorder (SUD) and posttraumatic stress disorder (PTSD; Stimmel et al., 2018). Due to those elevated rates, most veterans who had utilized the VJO

program and had a co-occurring SUD were more likely to receive PTSD treatment (Stimmel et al., 2015).

Researchers Tsai et al. (2018) evaluated VTC veteran participants who were referred to the VJO program. Tsai et al. found recidivism risks to be an abuse of both drugs and alcohol, a history of property offenses, or parole violations. Tsai et al. (2018) also reported that participants in a VTC program display moderately positive outcomes. Finlay et al. (2015) included criteria such as the frequency of mental health and SUD and treatment admission rates of female veterans compared to the male veterans in the justice system. Additionally, they examined the less-known differences in diagnosis and how it differs by sex, specifically within the female population. From that aspect of the study, Finlay et al. concluded that 88% of female JIVs had a mental health disorder, and 58% had a SUD.

In 2015, Blodgett et al. conducted a meta-analysis studying a subgroup of JIVs compared to nonveterans who were justice-involved adults. Blodgett et al. concluded that the subgroup of veterans with dual psychiatric and SUD diagnoses elevated the risk of homelessness and violent behavior. Elbogen et al. (2012) researched how veterans with PTSD or traumatic brain injury (TBI), who also report anger/irritability, indicate elevated criminal arrest rates. Elbogen et al. (2015) also concluded that veterans with PTSD and anger/irritability mood disorders might have an increased risk of criminal arrest. Shea et al.'s (2022) research explored problems with anger and aggression in multiple war-era veterans, including the most recent wars. Piloting a cognitive-behavioral treatment in 2013, Shea et al. adapted a cognitive behavioral intervention (CBI). Shea et al. stated that

"CBI is an adaptation of a psychotherapy developed specifically for the treatment of anger (Novaco, 2001) that conceptualizes anger in terms of interacting regulatory deficits in arousal, cognitive, and behavioral domains" (p. 276). Shea et al.'s findings helped address the gap in evidence for veterans' effective anger treatments with CBI treatment, significantly reducing the severity of anger. However, while this improves treatment outcomes for veterans struggling with anger problems, it does not minimize aggression.

Hartley and Baldwin (2019) empirically analyzed a relatively substantial VTC in an urban area. By examining rearrests in a treatment group of VTC participants and comparing them to a group of veteran probationers, the researchers provided some evidence that participation in this program helped reduce recidivism up to 36 months after entry. Johnson et al. (2015) studied JIVs' susceptibility to recidivism based on their average stay in a treatment program, the number of judicial sanctions issued, or their type of discharge. Johnson et al. assessed that there was an elevated risk of recidivism when JIVs had an opiate abuse diagnosis, were arrested while enrolled in the program, or received a Factor Score 1. Factor Score 1 represented the manner of discharge, the length of stay, and the length of follow-up post-separation (Johnson et al., 2015). Blonigen et al. (2017) conducted a qualitative study to examine services that address recidivism risk factors among JIVs, and they found that some risk factors impacted services. Blonigen et al. reported that most risk factors were addressed using the risk-need-responsivity (RNR) model. Few services were addressing antisocial characteristics, associates, and empirically based treatments. Blonigen et al. attempted to fill these gaps in the literature by providing policy-based solutions.

To date, no study has examined whether the VJO program influences recidivism once a JIV completes the program. Nor has a study examined the diagnoses and comorbidities between a JIV's propensity for recidivism following separation from the VJO (Johnson et al., 2015). Finlay et al. (2016) reported a need to reassess JIVs who received treatment from the VJO to determine the program's effectiveness in achieving its goals. This, in this dissertation, I aimed to examine the relationship between VJO treatment, JIVs, and the risk of recidivism. One of the VJO program goals has been to end JIVs' contact with the criminal justice system. However, this has yet to be assessed by existing research. I explored whether the VJO meets its goals and benefits veterans involved with the criminal justice system.

Problem Statement

JIVs comprise 10% of the incarcerated population; however, incarceration does not address crime's underlying cause (Blodgett et al., 2015). To eliminate or reduce recidivism and repeat contact with the justice system, VJO specialists connect veterans to treatment and supplementary services. VJO specialists work as liaisons between the VA and the VTC to identify, assess, and link JIVs to the appropriate services (Finlay et al., 2016).

To date, no study has examined whether the VJO program influences recidivism once a JIV completes the program. Nor has a study examined the diagnoses and comorbidities between a JIV's propensity for recidivism following separation from the VJO (Johnson et al., 2015). One of the VJO program goals has been to end JIVs' contact with the criminal justice system. Finlay et al. (2016) showed a need to reassess JIVs

periodically during their treatment from the VJO to determine the program's effectiveness in achieving its goals. Elbogen et al. (2012) also reported that veterans' criminal behavior is a growing problem among veterans with a history of PTSD or traumatic TBI and reported high levels of anger or irritability events, which could indicate they have an increased risk of antisocial conduct (Elbogen et al., 2012). Combat veterans had increased anger and aggression problems, potentially creating increased domestic violence, arrests, and incarceration (Shea et al., 2018).

More than half of JIVs have at least one mental health concern, such as psychiatric or anxiety disorders (Blodgett et al., 2013). Approximately 87% of incarcerated veterans have at least one-lifetime traumatic experience (Blodgett et al., 2013). In addition to JIVs dealing with ongoing mental health issues, combat veterans are more likely to suffer from PTSD. One such study reported that approximately 39% of incarcerated veterans screened positive for PTSD. Simultaneously, many JIVs have a history of combat-related TBI, which has been linked to criminal activity (Blodgett et al., 2013; Yerramsetti et al., 2017;). Lastly, JIVs who had a shorter stay or an unsuccessful discharge from treatment had higher recidivism (Johnson et al., 2015).

Purpose of the Study

The purpose of this qualitative generic design was used to explore JIVs who received treatment from the VJO and whether there was an effect on their risk of recidivism. Additional elements that were explored included PTSD, TBI, and mental health diagnosis and how this phenomenon affects the risk of recidivism. These elements were chosen because each could potentially exacerbate a JIV's relationship to the justice

system and recidivism. For example, JIVs notably experience high rates of PTSD and SUDs (Stimmel et al., 2018). Furthermore, veterans with PTSD had an increased risk of criminal recidivism among JIVs with co-occurring mental disorders (Sadeh & McNiel, 2015). TBIs have been labeled the signature injury of veterans who have served in Iraq and/or Afghanistan.

Research Questions

Research question (RQ)1: Is there a risk of recidivism among those diagnosed with a psychological disorder, a SUD, or both among JIVs who took part in VTO?

RQ2: How does TBI affect the risk of recidivism among JIVs who received treatment from the VTO program?

RQ3: How does PTSD affect risk of recidivism among JIVs who received treatment from the VTO program?

Theoretical Foundation

The theoretical foundation of this research topic derived from Agnew's (1985) general strain theory (GST), which helps determine the factors that affect various strains or stressors that increase the likelihood of crime. These strains or stressors have an elevated risk of negative emotions like anger and frustration, and such emotions create pressure for corrective action, with crime being a potential response (Agnew, 2001). Elbogen et al. (2012) utilized Agnew's GST to explain criminal behavior among JIVs, stating that they have an increased risk of antisocial behavior if they have previously been exposed to trauma in addition to subjectively reporting adverse effects, specifically irritability or anger. Criminal behavior in veterans has been a growing problem; Elbogen

et al. believed one cause was veterans with PTSD or TBI who report high anger or irritability levels. Empirical research has supported the GST by demonstrating that in the wake of stressful environments or traumatic events, irritability or anger predicts delinquency, peer deviance, alcohol-related crimes, aggression, psychopathic violence, and sex offending (Elbogen et al., 2012). According to Elbogen et al., adverse effects are frequent in PTSD and TBI, with many reporting irritability and anger symptoms.

Nature of the Study

This qualitative generic design study aimed to explore whether graduates of the VJO program benefitted from their treatment by reducing their risk of recidivism. Qualitative research can help better understand the participants' experiences and perceptions that may affect specific populations (Tenny et al., 2022). The qualitative approach was used for this study because it provided an opportunity to use open-ended questions, which allowed participants to share data-rich detail (see Weller et al., 2018). The semistructured questionnaire allowed the research participants to discuss their perceptions, views, and thoughts on their experiences with the topic (Weller et al., 2018).

Data were collected utilizing SurveyMonkey to ensure anonymity. Participants were recruited through social media to answer demographic and nine open-ended questions, allowing them to respond in their own words. This study's sample population was JIVs who had received treatment from the VJO program and had been discharged for at least 6 months. The study utilized a thematic analysis approach to conducting the data analysis. This approach was a translator for researchers employing alternate methodological approaches to understand and communicate effectively (Nowell et al.,

2017). Data analysis consists of the following stages: gather relevant data from the questionnaires, categorize data once they are thoroughly reviewed, identify themes, and then identify a new topic developed (Nowell et al., 2017). Once an overall theme was found, it was identified and showed the study's relevance (see Lester et al., 2020).

Operational Definition of Terms

Aggression: "Hostile or violent behavior toward another" (Angkaw et al., 2013; Johnson, 2018, p. 4).

Alcohol use disorder: A problematic alcohol use pattern leading to clinically significant impairment or distress, as manifested by at least two diagnostic criteria listed in the Diagnostic and Statistical Manual of Mental Disorders 5, occurring within 12 months (American Psychiatric Association, 2013). For the purposes of this study, alcohol use disorder (AUD)falls under SUD.

Anger: "An emotional state caused by frustration or provocation that can range from annoyance to rage" (Johnson, 2018, p. 4; Teten et al., 2010).

Criminal thinking: "Cognition designed to initiate and/or maintain the habitual violation of rules, codes, and laws previously established by a legitimate governing body" (Walters, 2009, p. 281).

Justice-involved veterans (JIVs): "U.S. military veterans detained by, or under the supervision of the criminal justice system" (Blonigen et al., 2016, p. 813).

Mental health and substance use disorder diagnosis: A veteran who has had a mental health or SUD if they had at least one instance of the diagnosis associated with their health record in the 1 year after their VJO specialist encounter (Finlay et al., 2016).

Diagnoses were determined as part of a more detailed clinical assessment by VHA clinicians outside the VJO program. Mental health and SUDs were defined based on the International Classification of Diseases, Ninth Revision (ICD-9) diagnosis codes (Finlay et al., 2016).

Posttraumatic stress disorder (PTSD): A psychological distress following exposure to a traumatic or stressful event (American Psychiatric Association, 2013).

Recidivism: Rearrest, reconviction, or reincarceration for a new crime or violation of the terms of one's parole or probation (Blonigen et al., 2016).

Social media: Any online platform where individuals may share content, communicate, and/or seek or offer guidance to others. Examples include, but are not limited to, YouTube, Facebook, Instagram, and Twitter.

Substance use disorder (SUD): A complex condition in which there is the uncontrolled use of a substance despite harmful consequences. SUDs encompass the following use disorders but are not limited to those listed here: alcohol, caffeine, cannabis, inhalants, and opioids (American Psychiatric Association, 2013).

Traumatic brain injury (TBI): "A disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head or penetrating head injury" (TBI/ Concussion, 2020, August 28, para. 1).

Assumptions

As a general belief going into this study, it was assumed that qualified participants would be identified. I also assumed that the participants would be truthful and thus respond honestly about their personal experiences. Another assumption was that the

participant could describe and clearly articulate these experiences. Finally, participants were assumed to be willing and open to engaging in a meaningful qualitative dialogue.

Scope and Delimitations

This study's scope is limited to examining the relationship between JIVs who have received treatment from the VJO and recidivism risk. Additional elements include mental health diagnosis, PTSD, and TBI. As the researcher, I did not control for other factors, such as other treatment programs, and I did not utilize a control group for comparison. The decision to limit the scope to the risk of recidivism in JIVs who received treatment from the VJO was to provide a central focus for exploring whether there were reoccurring themes that could unearth phenomena. Additional research is needed to determine whether VJO treatment affects recidivism after separation from the program.

This study's scope included veterans who had been discharged from the program for at least 6 months, were not currently incarcerated, and had access to social media. The study was open to JIVs who have served in various locations with different ranks and active years. However, this dissertation did not conduct a separate analysis based on these differences. Finally, I explored the risk of recidivism instead of recidivism itself. If I were only to examine recidivism, I would have limited my population to veterans who are currently not incarcerated, thus skewing the results in favor of JIVs who successfully transitioned from the program.

Limitations

One limitation involves using self-reported data as there was a possibility for inaccuracies. Self-reporting also allowed participants to decline to answer any or all

questions, which led to limited or incomplete data. A second limitation involved the specific population of JIVs who had received treatment from the VJO program. Although the format for treatment facilities was similar to existing programs, this program was unique to veterans, making this research less generalizable to all treatment programs. Due to the uniqueness of this program, it was difficult to connect with program graduates for data collection, which led to limited participants. A third limitation involved the COVID-19 pandemic. At that time, I was gathering recruitment information; facilities such as the VA hospital were shut down due to the pandemic, which made it difficult to reach employees from the VJO with inquiries.

A fourth limitation to consider is that TBI is often scored through the Glasgow Coma Scale (GCS) and impacts different domains in varying ways. For instance, one may suffer functional limitations, aggressive tendencies, minor injury, or a higher severity level. TBI could result in depression and difficulty with coping skills, which may lead to other secondary diagnoses. Looking at the data, this may be evidenced by higher levels of substance and/or AUDs in addition to TBI and/or PTSD. The fifth limitation of this study was low participant numbers and a lack of information on each participant's level of functionality due to their diagnostic profiles. Lastly, this study allowed for participant anonymity, which did not account for the possibility of contacting participants with follow-up questions.

Significance

This study's findings help fill the gaps in research regarding the relationship between VJO treatment, JIVs, and the risk of recidivism. The forensic psychology and

veteran community can benefit from this qualitative study, where a gap is addressed in research related to VJO treatment and the risk of recidivism. Researching to explore whether the VJO meets its goals is beneficial to veterans involved with the criminal justice system. One of the VJO program goals is to reduce the risk of recidivism by ending their involvement with the justice system. This dissertation is focused on exploring whether there is an effect between VJO treatment and reduced risk of recidivism. If the program reduces recidivism risk in JIVs, this dissertation will provide a thematic analysis based on the phenomena. Such exploratory research could assist in determining whether treatment affects the risk of recidivism, thus taking an essential step toward positive social change.

Summary

Since 2014, an estimated 1.5 million Americans have served in or around active combat theaters (Lucas & Hanrahan, 2016). One in five veterans of the wars in Iraq and Afghanistan shows signs of mental illness, wounds that do not stay on the battlefield but follow them home into their communities (Lucas & Hanrahan, 2016). Three-hundred thousand veterans suffer from TBI, PTSD, and other mental and substance abuse disorders (Lucas & Hanrahan, 2016; Schaffer, 2016). Historically, veterans struggle with issues related to their military service; issues that stem from substance abuse and mental illness increase their risk of contact with the criminal justice system (Lucas, 2017). Furthermore, veterans in the United States have reported increased rates of PTSD, a disorder that can intensify criminal justice involvement (Knudsen & Wingenfeld, 2016).

Based on such statistical evidence, it is essential to research topics such as VJO treatment and recidivism risk to determine whether the program fulfills its goals.

Chapter 2 will provide an in-depth overview of the current literature on psychiatric disorders, SUDs, TBI, PTSD, and recidivism. I will discuss how each variable is connected to JIVs and their relationship with the criminal justice system, making them susceptible to recidivism. Chapter 2 will contain literature on TBIs, the signature injury of the modern war, and a small section on TBI anger. Furthermore, there will be literature on the connection between PTSD and TBI. This chapter will also include my search strategy to find the articles to back up the research hypothesis and questions stated in Chapter 1. The theoretical framework of the study will also be explained.

Chapter 2: Literature Review

Introduction

VTC, modeled after drug and mental health courts, was created to address the needs of JIVs. This rapidly growing specialty court is utilized to divert qualified veterans from incarceration. The VTC, although designed specifically for veterans facing criminal charges, is independently operated by the VA while strongly supported by the VJO. The primary mission of the VJO is to link JIVs to mental health and substance use treatment. The VJO has proven vital in helping veterans who qualify for the program. Programs like the VJO are linked with the VTCs, each an essential part of JIV treatment. However, little is known about the outcomes of these programs.

JIVs comprise approximately 210,000 veterans, or 10% of the incarcerated population (Blodgett et al., 2015). However, incarceration does not address the underlying causes of crime. VJO's specialists connect veterans to treatment and supplementary services to eliminate recidivism and repeat contact with the justice system. VJO specialists work as liaisons between the VA and the VTC to identify, assess, and link JIVs to the appropriate services (Finlay et al., 2016). To date, no study has examined whether the VJO program influences recidivism once a JIV completes the program. Nor has any of the above-referenced studies included the diagnoses and comorbidities between a JIV's propensity for recidivism following separation from the VJO or the treatment program's effectiveness, treatment modalities, or participation information (Johnson et al., 2015). Researchers Finlay et al. (2015) reported a need to reassess JIVs who received treatment from the VJO to determine the program's effectiveness in

achieving its goal. That goal is for the VJO to end JIV's contact with the criminal justice system. This study aimed to research the potential relationship between VJO treatment and JIV recidivism. The forensic psychology and veteran community can benefit from this qualitative study, where I address a research gap related to VJO treatment and recidivism.

In Chapter 2, I discuss my literature search strategy and the theoretical foundation that I utilized. An extensive literature review will be covered on the following topics: psychiatric disorders and SUDs, PTSD and SUD, PTSD and AUD, TBI, anger, recidivism, and criminal thinking.

Literature Search Strategy

My development of the literature review involved research through various online sources and search engines, including journals, government articles, dissertations from multidisciplinary databases, and the U.S. Census Bureau (2020), which lists the total number of veterans as 18.2 million. Search engines included Google Scholar and the Thoreau multi-database. Keyword terms I searched included *Veteran Justice Outreach, substance use disorder, veteran's health, homeless veterans, military veterans, posttraumatic stress disorder, mental health services, incarcerated veterans, justice-involved veterans, legal involvement, combat exposure, combat trauma, recidivism, risk-need-responsivity, anger or aggression, criminal justice veterans, empirically based treatment,* and *criminal thinking* as well as different combinations of these terms in Boolean searches. Most sources used were from 2015—2020; the remainder consisted of

older works that contained information relevant to this study, including those that support the theoretical framework.

Theoretical Foundation

The theoretical basis for this study was Agnew's (1985) GST, which is one of the theories that highlight the factors that affect various strains or stressors that increase the likelihood of crime, especially the social and economic strains that affect recitative rates. These strains or stressors have an elevated risk of negative emotions like anger and frustration, and such emotions create pressure for corrective action, with crime being a potential response (Agnew, 2001). Elbogen et al. (2012) utilized Agnew's GST to explain criminal behavior among JIVs, stating that they have an increased risk of antisocial behavior if they have previously been exposed to trauma in addition to subjectively reporting adverse effects, specifically irritability or anger. Criminal behavior in veterans has been a growing problem; Elbogen et al. believed one cause was veterans with PTSD or TBI who report high anger or irritability levels. Empirical research has supported the GST by demonstrating that in the wake of stressful environments or traumatic events, irritability or anger predicts delinquency, peer deviance, alcohol-related crimes, aggression, psychopathic violence, and sex offending (Elbogen et al., 2012). According to Elbogen et al., adverse effects are frequent in PTSD and TBI, with many reporting irritability and anger symptoms.

Past literature on JIVs and recidivism has focused almost equally on qualitative and quantitative methods. Four qualitative research articles were displayed when I searched the Thoreau database. Such articles included Blonigen et al.'s (2017) qualitative

study, where researchers explored the availability and utility of services that address recidivism risk factors among JIVs. Similarly, Watson (2016) conducted a qualitative study of JIVs and their experiences utilizing VTC instead of incarceration. However, in conducting the same search except for searching for quantitative studies, there was one article. Utilizing Google scholar, there was a total of 449 qualitative articles and 447 quantitative articles. Although the research methodology has been somewhat equally divided, this study used a qualitative method to determine the relationship between JIVs receiving treatment through the VJO and recidivism. Qualitative methods allow for an inductive thematic analysis accounting for any reoccurring themes to surface organically to describe the subjective and true essence underlying the participants' lived experiences. I explored JIVs who had received VJO treatment and its effects on their risk of recidivism based on their own words, making qualitative methods more appropriate for this study.

Psychiatric Disorders and SUDs

Historically, veterans struggle with issues related to their military service; issues initiated by substance abuse and mental illness increase their risk of contact with the criminal justice system (Lucas, 2017). Pinals (2010) discussed the emerging data regarding the importance of recognizing comorbid conditions of mental health problems and substance abuse creating obstacles for returning veterans. Pinals reported that approximately 3,000 male veterans who returned from Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) deployment, aged 18 to 25, had higher rates of mental health problems than soldiers returning from other conflicts. Of soldiers

who were surveyed after deployment and again approximately 6 months later, 27 to 35% reported symptoms of mental health risk (Huskey, 2015; Lucas, 2017; Pinal, 2010). Such mental health risks included symptoms of PTSD, depression, alcohol misuse, suicidal ideation, and self-reported aggression (Pinal, 2010). Additionally, TBI and PTSD in veterans commonly occur together and can be associated with comorbid SUDs (Pinal, 2010). Veterans who experienced PTSD and TBI reported substance use issues and attempted to self-medicate, resulting in increased contact with the criminal justice system (Brummet, 2013; Lucas, 2017).

Researchers Lucas and Hanrahan (2016) estimated that in 2014, the number of American veterans who served in or around active combat theaters was 1.5 million. In 2020, Pajak estimated that over 2.5 million service members had been deployed to Iraq and Afghanistan. Additionally, 300,000 veterans suffer from TBI, PTSD, and other mental health and substance abuse disorders (Lucas & Hanrahan, 2016; Schaffer, 2016). One in five veterans of the wars in Iraq and Afghanistan showed signs of mental illness, wounds that did not stay on the battlefield but followed them home into the same neighborhoods and communities they fought to protect (Lucas & Hanrahan, 2016).

Survival rates of veterans deployed to Iraq and/or Afghanistan were higher than veterans of other service eras, partially due to improvements in body armor and combat trauma medicine (Pajak, 2020). Consequently, Pajak (2020) also reported that with the rise in survival rates, there was an increase in veterans' volume with severe wounds, both physical and mental, therefore often exacerbated by the increased report of combat exposure compared to veterans of other service eras (Pajak, 2020).

Although not every factor is known for the rise in psychiatric disorders among service members in Iraq and Afghanistan, there has been a noted increase in the use of improvised explosive devices (IEDs) from the current war, which became a characteristic feature of the Iraq and Afghanistan combat zones (Pajak, 2020). The combat level has been the primary factor of mental health status among these veterans (Pajak, 2020). The most frequently diagnosed mental illnesses from this era include PTSD, depression, TBI, and often a combination of the three (Pajak, 2020). Notably, these veterans differ from other service eras in substance abuse rates and utilization of mental health treatment services (Pajak, 2020).

PTSD

Sadeh and McNiel (2015) studied how PTSD increases criminal recidivism risk among JIVs with a comorbid mental disorder. Based on Sadeh and McNiel's (2015) research, PTSD was associated with a higher likelihood of both general and severe recidivism during the year following the index arrest. According to Knudsen and Wingenfeld (2016), veterans in the United States reported increased rates of PTSD, a disorder that can increase their involvement within the criminal justice system. Moreover, approximately 18% of veterans experience PTSD and symptoms of depression. Additionally, a National Comorbidity Study's data suggested PTSD prevalence to be approximately three times higher within the veteran population than in community samples. Such a prevalence revealed that roughly 200,000 veterans were incarcerated in the United States in 2007, accounting for 10% of the total inmate population (Elbogen et al., 2012; Knudsen & Wingenfeld, 2016).

Furthermore, Bennett et al. (2018) examined the associations between PTSD and legal charges among substance-using veterans. They discussed the prevalence of substance misuse among veterans entering the criminal justice system and how it was related to recidivism. Research has demonstrated that trauma exposure and PTSD symptoms, which commonly co-occur with substance misuse, further increase the risk of legal involvement and recidivism (Bennett et al., 2018). Criminal behavior in veterans reportedly was a growing problem, with estimates of over 180,000 veterans being incarcerated annually; the majority were for violent offenses (Bennett et al., 2018; Bronson et al., 2015). Bennett et al. (2018) reported that evidence suggests substance use is linked to an increased risk of physical aggression and increased violent offending, particularly in alcohol and cocaine use. Furthermore, other mental health problems, such as PTSD, also increase the risk of perpetrating violence and criminal involvement among military and veteran samples (Bennett et al., 2018). Moreover, Blonigen et al. (2020) reported PTSD to be associated with postdeployment arrests in a national sample of veterans returning from Iraq and Afghanistan.

Pajak (2020) reported that PTSD was the most often diagnosed mental illness among current-era veterans, who were three times more likely to receive this diagnosis. Additionally, the forms of trauma often differed based on gender. Female veterans were more likely to be diagnosed with PTSD secondary to military sexual trauma, while male veterans were more likely to develop PTSD following combat exposure (Krupnick, 2017; Pajak, 2020). Rates of PTSD diagnosis further differed based on marital status; single veterans had a higher risk of PTSD (Pajak, 2020).

Research exploring “predictors of PTSD has emphasized that it is not necessarily the traumatic experience itself but the individual’s perception of a direct threat to their life resulting from the experience associated with the development of PTSD” (Vest et al., 2018, p. 414). Based on their theoretical perspective, the impact of a stressor hinges on the individual’s appraisal of the stress's demands relative to their capacity to cope. Furthermore, this cognitive appraisal dictates the response to the event; the perception of the threat occurs when the situation's demands are perceived as exceeding one’s capacity to cope. Additionally, Lancaster et al. (2016) found that combat-exposed military personnel were four to five times more likely to develop PTSD than those without exposure. However, less than 10% develop PTSD symptoms, and fewer meet the diagnostic criteria for PTSD (Lancaster et al., 2018).

Freeland (2017) reviewed the effects of PTSD on veterans, both with and without combat experience. They also reported that combat-experienced veterans had significantly higher PTSD rates than non-combat veterans. Additionally, veterans stationed in Iraq compared to Afghanistan were significantly correlated with developing PTSD. Veterans killed in combat had elevated rates of PTSD symptoms (Freeland, 2017).

Military sexual trauma (MST) is a common cause of PTSD that can affect veterans who had and had not been exposed to combat. The Department of Veterans Affairs defined MST as “physical assault of a sexual nature, battery of sexual nature, or sexual harassment that occurred while the individual was in the military, regardless of geographic location of the trauma, gender of the victim, or the relationship to the perpetrator” (Khan et al., 2020, p. 90). MST is associated with a fourfold risk for PTSD,

higher rates of disability, more significant challenges with emotional regulation, and higher rates of interpersonal trauma than combat veterans (Khan et al., 2020). The prevalence rates for MST vary from 22 to 71% for women veterans and 2% for men (Khan et al., 2020).

Historically, Pajak (2020) stated that mental health problems had increased the risk of incarceration among veterans. Veterans mainly diagnosed with PTSD could directly cause criminal behavior through impulsivity, risk-taking behaviors, aggression, hypervigilance, and intimate partner aggression (Pajak, 2020). PTSD has been found to have a closer association with violent charges than nonviolent charges among veterans in the legal system (Bennett et al., 2018; Pajak, 2020). Furthermore, Pajack's (2020) research indicates combat exposure as a risk factor for violence in current-era veterans, especially when paired with PTSD and alcohol abuse.

PTSD and SUD

Blonigen et al. (2020) reported SUD to be prevalent among veterans. Approximately 11% of veterans who experienced conflicts in Iraq and Afghanistan and received VA care met the criteria for a SUD diagnosis (Blonigen et al., 2020). Blonigen et al. (2020) also reported that the criminal justice system had the highest SUD rates. Furthermore, they reported that veterans in SUD treatment often had a history of criminal offending. Among veterans diagnosed with SUD in jails or treatment courts who initiated VA care, 58% were women, and 72% were men (Blonigen et al., 2020).

Finlay et al. (2015) conducted a study that documented the frequency of mental health and SUD and treatment admission rates of female veterans compared to the male

veterans in the justice system. Finlay et al. discussed the more well-known fact that veterans involved in the criminal justice system had mental health or SUDs. However, it is less known how such diagnoses differ by sex, specifically within the veteran female population. This study concluded that 88% of female JIVs had a mental health disorder, and 58% had a SUD (Finlay et al., 2015). Sadeh and McNiel (2015) reported that 60% of jail inmates had mental health problems. Based on a large-scale study, 14.5% of male and 31% of female inmates met the criteria for a severe mental disorder (Sadeh & McNiel, 2015).

Killian et al. (2018) also focused on the female population, stating that incarcerated women had extensive trauma histories. Additionally, PTSD and co-occurring SUDs are common among incarcerated women. Killian et al. studied the relationship between trauma and the willingness to change substance use behaviors. They found a need to understand further the links between trauma and the readiness to change. More specifically, the role of posttraumatic growth and psychological distress. However, Killian et al. revealed that women with high trauma symptoms were more willing to address change.

Blodgett et al. (2015) conducted a meta-analysis where they examined a subgroup of JIVs, comparing them to nonveteran justice-involved adults. Blodgett et al. reported that the subset of veterans with dual diagnoses of a psychiatric disorder and SUD had an elevated risk of homelessness and violent behavior. Stimmel et al. (2018) explored SUDs and their impact on treatment engagement among JIVs with PTSD. JIVs experience high rates of PTSD and SUDs, a particularly vulnerable population within the criminal justice

system. Stimmel et al.'s research indicated that most veterans diagnosed with PTSD utilizing the VTO program had a SUD diagnosis (73%). Those with comorbid diagnoses were associated with higher odds of receiving PTSD treatment.

PTSD and AUD

Vest et al. (2018) examined what drives soldiers' relationship between combat and alcohol problems. A topic recently gained more attention; specifically, several studies examined the amount and types of combat exposure. For example, Eisen et al. (2012) found that veterans deployed to Iraq for Operation Iraqi Freedom experienced significantly worse outcomes, including alcohol use, than veterans deployed to Afghanistan for Operation Enduring Freedom (Eisen et. al., 2012; Vest et al., 2018). Additionally, Bray et al. (2013) demonstrated that those with higher combat exposure levels were significantly related to binge drinking, heavy drinking, and alcohol problems than soldiers with no and low to moderate combat exposure levels (Vest et al., 2018). Furthermore, among active-duty Army infantry combat teams, 25% screened positive for alcohol misuse from those surveyed three to four months post-deployment (Vest et al., 2018; Wilk et al., 2010). Those who screened positive had significantly more combat experiences, increasing the risk of alcohol abuse (Vest et al., 2018; Wilk et al., 2010). Additionally, "alcohol misuse was more likely in soldiers who experienced the direct threat of death or injury to themselves" (Vest et al., 2018, p. 414).

Norman et al. (2018) discussed how the relationship between AUD and PTSD is among the most prevalent psychiatric disorders in U.S. military veterans. AUD and PTSD, commonly comorbid, were reported to be high among veterans who sought

treatment, “with 63% of veterans who served in Iraq and Afghanistan accessing Veterans Affairs care between 2001 and 2010 with AUD meeting criteria for PTSD” (Norman et al., 2018, p. 224). Furthermore, Norman et al. indicated that veterans with comorbid AUD and PTSD might have increased these psychiatric disorder rates. Norman et al.’s study built on Fuehrlein et al.’s (2016) study, utilizing the same sample. Fuehrlein et al. reported that veterans had an increased risk for psychiatric morbidities associated with AUD. Heavy drinking has often been normalized in military cultures. Veterans with a lifetime of AUD were four times more likely to have had a history of PTSD, major depressive disorder, and suicidal ideation (Fuehrlein et al., 2016). Additionally, veterans who were involved in OEF/OIF had a higher prevalence of PTSD (23%) compared to the nonveteran PTSD population (6.4—7.8%; Fuehrlein et al., 2016). Lastly, Fuehrlein et al. listed multiple factors linked to AUD in veterans, such as younger age, trauma history, combat exposure, and unpartnered marital status.

TBI

A TBI is defined as “a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head or penetrating head injury” (TBI/ Concussion, 2020, August 28, para. 1). However, not all blows or jolts to the head result in TBI. The severity of a TBI may range from mild (i.e., a brief change in mental status or consciousness) to severe (i.e., an extended period of unconsciousness or memory loss after the injury; TBI, n.d.). Most TBIs that occur each year are mild and commonly called concussions. Military service members and veterans are at risk of brain injury from explosions experienced during combat or training exercises (TBI, n.d.).

Depending on the severity of the brain injury, a person with TBI may experience a change in consciousness that can range from being dazed and confused to losing consciousness (TBI, n.d.). They may also experience memory loss. The Defense and Veterans Brain Injury Center reported nearly 414,000 TBIs among U.S. service members worldwide between 2000 and late 2019 (TBI, n.d.). More than 185,000 veterans who use the VA health care system had been diagnosed with at least one TBI (TBI, n.d.). The majority of those are classified as mild.

Conditions stemming from TBI can range from headaches, irritability, and sleep disorders to memory problems, slower thinking, and depression (TBI, n.d.). These conditions often lead to long-term mental and physical health problems that impair veterans' employment, family relationships, and reintegration into home communities (TBI, n.d.). A TBI severity can often be assessed through a computed tomography (CT) scan, where there may be evidence of brain bleeding, bruising, or swelling (TBI, n.d.). Additional assessments include the length of loss or alteration of consciousness, the length of memory loss, and how responsive the individual was after the injury (TBI, n.d.). Although most TBIs are considered mild, even mild cases can involve serious long-term effects on thinking ability, memory, mood, and focus (TBI, n.d.). Other symptoms can include headaches, vision, and hearing problems (TBI, n.d.).

In 2017, Schwab et al. examined the postconcussive symptoms after deployment. Nearly half of the soldiers with a mild TBI while serving in Afghanistan or Iraq had postconcussive symptoms such as sleep problems, forgetfulness, irritability, and headaches 3 months after deployment. According to Schwab et al., this suggests that mild

TBI is associated with continuing problems for longer than has been recognized in the active-duty population.

Elbogen et al. (2012) studied veterans with PTSD or TBI who reported anger/irritability and showed higher criminal arrest rates. Elbogen et al. concluded that veterans with PTSD and anger/irritability might have an increased risk of criminal arrest. Drapela et al. (2019) discussed the growing awareness of JIVs and how TBIs relate to criminal behavior, program participation, and resource utilization. Drapela et al. described TBIs as a signature wound for contemporary war veterans, which has made combined JIVs and TBI issues a critical concern. In isolation and in combination with PTSD, TBI increases the risk of criminal justice involvement among veterans, specifically veterans who also abuse drugs and alcohol (Drapela et al., 2019). TBI has been positively correlated with mental illness and substance abuse. Furthermore, research shows that TBI increases the risk of a veteran experiencing PTSD, mental health problems, suicide risk, and addiction-related disorders.

Lawrence et al. (2017) also discussed how TBIs were the signature injury of Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF) veterans, and Operation New Dawn (OND), with as many as 19-23% of military service members affected (Lawrence et al., 2017; Porter et al., 2018). Porter et al. (2018) indicated the percentages to be between 12-23%. Lawrence et al. reported that an estimated 7% of that percentage have a comorbidity of PTSD and/or depression. However, most percentages were classified as mild traumatic brain injuries (mTBI), commonly known as concussions (Porter et al., 2018). Porter et al.'s research focused on the lasting experience of

postconcussive symptoms (PCS) associated with common to severe health outcomes. Comorbid issues of PTSD and TBI exacerbate such symptoms. Porter et al. referred to several studies explicitly highlighting the relationship between PTSD and PCS in veterans and service members, revealing that participants with a history of TBI reported a significantly higher number of PCS in addition to those who experienced TBI during deployment were more likely to have PTSD.

Research examining TBI's effects on military personnel has intensified due to the growing concerns regarding the increasing number of head injuries sustained during OIF and OEF conflicts (Kalkstein et al., 2017). Among the 2.5 million OEF/OIF military personnel, an estimated 300,000 had a TBI (Kalkstein et al., 2017). Mild TBIs from exposure to IEDs have been highly prevalent among OEF/OIF veterans. Behavioral outcomes associated with TBIs reveal links between TBI and neurological outcomes, including Alzheimer's dementia, Parkinsonism, and postconcussive symptoms, including attention and memory difficulties (Kalkstein et al., 2017).

Between 2007 and 2015, the VA screened 1 million combat veterans for TBIs from the 2.6 million deployed during OEF/OIF/OND era (DePalma & Hoffman, 2018). An estimated 8.4% received a TBI diagnosis from those screened, the majority characterized as mild TBI/Concussion (mTBI), most relating to blast exposure (DePalma & Hoffman, 2018). Of these conflicts, DePalma and Hoffman (2018) further explained why mild TBI is called a signature injury or invisible injury. Researchers Young et al. (2015) described the physics behind various brain injuring modalities (as cited in DePalma & Hoffman, 2018). One modality predicted brain tissue damage occurs within

extremely minute intervals with cell membrane breakage (DePalma & Hoffman, 2018; Young et al., 2015). The damage occurs within microseconds after the blast shock wave passes through the brain tissue; conventional CT imaging cannot detect initial cellular effects (DePalma & Hoffman, 2018).

Researchers Martindale et al. (2020) reported that between 2000 and 2019, nearly 413,858 OEF/OIF/OND veterans were diagnosed with TBI, and an estimated 19-23% were due to blast forces. Explosions were involved in an estimated 79% of all combat injuries and 88% of head and neck injuries of OEF/OIF/OND veterans (Martindale et al., 2020). However, the actual number of service members with significant blast exposure is unknown due to the many unrecorded exposures that did not result in a TBI (Martindale et al., 2020). Martindale et al. (2020) reported that veterans with both blast and nonblast TBI and PTSD had been associated with veterans' lower cognitive functioning. More specifically, veterans with PTSD were more deficient in processing speed and executive functioning (Martindale et al., 2020). According to Martindale et al., most TBIs are mild, and any cognitive changes are not expected to endure more than 3 to 12 months. However, this does not account for veterans with a comorbid diagnosis of PTSD or those with multiple injuries.

Researchers Adams et al. (2017) studied the relationship between TBI and post-deployment binge drinking among service members returning from OEF/OIF. Binge drinking was defined as consuming five or more drinks on one occasion for males and four or more drinks for females (Adams et al., 2017). Previous research has shown a relationship between combat deployment and an increased risk for binge drinking and

problem alcohol use (Adams et al., 2017). Additionally, research has suggested that experiencing a TBI while deployed increases the risk for postdeployment frequent binge drinking, alcohol misuse, and negative drinking-related consequences (Adams et al., 2017).

Adams et al. (2017) detail the link between the brain's reward circuit and its implications in substance abuse. Adams et al. described how

> TBI of sufficient force will damage the frontal lobes, ventral medial prefrontal cortex, and orbital frontal cortex regardless of head impact location. The neural networks connecting these areas of the prefrontal cortex to the basal ganglia and midbrain constitute the so-called "reward circuit". (p. 1458)

Significantly, damage to the orbital frontal cortex has been associated with a reduced ability to prevent impulsive behavior, such as drinking regulation (Adams et al., 2017). Additionally, there may be an interaction between "neuroinflammation" resulting from TBI, which increases postinjury drinking (Adams et al., 2017, p. 1458).

Researchers Waltzman et al. (2017) reported that PTSD and TBI are exceedingly common in veterans. The prevalence of diagnosed PTSD ranged from 10 to 30% and 15 to 30% for diagnosed TBI (Waltzman et al., 2017). Both PTSD and TBI have been known to cause impairments in memory. Waltzman et al. discussed the different properties of declarative and nondeclarative memory systems. The "medial temporal lobe supports declarative memory, which is the conscious recollection of facts and events," and the "basal ganglia supports nondeclarative memory, which is nonconscious and is implicitly learned through performance rather than recollection" (p. 2). However, it is

less understood how the two memory systems interact, yet both systems may be involved in PTSD and TBI (Waltzman et al., 2017).

Waltzman et al. (2017) reported that gray brain matter damage is a relevant feature in PTSD and TBI based on existing research. Waltzman et al. utilized diffusion tensor imaging (DTI) to understand whether disruptions occurred on a macro or microstructural level. This method would help identify the "neuroanatomical basis of functional abnormalities of memory" (p. 2). Based on DTI, there were significant alterations on a microstructural level in the caudate (tail-shaped basal ganglion) in the study's PTSD group but not in the TBI group (Waltzman et al., 2017). The caudate is thought to play a role in the physiopathology of PTSD (Waltzman et al., 2017).

Anger

Hart et al. (2017) reported problematic anger and/or irritability and how it affects many TBI survivors. Up to one-third of those affected reported new or worse anger since their injury. Shea et al. (2018) explored problems with anger and aggression in multiple war-era veterans, including the most recent wars. Shea et al.'s findings helped address the gap in evidence for veterans' effective anger treatments. Shea et al.'s treatment involved an active control condition that could potentially improve treatment outcomes for veterans struggling with anger problems. Bishop-Deaton (2019) discussed how veterans adjust to anger as a new baseline in combat as an acceptable means of militaristic motivations and a way of coping with the atrocities of war.

Novaco and Chemtob (2015) discussed how PTSD had been associated with violence among combat veterans. The study hypothesized that violence would be

intensified when combat-related PTSD was conjoined with anger. Taft et al. (2017) reported that trauma and PTSD have negative consequences, particularly damaging when accompanied by anger and aggression. A sample study of veterans showed a close relation between PTSD and aggression. Current conceptualizations of anger include physiological, affective, and behavioral components (Taft et al., 2017). Anger can be considered a prelude to aggression, while anger statistically mediates the effects of PTSD on aggression; not all who are angry will transition to aggression (Taft et al., 2017).

According to Miles et al. (2016), veterans with PTSD are strongly connected to anger, hostility, and certain forms of aggression. The Veterans Affairs report that up to 21% of veterans diagnosed with PTSD receive health care, which is much higher than the 8-12% prevalence rate in the general population (Miles et al., 2016). Emotion regulation difficulties or emotion dysregulation are related to increased PTSD symptom severity and may also play a role in aggressive behavior (Miles et al., 2016). Furthermore, Heinz et al. (2015) report that a wealth of epidemiological data demonstrates that aggressive behavior is dramatically more prevalent among individuals with SUDs. Heinz et al. examined PTSD symptom severity and impulsivity as predictors of aggressive behavior among veterans receiving substance abuse treatment who also reported difficulty controlling their anger within the past year. Heinz et al. reported that past aggression trends are a good indicator of future aggression.

Miles et al. (2020) reported irritability, anger, and aggression to be relatively common symptoms of TBI and PTSD. Irritability and anger pertain to emotional responses, whereas aggression is an actual behavior intended to harm another (Miles et

al., 2020). Irritability, anger, and aggression have been known to lead to devastating interpersonal, legal, and medical consequences (Miles et al., 2020). Impairment in one's capacity to engage in autonomous, goal-directed, self-serving behavior (executive dysfunction) has been a problem observed in TBI, PTSD, irritability, anger, and aggression (Miles et al., 2020). The prefrontal cortical functioning serves as an emotional control region, which, if impaired, can dysregulate its engagement, resulting in irritability, anger, and aggression (Miles et al., 2020). Furthermore, the prefrontal cortical function is imperative to manage PTSD symptoms (Miles et al., 2020). Additionally, veterans who have sustained penetrating TBI in frontal lobe regions were rated as more aggressive than those who sustained TBI affecting other regions of their brain (Miles et al., 2020).

Miles et al. (2020) further discussed how PTSD was independently associated with veterans' irritability, anger, and aggression. Veterans with PTSD were likelier to have higher rates of irritability, anger, and aggression than civilians with PTSD (Miles et al., 2020). Miles et al. reported that 48% of veterans with PTSD symptoms reported having engaged in physical aggression within 1 year of returning from deployment. One possible reason behind the irritability, anger, and aggression could be the emotional dysregulation of the prefrontal lobe associated with PTSD (Miles et al., 2020).

Recidivism

Hartley and Baldwin (2019) empirically examined a relatively large VTC. This area was reported to have failed to reach significance in evaluating its impact on recidivism despite its rapid expansion. Hartley and Baldwin examined rearrests in a

treatment group of VTC participants, comparing them to a group of veteran probationers. The study provided some evidence that participation in their VTC program helped reduce recidivism up to 36 months following the program's successful completion.

Knudsen and Wingenfeld (2016) explored the implications for the field regarding specialized treatment courts for veterans with trauma exposure. Examining the efficacy of providing a VTC-specialized docket to trauma-affected veterans, participants in the program suggest a significant improvement in PTSD, depression, substance abuse, and overall functioning and emotional wellbeing (Knudsen & Wingenfeld, 2016).

Before Blonigen et al.'s 2017 study, in 2016, they conducted a systematic literature review of recidivism's risk JIVs and found limited empirical research. By utilizing the RNR model, they performed their analysis to identify gaps in the literature and offer future research recommendations. In 2017, Blonigen et al. conducted a study examining services that addressed recidivism risk factors among JIVs to improve access to mental health services. They found that services assisted in some but not all risk factors. Blonigen et al. reported that most risk factors were addressed by utilizing the RNR model. However, few services addressed antisocial characteristics, associates, and empirically based treatments (Blonigen et al., 2017). Blonigen et al. attempted to fill these gaps in the literature by providing policy-based solutions.

Blonigen et al. (2020) further discussed the lack of research on personality factors as predictors of recidivism despite the prominence of such factors in leading recidivism risk management models. Blonigen et al. reported that factors such as higher quality friend relationships and "higher staff ratings of patients' relationship quality with other

residents during treatment" predicted lower recidivism rates (2020, p. 1). In contrast, veterans with the negative emotionality personality trait predicted an increased risk for criminal recidivism (Blonigen et al., 2020). Negative emotionality was described as a propensity to experience negative emotions such as anxiety, mistrust, and anger (Blonigen et al., 2020).

Johnson et al. (2015) examined JIVs' susceptibility to recidivism based on their average stay in a program, the number of judicial sanctions issued, or their type of military discharge. Johnson et al. found an elevated risk of recidivism when JIVs had an opiate abuse diagnosis, were arrested while enrolled in the program, or received an RNR Factor Score 1. Factor Score 1 represented the manner of discharge, length of stay, and length of follow-up post-separation from the program. Tsai et al. (2018) examined the outcomes of VTCs from veterans who participated in the VJO program. Tsai et al. found recidivism risks to be an abuse of both drugs and alcohol and a history of property offenses or parole violations. Tsai et al. also reported that participants in a VTC program display moderately positive outcomes.

Criminal Thinking

Criminal thinking is a significant risk factor in both the onset and maintenance of criminal behavior (Caudy et al., 2015). Research has consistently found significant associations between criminal thinking (e.g., antisocial attitudes) and criminal behavior (Knight et al., 2006). Criminal thinking can encompass "offense-supportive attitudes, cognitive processing during an offense sequence, as well as post-hoc neutralizations or excuses for offending" (Caudy et al., 2015; Maruna & Mann, 2006, p. 155). Walters

(2009) defined it as “cognition designed to initiate and/or maintain the habitual violation of rules, codes, and laws previously established by a legitimate governing body” (p. 281).

According to the criminal lifestyle theory, there are two significant dimensions of the criminal thought process or how an offender thinks: initiative-taking and reactive criminal thinking (Walters, 2020). The initiative-taking dimension reflects the amoral aspects of the criminal thought process calculated in nature (Walters, 2020). In contrast, the reactive dimension reflects weak control over the thought process and is characterized by impulsivity, irresponsibility, and emotionality (Walters, 2020). Both dimensions may interact with the decision-making process's rational requirements to alter intentions to engage in future antisocial behavior (Walter, 2020).

According to Walter’s 2006 study, the theoretical roots of criminal thinking are derived from Sutherland’s differential association theory. Walter’s theory stemmed from the thought that crime is learned in association with criminals and that both the techniques of crime and motivations, rationalizations, and attitudes are learned. Another model, neutralization theory, argued that most lawbreakers saw themselves as conventional rather than antisocial and that many sought to justify and rationalize their actions (Walters, 2006). A third model is the criminal personality perspective, which works principally with repeat offenders who have been found not guilty by reason of insanity (Walters, 2006). These models served as a foundation for modern measures of criminal thinking.

A conceptual model of criminal thinking was borrowed from Piaget. Schemes develop through a person’s interactions with the environment, a function of the complex

interaction of assimilation and accommodation (Walters, 2006, 2009). The childhood precursors of the crime scheme can be traced to a child's understanding of rules and rule-breaking and fundamental schemes as bad and wrong (Walters, 2006, 2009). With experience and practice, these schemes become more precise, differentiated, and abstract (Walters, 2006, 2009).

It should be noted that when explaining criminal thinking, it must be understood within the proper cultural, developmental, and temporal context (Walters, 2009). Criminal thinking exists in a cultural context; it must consider the culture in which it occurs (Walters, 2009). Culture defines a criminal, and while many acts are considered criminal in most cultures, many other acts are only criminal in certain cultures and subcultures (Walters, 2009). Secondly, referring to Piaget's assimilation and accommodation concepts, criminal thinking has a developmental context (Walters, 2009). Developmental criminal thinking stems from individual schemes and major belief systems (Walters, 2009). Lastly, criminal thinking as a temporal context varies as a function of the point at which it occurs in the criminal event or career (Walters, 2009). This includes patterns of violence and a singular violent episode; the sequence can be divided into at least two phases: an initiation and a maintenance phase (Walters, 2009). The initiation phase explains how violence begins, while the maintenance phase explains how violence continues (Walters, 2009). Different factors are responsible for both phases of criminal thinking, such as situational cues and perceptual distortions. Cues and distortions are instrumental in initiating a violent criminal episode, while reinforcement and feedback are instrumental in maintaining a violent criminal episode (Walters, 2009).

Various ideas an individual has about specific criminal acts appear to be more involved in initiating a pattern of criminal violence than maintaining a pattern of criminal violence (Walters, 2009). Such ideas may include content about criminal thought, such as target selection and criminal technique (Walters, 2009). Alternatively, violent criminal maintenance would appear to be a function of the criminal thought process, from labeling to outcome expectancies for crime to thinking styles (Walters, 2009).

Summary and Conclusion

JIVs comprise 10% of the incarcerated population. Incarceration does not address the underlying cause of crime (Blodgett et al. 2015). Veterans struggle with issues related to their military services, issues stemming from mental illness, and substance abuse that increase their risk of contact with the criminal justice system (Lucas, 2017). Additional issues such as PTSD and TBI have contributed to substance abuse to self-medicate, thus increasing contact with the criminal justice system (Lucas, 2017). Twenty-seven to 35% of veterans who served in Iraq and Afghanistan reported PTSD symptoms, depression, alcohol misuse, suicidal ideation, and aggression (Huskey, 2015; Lucas, 2017).

TBIs have been labeled the signature wound for contemporary war veterans. Among the 2.5 million OEF/OIF military personnel, it has been estimated that over 300,000 have a TBI (Kalkstein et al., 2017). Veterans with and without PTSD have an increased risk of criminal justice involvement (Drapela et al., 2019). More specifically, veterans with TBI and PTSD have an increased risk of drug and alcohol abuse (Drapela et al., 2019). Furthermore, veterans reported problematic anger and/or irritability that was

either new or worsened since their TBI. Veterans with PTSD have stronger associations with anger, hostility, and certain forms of aggression (Miles, et al., 2016).

Since the conception of VTC, little research has been conducted on evaluating the program and whether it positively impacts recidivism despite its rapid expansion (Hartley & Baldwin, 2019). The VA created the VJO to connect veterans to treatment and supplementary services to eliminate or reduce recidivism. The VA and VTC assign VJO specialists to identify, assess, and link JIVs to the appropriate services (Finlay et al., 2016). One of the VJO program goals is to end JIV's contact with the criminal justice system. To date, no study has examined whether the VJO program influences recidivism once a JIV completes the program. Nor has a study examined the diagnoses and comorbidities between a JIV's propensity for recidivism following separation from the VJO (Johnson et al., 2015). Researchers Finlay et al. (2016) reported a need to reassess JIVs who received treatment from the VJO to determine the program's effectiveness in achieving its goals.

Chapter 3: Research Method

Introduction

The purpose of this study was to explore JIVs who received VJO treatment and whether it affected the risk of recidivism. These were essential elements because JIVs experience high rates of PTSD and SUD (Stimmel et al., 2018). Additionally, PTSD increases the risk of criminal recidivism among JIVs with co-occurring mental disorders (Sadeh & McNiel, 2015). TBIs have been labeled the signature injury of veterans who have served in Iraq and/or Afghanistan.

A generic qualitative research design was used to explore JIVs who received treatment from the VJO and whether there was an effect on their risk of recidivism. Additional elements that were explored included PTSD, TBI, and mental health diagnosis and how this phenomenon affected the risk of recidivism. These elements were chosen because each could potentially exacerbate a JIV's relationship to the justice system and recidivism. For example, JIVs notably experience high rates of PTSD and SUDs (Stimmel et al., 2018). Furthermore, veterans with PTSD had an increased risk of criminal recidivism among JIVs with co-occurring mental disorders (Sadeh & McNiel, 2015). TBIs have been labeled the signature injury of veterans who have served in Iraq and/or Afghanistan. This generic qualitative study helped qualitatively explore whether VJO treatment affected JIVs' risk of recidivism.

This chapter begins with a brief overview of the study's qualitative research design, rationale, and methodology. This includes the procedures for recruitment, participation, data collection strategy, and the data analysis plan. Additional sections

include a description of the target population, which leads to sampling and sampling procedures. Next, threats to validity are discussed, including internal and external threats. Lastly, the ethical procedures and treatment of data are discussed.

Research Design and Rationale

The central concepts under exploration were the potential effect of VJO treatment and JIV risk of recidivism. JIVs were considered essential elements due to their vulnerability to high rates of PTSD and SUDs (Stimmel et al., 2018). Additionally, PTSD increases the risk of criminal recidivism among JIVs with co-occurring mental disorders (Sadeh & McNiel, 2015). TBIs have been labeled the signature injury of veterans who have served in Iraq and/or Afghanistan. The research design utilized was a generic qualitative design used to discover and understand a phenomenon, a process, or the perspectives of participants (Kostere & Kostere, 2021). Thematic information was derived from participants' accounts based on the semi-structured interview utilizing the asynchronous technique (Belotto, 2018). This design was utilized to understand whether graduates of the VJO program benefitted from their treatment by reducing their risk of recidivism.

Qualitative methodology was used to understand human experience in this study from JIVs who completed the VJO program. The RQs were designed to explore how those individuals made sense of their experiences (Kostere & Kostere, 2021). In this generic qualitative research study, I sought to illuminate and interpret meanings of the phenomenon based on participant perceptions and experiences (see Kostere & Kostere, 2021). The rationale for using the generic qualitative design was due to the nature of this

study, which focuses on words and language, not numbers and measurements (Kostere & Kostere, 2021). The study utilized a thematic analysis approach to conducting the data analysis. Thematic analysis was a widely utilized approach that may be foundational in a qualitative study (Nowell et al., 2017). Generic qualitative research resulted in a better understanding of undiscovered phenomena. The meaning derived from human experiences resulted in detailed descriptions and interpretations to guide future research (Errastibarrondo et al., 2018).

The thematic analysis approach was ideal for this data set to look for patterns in the meaning of the data to find themes. This methodology allowed me to examine the participants' perspectives to provide insight into their lived experiences. For the reasons behind utilizing the generic qualitative methodology, other methodologies such as ethnography, narrative, grounded theory, and a case study were not ideal for this research. Generic qualitative research was the best fit as a descriptive methodology for understanding how JIVs made meaning of their experiences within the VJO and how it affected their risk of recidivism after program completion.

Role of the Researcher

My role as a researcher was nontraditional due to how the data was collected. The data were confidential and anonymous; participants were not asked to provide their names or identifying information. Data collection was conducted on SurveyMonkey, and recruitment was conducted through social media, which involved very few ethical factors for me as the researcher. One ethical factor included respect for privacy, grounded in the foundational norms of respect for persons and beneficence (Gelinas et al., 2017).

Measures were taken to ensure confidentiality. Responses were anonymous, and participants were not asked to provide sensitive information.

A second ethical consideration was the context of social media recruitment to ensure transparency. The importance of transparency was grounded primarily in respect for persons, which demands researcher truthfulness and honesty throughout the data collection process (Gelinas et al., 2017). Transparency requires researchers to be truthful and honest when describing the study's aims, details, risks, and benefits (Gelinas et al., 2017). For transparency purposes, the research study's description was provided along with a consent form. My IRB approval number was included along with Walden University's information. Participants were encouraged to contact the school or me with any questions.

Methodology

Participant Selection Logic

Since 9/11, more than 2.5 million Americans have served in the military (VIVs, n.d.). As of 2015, the JIV population comprises approximately 210,000 veterans, or 10% of the incarcerated population (Blodgett et al. 2015). Veterans from 1974 to 2000 were less likely to be incarcerated than 9% of post-9/11 veterans who have been arrested since returning home from serving in Iraq and Afghanistan (Richman, 2018). This study's sample population was JIVs who had received treatment from the VJO program and had been discharged for at least 6 months.

Instrumentation and Operationalization of Constructs

Data were collected from five participants using SurveyMonkey, which provided total anonymity. However, I could not contact participants for any follow-up questions due to the anonymity. Participants completed the survey using an electronic device without contact with another person. There were two reasons for maintaining zero contact. One, the VJO program could not assist me with this study; therefore, I did not have access to veterans who had participated in the program. Secondly, the decision of how data would be collected was made during the height of the COVID-19 pandemic. The pandemic made in-person contact less than ideal, if not impossible. Due to the pandemic, I utilized social media to recruit and promote my survey through SurveyMonkey. The survey included 17 questions, five were demographic, and four inquired about participants' mental health diagnoses. A total of 33 participants gave consent to complete the qualitative survey. Out of 33 participants, five completed the survey.

The RQs I designed were developed to explore phenomena through participants' perceptions in their own words (see Ellis & Hart, 2023). Validity was essential to any research within the social sciences. Threats to validity could come in many forms, and ensuring the standards are entirely met is vital. The measurement tools previously mentioned assisted in securing internal and external validity in this research. Additionally, the tools ensured confidentiality when participating in the study.

Operationalization

Mental health diagnoses were measured by asking the participants if the VA had diagnosed them with a psychiatric disorder and/or a SUD. The definition of SUD was outlined in detail in chapter one as it related to this study. If the participant answered yes to having been diagnosed with a psychiatric and SUD, they would have a dual diagnosis. PTSD was measured by asking the participants if the VA had ever diagnosed them with PTSD. Similarly, TBI was measured by asking the participant if the VA had ever diagnosed them with TBI. The risk of recidivism was calculated by asking the participants if they had been arrested after completing VJO treatment.

Sampling and Sampling Procedures

When I began promoting my research study, a Facebook page was set up to describe the dissertation. I provided my Walden email address and shared the link to SurveyMonkey. I sent study solicitation emails to VJO Specialists, VTC coordinators, VA social workers, and other VA personnel. The emails contained the IRB recruitment flyer, which listed the purpose of the study, qualifications requirements, a sample of questions, and a link to the SurveyMonkey questionnaire. Participants were encouraged to contact me if they had questions about the study. All persons were encouraged to share the study information for convenience sampling.

In this study, it was not possible to work with the VA to obtain the necessary data. However, multiple sources within the VA recommended that the data be obtained independently. JIVs who qualified for the study must have completed VJO treatment and been discharged from the program for at least six months. Those who had not completed

the program or had been discharged for less than six months were excluded from the study.

Procedures for Recruitment, Participation, and Data Collection

Recruiting was conducted through social media platforms, targeting areas catering to JIVs online. Social media sites offer various platforms for connecting and sharing interests and information while allowing users to maintain physical separation and anonymity (Gelinas et al., 2017). Recruitment measures were taken by requesting permission to advertise the study on online communities and websites to enroll participants. With permission, a SurveyMonkey link and a study description were posted online, and participants were then directed to the consent form. Participants could check a box indicating consent to participate in the study or exit the link. Participants who agreed to participate were directed to the survey. Before the survey, demographic information was requested, including age, gender, ethnicity, service branch, the number of deployments, and whether they had been diagnosed with a mental disorder, PTSD, and/or TBI. Once participants had completed the survey, they could exit the site.

RQs

RQ1: Is there a risk of recidivism among those diagnosed with a psychological disorder, a SUD, or both among JIVs who took part in VTO?

RQ2: How does TBI affect the risk of recidivism among JIVs who received treatment from the VTO program?

RQ3: How does PTSD affect risk of recidivism among JIVs who received treatment from the VTO program?

Evidence of Trustworthiness

Credibility

Lincoln and Guba (1985) described credibility as the extent to which findings from one study can apply to other populations, situations, or contexts (as cited in Nowell et al., 2017). To ensure that the findings of this study accurately reflected reality as seen by the JIVs, I utilized persistent observation, peer debriefing, and a reflexive journal. Data were collected for 1 year to ensure persistent observation to identify and assess salient factors and investigate in sufficient detail to separate what was relevant from the irrelevant (see Lincoln & Guba, 1985). A peer briefing was also conducted with a graduate of Walden's forensic psychology doctoral program who was considered a neutral peer (see Lincoln & Guba, 1985). Lastly, a reflexive journal was used throughout the research process to assist with documented notes or thought processes (see Lincoln & Guba, 1985).

Transferability

Transferability is the extent to which findings from one study can apply to other populations, situations, and contexts (Lincoln & Guba, 1985). The level of transferability for this population was difficult to determine due to the limited amount of information. To adjust for this limitation, background information was gathered to provide enough description of the context of interest so others could determine whether the findings might apply to others (see Lincoln & Guba, 1985).

Dependability

Lincoln and Guba (1985) defined dependability as the extent of consistency related to the findings. To ensure dependability, I maximized the density of the research by explicitly providing a descriptive process with rich information (see Lincoln & Guba, 1985). Additionally, I solicited the perspectives of outsiders who were not directly involved in the data collection or project (see Lincoln & Guba, 1985). The outsider was a 20-plus-year clinical social worker who was retired from the VA and familiar with the VJO program.

Confirmability

Confirmability is the extent to which the researcher is aware of monitored and ensured that biases did not influence the research process and findings (see Lincoln & Guba, 1985). To ensure confirmability, I maintained an audit trail that provided a complete account of every part of the research process, including all decisions and how they were made (see Lincoln & Guba, 1985). Additionally, memos were used to write down thoughts, insights, or potential codes during the analysis process (see Lincoln & Guba, 1985).

Ethical Procedures

Treatment of Data

Data were confidential and anonymous; participants were not asked to provide their names or identifying information. The data were stored in a SurveyMonkey account for the data collection process and exported to a PDF for data analysis. A username and password were required to access the data from the SurveyMonkey account.

Additionally, the computer that stores and accesses the data utilizes facial recognition software and is password-protected. All electronic files were backed up on a password-protected cloud drive. Walden requires the maintenance of all raw data for no less than 5 years. The data collected will be destroyed 5 years after completing this study, per Walden's Institutional Review Board (IRB) instructions. The digital media will be deleted by using certified data deletion software. Additionally, all data collected by SurveyMonkey will be deleted along with the account.

Protection of Identity

Because this study took place through social media, there were a few ethical factors to consider. First is respect for privacy, grounded in the foundational norms of respect for persons and beneficence (see Gelinas et al., 2017). Measures were taken to ensure confidentiality. Responses were anonymous, and participants were not asked to provide sensitive information. Any identifying information was retracted or removed, producing an entirely anonymous database. Furthermore, privacy practices were shared in the survey introduction to help ease data concerns.

Respect for Persons

The second ethical consideration in the context of social media recruitment was researcher transparency. The importance of transparency was grounded primarily in respect for persons, which demands researcher truthfulness and honesty throughout the data collection process (see Gelinas et al., 2017). Transparency requires researchers to be truthful and honest when describing the study's aims, details, risks, and benefits (Gelinas et al., 2017). A description of the research study and a consent form were provided for

transparency. Participants willing to complete the survey provided consent by checking a box. Once consent had been provided, participants were directed to the survey. Participants who did not want to participate could exit the website anytime.

Summary

In this chapter, I discussed the methods and procedures that were used in the study as well as the qualitative methods and designs used to gather relevant information needed to explore whether there is a connection between mental health diagnosis, PTSD, TBI, and the risk of recidivism in JIVs who received treatment from the VJO. This chapter addressed the RQs, hypotheses, and data collection methods, how the data were analyzed, the limitations, and the tools used to conduct the study. Lastly, I explained the ethical considerations of this study's methodology.

Chapter 4: Results

In this study, I researched the potential effect of VJO treatment and JIV risk of recidivism. To date, no study has examined whether the VJO program influences recidivism once a JIV completes the program. Nor has a study examined the diagnoses and comorbidities between a JIV's propensity for recidivism following separation from the VJO (Johnson et al., 2015). One of the VJO program goals has been to end JIVs' contact with the criminal justice system. Finlay et al. (2016) determined a need to reassess JIVs who received treatment from the VJO to determine the program's effectiveness in achieving its goals.

RQ1: Is there a risk of recidivism among those diagnosed with a psychological disorder, a SUD, or both among JIVs who took part in VTO?

RQ2: How does TBI affect risk of recidivism among JIVs who received treatment from the VTO program?

RQ3: How does PTSD affect risk of recidivism among JIVs who received treatment from the VTO program?

This chapter reviews information based on the answers provided in the qualitative survey. The RQs are restated along with the interpreted results. To illustrate the data analysis, a few tables provide direct quotes from participants. Additional sections in this chapter include research setting, data collection, data analysis, and evidence of trustworthiness.

Research Setting

IRB approval for this study (08-13-21-0222221) was granted on August 13, 2021). SurveyMonkey was utilized, which allowed participants to take the survey on most electronic devices. Participation was anonymous; therefore, individual settings are unknown. It was estimated that the survey would take approximately 15 minutes to complete. According to SurveyMonkey's insights, there was a completion rate of 22%, and the typical time participants spent completing the survey was 33 seconds.

Demographics

Through Facebook advertising, 17,124 people were reached, and 575 people clicked the SurveyMonkey link. The qualitative survey had a total of 33 participants. However, only five participants completed the survey, giving it a 22% completion rate. The average time spent completing the survey was 33 seconds. The five participants were male between the ages of 45 and 64. Participants represented the following military branches: Army, Marine Corps, Navy, Air Force, and Coast Guard. The number of deployments ranged from zero to five. Two of the four participants reported legal involvement since completing the VJO program. Three participants were diagnosed with a psychological disorder, none with a SUD, four with PTSD, and three with TBI (see Table 1).

Table 1

Demographic Data

Participants	Age	Gender	Diagnosis	Recidivism risk postprogram	Branch	Deployment(s)
Row 1	45-54	Male	PTSD TBI	Yes	All branches	5
Row 2	45-54	Male	Psychological PTSD TBI	No	Army	3
Row 3	45-54	Male	Psychological PTSD	Yes	Army	1
Row 4	55-64	Male	Psychological PTSD TBI	No	Air Force	1
Row 5	55-64	Male	Psychological PTSD	No	Army, Navy	3

Data Collection

Seventeen questions were designed to explore JIV's lived experiences with those who had completed the VJO program. Of seventeen questions, five were demographic, and four inquired about participants' mental health diagnoses. A total of 33 participants gave consent to complete the qualitative survey. Out of 33 participants, five completed the survey. All data were collected through the SurveyMonkey program, which provided total anonymity. Participants could complete the survey using an electronic device without contact with another person. There were two reasons for maintaining zero contact. One, the VJO program could not assist me with this study; therefore, I did not have access to veterans who had participated in the program. Secondly, the decision of how data would be collected was made during the height of the COVID-19 pandemic. The pandemic made in-person contact less than ideal, if not impossible. Due to the

pandemic, I utilized social media to recruit and promote my survey through SurveyMonkey.

Data Analysis

All data were collected on SurveyMonkey. The survey responses were transferred to a Microsoft Word table format using SurveyMonkey, where they were then analyzed. Data were collected over 4 months, and participants could complete untimed interviews. Upon analyzing the dates and interviews, there were 12 dates on which participants consented to be interviewed. SurveyMonkey noted that between August 8th and 15th, 10 individuals responded to the survey. From those dates, there was a total of five completed interviews. Based on the interviews, eight themes were established from the participants as a whole. Saturation was determined by utilizing Guest et al.'s (2020) method (see Figure 1). In Guest et al.'s (2020) approach, three primary elements were used to calculate and assess saturation. These elements include base size (numerator), run length (denominator), and new information threshold. The new information threshold was the percentage from the base size and run length, which was used as a benchmark to determine whether enough evidence existed for saturation to have been met (Guest et al., 2020). Guest et al. proposed two levels of new information that represent the quantity of new information accepted as "evidence that saturation has been met at any point in the data collection process: ≤5% new information and no (0%) new information" (para. 19). The final base size was 12 collection events; however, no additional themes existed past the fifth interview. The five interviews established, as a whole, eight total themes in

addition to eight subthemes. Based on Guest et al.'s saturation methodology, a confidence saturation of less than 5% was reached after the fifth interview.

Rigorous and methodical research is imperative in yielding meaningful results (Nowell et al., 2017). The study utilized a thematic analysis approach to conducting the data analysis. Data analysis has been considered the most complex phase in research and provides a systematic approach that can be communicated (Nowell et al., 2017). By conducting the data analysis, the researcher becomes the instrument through judgments, coding, theming, decontextualizing, and more (Nowell et al., 2017).

Thematic analysis is a widely utilized approach that has enormously increased in popularity in the 21st century (Humble & Mozelius, 2022). This approach is a translator for researchers employing alternate methodological approaches to understand and communicate effectively (Nowell et al., 2017). One of the many benefits of thematic analysis is that novice researchers learn how to analyze data when applying this approach (Nowell et al., 2017). Researchers Braun and Clarke (2006) have outlined thematic analysis in a 6-step process:

1. Familiarizing yourself with your data, involving transcription, immersion and noting down initial ideas;
2. Generation initial codes from the data that identify a features of the data, semantic content or latent, that appears interesting;
3. Searching for themes by collating codes into potential themes,
4. Reviewing themes, and checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2),

5. Defining and naming themes, and refine the specifics of each theme, and the overall story the analysis tells, and
6. Writing up the presentation of the found theme and fine-tuning the overall story. (Braun & Clarke, 2006)

First, the data were transferred to a Word document, where I read and reread the participants' answers to familiarize myself with the data. Second, I simplified sentences and identified keywords and phrases that stood out. This information was then organized, labeled, and grouped; these words and phrases generated codes and aided in understanding the essential information relevant to the RQs. For example, one code included “orphaned” and “abusive father,” which developed into the childhood trauma theme. Third, all data were identified and collated; related codes were grouped into themes and aided in describing broader ideas with similar meanings. There were 20 codes, seven themes, and eight subordinate themes. The fourth step involved reviewing the themes for accuracy and possible refinement. The themes were compared to find likenesses and differences to ensure the themes were clear, identifiable, meaningful, and supported by the data.

Additionally, the nodes were reevaluated for clarity and to ensure that each node represented a single idea and did not need further breakdown. The fifth step involved defining the meaning of the themes and then naming each. Participant themes and accompanying quotes are outlined in Table 2. Themes that were further defined into subthemes were outlined in Table 3. Additionally, the codes assigned to each theme were

reviewed and compared to the RQs—the sixth and final step involved producing the report and providing the results in this chapter.

Figure 1

Summary of Saturation

Interview number	1	2	3	4	5	6	7	8
New themes per IDI	1	4	1	2	0	0	0	0
New themes in run	8				0		0	0
%change over base	50%					0%	0%	0%

Evidence of Trustworthiness

Credibility

Lincoln and Guba (1985) described credibility as the extent to which findings from one study can apply to other populations, situations, or contexts (Nowell et al., 2017). To ensure that the findings of this study accurately reflected reality as seen by the JIVs, I utilized persistent observation, peer debriefing, and a reflexive journal. Data were collected for 1 year to ensure persistent observation to identify and assess salient factors and investigate in sufficient detail to separate what was relevant from the irrelevant (see Lincoln & Guba, 1985). A peer briefing was also conducted with a graduate of Walden's forensic psychology doctoral program who was considered a neutral peer (see Lincoln & Guba, 1985). Lastly, a reflexive journal was used throughout the research process to assist with documented notes or thought processes (see Lincoln & Guba, 1985).

Transferability

Transferability is the extent to which findings from one study can apply to other populations, situations, and contexts (Lincoln & Guba, 1985). The level of transferability for this population is difficult to determine due to the limited amount of information. To adjust for this limitation, Chapter 3 details the background information gathered to describe this study's context.

Dependability

Lincoln and Guba (1985) defined dependability as the extent of consistency related to the findings. To ensure dependability, I maximized the density of the research by explicitly providing a descriptive process with rich information (see Lincoln & Guba, 1985). Additionally, I solicited the perspectives of outsiders who were not directly involved in the data collection or project (see Lincoln & Guba, 1985). The outsider was a 20-plus-year clinical social worker who was retired from the VA and familiar with the VJO program.

Confirmability

Confirmability is the extent to which the researcher is aware of monitored and ensured that biases did not influence the research process and findings (Lincoln & Guba, 1985). To ensure confirmability, I maintained an audit trail that provided a complete account of every part of the research process, including all decisions and how they were made (see Lincoln & Guba, 1985). Additionally, memos were used to write down thoughts, insights, or potential codes during the analysis process (see Lincoln & Guba, 1985).

Study Results

RQ1: Is there a risk of recidivism among those diagnosed with a psychological disorder, a SUD, or both among JIVs who took part in the VTO program?

Four of the five participants reported being diagnosed with a psychological disorder; no one reported an addiction disorder diagnosis—four participants with PTSD and three with TBI (see Table 1). Based on the sample, some noteworthy items were the relatively high rates of mental health diagnoses comorbid with TBI and PTSD, further discussed in RQs 2 and 3. However, I could not make any determinations linking SUD to those diagnosed with a psychological disorder.

RQ2: How does TBI affect risk of recidivism among JIVs who received treatment from the VTO program?

Based on the demographic portion of the survey, three out of five participants reported having been diagnosed with TBI. However, there was no definitive link between participants who reported having had TBI and how it may or may not have affected the risk of recidivism.

RQ3: How does PTSD affect risk of recidivism among JIVs who received treatment from the VTO program?

Five out of five participants reported having been diagnosed with PTSD. Most notably, Participant 5 illustrated a narrative of childhood trauma, trauma while serving, PTSD, prolonged trauma, and family breakdown, and how this trauma impacted domains of functionality. The impacts of trauma ultimately lead to criminality and maladaptivity when avoided. Individuals who reported a PTSD diagnosis may require ongoing support

and collaborative rehabilitation efforts to reduce the multiple factors leading to higher chances of future recidivism.

Researcher Observations and Conclusions

Some participants felt the program was helpful and did not report ongoing criminality or justice system entrenchment. Other participants reported further criminal justice involvement. Based on the current sample, some noteworthy items were the relatively high rates of mental health diagnoses comorbid with TBI and PTSD. Some noted common diagnoses were alcohol and/or SUD. Understanding how certain comorbid conditions and behavioral profiles impact future trajectories postprogram competition would be critical to gathering data on individual needs for diagnosing, treatment modalities, and viewing persons through a more transdiagnostic lens. For instance, understanding medical challenges, behavioral profiles/changes, living arrangements, cognitive profiles, and other diagnoses (depression, anxiety, psychosis) would be critical in understanding the level of risk and need per participant upon program completion.

Based on an in-depth analysis of one participant's account, healing is a journey that depends on accountability and ongoing work toward healing. Observation of aggregate data in correspondence to Participant 5's account may lead to conclusions that success is largely contingent upon the individual and their dynamic needs stemming from diagnoses, past experiences, traumas, risk factors, and an understanding of which platform(s) will be most conducive for learning or relating to others. Furthermore, although there were some benefits from the program, data analysis led to conclusions that

the VJO program may be more successful if coupled with other therapeutic approaches, with the individuals' profiles in mind.

An in-depth narrative review of Participant 5 revealed multiple themes through an inductive coding methodology (see Table 2). Thematic data shows the trajectory of how trauma impacted one person's experience and journey for healing. Participant 5 illustrated a narrative of childhood trauma, trauma while serving, PTSD, prolonged trauma, and family breakdown, and how this trauma impacted domains of functionality. The impacts of trauma ultimately lead to criminality and maladaptivity when avoided.

Table 2

Thematic Data and Quotes

Participant themes	Quotes
Childhood trauma	"I was orphaned at age 2, adopted at age 7, and survived a physically abusive father."
Self-deprecation	"I blamed myself for not being good enough."
The need for control	"I struggled with turning my life over to a higher power. That meant giving up control. No way."
Family breakdown	"Then I returned home from the eight-month deployment to find my wife six months pregnant. We divorced, she gave birth to my son, Aaron. I knew he was not my son, but I could not imagine a kid growing up without a father."
Survival mode (PTSD)	"Over the next seven years, she was on the front line of my anger, verbal abuse, and nightmares. She lied to cover my abuses so no one would think I was a bad person because of how I behaved. She knew something was wrong but had no idea about the monster that I was hiding."
Prolonged and compounded trauma	"I witnessed a beheading at a range of two meters, for which I blamed myself. I blamed myself because when the head hit the ground, it was as if he looked at me and asked, 'why did you let this happen.'"
Lacking healthy coping skills	"During a fight in September 2013, I came to a breaking point when I lost control. I felt trapped as I did back in Riyadh. I went to the closet to retrieve a 9mm Smith & Wesson."
Avoidance	"To say that I scared her is an understatement. Before my arrest, my life consisted of two things: work and daily attempts to bury my problems. I found my identity in working over 100 hours per week where I could be nearly perfect."

Subordinate themes illustrate the ongoing needs of persons who have experienced such trauma (see Table 3). Participant 5 illustrated the ongoing need for multiple therapies and individualized treatment. Many of the recommendations compiled by Participant 5 have effectively treated trauma-based disorders. Although there are inherent

limitations in sample size, other persons with PTSD may have had similar experiences, and research can build on the current analysis.

Table 3

Subordinate Themes

Participant themes	Quotes
Vulnerability	"Being authentic, recognizing that I don't know everything, and asking for and accepting help…that's being vulnerable to me. I never before opened myself up to being vulnerable because I was afraid."
Learning healthy coping skills	"The experience and reactions aren't entirely gone, but I now have the tools to manage my stress that doesn't include an anger-based response. I use things like self-talk, rational thinking, and meditation to ensure I think before I respond. The tools slow my thinking to get me to a safe place."
Perspective sharing	"One Veteran said that while writing his essay, he realized that he was not writing for himself but was writing for his brothers in the audience to gain from his journey. Most meaningful to me was discovering the ways that others had struggled were not so different than mine."
Healing as a journey	"I am attempting to earn their trust by being consistent and predictable. I think that I am getting there. Ongoing treatment plans include meditation, PTSD group and Thai Chi at the VA, Jack's Thursday group, and volunteering at Mariners and the Oasis Senior Center. Hiking, yoga, and riding my motorcycle will all also be priorities. And given the opportunity, I will return to Veterans Treatment Court as a mentor."
Self-forgiveness	"I entered the retreat as a boy and came out as a man. Through different therapies and ceremonies, I relieved my guilt around my brother's suicide and genuinely forgave myself for the domestic violence."
Self-actualization	"In summation, I've learned that I must discover my truth to become whole and that this truth will cause pain before it yields its bounty – freedom. The damage done to me and by me cannot be undone since I can't change my past. I can, however, change me. I can repair myself and restore my integrity."
Making peace	"The path is neither easy nor well-traveled. I challenge you to join me in choosing the path less traveled and leave behind the victim and become a person who lives in the present while still aware of the past and able to live with it. Every end is nothing more than the step before a new beginning. I feel, no, I know that I've done the work and have earned the

Participant themes	Quotes
	right to stand next to those who have graduated from this program before me."
Serving others	"I believe that I may have found my calling – that of helping others who struggle and who have lost their way just as I did."

Participant 5 revealed that sharing their story helped promote healing and produce a level of vulnerability and trust. Furthermore, therapy influenced the development and use of healthy coping skills. Mediation and mindfulness training were particularly helpful in slowing the body's natural response to anger, fear, or an overactive HPA axis response. Remarkably, jail time also provided a conduit for the participant to reflect and continue healing and self-actualization. Once Participant 5 found peace and healing, they discussed the ongoing need for exposure therapy, spiritual support, being outdoors, and serving others to maintain that balance. Other ongoing therapies and needs discussed include meditation, PTSD group and Thai Chi at the VA, Jack's Thursday group, and volunteering at Mariners and the Oasis Senior Center. Participant 5 lastly reported hiking, yoga, and riding his motorcycle as priorities, and if given the opportunity, he would return to Veterans Treatment Court as a mentor.

The concluded themes include compounded childhood trauma, self-deprecation, the need for control to survive trauma, and lack of healthy coping skills. Thematic elements suggested for future programming based on these themes include social skills training, learning access to healthy coping skills, learning perspective sharing, mindfulness training (slowing thinking through yoga, meditation, breathing techniques), prolonged exposure therapy (for persons with PTSD), self-talk, exercise, focus on

possible spirituality (practice giving up the need for control or manipulation), learning accountability and forgiveness, serving others. An inclusive program approach for each profile, viewed through a transdiagnostic lens, may result in higher success towards self-actualization, healing, and freedom from unhealthy risk, resulting in recidivism or poor life trajectories for veterans with PTSD and/or TBI.

Summary

Chapter 4 addressed the study results at length in the study results section. Additional topics include the research setting, demographics, data collection, data analysis, and evidence of trustworthiness. Under evidence of trustworthiness, we will examine credibility, transferability, dependability, and confirmability.

Within this chapter, the results were discussed at length. RQ1addressed the link between psychological disorders and their comorbidity to PTSD and TBIs. At the same time, this study had no link to SUD and psychological disorders. Results from RQ2 found that TBI results in varying complications, which will likely need to be addressed through a more collaborative therapeutic delivery approach and components offered through the VJO program to increase the chances of successful reduction in recidivism risk. Similar to individuals suffering from TBI, RQ3 addressed those with PTSD and how they may require ongoing support and collaborative rehabilitation efforts to reduce the multiple risk factors leading to higher chances of future recidivism.

In Chapter 5, topics discussed include the interpretation of findings, study limitations, recommendations, and implications.

Chapter 5: Discussion, Conclusions, and Recommendations

This study aimed to research the potential effect of VJO treatment and JIV risk of recidivism. To date, no study has examined whether the VJO program influences recidivism once a JIV completes the program. Nor has a study examined the diagnoses and comorbidities between a JIV's propensity for recidivism following separation from the VJO (Johnson et al., 2015). One of the VJO program goals has been to end JIVs' contact with the criminal justice system. Finlay et al. (2016) reported a need to reassess JIVs who received treatment from the VJO to determine the program's effectiveness in achieving its goals.

Some veterans who participated in the VJO program felt the program was helpful and did not report ongoing criminality or justice system entrenchment. Other participants reported further criminal justice involvement. Based on the current sample, some noteworthy items were the relatively high rates of mental health diagnoses comorbid with TBI and PTSD. Some noted common diagnoses were alcohol and/or SUD. Understanding how certain comorbid conditions and behavioral profiles impact future trajectories postprogram competition would be critical to gather data on individual needs for diagnosing, treatment modalities, and viewing persons through a more transdiagnostic lens.

Interpretation of Findings

In the first RQ, I wanted to explore whether there was a risk of recidivism among those diagnosed with a psychological disorder, a SUD, or both among JIVs who took part in the VJO. Four of the five participants reported being diagnosed with a psychological

disorder; no one reported an addiction disorder diagnosis—four participants with PTSD and three with TBI (see Table 1). Based on the sample, some noteworthy items were the relatively high rates of mental health diagnoses comorbid with TBI and PTSD, further discussed in RQ2 and RQ3. However, I could not make any determinations linking SUD to those diagnosed with a psychological disorder. The remaining two RQs are similar in their conclusion. TBI results in varying complications, which will likely need to be addressed through a more collaborative therapeutic delivery approach in addition to components offered through the VJO program to increase the chances of successful reduction in recidivism risk. Similarly to veterans suffering from TBI, those with PTSD may require ongoing support and collaborative rehabilitation efforts to reduce the multiple risk factors leading to higher chances of future recidivism.

Based on the current sample, some noteworthy items were the relatively high rates of mental health diagnoses comorbid with TBI and PTSD. Some noted common diagnoses were alcohol and/or SUD. Understanding how certain comorbid conditions and behavioral profiles impact future trajectories postprogram competition would be critical to gather data on individual needs for diagnosing, treatment modalities, and viewing persons through a more transdiagnostic lens. For instance, understanding medical challenges, behavioral profiles/changes, living arrangements, cognitive profiles, and other diagnoses (depression, anxiety, psychosis) would be critical in understanding the level of risk and need per participant upon program completion.

This information is key because, historically, veterans struggle with the issues related to their military service; issues originating from substance abuse and mental

illness increase their risk of contact with the criminal justice system (Lucas, 2017). As a result, veterans who experience PTSD and TBI had developed substance use issues while attempting to self-medicate, contributing to increased contact with the criminal justice system (Brummet, 2013; Lucas, 2017). Lucas (2017) pointed out that veterans who served in Iraq and Afghanistan found that 27% to 35% reported PTSD symptoms, depression, alcohol misuse, suicidal ideation, and self-reported aggression (Huskey, 2017). From this era, the most frequently diagnosed mental illnesses include PTSD, depression, TBI, and often a combination of the three (Pajak, 2020).

Some participants felt the program was helpful, reporting no ongoing criminality or justice system entrenchment. Others did report further criminal justice involvement. However, due to the relatively low sample and the importance of capturing the length of time post-program completion, it would be critical to repeat a large-scale longitudinal study in the future. Additionally, based on an in-depth analysis of one participant's account, healing is a journey that depends on accountability and ongoing work toward healing. Observation of aggregate data in correspondence to Participant 5's account may lead to conclusions that success is largely contingent upon the individual and their dynamic needs stemming from diagnoses, past experiences, traumas, risk factors, and an understanding of which platform(s) will be most conducive for learning or relating to others.

Furthermore, although there were some benefits from the program, data analysis led to conclusions that the VJO program may be more successful if coupled with other therapeutic approaches, with the individuals' profiles in mind. Moreover, any gaps in

service delivery may be developed from future data gathered. Although the program may have had a positive effect, it seems that many of the participants needed additional support. Thus, recidivism may be more likely for certain persons needing services. Veterans may be regarded as highly vulnerable and require adequate support to mitigate the public safety risk of recidivism or possibly suicidality.

Limitations of the Study

Limitations previously listed involve using self-reported data as there is a possibility for inaccuracies. Self-reporting also allowed participants to decline to answer any or all questions, which led to limited or incomplete data. A second limitation involves the specific population of JIVs who had received treatment from the VJO program. Although the format for treatment facilities is similar to existing programs, this program is unique to veterans, making this research less generalizable to all treatment programs. Due to the uniqueness of this program, it was not easy to connect with program graduates for data collection, which led to the discontinuation of the quantitative methodology. A third limitation involved the COVID-19 pandemic. At that time, I was gathering recruitment information; facilities such as the VA hospital were shut down due to the pandemic, which made it difficult to reach employees from the VJO with inquiries.

A fourth limitation is that TBI is often scored through the GCS and impacts different domains in varying ways. For instance, one may suffer functional limitations, aggressive tendencies, minor injury, or a higher severity level. TBI can result in depression and difficulty with coping skills, which may lead to other secondary diagnoses. Looking at the data, this may be evidenced by higher levels of substance

and/or AUDs in addition to TBI and/or PTSD. The fifth limitation of this study is low participant numbers and a lack of information on each participant's level of functionality due to their diagnostic profiles. Lastly, this study allowed for participant anonymity, which did not account for the possibility of contacting participants with follow-up questions.

Recommendations

It is recommended that a more extensive longitudinal study coupled with a guided qualitative thematic analysis to understand experiences of TBI or PTSD, paired with diagnostic information and the need for services, would be recommended to fill any gaps in methodology or information from this current study. This research could guide future research on understanding TBI, PTSD, and recidivism risk for veterans who completed the program. Furthermore, any gaps in service delivery may be developed from future data gathered. Although the program may have had a positive effect, it seems that many of the participants needed additional support. Thus, recidivism may be more likely for certain persons needing services. Veterans may be regarded as highly vulnerable and require adequate support to mitigate the public safety risk of recidivism or possibly suicidality.

Implications

This study aimed to fill in research gaps regarding the relationship between VJO treatment, JIVs, and the risk of recidivism. Ideally, to benefit the forensic psychology and veterans' community as a quantitative study, addressing a research gap directly related to VJO treatment and the risk of recidivism. Researching whether the VJO meets its goals is

beneficial to veterans involved with the criminal justice system. One of the VJO program goals is to reduce the risk of recidivism by ending their involvement with the justice system. This qualitative study focused on exploring whether there is a difference between VJO treatment and reduced risk of recidivism. Although this study could not establish whether VJO treatment could conclusively reduce recidivism risk, this research could guide future studies to understand TBI, PTSD, and the risk of recidivism for veterans who completed the program. The VJO program may have had a positive effect, and many participants needed additional support. In order to contribute to positive social change, it is essential to consider veterans as a highly vulnerable population who require adequate support to mitigate the risk of recidivism. Veterans need to be evaluated on an individual basis to effect recidivism by providing treatment short-term as well as long-term.

Conclusions

Historically, veterans struggle with issues related to their military service. This study aimed to research the potential effect of VJO treatment and JIV risk of recidivism in addition to comorbid diagnoses that may further influence recidivism risk. JIVs have been linked to high rates of PTSD and SUDs (Stimmel et al., 2018). Furthermore, PTSD increases the risk of criminal recidivism among JIVs with co-occurring mental disorders (Sadeh & McNiel, 2015). This study provides a good example of such risks because five out of five participants reported having a diagnosis of PTSD. Based on Participant 5's responses, they illustrated a narrative of trauma from various points in their life. Participant 5 revealed that they experienced childhood trauma, trauma while serving, PTSD, and prolonged trauma. Participant 5's past trauma further illustrates how various

strains or stressors increase the likelihood of crime (see Agnew, 2001). The impact of trauma ultimately leads to criminality and maladaptivity when left untreated.

To conclude this research study, I could not say that the VJO program positively affects recidivism in JIVs. While some participants felt the program was beneficial, others found it less so. The veterans who found the program helpful reported no ongoing criminality or justice system entrenchment. Alternately, some veterans reported further criminal justice involvement. However, it is recommended that due to the relatively low sample and the importance of capturing the length of time post-program completion, it would be critical to repeat a large-scale longitudinal study in the future. Understanding how certain comorbid conditions and behavioral profiles impact future trajectories postprogram completion would be critical to gathering data on individual needs for diagnosing, treatment modalities, and viewing persons through a transdiagnostic lens. The concluded themes include compounded childhood trauma, self-deprecation, the need for control to survive trauma, and lack of healthy coping skills. Based on these themes, thematic elements suggested for future programming include social skills training, learning access to healthy coping skills, learning perspective sharing, mindfulness training, and prolonged exposure therapy. An inclusive program approach for each profile, viewed through a transdiagnostic lens, may result in higher success towards self-actualization, healing, and freedom from unhealthy risk, resulting in recidivism or poor life trajectories for veterans with PTSD and/or TBI. Additionally, based on an in-depth analysis of one participant's account, healing is a journey that depends on accountability and ongoing work toward healing. Observations based on that same veteran's account

may suggest that success is largely contingent upon the individual and their dynamic needs stemming from diagnoses, past experiences, traumas, risk factors, and understanding of which platform(s) will be most conducive for learning or relating to others.

Furthermore, although there were some benefits from the program, data analysis led to conclusions that the VJO program may be more successful if coupled with other therapeutic approaches, with the individuals' profiles in mind. Moreover, any gaps in service delivery may be developed from future data gathered. Although the program may have had a positive effect, it seems that many of the participants needed additional support. Thus, recidivism may be more likely for certain persons needing services. Veterans may be regarded as highly vulnerable and require adequate support to mitigate the public safety risk of recidivism.

References

Adams, R. S., Corrigan, J. D., Mohr, B. A., Williams, T. V., & Larson, M. J. (2017). Traumatic brain injury and post-deployment binge drinking among male and female army active duty service members returning from operation enduring Freedom/Operation Iraqi freedom. *Journal of Neurotrauma*, *34*(7), 1457-146. https://doi.org/10.1089/neu.2016.4693

Agnew, R. (2001). Building on the foundation of general strain theory: Specifying the types of strain most likely to lead to crime and delinquency. *Journal of Research in Crime and Delinquency, 38*(4), 319-361. https://doi.org/10.1177/0022427801038004001

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.).

Belotto, M. J. (2018). Data analysis methods for qualitative research: Managing the challenges of coding, interrater reliability, and thematic analysis. *Qualitative Report, 23*(11), 2622-2633. https://doi.org/10.46743/2160-3715/2018.3492

Bennett, D. C., Morris, D. H., Sexton, M. B., Bonar, E. E., & Chermack, S. T. (2018). Associations between posttraumatic stress and legal charges among substance using veterans. *Law and human behavior*, *42*(2), 135. http://dx.doi.org/10.1037/lhb0000268

Bishop-Deaton, D. (2019). *Veteran anger dysregulation: A phenomenological analysis of help-seeking through social media*. [Doctoral Dissertation, Walden University] ScholarWorks. https://scholarworks.waldenu.edu/dissertations/6715

Blodgett, J. C., Fuh, I. L., Maisel, N. C., & Midboe, A. M. (2013). *A structured evidence review to identify treatment needs of justice-involved veterans and associated psychological interventions.* Center for Health Care Evaluation VA Palo Alto Health Care System.

Blodgett, J. C., Avoundjian, T., Finlay, A. K., Rosenthal, J., Asch, S. M., Maisel, N. C., & Midboe, A. M. (January 2015). Prevalence of mental health disorders among justice-involved veterans. *Epidemiologic Reviews*, 37(1), 163–176. https://doi/org/10.1093/epirev/mxu003

Blonigen, D. M., Bui, L., Elbogen, E. B., Blodgett, J. C., Maisel, N. C., Midboe, A. M., Asch, S. M., McGuire, J. F., & Timko, C. (2016). Risk of recidivism among justice-involved veterans: a systematic review of the literature. *Criminal justice Policy Review*, *27*(8), 812-837. https://doi.org/10.1177/0887403414562602

Blonigen, D. M., Rodriguez, A. L., Manfredi, L., Britt, J., Nevedal, A., Finlay, A. K., Rosenthal, J., Smelson, D., & Timko, C. (2017). The availability and utility of services to address risk factors for recidivism among justice-involved veterans. *Criminal Justice Policy Review*, *28*(8), 790-813. https://doi.org/10.1177/0887403416628601

Blonigen, D. M., Macia, K. S., Smelson, D., & Timko, C. (2020). Criminal recidivism among justice-involved veterans following substance use disorder residential treatment. *Addictive Behaviors, 106,* 106357. https://doi.org/10.1016/j.addbeh.2020.106357

Bray, R. M., Brown, J. M., & Williams, J. (2013). Trends in binge and heavy drinking,

alcohol-related problems, and combat exposure in the US military. *Substance Use and Misuse,* 48(10),799–810. https://doi.org/10.3109/10826084.2013.796990

Bronson, J., Carson, A., Noonan, M., & Berzofsky, M. (2015). *Veterans in prison and jail, 2011-12*. US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.

Brummett, T. (2013). Veterans treatment courts: An experiment in therapeutic jurisprudence for combat veterans. *Social Sciences Capstone Projects*, 1-38. https://core.ac.uk/download/pdf/48854001.pdf

Caudy, M. S., Folk, J. B., Stuewig, J. B., Wooditch, A., Martinez, A., Maass, S., Tangney, J. P., & Taxman, F. S. (2015). Does substance misuse moderate the relationship between criminal thinking and recidivism. *Journal of Criminal Justice, 43*(1), 12-19. https://doi.org/10.1177%2F0306624X17694405

DePalma, R. G., & Hoffman, S. W. (2018). Combat blast related traumatic brain injury (TBI): Decade of recognition; promise of progress. *Behavioural Brain Research*, *340*, 102-105. http://dx.doi.org/10.1016/j.bbr.2016.08.036

Drapela, L. A., Lutze, F. E., Tollefsbol, E. T., & Pimley, N. (2019). Assessing the behavior and needs of veterans with Traumatic Brain Injury in Washington State Prisons: Establishing a foundation for policy, practice, and education. *Justice Quarterly*, *36*(6), 1023-1049. https://doi.org/10.1080/07418825.2018.1481221

Edalati, H., & Nicholls, T. L. (2019). Childhood maltreatment and the risk for criminal justice involvement and victimization among homeless individuals: A systematic review. *Trauma, Violence, & Abuse*, *20*(3), 315-330.

Eisen, S.V., Schultz, M.R., Vogt, D., Glickman, M.E., Elwy, A.R., Drainoni, M.L., Osei-Bonsu, P.E., & Martin, J. (2012). Mental and physical health status and alcohol and drug use following return from deployment to Iraq or Afghanistan. *American Journal of Public Health*, 102 (Suppl 1), S66–S73. https://doi.org/10.2105/AJPH.2011.300609

Elbogen, Johnson, Newton, Straits-Troster, Vasterling, Wagner, & Beckham. (2012). Brief report: criminal justice involvement, trauma, and negative affect in Iraq and Afghanistan war era veterans. *Journal of consulting and clinical psychology*, 80(6), 1097-1102. http://dx.doi.org/10.1037/a0029967

Ellis, J. L., & Hart, D. L. (2023). Strengthening the Choice for a Generic Qualitative Research Design. The Qualitative Report, 28(6), 1759-1768. https://doi.org/10.46743/2160-3715/2023.5474

Errastibarrondo, B., Jordán, J. A., Díez Del Corral, M. P., & Arantzamendi, M. (2018). Conducting phenomenological research: Rationalizing the methods and rigour of the phenomenology of practice. Journal of Advanced Nursing, 74(7), 1723-1734. doi:10.1111/jan.13569

Finlay, A. K., Binswanger, I. A., Smelson, D., Sawh, L., McGuire, J., Rosenthal, J., Blue-Howells, J., Timko, C., Blodgett, J. C., Harris, A. H. S., Asch, S. M., & Frayne, S. (2015). Sex differences in mental health and substance use disorders and treatment entry among justice-involved veterans in the Veterans Health Administration. *Medical Care*, 53(4 Suppl 1), S105. https://dx.doi.org/10.1097%2FMLR.0000000000000271

Finlay, A. K., Smelson, D., Sawh, L., McGuire, J., Rosenthal, J., Blue-Howells, J., Timko, C., Binswanger, I., Freyne, S. M., Blodgett, J. C., Bowe, T., Clark, S. C., & Harris, A. S. (2016). U.S. Department of Veterans Affairs Veterans Justice Outreach Program: connecting justice-involved veterans with mental health and substance use disorder treatment. *Criminal Justice Policy Review*, 27(2), 203-222. https://doi.org/10.1177%2F0887403414562601

Finlay, A. K., Owens, M. D., Taylor, E., Nash, A., Capdarest-Arest, N., Rosenthal, J., Blue-Howells, J., Clark, S., & Timko, C. (2019). A scoping review of military veterans involved in the criminal justice system and their health and healthcare. *Health and Justice*, 7(6), 1-18. https://doi.org/10.1186/s40352-019-0086-9

Flocco, S. F., Caruso, R., Barello, S., Nania, T., Simeone, S., & Dellafiore, F. (2020). Exploring the lived experiences of pregnancy and early motherhood in Italian women with congenital heart disease: An interpretative phenomenological analysis. BMJ Open, 10(1), 1–9. doi:10.1136/bmjopen-2019-034588

Freeland, T. P. (2017). Effects of PTSD in Combat Deployed vs. Non-Combat Deployed Military Cohorts.

Fuehrlein, B. S., Mota, N., Arias, A. J., Trevisan, L. A., Kachadourian, L. K., Krystal, J. H., Southwick, S. M., & Pietrzak, R. H. (2016). The burden of alcohol use disorders in US military veterans: Results from the National Health and Resilience in Veterans Study. *Addiction*, 111, 1786–1794. http://dx.doi.org/10.1111/add.13423

Garwood, P. T., & Hassett, A. (2019). Service user involvement in cognitive behavioral

therapy training: An interpretive phenomenological analysis. The Journal of Mental Health Training, Education and Practice, 14(3), 186-198. doi:10.1108/jmhtep-02-2018-0014

Gielen, N., Havermans, R. C., TGelinas, L., Pierce, R., Winkler, S., Cohen, I. G., Lynch, H. F., & Bierer, B. E. (2017). Using Social Media as a Research Recruitment Tool: Ethical Issues and Recommendations. *The American journal of bioethics: AJOB*, *17*(3), 3–14. https://doi.org/10.1080/15265161.2016.1276644

Hart, T., Brockway, J. A., Maiuro, R. D., Vaccaro, M., Fann, J. R., Mellick, D., Harrison-Felix, C., Barber, J., & Temkin, N. (2017). Anger self-management training for chronic moderate to severe traumatic brain injury: results of a randomized controlled trial. *The journal of head trauma rehabilitation*, *32*(5), 319. doi:10.1097/HTR.0000000000000316

Hartley, R. D., & Baldwin, J. M. (2019). Waging war on recidivism among justice-involved veterans: An impact evaluation of a large urban veterans treatment court. *Criminal Justice Policy Review*, *30*(1), 52-78, doi:10.1177/0887403416650490

Heinz, A. J., Makin-Byrd, K., Blonigen, D. M., Reilly, P., & Timko, C. (2015). Aggressive behavior among military veterans in substance use disorder treatment: the roles of posttraumatic stress and impulsivity. *Journal of substance abuse treatment, 50*, 59-66. http://doi.org/10.1016/j.jsat.2014.10.014

Hooley, J. M., Butcher, J. N., Nock, M. K., & Mineka, S. (2017). Abnormal psychology. *Handbook of Psychology, Seventeenth Edition*, *1*.

Hsieh, H. F., & Shannon, S. E. (2005). Three approaches to qualitative content

analysis. *Qualitative health research*, *15*(9), 1277-1288.

Humble, N., & Mozelius, P. (2022, May). Content analysis or thematic analysis: Similarities, differences and applications in qualitative research. In *European Conference on Research Methodology for Business and Management Studies* (Vol. 21, No. 1, pp. 76-81).

Huskey, K. A. (2015). Reconceptualizing "the crime" in veterans treatment courts. *Federal Sentencing Reporter*, *27*(3), 178-186. Retrieved from https://advance-lexis-com.ezp.waldenulibrary.org/api/document?collection=analytical-materials&id=urn:contentItem:5GD1-MJG0-003R-00G1-00000-00&context=1516831.

Johnson, R. S., Stolar, A. G., Wu, E., Coonan, L. A., & Graham, D. P. (2015). An analysis of successful outcomes and associated contributing factors in veterans' court. *Bulletin of the Menninger Clinic*, *79*(2), 166-173. https://doi.org/10.1521/bumc.2015.79.2.166

Justice-involved veterans. (n.d.). National institute of corrections. Retrieved September 4, 2020, from https://nicic.gov/justice-involved-veterans

Kalkstein, S., Scott, J. C., Biester, R., Brownlow, J. A., Harpaz-Rotem, I., & Gur, R. C. (2017). Comparison of blast-exposed OEF/OIF veterans with and without a history of TBI symptoms on a brief computerized neuropsychological battery. *Applied Neuropsychology: Adult*, *24*(1), 92-97. http://dx.doi.org/10.1080/23279095.2015.1119693

Khan, A. J., Holder, N., Li, Y., Shiner, B., Madden, E., Seal, K., Neylan, T. C., &

Maguen, S. (2020). How do gender and military sexual trauma impact PTSD symptoms in cognitive processing therapy and prolonged exposure? *Journal of psychiatric research*, *130*, 89-96. https://doi.org/10.1016/j.jpsychires.2020.06.025

Killian, M., Cimino, A. N., Mendoza, N. S., Shively, R., & Kunz, K. (2018). Examining trauma and readiness to change among women in a community re-entry program. *Substance use & misuse*, *53*(4), 648-653. https://doi.org/10.1080.10826084.2017.1355387

Knight, K., Garner, B. R., Simpson, D. D., Morey, J. T., Flynn, P. M., & Texas Christian University. (2006). Texas Christian University Criminal Thinking Scales [Database record]. PsycTESTS. doi: https://dx.doi.org/10.1037/t04427-000

Knudsen, K. J., & Wingenfeld, S. (2016). A specialized treatment court for veterans with trauma exposure: Implications for the field. *Community mental health journal*, *52*(2), 127-135. doi: 10.1007/s10597-015-9845-9

Kondracki, N. L., Wellman, N. S., & Amundson, D. R. (2002). Content analysis: Review of methods and their applications in nutrition education. *Journal of nutrition education and behavior*, *34*(4), 224-230.

Kostere, S., & Kostere, K. (2021). The generic qualitative approach to a dissertation in the social sciences: A step by step guide. Routledge.

Krupnick, J. L. (2017). Gender differences in trauma types and themes in veterans with posttraumatic stress disorder. *Journal of Loss and Trauma*, 22(6), 514–525. https://doi-org.ezp.waldenulibrary.org/10.1080/15325024.2017.1335151

Lancaster, C. L., Cobb, A. R., Lee, H. J., & Telch, M. J. (2016). The role of perceived

threat in the emergence of PTSD and depression symptoms during warzone deployment. Psychological Trauma: Theory, Research, Practice, and Policy, 8(4), 528. http://dx.doi.org/10/1037/tra0000129

Lawrence, K. A., Matthieu, M. M., & Robertson-Blackmore, E. (2017). Completion of a veteran-focused civic service program improves health and psychosocial outcomes in Iraq and Afghanistan veterans with a history of traumatic brain injury. *Military medicine*, *182*(7), e1763-e1770. doi:10.7205/MILMED-D-16-00150

Lester, J., Cho, Y., & Lochmiller, C. R. (2020). Learning to do qualitative data analysis: a starting point. Human Resource Development Review, 19(1), 94-106. https://doi.org/10.1177/1534484320903890

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry.* Thousand Oak, CA: Sage

Lucas, P. A., & Hanrahan, K. J. (2016). No soldier left behind: The veterans court solution. *International journal of law and psychiatry*, *45*, 52-59. http://doi.org/10.1016/j.ijlp.2016.02.010

Lucas, P. A. (2017). Advancing the line: Increasing empirical literature on justice-involved veterans. doi: 10.1177/0887403416673699

Martindale, S. L., Ord, A. S., & Rowland, J. A. (2020). Influence of blast exposure on cognitive functioning in combat veterans. *Neuropsychology*, 34(7), 735-743. http://dx.doi.org/10.1037/neu0000672

Maruna, S., Mann, R. E. (2006). A fundamental attribution error? Rethinking cognitive distortions. Legal and Criminological Psychology, 11, 155-177.

https://psycnet.apa.org/doi/10.1348/135532506X114608

Miles, S. R., Menefee, D. S., Wanner, J., Teten Tharp, A., & Kent, T. A. (2016). The relationship between emotion dysregulation and impulsive aggression in veterans with posttraumatic stress disorder symptoms. *Journal of interpersonal violence*, *31*(10), 1795-1816. https://doi.org.ezp.waldenulibrary.org/10.1177/0886260515570746

Miles, S. R., Brenner, L. A., Neumann, D., Hammond, F. M., Ropacki, S., Tang, X., Eapen, B. C., Smith, A., & Nakase-Richardson, R. (2020). Posttraumatic stress disorder symptoms contribute to staff perceived irritability, anger, and aggression after TBI in a longitudinal veteran cohort: a VA TBI Model Systems study. *Archives of physical medicine and rehabilitation*, 101(1), 81-88. https://doi.org/10.1016/j.apmr.2019.07.018

Noon, E. J. (2018). Interpretive phenomenological analysis: An appropriate methodology for educational research? Journal of Perspectives in Applied Academic Practice, 6(1), 75-83. doi:10.14297/jpaap.v6i1.304

Norman, S. B., Haller, M., Hamblen, J. L., Southwick, S. M., & Pietrzak, R. H. (2018). The burden of co-occurring alcohol use disorder and PTSD in US Military veterans: Comorbidities, functioning, and suicidality. *Psychology of addictive behaviors*, 32(2), 224. https://psycnet.apa.org/doi/10.1037/adb0000348

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic Analysis: Striving to Meet the Trustworthiness Criteria. International Journal of Qualitative Methods. https://doi.org/10.1177/1609406917733847

Novaco, R. W., & Chemtob, C. M. (2015). Violence associated with combat-related posttraumatic stress disorder: The importance of anger. *Psychological trauma: theory, research, practice, and policy*, *7*(5), 485. http://dx.doi.org/10.1037/tra0000067

Pajak, A. (2020). Special needs of and promising solutions for incarcerated veterans of Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn. *Journal of correctional health care*, 26(3), 227-239. https://doi-org.ezp.waldenulibrary.org/10.1177%2F1078345820938032

Pinals, D. A. (2010). Veterans and the justice system: The next forensic frontier. *Journal of the American Academy of Psychiatry and the Law Online*, *38*(2), 163-167.

Porter, K. E., Stein, M. B., Martis, B., Avallone, K. M., McSweeney, L. B., Smith, E. R., Simon, N. M., Gargan, S., Liberzon, I., Hoge, C. W., & Rauch, S. A. (2018). Post-concussive symptoms (PCS) following combat-related traumatic brain injury (TBI) in veterans with posttraumatic stress disorder (PTSD): influence of TBI, PTSD, and depression on symptoms measured by the Neurobehavioral Symptom Inventory (NSI). *Journal of psychiatric research*, *102*, 8-13. https://doi.org/10.1016/j.jpsychires.2018.03.004

Richman, M. (2018, September 7). *Veterans and the criminal justice system*. https://www.research.va.gov/currents/0918-VA-researcher-examines-Vets-who-collide-with-criminal-justice-system.cfm

Sadeh, N., & McNiel, D. E. (2015). Posttraumatic stress disorder increases risk of criminal recidivism among justice-involved persons with mental disorders.

Criminal Justice and Behavior, *42*(6), 573-586. https://doi-org.ezp.waldenulibrary.org/10.1177/0093854814556880

Schaffer, B. J. (2016). Incarcerated veterans outreach program. *Journal of evidence-informed social work*, *13*(3), 293-304, doi: 10.1080/23761407.2015.1006945

Schwab, K., Terrio, H. P., Brenner, L. A., Pazdan, R. M., McMillan, H. P., MacDonald, M., Hinds, S. R., & Scher, A. I. (2017). Epidemiology and prognosis of mild traumatic brain injury in returning soldiers: A cohort study. Neurology, 88(16), 1571–1579. https://doi.org/10.1212/WNL.0000000000003839

Shea, M. T., Stout, R. L., Reddy, M. K., Sevin, E., Presseau, C., Lambert, J., & Cameron, A. (2022). Treatment of anger problems in previously deployed post-911 veterans: A randomized controlled trial. *Depression and anxiety*, *39*(4), 274-285.

Stimmel, M. A., Rosenthal, J., Blue-Howells, J., Clark, S., Harris, A. S., Rubinsky, A. D., Bowe, T., & Finlay, A. K. (2018). The impact of substance use disorders on treatment engagement among justice-involved veterans with posttraumatic stress disorder. *Psychological Service.* doi:10.1037/ser0000238

Taft, C. T., Creech, S. K., & Murphy, C. M. (2017). Anger and aggression in PTSD. *Current opinion in psychology*, *14*, 67-71. https://doi.org/10.1016/j.copsyc.2016.11.008

Tatman, A., & Huss, M. T. (2019). Criminal thinking and pre-employment integrity testing: correlations between the Texas Christian university criminal thinking scales and critical hire-screen. *Journal of HRM*, *22*(1), 65–69.

Taxman, F. S., Rhodes, A. G., & Dumenci, L. (2011). Construct and predictive validity

of criminal thinking scales. *Criminal Justice and Behavior*, *38*(2), 174–187. https://doi-org.ezp.waldenulibrary.org/10.1177/0093854810389550

TCU Criminal Thinking Scales. (n.d.). Retrieved September 11, 2020, from https://ibr.tcu.edu/forms/tcu-criminal-thinking-scales/

Tenny, S., Brannan, J., & Brannan, G. (2022). Qualitative study. StatPearls, https:///www.ncbi.nlm.nih.gov/books/NBK47035/

Traumatic Brian Injury/ Concussion. (2020, August 28). Retrieved September 28, 2020, from https://www.cdc.gov/traumaticbraininjury/index.html

Traumatic Brain Injury (TBI). Office of Research and Development. (n.d.). Retrieved January 25, 2021, from https://www.research.va.gov/topics/tbi.cfm

Tsai, J., Flatley, B., Kasprow, W. J., Clark, S., & Finlay, A. (Apr 2017). Diversion of Veterans with criminal justice involvement to treatment courts: participant characteristics and outcomes. *Psychiatric Servies: A Journal of the American Psychiatric Association*, 68(4), 375-383. doi: 10.1176/appi.ps.201600233

Tsai, J., Finlay, A., Flatley, B., Kasprow, W. J., & Clark, S. (2018). A National Study of Veterans Treatment Court Participants: Who Benefits and Who Recidivates. *Administration and Policy in Mental Health and Mental Health Services Research*, *45*(2), 236-244. https://doi.org/10.1007/s10488-017-0816-z

U.S. Census Bureau (2020). Census Bureau releases new report on veterans. Retrieved from https://www.census.gov/topics/population/veterans.html

Van Nevel, J. M. (2017). From Combat Veterans to Criminals: Posttraumatic Stress Disorder and Criminal Justice Involvement. *Walden Dissertations and Doctoral*

Studies. 4183. https://scholarworks.waldenu.edu/dissertations/4183

Vest, B. M., Homish, D. L., Hoopsick, R. A., & Homish, G. G. (2018). What drives the relationship between combat and alcohol problems in soldiers? The roles of perception and marriage. *Social psychiatry and psychiatric epidemiology*, 53(4), 413-420. https://doi.org/10.1007/s00127-017-1477-7

Walters, G. D. (2006). Appraising, researching and conceptualizing criminal thinking: A personal view. Criminal Behaviour and Mental Health, 16(2), 87-99. doi: 10.1002/cbm.50

Walters, G. D. (2009). Criminal thinking. Personality, personality disorder and violence, 281-298.

Walters, G. D. (2020). Criminal thinking as a moderator of the perceived certainty–offending relationship: age variations. Psychology, Crime & Law, 26(3), 267-286. https://doi-org.ezp.waldenulibrary.org/10.1080/1068316X.2019.1652749

Waltzman, D., Soman, S., Hantke, N. C., Fairchild, J. K., Kinoshita, L. M., Wintermark, M., Ashford, J. W., Yesavage, J., Williams, L., Adamson, M. M., & Furst, A. J. (2017). Altered microstructural caudate integrity in posttraumatic stress disorder but not traumatic brain injury. *Plos one*, 12(1), e0170564. https://doi.org/10.1371/journal.pone.0170564

Watson, T. (2016). A Phenomenological Study of Justice-Involved Veteran Experiences of Veterans Court. http://digscholarship.unco.edu/dissertations/379

Weller, S.C., Vickers, B., Bernard, H.R., Blackburn, A.M., Borgatti, S., Gravlee, C.C., & Johnson, J.C. (2018). Open-ended interview questions and saturation. PloS one,

13(6), e0198606. https://doi.org/10.1371/journal.pone.0198606

Wilk, J.E., Bliese, P.D., Kim, P.Y., Thomas, J.L., McGurk, D., & Hoge, C.W. (2010). Relationship of combat experiences to alcohol misuse among US soldiers returning from the Iraq war. *Drug and alcohol dependence*, 108(1–2), 115–121. https://doi.org/10.1016/j.drugalcdep.2009.12.003

Yerramsetti, A. P., Simons, D. D., Coonan, L., & Stolar, A. (2017). Veteran treatment courts: A promising solution. *Behavioral sciences & the law*, *35*(5-6), 512-522. doi: 10.1002/bsl.2308

Young, L., Rule, G. T., Bocchieri, R. T., Walilko, T. J., Burns, J. M., & Ling, G. (2015). When physics meets biology: low and high-velocity penetration, blunt impact, and blast injuries to the brain. *Frontiers in neurology*, 6, 89. https://doi.org/10.3389/fneur.2015.00089

Zoellick, K. (n.d.). The role of veterans justice outreach specialists in veterans treatment courts. Justice Programs Office School of Public Affairs. Retrieved from https://ndcrc.org/wp-content/uploads/2017/06/Role-of-VJO-Specialists.pdf

Appendix A: Advertisement Flyer

Have YOU Participated in the Veterans Health Administration Program: Veteran's Justice Outreach?

Did the Veterans Justice Outreach Program Help You?

This is an independent dissertation research study through Walden University and is not at all connected to the VA. All answers are anonymous.

The purpose of this study is to examine the future risk of legal involvement after participating in the Veterans Justice Outreach program.

Listed below are the criteria for participating in the study:

- The Veteran has successfully completed treatment through the Veterans Justice Outreach Program and has been discharged for at least 6 months
- The VA has diagnosed you with any of the following: psychological disorder, an alcohol or substance use disorder, posttraumatic stress disorder, and/or a traumatic brain injury.

As part of this research, you will be asked:

- To answer 5 demographic questions
- If you have been diagnosed by the VA with any of the following: psychological disorder, an alcohol or substance use disorder, posttraumatic stress disorder, and/or a traumatic brain injury
- To complete an anonymous online survey taking approximately 15 minutes; all 9 questions are open-ended

The aim of this study is to benefit society by adding to the general knowledge regarding the relationship between the Veterans Justice Outreach program, the veterans who complete the treatment program, and risk of rearrest.

Veterans Crisis Line
1-800-273-8255 PRESS 1

If you're unsure if you meet the requirements, please email me at:

Doctoral Student
Walden University

If you want to talk privately about your rights as a participant or any negative parts of the study, you can call Walden University's Research Participant Advocate at 612-312-1210

Appendix B: Interview Questions

Demographics and History of Mental Health Diagnoses

1. Age: 18-24; 25-34; 35-44; 45-54; 55-64; 65-74; 75 or older
2. Gender: female; male
3. Service Branch: Army; Marine Corps; Navy; Air Force; Coast Guard
4. Total Number of Deployments
5. Have you had legal involvement since completing the Veterans Justice Outreach program? Yes/No
6. Have you been diagnosed with a psychological disorder by the VA? Yes/No
7. Have you been diagnosed with an addiction disorder by the VA? Yes/No
8. Have you been diagnosed with posttraumatic stress disorder by the VA? Yes/No
9. Have you been diagnosed with a traumatic brain injury by the VA? Yes/No

Qualitative Questions

10. How did you enroll in the Veterans Justice Outreach program?
11. Did you feel that you needed or wanted treatment at the time?
12. Which parts of the Veterans Justice Outreach program were beneficial? Explain.
13. Which parts of the Veterans Justice Outreach program were least beneficial? Explain.
14. Describe your life before and after the Veterans Justice Outreach program.
15. In what ways did your life change, if any, after the program?
16. In what way, if any, have the Veterans Justice Outreach Specialist done or said anything that was helpful or unhelpful and why?
17. Is there an outcome you would have preferred? If yes, what would you have preferred?
18. Has the program helped to end your involvement with the justice system? Explain.