



Public-Private Partnerships for Providing Behavioral Health Care to Veterans and Their Families

What Do We Know, What Do We Need to Learn, and What Do We Need to Do?

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Key findings

- Public-private partnerships offer a potential opportunity to improve the standard of current care for veterans and their families.
- A champion is needed. Typically, key people within the public agency take the lead on creating the partnership.
- Stakeholder support is critical. Support from the nonpublic communities involved in the partnership is necessary at the regional and local levels.
- Successful public-private partnerships develop a clear description of the plan for addressing the established need and consider the risks in addition to the benefits likely to emerge from the partnership.
- The structure of the public-private partnership is typically established at the beginning of the relationship, with a dedicated support structure and staff that monitor the process from inception to the evaluation of outcomes.
- Successful public-private partnerships draw on the strengths of the public and the private entities so that both can work together toward a common goal.
- Most partnerships are time limited by way of contracts and agreements, but there should be consideration of financial capacity for the long-term sustainability of efforts.
- Sustainability is important to ensure that the partnership is making an impact on the targeted systems or populations.
- Flexibility is key. Partners need to be flexible in adapting to technological innovations, information technology, needs of the target population, funding environments, and changes to strategic objectives over time.

SUMMARY ■ American veterans and their family members often struggle with behavioral health problems, such as posttraumatic stress disorder, depressive disorders, and family conflict, yet few engage in behavioral health treatment to address these problems. Barriers to care include trouble accessing treatment and limited communication between civilian and military health care systems, which treat veterans and their family members separately. Even though the Department of Veterans Affairs (VA) is making efforts to address barriers to care among veterans, more work is needed to effectively serve veterans and their families. Federal entities—notably, the President of the United States, the Department of Defense (DoD), and the VA—have discussed public-private partnerships as a potential solution to overcome barriers to care in this population. Such partnerships could include collaborations between a public agency, such as the VA, and a private organization, such as a veteran service organization, private industry, or private hospital. Despite the call for such partnerships, not much is known about what a public-private partnership would entail for addressing behavioral health concerns for veterans and their families. The health care literature is sparse in this area, and published examples and recommendations are limited. Thus, we designed this report to inform the creation of public-private partnerships to better serve veterans and their families.

First, we define the term *public-private partnership* and discuss what is known about these collaborations in areas within and outside health care. We next discuss why public-private partnerships are an important next step in addressing the behavioral health needs of veterans and their families by reviewing the literature on veteran behavioral health, veterans' family members' behavioral health problems, barriers to accessing care for veterans and their families, and collaborative care models for veterans and their families. Using the knowledge gleaned from these literature reviews and from the available information about public-private partnerships in the health care arena and other areas, we outline nine key components for public-private partnerships addressing veteran behavioral health care. The importance of these key components is supported by qualitative interview data we collected from five successful public-private partnerships serving veterans and their families. By describing these recommended key components, this report will assist policymakers in the VA and other federal agencies in developing and fostering public-private partnerships to address the behavioral health care needs of veterans and their families. In addition, using the nine key components as a guide can allow both public and private partners to assess whether their partnerships are working and how to improve them. Lastly, we discuss next steps for research and policymaking efforts with regard to these partnerships in the future, including clearly defining successful public-private partnerships, conducting formal research and evaluation of these partnerships, and adopting quality-improvement frameworks for partnerships.

BACKGROUND, FOCUS, AND STRATEGY

In August 2012, President Barack Obama signed an executive order to improve the behavioral health care of veterans, service members, and their families through several measures, including increasing capacity for health care at the Veterans Health Administration (VHA), promoting research for effective treatments, and promoting suicide-prevention efforts (DoD, VA, and U.S. Department of Health and Human Services [DHHS], 2013; Office of the Press Secretary, The White House, 2012). In addition, this order called for collaboration between the VHA and DHHS to identify local community partners to improve access to care for veterans in the community. In August 2014, the President called for more-formalized public-private partnerships (sometimes referred to as *PPPs* or *P3s*), primarily in the areas of employment and homelessness (Office of the Press Secretary, The White House, 2014; VA and DoD, 2014). The Office of the Chairman of the Joint Chiefs of Staff (OCJCS) also recently called for more public-private partnerships to target the emerging health and wellness needs of veterans as the conflicts in Iraq and Afghanistan end (OCJCS, 2014). Public-private partnerships are also a focus of the VA Veterans Policy Research Agenda, which specifically calls for more research that evaluates and monitors public-private partnerships, informs best practices for defining and measuring success between partners and success on targeted outcomes, and helps develop creative and innovative platforms for enhancing communication between veterans, family members, and caregivers about services available through partners of the VA (VA, Office of Policy and Planning, 2014). The VA's strategic plan for fiscal years 2014–2020 also aims, as one of its three strategic goals, to “enhance and develop trusted partnerships,” which specifically calls to “enhance VA's partnerships with federal, state, private sector, academic affiliates, veteran service organizations and nonprofit organizations” (VA, 2014b). Public-private partnerships have thus been promoted as a potential solution

to fill many of the gaps between veterans' need for services and the availability of those services, yet little is known about the partnerships. Indeed, there is little research specifically addressing these partnerships in the broader behavioral health arena—including, more specifically, how they can be used to improve the behavioral health care of veterans and their families.

The overarching goals of this report are to broadly inform public-private partnerships in the area of veteran behavioral health and to serve as a guide for the development of future public-private partnerships to meet the needs of veterans and their families. We aim to assist policymakers in the federal government to use this information while developing public-private partnerships in behavioral health care for veterans and their families. We also aim to provide guidance for private-sector organizations as they consider how to establish meaningful relationships with the public sector. We pursue three aims based on these overall goals:

1. **Define public-private partnerships.** We begin with a definition of public-private partnerships and discuss what is known about the need for these kinds of collaborations. We review the literature and guidelines for public-private partnerships in the health arena (e.g., health care and global health), particularly focused on behavioral health and, more specifically, veteran behavioral health. Given the limited literature available that directly targets these areas, we also draw on work in other key areas of public-private partnerships where much has been written, such as infrastructure (e.g., building and facilities, parks, highways), emergency response (e.g., environmental disasters), and energy and resource savings (e.g., water treatment services), to give some guidance on common definitions of public-private partnerships.
2. **Explain why public-private partnerships might be helpful in addressing the behavioral health needs of veterans and their families.** We review the behavioral health needs of veterans and their families, discuss barriers to seeking care (including unmet needs and access barriers), and review

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evidence for the benefit of collaborative care models and public-private partnerships in multiple areas within and beyond health care.

3. **Develop key components for successful public-private partnerships in veteran behavioral health.** Based on reviews of public-private partnerships and veteran behavioral health need, we develop and present components of public-private partnerships relevant for veteran behavioral health that appear essential for successful implementation and sustainability. We supplement this review with examples of public-private partnerships in areas of veteran homelessness and employment, two areas that overlap with veteran behavioral health needs (Edens et al., 2011; Tsai, Pietrzak, and Rosenheck, 2013; Zivin et al., 2011) and essential components of the veterans' wellness model proposed by Berglass and Harrell (2012). These examples and key components are informed by interviews with staff of private nonprofit organizations that have developed partnerships with public agencies. We conclude with recommendations for research and evaluation that are needed in this area, as well as a discussion of the necessary next steps to advance the field.

METHODS

To meet our objectives, we searched for literature in MEDLINE and EBSCOhost, as well as Google Scholar databases, for studies related to the topic areas of public-private partnerships, service members and veteran behavioral health, and military family behavioral health. We identified additional literature of interest from the reference sections of some of the reports found through our initial search strategy. We also searched for “grey literature” by using the WorldCat database, which indexes books, reports, and other non-peer reviewed journal literature, and the Defense Technical Information Center (DTIC) database. We performed Internet searches for a broad range of terms (e.g., *public-private partnerships*, *military/veteran + behavioral health*, *veteran collaborative models*) related to the project content areas over the past ten years, but we also cite some high-impact articles published prior to 2004 when appropriate. These years were selected to focus on behavioral health problems and recent examples of public-private partnerships relevant to contemporary military operations—mainly veterans who had served in the conflicts of Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) since September 11, 2001. In addition, we reviewed white papers and available policy

documents from public entities, including the VA and DoD; informally interviewed a senior VA official; and observed VA webinars on public-private partnerships to learn more about the public perspective.

To augment this literature review, we conducted five case study interviews with staff of private nonprofit organizations that have developed partnerships with public agencies. These case studies, which are featured in text boxes throughout the report, were included to help describe examples of public-private partnerships primarily in the areas of veteran behavioral health, homelessness, and employment. Case studies were identified through a combination of methods and factors. Some of the authors of this report were aware of these public-private partnerships from prior research on military caregivers and performance-monitoring activities associated with the Welcome Back Veterans initiative (see Tanielian, Martin, and Epley, 2014). The research team also reviewed recent media coverage that highlighted public-private partnerships, with a focus on veteran health and related social services. We specifically chose two public-private partnerships related to behavioral health for veterans and their families, because the VA cannot offer some services and care for families. We also selected three partnerships that tackled issues related to behavioral health: Two focused on homelessness and one was related to employment. We selected the public-private partnerships that focused on reducing veteran homelessness, because there is potentially less reluctance associated with the VA's partnering on homelessness than with its partnering on health care delivery. Furthermore, we selected the Supportive Services for Veteran Families (SSVF) program because it is included in Title 38 of the Code of Federal Regulations, which allows us to compare an institutionalized partnership with less formalized partnerships. Researchers conducted one-hour phone interviews that followed a structured guide based on nine key components of public partnerships (described later in this report). To give readers background on the case studies we reference, we include text boxes throughout the report with brief descriptions of the partnerships. Each box includes a link to the main website for the organization or program. Links within each website provide further information about each collaborative, including details on the funders and other private partners, as well as further resources that offer more information.

We identified nine key components of public-private partnerships that were relevant for veteran behavioral health. The development of these key components followed a three-stage process. First, we generated a list of potential key components

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after our review of the literature on public-private partnerships, which consisted of studies, articles, and published examples primarily outside the health care area. Key components needed to be referenced directly in at least two substantive areas of public-private partnership work (e.g., the seven keys to success of public-private partnerships from the National Council for Public-Private Partnerships [NCPPT, undated-a], building and facilities, emergency response, health care, global health care). Second, the research team met to decide if the key components were relevant to veteran behavioral health care and discussed specific wording and definitions of each of the key components. This work led to the development of the final nine key components. Finally, during a third phase, we vetted these nine key components with the five interviewees. After querying them about the nine components, we asked the interviewees whether there was anything else we should have asked that we had not. They either expressed that we had covered all the important components or gave responses that fell under one of the nine existent components. Thus, no additional components beyond the nine we had developed were justified for inclusion by the interviewees.

This report primarily focuses on public-private partnerships where a working relationship for a mutual goal is developed among organizations that operate in the public sector (government) and the private sector (nonprofit or corporate). Multiple entities have pursued partnerships between public entities (e.g., one agency partnering with another public or government agency) at the local, state, and federal levels. For example, the DoD–U.S. Public Health Service (USPHS) Partnership for Psychological Health and the partnership between the VA and the Department of Housing and Urban Development (HUD) aim to increase access to services for service members and veterans. Similarly, organizations in the nongovernmental or private

sector have established working relationships and collaborative partnerships between themselves without official government or public-sector engagement. For example, several specialized military family clinics have been established in the private sector in partnerships between academic institutions and the philanthropic community. A few examples include the New York University Cohen Military Family Clinic, the Red Sox’s Home Base program, and the Road Home program at Rush University. All these types of partnerships are important, but given recent research and policy focus on public-private partnerships, we focused the current review on informing this particular type of partnership.

DEFINITION AND EXAMPLES OF PUBLIC-PRIVATE PARTNERSHIPS IN HEALTH CARE AND OTHER AREAS

Definitions

In general, *public-private partnership* is an umbrella term used for any type of public-private cooperation, whether highly formal and hierarchical or informal and lateral. It is a broad term used to describe collaborations between a public entity (such as a state or federal government institution—e.g., the VHA) and a private entity, either for-profit or not-for-profit. The term has been used to refer to any collaboration between public and private entities, including hierarchical long- and short-term contracts—such as, in some cases, when a private company is hired by a public institution for specified tasks, as well as lateral commitments where the risks and responsibilities are transferred to the private entity, such as when a private entity is responsible for the design, construction, financing, maintenance, and operation of a public service (Reynaers, 2014). In this contractual relationship, the skills and assets of each entity (public and private) are shared while delivering a service or facility for the use of the general community. Resources are shared, as are the potential risks and rewards of the service or facility. Some researchers have referred to five variations of public-private partnerships: institutional cooperation for joint production and risk sharing, public policy networks, civil society and community development, urban renewal and downtown economic development, and long-term infrastructure contracts (G. Hoge, 2010). However, the term *public-private partnership* is used in a variety of contexts in the published literature and in the media, which makes it difficult to determine

when a true public-private partnership is evident or whether a writer is referring to a broad term, a variation, or another type of partnership outside the umbrella term (Hilvert and Swindell, 2013). It should be noted that public-private partnerships are not the same as *privatization*. For example, the downsides of the privatization of government have been documented, such as when the public sector obtains short-term financial gain but experiences unanticipated and significant long-term financial losses that might negatively affect the general public (see, e.g., Ball, 2014).

The VA defines a public-private partnership as “a voluntary, collaborative, working relationship between VA and NGOs [nongovernmental organizations] in which the goals, structures, governance, and roles and responsibilities are mutually determined to deliver the best possible services” (VA, Office of Policy and Planning, 2014, p. 6). For the duration of this report, this will be the type of public-private partnership on which we focus.

Catalysts for Public-Private Partnerships: Desire for Improved Services and Financial Impetus

In most cases outside health care, momentum for the partnerships comes from financial pressure, as public agencies have sought to reduce their operating budgets by enlisting the help of private companies to operate and maintain facilities (Sabol and Puentes, 2014). Although financial matters are a consideration, the impetus for all public-private partnerships is not solely to help the public partner reduce costs. Indeed, the main catalyst for these partnerships is to deliver services to the targeted population that are more efficient, more expedient, better quality, and more innovative (Ministry of Municipal Affairs, 1999). Many of the public-private partnerships in health care have been initiated by the public entity to manage government spending, which is unlikely to be sustainable at the current pace unless new funding sources are located (Health Research Institute, 2010). While the focus has been on reducing costs

and establishing better value for the money spent, success is also measured by better health outcomes and improved performance. These partnerships are increasingly being developed at the local level, as communities better understand their local health care needs. Examples include efforts by Accenture and the Institute for Veterans and Military Families at Syracuse University to provide educational, employment, and other life-skills training to assist veterans and their families with the transition from the military to civilian life; the National Association of Veterans Service Organization (NAVSO), which seeks to connect and foster collaborations between nonprofit organizations, private companies, and government agencies interested in supporting service members, veterans, and their families; and the Code of Support Foundation, which—in addition to providing service members, veterans, and their families with a supportive network and transition assistance—helps increase awareness among civilians about the challenges veterans face and garner continued community support. However, nationwide partnerships are needed to serve as successful models and to set policy frameworks for local governments to follow.

Disadvantages of public-private partnerships have also been documented (Katz, 2006). For example, contracts for these partnerships are typically complicated and cover a long period of time, which sometimes makes renegotiation necessary. Estimating costs over a long period of time can be difficult, and there might be risks of bankruptcy on the private-sector side or a strong shift in political support of the partnership with changing public leaderships. Other complications arise as well, which can include differences in how goals are evaluated, lack of clear hierarchical structure (if appropriate with that public-private partnership), and differing methods for enforcing performance standards. In many cases, public-private partnerships are not the least expensive option; however, they are seen as a means to improve the current state in an efficient manner with better value for the cost (Sabol and Puentes, 2014). Public-private partnerships also do not relieve local and national governments of their roles and responsibilities; rather, a partnership

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allows two entities to more effectively deliver services to the public (Ministry of Municipal Affairs, 1999). A partnership enhances an area that neither could address individually. In many cases, public employees are hired by the private entity involved in the partnerships to continue doing similar work in a different capacity, and more jobs might be created, thus benefiting the financial structure of both the public and private entities in the long run (NCPPP, undated-b).

It is also important to note that public-private partnerships might develop out of public-public partnerships or private-private partnerships. Indeed, for veteran behavioral health, private-private partnerships might help address immediate issues in the veteran community, as efforts are made to address a crisis or problem in the short term. Yet these partnerships might run out of funding quickly, be primarily driven by philanthropic efforts (among funders and also staff that might be underresourced), or be difficult to sustain over time. However, important preliminary information from these initial efforts, whether successful or not, can suggest that more needs to be done than what two or more organizations within the private sector could fully accomplish without further support. Likewise, public-public partnerships have been successful in addressing veteran behavioral health needs in such areas as homelessness (e.g., the VA and HUD), but these partnerships might recognize over time that involvement from the private sector could improve already successful outcomes.

Areas of Public-Private Partnerships

Published studies documenting the effectiveness of public-private partnerships in providing quality health care to civilians and veterans are rare in the research literature. Indeed, it is estimated that only 10 percent of public-private partnerships in the United States are in the health care area (Health Research Institute, 2010), while most examples in this country come from such areas as energy, operation and management, public safety, public works and construction, real estate and economic development, technology infrastructure, transportation infrastructure, federal building and facility maintenance, and water and waste infrastructure (NCPPP, undated-b; U.S. General Accountability Office [GAO], 1999; Tang, Shen, and Cheng, 2010). One reason for the limited use of public-private partnerships in health compared with other areas might be the complexity of creating sustainable end products that serve communities on an ongoing basis. For example, in areas outside health, the partnership goal is often to create a physical infrastructure

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(e.g., roadways or parks), whereas in health, the creation of a hospital building itself is less important than maintaining the health care needs of individuals located within the building. Here, the goal of the partnership focuses on meeting the health and wellness needs of the community. Although they might be more difficult to implement in this area, public-private partnerships have important applications in the health arena and might be increasingly common in the future.

THE NEED FOR PUBLIC-PRIVATE PARTNERSHIPS TO ADDRESS BEHAVIORAL HEALTH PROBLEMS OF VETERANS AND THEIR FAMILIES

Public-private partnerships have been proposed as a strategy to meet the health and wellness needs of veterans and their families (Office of the Press Secretary, The White House, 2014; VA, Office of Policy and Planning, 2014; VA and DoD, 2014). These partnerships have been encouraged to help supplement VA services for veterans, provide adjunct and supportive services to family members (which are not traditionally available for family members), and help fill other emerging gaps in services for veterans and their families (VA, 2014b). Partnerships in this vein are primarily related to partnerships between the VA and other federal agencies (e.g., DoD, which is an example of a public-public partnership); state, tribal, and local governments; local- and national-level veteran service organizations and military service organizations; academic affiliates (e.g., both public and private colleges and universities where faculty have joint appointments at the academic institution and the

VA); unions; other nonprofit organizations; and private industries. Before we discuss the public-private partnerships in the area of veteran behavioral health, it is important to discuss why such partnerships are necessary and why the U.S. government has recently called for such partnerships.

Behavioral Health Problems of Recent Veterans

Approximately one-fifth of the over 2.5 million veterans of the conflicts in Iraq and Afghanistan are struggling with behavioral health concerns, such as posttraumatic stress disorder (PTSD), traumatic brain injury (TBI), depression, and substance use disorders (Schell and Marshall, 2008; Seal et al., 2011). Almost 20 percent of veterans meet the criteria for PTSD or depression, approximately 10 percent meet the criteria for an alcohol use disorder, and approximately two-thirds of veterans who meet the PTSD criteria also meet the criteria for probable depression (Seal et al., 2011; Schell and Marshall, 2008). Veterans suffering with PTSD or depressive disorders are at increased risk for alcohol use disorders (Jakupcak et al., 2010; Ouimette et al., 2011; Tanielian and Jaycox, 2008), and studies have documented that rates of PTSD, depression, and heavy drinking are higher in OEF and OIF veteran samples than they are in active duty and civilian samples (Bray and Hourani, 2007; Kessler et al., 2005; Ramchand, Miles, et al., 2011; Schell and Marshall, 2008). Young-adult veterans are more likely than young-adult civilians to report mental health problems, such as anxiety and depression (Grossbard et al., 2013). Veterans of the recent conflicts are also struggling with sleep disturbances (e.g., short sleep duration, insomnia, nightmares) and TBI, both of which are associated with behavioral health problems related to anxiety, diagnosed PTSD and depression, anger and aggression, poor concentration, and family problems (Gellis et al., 2010; Wallace et al., 2011; Plumb, Peachey, and Zelman, 2014; B. Taylor et al., 2012). Veterans with symptoms of anxiety, depression, and hazardous alcohol use that do not quite meet diagnostic criteria are

still reported as distressing, and these subclinical symptoms can be successfully targeted in treatments (Kornfield et al., 2012; Cuijpers, Smit, and van Straten, 2007; Brief et al., 2013).

Behavioral Health Problems of Veterans' Family Members

Veterans are not alone in their behavioral health needs. The military population is more likely to be married than civilian peers (Karney, Loughran, and Pollard, 2012), and nearly half have children under the age of 18 (Vaughan et al., 2011). These military families face unique stressors that might place a strain on their relationships and make reintegration into family life especially difficult (Hinojosa et al., 2010; Makin-Byrd et al., 2011). Indeed, married veterans report substantial family-reintegration difficulties (Sayers et al., 2009), and younger military couples report more family concerns and troubled relationships with their partners than couples with longer relationship histories (Sayers et al., 2009). Rates of marital satisfaction among military couples have declined significantly in recent years, while rates of infidelity and intention to separate or divorce have increased (Riviere et al., 2012). For veterans, behavioral health concerns, such as PTSD, are also associated with a host of interpersonal family problems—e.g., partner distress and poor psychological well-being, poor parenting skills, bursts of anger or aggression, and behavioral problems for children (Galovski and Lyons, 2004). PTSD among service members also accounts for significant emotional distress and poor relationship satisfaction, as reported by spouses (Meis, Erbes, et al., 2010). Likewise, substance-use concerns affect military families. For example, alcohol misuse among service members is associated with poor marital quality, greater rates of infidelity and separations and divorces, intimate-partner violence, and child maltreatment (Rowe et al., 2013; Headquarters, Department of the Army, 2012; Erbes et al., 2012).

In addition to dealing with the behavioral health issues of their veteran partners, military spouses themselves experience

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high rates of behavioral health concerns, such as depression and anxiety (Eaton et al., 2008; Mansfield, Kaufman, Marshall, et al., 2010; Erbes et al., 2012). Children of deployed combat veterans also suffer from poor relationships with their parents and report behavioral health concerns, such as depression and conduct problems (G. Gorman, Eide, and Hisle-Gorman, 2010; Jordan et al., 1992; Lester, Peterson, et al., 2010; Mansfield, Kaufman, Engel, et al., 2011; McFarlane, 2009). In a large study of children aged 11 to 17 who experienced parental deployments, researchers found that military children experience more emotional and behavioral difficulties than age- and gender-matched civilian children (Chandra et al., 2010).

Other work points to the potential negative impact of deployments and parental stress on children in military families (Lester, Peterson, et al., 2010; Flake et al., 2009; Reed, Bell, and Edwards, 2011). A recent meta-analysis of 16 studies of children with deployed parents concludes that there are small yet significant associations between parental deployments and children's experience of internalizing problems (e.g., anxiety, depression), externalizing behaviors (conduct and behavioral problems), and poor academic achievement (Card et al., 2011). In addition, models from civilian literature indicate that marital discord can affect children's distress and disrupt parent-child relationships (Stroud et al., 2011). While these studies offer important insight into the impact of deployments and parental stress on children of active duty service members, little is known, specifically, about how these problems continue into adulthood or how children of veterans experience emotional and social problems.

The fact that service members are returning home with more physical and emotional injuries than ever before (Tanielian and Jaycox, 2008) is creating caregiving responsibilities for spouses and making already stressed relationships more difficult to manage. Indeed, there are more than 5.5 million military and veteran caregivers in the United States today, with nearly 20 percent of these individuals caring for veterans and service members from the Iraq and Afghanistan conflicts (Tanielian, Ramchand, et al., 2013; Ramchand et al., 2014). The majority (64 percent) of the veterans receiving care are diagnosed with such mental health concerns as PTSD, depression, and substance-use disorders, and the majority of these caregivers (53 percent) report having no support network to assist with caretaking. They are also at increased risk for mental health concerns, such as depression, compared with counterparts not involved in caretaking.

Barriers to Seeking Mental Health Care for Veterans and Their Families

High Unmet Need for Care

For those veterans who do receive behavioral health care at the VHA, satisfaction ratings of helpfulness of care are moderate to high (Kimerling et al., 2011; Hepner et al., 2014), and nearly all service members who have received specialty behavioral health care report that it is helping at least somewhat (Wong et al., 2013). Unfortunately, many veterans suffering from behavioral health problems do not seek services for these problems. This is despite most recent veterans qualifying for VHA services; other veterans have private insurance plans through employers, and there are expanded options for care provided by the Affordable Care Act (Russell and Figley, 2014; Haley and Kenney, 2012). In general, even though most recent veterans have access to quality, affordable medical and behavioral health care at the VHA (Watkins, Pincus, Paddock, et al., 2011; Watkins, Pincus, Smith, et al., 2011; Percy, 2009), approximately 50 percent of OEF and OIF veterans do not seek services there (Bagalman, 2013; VHA, 2013), and younger veterans are less likely than veterans aged 45 and older to receive any care there (Nelson, Starkebaum, and Reiber, 2007). The number of veterans struggling with unmet mental health needs, yet not seeking care from the VHA or elsewhere, is substantial. It is estimated that, in 2007, there were approximately 303,000 OEF and OIF service members and veterans with probable diagnoses of PTSD or depression, of which only half made at least one visit to a mental health specialist or doctor (Schell and Marshall, 2008). Similar studies indicate that rates of treatment seeking in veterans with documented behavioral health needs vary between 39 percent and 50 percent (L. Gorman et al., 2011; Pietrzak et al., 2009). In addition to diagnosed behavioral health problems, veterans are also reluctant to seek care for family relationship problems. Of the nearly one-fifth of married service members who report interpersonal conflicts, only 22 percent receive care for these concerns (Gibbs, Clinton-Sherrod, and Johnson, 2012). As with veterans, spouses and other members of military families also report minimal engagement in adequate behavioral health treatment (Eaton et al., 2008; Vaughan et al., 2011). For example, only 41 percent of military spouses screening positive for behavioral health concerns report seeking specialty mental health services, primarily due to difficulty finding an appointment or child care, as well as cost (Eaton et al., 2008).

Barriers to Accessing Care

Nationwide, upwards of one-half of veterans and their spouses report barriers related to the high cost of behavioral health care, difficulty getting child care or time off work, not knowing where to receive care, and not knowing what affordable care options are available, as well as concerns related to the stigma of seeking such care (Eaton et al., 2008; C. Hoge et al., 2004; Pietrzak et al., 2009; Schell and Marshall, 2008; Acosta et al., 2014). Similar barriers are also seen within regional studies of veterans—for example, in New York state and California (Castro, Kintzle, and Hassan, 2014; Castro, Kintzle, and Hassan, 2015; Vaughan et al., 2011). Major barriers to behavioral health care for veterans and military personnel include logistical barriers (e.g., high costs, not knowing where to get help), institutional and cultural barriers (e.g., belief that treatment would not be kept confidential, reduced respect from friends and family), and beliefs and preferences for treatment (e.g., belief that problems can be handled alone or that available treatments are not effective) (C. Hoge et al., 2004; Pietrzak et al., 2009; Schell and Marshall, 2008; Vogt, 2011). Even once veterans and their family members do seek care, there are systemic barriers within the VHA system itself. For example, research and media attention has highlighted negative implications associated with long wait times for behavioral health appointments (Hepner et al., 2014; Bronstein and Griffin, 2014), which averaged more than one month for most of 2014 (VA, 2014c). While much policy discussion has focused on improving wait times, the remnants of the 2014 media storm (including publicizing the deaths attributed to wait times at one VA hospital) might continue to foster negative perceptions of the VHA by those who have the ability to utilize services.

When service members are on active duty or in the reserve components, their family members have access to similar behavioral health coverage as the service member, through TRICARE or TRICARE Reserve Select insurance coverage (TRICARE, 2012). However, after military service ends, families are only continually covered through the service member's benefits if the service member retires from the military, which only approximately 20 percent do (Office of the Deputy Under Secretary of Defense, 2013). Thus, access to care is a major barrier to care among families of veterans, the vast majority of whom do not have access to the quality behavioral health care offered to veterans through the VHA. Spouses and children of permanently or totally disabled veterans or those who have died due to service-related conditions are eligible for the Civilian Health and Medical Program of the Department of

Veterans Affairs (CHAMPVA) (VA, 2014a), yet the majority of family members are not eligible for this type of government-funded care and cannot access services at the VHA. Indeed, in 2012, nearly half (45.7 percent) of 5.4 million adults who reported an unmet need for mental health care reported cost as a barrier to the receipt of care (Center for Behavioral Health Statistics and Quality, 2013). Other barriers include the belief that one can handle a problem alone (28.2 percent) and not knowing where to go for services (22.8 percent). For military caregivers specifically, 33 percent report they do not have health insurance, which presents a barrier to the personal care they can receive for their own mental health needs (Ramchand, Tanielian, et al., 2014).

While still on active duty, service members and their families can receive medical care in the same setting. However, when they are separated or discharged, families in which veterans rely on the VHA for care (e.g., nonretirees and those without private health insurance plans through their employers) have to learn to navigate two separate systems (i.e., the VHA and another hospital or clinic), often within unfamiliar communities after discharge. The exchange of information between the VHA's providers and family members' providers can be time-consuming and strain already limited resources while trying to coordinate care between two separate clinics. Also, in qualitative work, RAND researchers found that veterans and their spouses are generally unaware of their affordable and effective care options (Schell and Tanielian, 2011). Veterans perceive that there are very few services for family members at the VHA, despite a desire for such care themselves, and thus veterans recommend expanded and accessible VHA services for their family members (e.g., support programs and access to the same quality care that veterans receive) (Schell and Tanielian, 2011). Providing behavioral health care for veterans and their families through the same behavioral health system of care might reduce barriers to care for both veterans and their families and might help coordinate care and streamline information sharing between providers, but this would likely require legislative changes. Colocating these services within the same physical setting might further reduce logistical and stigma-related barriers to care for veterans and their families, and it can be done through innovative partnerships within existing authorities.

Another barrier preventing access to care concerns the move from tight-knit military communities to larger communities outside the military. Though stigma can be a barrier to seeking care in a setting where everyone knows each other's business,

Public-private partnerships are needed to bridge the gap between care systems for veterans and their families.

tight-knit military communities can help spouses and family members identify sources for behavioral health care on bases and in the communities. In addition, there are a multitude of organizations within the military and in the broader community to support family readiness and resilience, with many of these programs offering supportive behavioral health services or assistance with locating those organizations that do. As an example, there are at least 60 Army programs aimed at the total Army (including soldiers, families, and Department of Army civilians) for readiness and resilience, many of which assist with finding appropriate services (see U.S. Army, undated). However, navigation of the family support programs might be more difficult for family members after military service, and knowledge about where to find quality affordable care might be a barrier.

PUBLIC-PRIVATE PARTNERSHIPS TO ADDRESS BEHAVIORAL HEALTH NEEDS OF VETERANS AND THEIR FAMILIES: A CASE FROM COLLABORATIVE CARE

Public-private collaborations, in providing behavioral health care to veterans and their families, might address the needs for services and the barriers to care outlined earlier. The systems in place to treat these veterans and their families are traditionally separated: the VHA (public agency) for eligible veterans and private hospitals, clinics, and providers for the family members. Often times, however, family problems are systemic, and if providers can more easily communicate with each other across systems, there is potential for improved care for veterans, their family members, and family systems. In addition, private-sector providers are often not familiar with veteran-specific issues. Providers who do have a degree of “military cultural competency” are more likely to work in the VHA and therefore might be unavailable to the veteran’s family members (Tanielian, Farris, et al., 2014). Thus, public-private partnerships are needed to bridge the gap between care systems for veterans and their families.

In this section, we review the literature and theoretical models that support collaborative care structures by incorporating families into the behavioral health treatment of veterans.

This discussion includes research and theory about how the inclusion of family members can enhance behavioral health care for veterans, in addition to the benefits of providing services to families and veterans within a collaborative health care system. While we pay particular attention to health care models relevant to the population of veterans and their families, there is little research describing collaborative efforts between private health care systems (e.g., for families) and veteran and military health care systems (i.e., public systems for the veterans, such as the VHA). Thus, in some cases we looked to the civilian literature and expanded our discussion beyond health care systems.

Collaborative Care Models Enhance Care for Veterans and Their Families

As discussed, veterans and their families report interest in VHA care that incorporates family members, such as specified services for veterans’ partners and children, but also care that includes family members in treatment plans (Schell and Tanielian, 2011; Vaughan et al., 2011). However, in a sample of more than 5,000 veterans receiving behavioral health care at the VHA, only 31 percent perceived that VHA staff helped them to include others, such as family members, into their treatment plans (Hepner et al., 2014). Thus, despite veteran preference, families are often not included in treatment plans—though exceptions exist, as in the Family Care Collaborative (FCC) discussed later. Family members also need to find behavioral health care for themselves outside the system where veterans receive services.

Researchers have identified ways to improve the care of veterans and their families, including (1) considering family dynamics and systemic processes within the family when treating veterans, (2) including family members in prevention and intervention efforts and making the care needs of veterans’ families a public health priority, (3) identifying and evaluating effective strategies to engage veterans and their families in both prevention and intervention care efforts, (4) designing care systems around families to help prevent barriers to accessing services (e.g., home visits or expanded hours of treatment centers), and (5) pursuing research efforts to develop family-focused care models and evaluate effective implementation strategies

Coordination of care has the potential to overcome several of the barriers identified by veterans, their families, and their providers.

across systems of care (Wadsworth et al., 2013). Coordination of care can include involving spouses, partners, and family members in care coordination procedures for veterans, as well as treating veterans and their family members within the same behavioral health care system, which is what veterans and their family members are often familiar with from their experiences of being treated within the military health system. Coordination of care has the potential to overcome several of the barriers identified by veterans, their families, and their providers, such as increased communication between veterans' and their families' providers, increased ability to coordinate care for veterans and their family members in both family-based and individually based approaches, allowance for easier and streamlined information exchange between providers, reduction of stigma associated with receiving care by including family members in specialized care of such disorders as PTSD, and increased military cultural competency among the private-care providers treating veterans' family members.

Including Family Members in Veteran Behavioral Health Treatment Is Important

There is good theoretical reason to believe that family members who are not involved in treatment might contribute to sustaining the problems faced by the veteran. For instance, family systems theory (Bowen, 1966; Cox and Paley, 1997) suggests that an individual's behavioral health problems exist within a family system that works to keep homeostasis or equilibrium in the family. For example, a family system could be structured in a way that reinforces one's PTSD symptoms: In an attempt to keep the individual with PTSD safe and limit symptom expression, the family might reinforce the individual's avoidance of

leaving the house by bringing everything he or she needs to the home (e.g., food, entertainment). In turn, the individual feels cared for and protected but never addresses his or her PTSD symptoms, which could be addressed in the long term by seeking formal treatment outside the home. Family resilience theory (Walsh, 2006)—which proposes that shared beliefs, combined with healthy patterns of communication and organized structure, help families handle adversities with resilience—has also been applied to military families. This work suggests that such issues as coparenting and working together can be difficult when families have to manage deployments and relocations, but military family bonds are strengthened when they share beliefs, understand and support each other, and display healthy communication patterns (Saltzman et al., 2011).

These theories support systematic approaches to treatment of behavioral health problems that are inclusive of family members, yet family members are often left out of clinical discussions regarding behavioral health treatment. Family members might be uninformed about the symptoms and natural course of therapy and inadvertently reinforce their loved ones' disengagement with therapy. For example, if a spouse sees a veteran partner come home from a PTSD treatment session visibly distressed, he or she might reinforce the partner's decision to skip future sessions, which serves to temporarily relieve both the veteran's and the spouse's distress but continues the pattern of not treating the PTSD. In addition, much of the work associated with the VHA's primary PTSD treatments (prolonged exposure and cognitive processing therapy) (Karlin et al., 2010; Chard et al., 2012; Eftekhari et al., 2013) takes place outside the therapy session through practice assignments, such as practicing breathing exercises, completing thought restructuring worksheets, and repeating in vivo exposures in the community (e.g., going to a crowded mall). Family members who understand a particular behavioral health disorder and the treatment and work collaboratively with patients and their care teams on treatment plans can help patients engage in these activities and encourage continued engagement in care.

Including partners and family members in the treatment of veterans might assist with earlier initiation and engagement, as well as follow through with treatment plans. Indeed, service members report encouragement from spouses as the most common facilitator of seeking care for substance-use concerns (Burnett-Zeigler et al., 2011), and individuals changing drinking patterns most often choose spousal support as the most helpful mechanism in supporting change (Project MATCH Research Group, 1997). Inclusion of family members in care

has also been successful for other behavioral health concerns, such as PTSD and depression. For example, support from family members can help facilitate the initiation of and engagement in behavioral health services among veterans with PTSD (Meis, Barry, et al., 2010; Sautter, Lyons, et al., 2006). Therapies that include both veterans and their partners have been successful at treating veterans' PTSD (Brown-Bowers et al., 2012; Monson et al., 2004; Sautter, Glynn, et al., 2009).

Family-Centered Care Increases Collaboration Between Providers and Helps Families Work Together on Rehabilitation Efforts

Collaborative care models typically incorporate family-centered care, which includes a collaboration of shared resources and decisionmaking among families, the health care system, and the health care providers. It is a standard of care in pediatric treatment settings and is associated with improved rates of care for family members in need (Kuo, Frick, and Minkovitz, 2011; American Academy of Pediatrics Committee on Hospital Care, 2003). Child behavioral health care systems have adopted integrated family-focused care into best practice efforts (Tolan and Dodge, 2005), yet limited resources and challenges associated with organizational changes have prevented these models from widespread implementation in both child and adult behavioral health care systems (Coyne et al., 2011; Hirschhoff, 2006; Perrin et al., 2007).

Models and programs have been developed specifically for veteran and family health care. For example, a model proposes that veterans and their families can be included in a collaborating system, with health care centers that: (1) include community- and family-based care, (2) address individual, couple, and parenting difficulties in addition to problems experienced collectively by the family, (3) increase communication skills within families through collaborative care efforts and provision of resources and information for caregiving, and (4) promote prevention and resilience to behavioral health problems among all members of the family (Wadsworth et al., 2013). Effective collaborations have been used within the VHA successfully, such as the FCC (Hall, Sigford, and Sayer, 2010). In this instance, the FCC was embedded in polytrauma rehabilitation centers, included family members in veterans' care delivery, and involved family members in clinical care decisionmaking. Thus, families are active partners with care providers in their loved ones' rehabilitation. Sites that utilized

the FCC improved family-centered practices and satisfaction with these practices.

There are some FCC programs for military populations that utilize collaborations among patients, families, and health care providers within medical settings. For example, the Preventive Medical Psychiatry consultation service at the Walter Reed Army Medical Center targets service members with combat-related injuries and includes early prevention of trauma-related behavioral health problems, patient and family education, continued consultation between health care and behavioral health care providers and families, and care management (Wain et al., 2004). In addition, Operation Mend at the University of California, Los Angeles, involves families in the treatment, coping, and recovery procedures for combat-related injury surgeries (Wadsworth et al., 2013). Although these programs are promising, we did not locate any published evidence for their effectiveness.

Outside of health care systems, there are programs that successfully use a family-centered systemic approach to care for veterans and their families. For example, the military's Strong Bonds program, which includes a couple-focused workshop and retreat centered around enriching couple and family relationships, has demonstrated positive effects on marital satisfaction and communication, as well as reduced divorce rates (Stanley et al., 1999; Allen et al., 2012). In addition, the FOCUS (Families OverComing Under Stress) program—which attempts to promote resilience to trauma-related behavioral health problems by involving families (i.e., veterans, partners, and children) in a multisession program that is supported by schools, military leadership, behavioral health providers, and other community agencies—has been widely implemented, with positive results for both service members and veterans and their family members (Beardslee et al., 2011; Lester, Saltzman, et al., 2012).

Collaborative Care Models for Veteran Behavioral Health

Collaborative care systems for veterans and their family members are rare. However, many Vet Centers, which are typically smaller VA-affiliated community clinics with nonemergency services (e.g., counseling, outreach), do offer family counseling for military-related issues. In addition, various private philanthropic efforts on Long Island in New York state led to the creation of the North Shore-Long Island Jewish/Northport Veterans Affairs Medical Center: The Unified Behavioral Health Center for Military Veterans and Their Families. To our knowledge, this public-

private partnership is the only program that targets both veterans and their family members in a collaborative family-centered care model, where veteran and family providers work collaboratively to share information and expertise. Very little is known about how a public-private partnership model of this kind could lead to improved behavioral health care and improved behavioral health outcomes (e.g., reduced symptoms, improved functioning) for veterans and their families. Thus, the importance of evaluating such a model is evident and has implications for future public-private partnerships of this kind. RAND is currently engaged in such an evaluation, with results forthcoming.

PUBLIC-PRIVATE PARTNERSHIPS TO MEET THE BEHAVIORAL HEALTH NEEDS OF VETERANS AND THEIR FAMILIES

Although public-private partnerships are a promising approach to meeting veterans' behavioral health needs, there is little research specifically addressing these partnerships in the veteran behavioral health arena. In this section, we review the available literature on public-private partnerships with veteran populations.

General Veteran Public-Private Partnerships

Examples of public-private partnerships specifically for veterans are evident when federal, state, or local institutions (e.g., the VHA, DoD) partner with Veterans Service Organizations (VSOs) or other nonprofit organizations to provide veterans with a specified service. VSOs are privately or philanthropy-funded organizations that provide a variety of services to veterans; chartered VSOs are federally authorized to represent veterans before the VA. It is estimated that there are more than 40,000 nonprofit organizations that focus on service members, veterans, and military families (Berglass, 2012), and many

have nuanced understandings of the needs of local veterans and their families. Yet the organizations might be underfunded and lack coordination of the often overlapping efforts with other organizations in both the public and the private sectors. The OCJCS (2013) has called for more partnerships between federal institutions (mainly the VHA) and VSOs that are characterized by (1) an organized structure with strong leadership, (2) formalized timelines and milestones as part of well-defined goals, (3) consistent and recurring communication between the collaborating federal institutions and private organizations, (4) support of the local public, and (5) flexibility to meet changing priorities and funding environments. A few of these types of initiatives have begun to develop over the past five years. For example, the Los Angeles Veterans Collaborative (LAVC), administered by the University of Southern California Center for Innovation and Research on Veterans and Military Families (CIR), focuses on veterans' behavioral health via a structured network of public and private agencies working together toward a common goal (Hassan, 2014). Success is attributed to a community quarterback model, in which CIR is the coach guiding the LAVC to interact with community providers, build networks in the community, and directly connect veterans and their families with services to fit their needs. Key components of this coaching approach include (1) established connections in the community to convene relationships naturally and stay objective (e.g., not competing for funds), (2) credibility in the veteran community, and (3) access to resources (e.g., time, money, staff) to support partnerships. Similarly, several community models have emerged that are aimed at building local partnerships to support veterans during their transition to civilian life, including the Community Blueprint model from the Points of Light Foundation; the Altarum Institute's Veteran Community Action Teams in Detroit, San Antonio, and San Diego; and the Charlotte Bridge Home. Lastly, a major public-private effort is the Joining Forces Initiative, which is supported and funded by the federal government (led by First Lady Michelle Obama and Dr. Jill Biden) to

Several community models have emerged that are aimed at building local partnerships to support veterans during their transition to civilian life.

work with local governments and leaders, service organizations, and the general public to raise awareness and educate communities about the employment, education, and wellness needs of military families. Part of this initiative is to promote education and research with veterans and their families in partnerships with more than 100 medical schools across the country to better understand and address the unique health care needs of this population.

Though we were unable to find any published empirical research with outcome measures for a public-private partnership involving the VHA, there are innovative examples of public-private partnerships between the VHA and community partners. For example, the King County Department of Community and Human Services (DCHS) in Seattle (DCHS, 2013b) has developed a strategic plan to partner providers, community leaders, the Washington Department of Veterans Affairs, and nonprofit organizations to improve the services offered to veterans in areas of health care and behavioral health care, employment, education, financial benefits, and housing services (DCHS, 2013a). This Regional Veterans Initiative was sparked by concerns among veterans and service providers regarding the lack of coordination of services, difficulties managing and understanding services offered, and limited understanding of providers and the community at large of veterans' issues (Hoskins, 2013). The main goal of the initiative is the creation of a single system composed of public and private entities focused on overcoming these systemic problems to increase access to services in King County for veterans and their families.

A similar example of coordinating efforts under development is the Veteran Metrics Initiative, which will be a partnership among the Henry M. Jackson Foundation for the Advancement of Military Medicine, DoD, the VHA, VSOs, and other providers of veteran services to evaluate the effectiveness of veteran transitions into civilian life and provide a detailed list of evidence-based, successful program components offered through both public and private entities (Gilman, 2013). Other examples of public-private partnerships for veterans include the Million Records Project between Student Veterans of America, the National Student Clearinghouse, and the Veterans Benefits Administration (VBA), which was a collaborative research project to learn more about the higher education needs of veterans by matching data from VBA records and graduation rates (Cate, 2014).

Other innovative examples include web portals, community action teams, and corporate and educational institutions (OCJCS, 2013). Such web portals as Illinois Joining Forces

and the Nevada Green Zone Initiative bring together local VA Medical Centers, VSOs, and state-funded entities to pool resources for veterans and their families on single, user-friendly websites, including technical support staff to help users find what they are looking for (e.g., benefits assistance, behavioral health care). Community action teams include the Augusta Warrior Project, which partners with state and federal governments to locate local organizations serving veterans and their families in the Greater Augusta area and South Carolina's Central Savannah River Area. Finally, corporate and educational institutions, such as Syracuse University's Institute for Veterans and Military Families, work to partner private companies and public institutions to improve education and future employment opportunities for veterans, while DoD's USA4 Military Families initiative engages and educates policymakers, businesses, and federal and state leaders about the emerging health and wellness needs of veterans and their families.

While efforts exist, there are challenges to establishing public-private partnerships for veterans. For example, federal entities (such as DoD) are often hesitant to partner with private entities (such as nonprofit organizations) because such partnerships could be viewed as endorsements or might be restricted through federal policy (OCJCS, 2013). Choosing which nonprofit organization to partner with among an abundance (more than 40,000) can prove difficult (Berglass, 2012; Copeland and Sutherland, 2010). In addition, efforts are often overlapping, and federal, state, and local governments might disagree about which partnerships to foster and which organizations to support.

Veteran Public-Private Partnerships for Behavioral Health Care

As part of President Obama's 2012 executive order and 2014 executive actions (Office of the Press Secretary, The White House, 2012, 2014) to improve the behavioral health care of veterans, service members, and their families, there was a call for more collaboration between the VHA and the DHHS to identify local community partners to improve access to care services for veterans in the community. Thus, the VHA is currently partnering with several community-based mental health and substance abuse providers to provide pilot data regarding the effectiveness of these partnerships on improving behavioral health care for veterans and their families. These partnerships include helping state and community agencies with technical assistance on the military health care system (including the

VHA), using federally funded grants to provide veterans in the community with empirically based care, expanding outreach to community partners to increase both referrals to the VHA and referrals to community partners from the VHA, training community providers working with veterans and their families in cultural competency, and providing veterans and family members with the necessary tools to successfully treat these individuals. Several efforts are under way, including collaborations between local VHA facilities and community mental health clinics in such states as Georgia, Iowa, Wisconsin, Tennessee, Mississippi, Nebraska, and South Dakota. These pilot programs use telemental health care procedures to reach those without easy access to VHA hospitals (i.e., meeting with a provider over the computer), staff sharing and space utilization arrangements to allow VHA providers to offer services in communities distant from a VHA facility, and trainings and continuing education courses designed to increase military cultural competency so that non-VHA community providers better understand the unique needs of veterans and their families.

RESEARCH AND EVALUATION NEEDS FOR VETERAN BEHAVIORAL HEALTH

Key Components of Public-Private Partnerships Relevant to Veteran Behavioral Health

Much of what we know about successful public-private partnerships in health care comes from clinical service delivery (e.g., coordination between providers) and global health (Buse and Tanaka, 2011), but little is known beyond these two areas about the broader health care systems involved in these partnerships. Since only 10 percent of public-private partnerships in the United States are in the health care area (Health Research Institute, 2010), we looked to the literature outside health care to develop key components of public-private partnerships that could be relevant for veteran behavioral health. For areas outside health care, key elements of public-private partnerships identified by GAO include (1) a catalyst for change (i.e., reform to the current practice is recognized and needed; fiscal and community pressure for change is present), (2) statutory basis (i.e., legislation to permit the collaboration and agreements on costs and revenues generated from the partnership), (3) organizational structure (i.e., newly established or current public agencies designated to work with the private entities), (4) a detailed business

plan (i.e., agreements on financing, responsibilities, and decisions), and (5) stakeholder support (i.e., local community and stakeholder support partnerships) (GAO, 1999). The Federal Emergency Management Agency (FEMA) has detailed five principles for designing successful partnerships: (1) publicly accessible leadership, information, and resources; (2) dedicated staff and support structure; (3) resources to support partnership efforts; (4) active participation and communication between public and private entities; and (5) sustainability from strategic plans, funds, and resources (Kolluru, Stovall, and Stoneking, 2011). In addition, FEMA has also discussed how integrating and coordinating resources from multiple separate databases and sources might help track goods, services, and donations for disaster relief efforts (Beauchesne, Frias, and Small, 2011). Similar integration efforts are proposed for increasing access to and understanding of the multiple services offered to veterans (Gilman, 2013; DCHS, 2013a).

Lessons learned from successful global public-private partnerships, such as Global Fund to Fight AIDS and Global Alliance for Tuberculosis Drug Development, can help inform health care partnerships in the United States as well (Buse and Tanaka, 2011). For example, public-private partnerships need to (1) demonstrate their comparative advantage over single-run systems, (2) have adequate and sustainable resources, (3) practice good management and governance, (4) acknowledge and support partners' divergent and common interests, (5) evaluate and continue to improve policies and practices, and (6) ensure the partnership is making an impact on the targeted systems or populations (Buse and Tanaka, 2011). However, lack of specific, measurable, attainable, relevant, time-bound (SMART) objectives; performance management; and continuous internal assessment undermines many of the public-private partnerships described in the literature. Research and the need for rigorous study are too often overlooked in designing new programs, many of which are fueled by desires to help veterans and their families. The absence of rigorous evaluation designs restricts our ability to expand beyond anecdotal evidence and does not enable assessments of whether the program is effective or adds value. Thus, effective partnerships should use performance and outcome measures based on observable objectives (e.g., measuring patient satisfaction with care if the objective of the partnership is improving patient satisfaction with care, and assessing the impact on functional outcomes of those served through the partnership if a goal is improving patient functioning). Considerations for evaluation should be discussed at the point of funding so that there are adequate resources available to evaluate the impact

of the program. Further, if an evaluation provides evidence of success, it might be easier for the program to obtain continued funding to support its mission.

Compared with traditional separate public and private systems, public-private partnerships in global health are more focused on health outcomes and performance (e.g., better procurement and value for money), technologically advanced ways to improve care, and challenging the notion that private health care is for the rich and public health care is for the poor by equalizing care across populations (R. Taylor, 2011; Health Research Institute, 2010). However, public-private partnerships also face new challenges when implemented, such as unforeseen increases in demand, initial start-up funds, and cost shifting as one entity (e.g., the public entity) shifts the cost responsibilities onto the other (R. Taylor, 2011). Similar to guidelines suggested for successful public-private partnerships in other areas, guidelines and suggestions for successful health care public-private partnerships are available (Health Research Institute, 2010). These include (1) a well-articulated and established need to address a gap or improve the standard of current care; (2) willingness for both entities to work collaboratively in a partnership, which can be supported by incentives to bring willingness into actual practice; (3) each partner successfully performing to a required standard that is formally set up in a clear plan, and this success must be objectively evaluated through performance measures agreed on by both partners; and (4) partner flexibility in adapting to technological innovations, information technology, needs of the patients, and changes to strategic objectives of governments over time.

From the review of the literature, we identified nine key components of public-private partnerships designed to address the behavioral health needs of veterans and their families (see Figure 1). Although there is no literature specifically addressing public-private partnerships for veteran behavioral health, successful case studies and guidelines from other areas point to these nine components. The nine components will need to be rigorously examined to determine their need and effectiveness when applied to veteran behavioral health issues. We describe each of the key components and offer examples from the five case study interviews described in this section.

Key Component 1: Catalyst for Change/Established Need

The most straightforward of the key components is an established need for a change to the current system—a well-articulated and established need to address a gap or improve

Figure 1. The Nine Key Components of Public-Private Partnerships Relevant for Veteran Behavioral Health

1. Catalyst for change/established need
2. Leadership/public-sector champion
3. Support from nonpublic stakeholder communities at the regional and local levels
4. Detailed plans, agreements (e.g., memoranda of understanding or agreement, contracts), and resource strategies
5. Clear, organized structure with active participation from both parties
6. Shared interests and active communication between parties
7. Sustainability of plans and resources (e.g., funding, revenue)
8. Evaluation and improvement of practices and policies
9. Flexibility to changing priorities and funding environments

the standard of current care. There might be fiscal pressure to change (e.g., funding is running out for a program) or community pressure for change. Proponents of the partnership need to demonstrate that there is a comparative advantage over single-run systems or that the system has exhausted its efforts and needs to consider new avenues to address the problem. Interviewees from each of the case studies highlighted the importance of the clear overall goal (e.g., end veteran homelessness, help veterans find jobs) that sparked the initial interest in collaboration. Specific objectives might differ among the partnership participants, but partnerships are able to work together on reaching these within the confines of the overarching goal.

It is clear that despite the existence of quality behavioral health care for veterans at VHA facilities, veterans and their families are still experiencing behavioral health problems and report barriers to accessing care. Thus, veteran behavioral health needs warrant a new direction for targeted efforts that neither the public nor private entities alone can address adequately. For example, in 2010 the VA and HUD estimated that there were about 76,329 homeless veterans on the street on any given night, about one in 150 veterans were homeless, and about 17 percent of the homeless population were veterans (HUD, VA, and National Center on Homelessness Among Veterans, 2010). The growing shift to a “housing first” model in the nonprofit sector aligned with increased emphasis on ending veteran homelessness at the VA (VA, 2010; VA, 2014b) to open the door to more collaborative efforts, such as 100,000 Homes

(see example 1 from the case study interviews). The need for change exists at the local level as well. For example, Thresholds (see example 2 from the case study interviews) was founded decades ago when the need for a daytime “clubhouse” format of care for those with mental illness was evident in Chicago. Due to its assertive outreach programs, the organization noticed early on that the post-9/11 veteran population returning from conflict was becoming homeless and entering the criminal justice system, often due to untreated mental health conditions, sooner than their predecessors. To address this need, the organization designed a program specifically for veterans that resembled other Thresholds services but with peer-to-peer and trauma-focused elements.

Key Component 2: Leadership/Public-Sector Champion

The literature points to a key person or group of people within the public agency that takes the lead on creating the partnership. This appeared to be crucial for most of the interviewees we talked to; that is, in most cases there was clearly identified strong leadership from the public sector. This public figure served as a spokesperson to advocate for partnership and garner support within the public agency but also as a role model for the private partner. For example, Hiring Our Heroes (see example 3, from another case study interview) has garnered support from Michelle Obama and Jill Biden to lead the Department of Labor and Joining Forces into the partnership. Leaders were identified at both the federal and local levels by many of the interviewees. In one case, for the National Alliance on Mental Illness’s (NAMI’s) Family-to-Family program (see example 4, from another case study interview), a key leader began championing the partnership at a local VA and then, once she moved into a federal position, helped the program garner support at the national level.

Key Component 3. Support from Nonpublic Stakeholder Communities at the Regional and Local Levels

Just as support from the public agency is necessary, so is support from the nonpublic communities involved in the partnership. This includes stakeholder support from the nonpublic entity and engagement and buy-in from those affected by the partnership (e.g., employees who are expected to implement a change to the current system or work with new partners). Community leaders play an important role in gathering support

Example 1: Community Solutions and the 100,000 Homes Campaign

Public partners: VA, U.S. Interagency Council on Homelessness, HUD, various organizations at the local level

Private partners: Varies by local community

Population served: Homeless individuals (including veterans)

Model: Community Solutions founded 100,000 Homes in 2010 with the namesake aim of putting 100,000 chronically homeless people across the United States in permanent housing. The housing-first approach entails surveying homeless individuals on the street and in shelters to create and manage a registry to prioritize need for housing, which is determined through continued assessment of individuals’ illnesses, threats to their health, and the duration of their homelessness. 100,000 Homes community implementers then use the registry to link homeless individuals with housing and supportive services. To get participating communities up to speed and ensure fidelity to the model, Community Solutions ran boot camps to train local-level community implementers on processes and to discuss opportunities for customization and collaboration. The program accomplished its mission in July 2014, having placed 100,000 individuals in permanent housing.

Read more at <http://www.100khomes.org/>

Example 2: Thresholds and the Veterans Project

Public partner: Local VA Medical Centers (part of the VA)

Private partners: Various local (Greater Chicago area) and national partners

Populations served: Individuals living in Illinois with mental health needs (including veterans)

Model: Thresholds offers case management, housing, employment, education, psychiatry, primary care, and substance abuse treatment, among other services, to individuals in the Greater Chicago area (including the urban center, the adjacent suburbs, and McHenry and Kankakee Counties) suffering with mental health needs. The Veterans Project includes homeless outreach, housing services, supported employment, peer-driven supports, substance abuse treatment, integrated physical and mental health services, and trauma-based therapies. The Women Veterans Health Initiative provides a women-only “one-stop shop” for rapid housing placement, employment and education services, benefits linkage, trauma therapies, substance abuse treatments, child care, primary care, and psychiatry. In 2013, Thresholds served more than 6,700 adults and youths (veterans and nonveterans), with 75 percent of services delivered out in the community.

Read more at <http://www.thresholds.org/>

Example 3: U.S. Chamber of Commerce Foundation's Hiring Our Heroes

Public partners: U.S. Department of Labor, VA, National Guard Bureau

Private partners: Various local and national corporate and nonprofit partners

Populations served: Veterans, transitioning service members, and military spouses

Model: The program, which began in 2011, works with local and national employers through job fairs and gathers commitments from employers to hire veterans. The program reports that more than 1,700 businesses have pledged to hire nearly 450,000 veterans and their spouses as part of their Hiring 500,000 Heroes campaign, which is a three-year effort between the U.S. Chamber of Commerce Foundation and Capitol One to help find jobs for half of the projected 1 million service members separating from the armed forces in the next four to five years. The program's website offers resources, such as job search engines, webinars, and other career tools (e.g., résumé assistance), aimed at preparing individuals for work post-military. The program reports that it has helped more than 24,000 veterans and their spouses find jobs through the job fairs it hosts.

Read more at <http://www.uschamberfoundation.org/hiring-our-heroes>

Example 4: National Alliance on Mental Illness (NAMI) Family-to-Family/Homefront

Public partners: VA

Private partners: Various local and national corporate and nonprofit partners

Populations served: Individuals with mental illness and their caregivers (including veterans)

Model: NAMI offers two free programs in partnership with the VA that are designed to aid veterans and military families. The partnership began in 1998 at the local level (an Ohio VA Medical Center) and at the national level in 2005. Both are free multisession peer-to-peer training programs designed for loved ones of individuals living with mental illness, providing information about mental illnesses, their impact on the brain, current research on treatments, and skills and strategies for managing associated challenges. The first, Family to Family (F2F), is 12 sessions long, covers a range of mental illnesses, and was designated an evidence-based practice in 2013 by the Substance Abuse and Mental Health Services Administration. The second, Homefront, is a six-session cultural adaptation of the F2F model, focusing on PTSD and designed specifically for military families; it is being piloted in six states, with expected expansion. The VA contributes most significantly by providing referrals, as well as sometimes providing space in which to offer sessions. NAMI is able to provide services to both families and veterans whose discharge status may exclude them from receiving VA services. As of 2013, the Family-to-Family program has been presented 189 times in 114 different VA facilities in 49 states and the District of Columbia. In 2014, Homefront began the first round of presentation in the six states piloting the program (Illinois, Maryland, New York, North Carolina, Ohio, and South Carolina).

Read more at <http://www.nami.org/Find-Support/NAMI-Programs/NAMI-Family-to-Family> and <http://www.nami.org/Find-Support/NAMI-Programs/NAMI-Homefront>

from the local public, who often are affected in some way by the partnership. An example is the 100,000 Homes campaign, which began by conducting research on homelessness within the communities through observation, surveys, and interviews to gather accurate and relevant information about homelessness in particular areas. Thus, local community governments and law officials were needed to support this process. Another example is Hiring Our Heroes, which organizes large job fairs within communities. Advertising, permits for space, and other logistics are important considerations that require a degree of support from the community as a whole. Thresholds developed the Veterans Project using exclusively private funding; the partnership with the public sector developed later.

Key Component 4: Detailed Plans, Agreements, and Resource Strategies

Successful public-private partnerships develop a clear description of the plan for addressing the established need. They consider the risks in addition to the benefits likely to emerge from the partnership. They prepare ahead of time for complications that might arise and might develop a conflict resolution plan. There might also be a clearly defined revenue stream and

resources available to support partnership efforts. In more cases than not, there is a contractual agreement for a designated period of time. Some of the interviewees described formal contracts, while others reported that the agreements were less formal. NAMI, for example, described a series of three formal, national-level memoranda of understanding with the VHA to first encourage and later require (expected to be in place by 2015) each of the 23 VA Veterans Integrated Service Networks to offer or provide referral to Family-to-Family or Homefront. The VA is also required to educate patients and their families about the programs, maintain a list of classes and points of contact, assist with enrollment and printing some materials, and participate in monthly conference calls. NAMI provides the courses. For some, such as Hiring Our Heroes, agreements

(such as memoranda of understanding or memoranda of agreement) differed depending on specific partners. In some cases, such as Thresholds, there is no formal agreement.

Key Component 5: Clear, Organized Structure with Active Participation from Both Parties

Our examples suggested that the structure of the public-private partnership was typically established at the beginning of the relationship. There is usually a dedicated support structure and staff that monitor process, from the selection of the partnership to the evaluation of outcomes. At times with other public-private partnerships, there is a newly established group or subset of the current public agencies designated to work with the private entities. For example, NYC4Vets (see example 5 from the case study interviews) described a specific infrastructure used by both sides of the partnership. This includes a shared data platform and training opportunities available for employees as incentives for being part of the coordinated network. In other cases, however, there are not designated individuals to work between parties. For example, Thresholds uses the team approach to member care. This is because there is high turnover among social workers and Thresholds believes that a team can offer more than an individual in terms of specialties. In most of the cases we discuss here, as part of the agreements, there were formalized timelines and milestones as part of well-defined goals. For example, during job fairs hosted by Hiring Our

Heroes, the organization needs to coordinate the event with large numbers of public and private industries. Hiring Our Heroes reported that it is important to engage the stakeholders and designate clear roles, but also ensure that everyone gets to participate.

Key Component 6: Shared Interests and Active Communication Between Parties

Successful public-private partnerships are reported to draw on the strengths of both the public and the private entities so that both can work together toward a common goal (Ministry of Municipal Affairs, 1999). As with the first key component (catalyst for change/established need), the partners are clearly working toward the same overarching goal and thus have shared interests and investment in the success of the partnership. Specific objectives might vary, and interviewees discussed how, while these interests are often not conflicting, there is an understanding that both parties are also focused on their own objectives in the context of working collaboratively toward the mutual goal. For example, NAMI discussed how, since the VA has been focused on a recovery model of mental illness (VA, 2012), there was a need for NAMI to partner with local communities and organizations to assist veterans with severe behavioral health concerns (such as PTSD or severe mental illness [e.g., bipolar disorder, schizophrenia]) outside the VA clinics. The shared interests were to involve families and communities in a joint recovery model to assist the veteran in alleviating suffering, through community and family engagement and support. In addition, one interviewee said that each side of the partnership should be sensitive to statutes that the public agency must follow for its own purposes and reporting requirements. Thus, the organization celebrates what the agency is doing and determines how it can meet its objectives within what the public agency is already doing well, rather than highlighting the gaps and challenges and seeking to change the system entirely.

Another element of this key component is consistent and recurring communication between the collaborating federal institutions and private organizations. For example, NAMI holds monthly conference calls with the VA to continue active communication within both the national and local levels. However, this type of formal communication was not evident for all the interviewees with whom we talked. For example, there are no dedicated Thresholds teams for engaging with the VA, and engagement is less formal.

Example 5: NYC4Vets

Public partner: VA

Private partner: Institute for Veterans and Military Families at Syracuse University

Populations served: Homeless veterans and their families

Model: NYC4Vets, which began in 2013, was designed to implement a coordinated network of veteran and military family service, resource, and care providers. Through a designated administrative service organization (Services for the UnderServed) and with the assistance of an overarching technology platform to facilitate the work within the network, service providers collaborate and coordinate to enhance the provision of services for veterans and their families in New York City. The program now includes 36 pilot providers that span the scope of supportive services for veterans and their families in New York City's five boroughs. Each provider uses a single universal assessment or intake form, commits to sharing data, and has access to training and technical assistance.

Read more at <http://www.nys4vets.org/>

Key Component 7: Sustainability of Plans and Resources

Most partnerships are time limited by way of contracts and agreements, but there should be consideration of financial capacity for the long-term sustainability of efforts. That is, funding is typically needed for long-term support. For example, Thresholds was initially privately funded exclusively, which was not sustainable for the long term. Thus, the organization sought federal grant funds from the VA through an SSVF national housing program grant and is now 60 percent privately funded and 40 percent grant funded. NYC4Vets is also funded from the SSVF mechanism and followed a similar path, as it was originally supported only by a philanthropic grant from the Robin Hood Foundation. Also, 100,000 Homes discussed a model where it worked with the national and local governments as a partner and not just as a funder, the latter being the traditional approach. It reported that this partnership approach was very successful for achieving results and for ensuring the sustainability of the program. Thus, the very nature of the public-private partnership can lead to mission accomplishment and continued funding. As outcomes are observed by both parties, both become invested in the continuation and success of the partnership. As one interviewee mentioned, when one side sees the other investing in the efforts, it is motivated to invest as well.

It was also apparent that when the current agreements were concluded, most organizations had plans to continue the partnership to improve on the previous efforts. For example, the 100,000 Homes campaign has reached their goal of placing 100,000 individuals and families into permanent housing, and Community Solutions has now launched its Zero 2016 Campaign, in partnership with local communities, which seeks to end homelessness in all communities across the United States, including chronic and veteran homelessness. The campaign seeks to teach local communities to implement its approach and model (housing first and partnering with many organizations) toward this end goal.

There is also a potential cultural change in focus that was mentioned by interviewees and by others in the federal government: Public support of veterans could diminish in the wake of the drawdown of the current conflicts (OCJCS, 2014). Thus, nonprofit organizations and other programs directed toward meeting the wellness needs of veterans should prepare for the possibility of reduced community support over time. Hiring Our Heroes discussed this issue, reporting that it is seeing fewer veteran and service member promotions on the news and in

other media, and it needs more media attention to help ensure that companies are committed to veterans for the long haul and not just while the topic is popular. This is an area where private entities could play a key role—perhaps in garnering more public support, donations, and funding partners with other private entities. This idea also ties in with key component 8 (evaluation and improvement of practices and policies), which suggests that a program's solid performance evaluation plan (e.g., a publicly available report that shows that the program is working) might help with support of the program by private institutions and also by the general population.

Key Component 8: Evaluation and Improvement of Practices and Policies

Sustainability would be difficult if there were no evaluation of outcomes to determine whether the partnership was meeting its collective goals. Thus, it is important to ensure that the partnership is making an impact on the targeted systems or populations. Success can be objectively evaluated through performance measures agreed on by both partners based on observable objectives. Most interviewees discussed evaluation of outcomes as a major component of the partnership and a dimension of processes that was mutually agreed on as important. For example, NAMI discussed a proposed three- to four-page voluntary evaluation that would be given to its program participants as part of a collaborative research effort with academic partners. Hiring Our Heroes described the collection of survey data to get specific metrics of job fair impacts (the number of hires directly attributed to the event), with surveys to stakeholders (companies) and service members and veterans within 24 hours and then 30-, 60-, and 90-day follow-ups. Hiring Our Heroes also described collecting data from those who participate in the training programs to assess what needs each service member or veteran has at present and gathering data on trainees' competence in the different areas of the training content. In addition, 100,000 Homes tracks annual and monthly placements into permanent housing based on initial assessments of how many homeless people a community had and how many placements would need to be made to reduce this to zero within the allotted time. The strategy was defined by looking at the organization's targets and determining how long it had to meet that goal within each community. These data convey both a numerator and a denominator to federal agencies to show the relative impact of the organization's efforts to reduce homelessness. This approach also allowed 100,000 Homes to target resources to areas in greater need.

Key Component 9: Flexibility to Changing Priorities and Funding Environments

As the final key component, flexibility on both sides of the partnership appears essential. Partners need to be flexible in adapting to technological innovations, information technology, needs of the target population, funding environments, and changes to strategic objectives over time. For instance, 100,000 Homes noted that when public partners had reduced resources to commit to the program due to sequestration, public leaders were flexible and creative in finding ways to maintain program momentum. For example, to stay within reduced staffing hours and travel budget allocations during sequestration, public leaders alternated scheduled visits and leveraged video teleconferencing to attend meetings and stay apprised of local activities. Some of the interviewees discussed how changing objectives of the VA might affect their partnerships. That is, if the public partner institutionalizes a formal program that overlaps with the contribution from the private organization, the private partner could be phased out. Similarly, others discussed how the status of their partnerships was unclear after the agreements ended—primarily for those funded by federal grants that have a date when committed funds cease. Thus, the private organization needs to be flexible enough to pursue alternate partners and multiple sources of funding.

NEXT STEPS

As discussed, the President of the United States, DoD, and the VA have called for more public-private partnerships to address the health and wellness needs of veterans and their families. The literature suggests there is a great need for such partnerships, and models exist that can help inform their development and maintenance. However, more information is needed to guide the creation and sustainment of effective public-private partnerships. Thus, there are important next steps to consider. We propose the following next steps and recommendations (see Figure 2).

Establish a Clear Definition of a Successful Public-Private Partnership

A first course of action is to clearly define the core elements of a successful veterans' behavioral health–focused public-private partnership. This report proposes key components that might be necessary for successful partnerships, but formal evaluation

Figure 2. Next Steps for Public-Private Partnerships in Veteran Behavioral Health

1. Establish a clear definition of a successful public-private partnership
2. Conduct rigorous research on public-private partnerships
3. Adopt a continuous quality-improvement framework into public-private partnerships
4. Make clear funding allocations to evaluate programs and obtain data to support future sustainability efforts
5. Expand on established community-based public-private partnerships
6. Encourage organizations to seek out public-private partnerships to meet their goals

of these is warranted. For example, research is needed to determine the role of each of the nine key components of public-private partnerships on such outcome areas as longevity, costs, and fulfillment of goals, as compared with partnerships lacking all or some of these components.

Conduct Rigorous Research on Public-Private Partnerships

There is little published research on the effectiveness of public-private partnerships for veteran behavioral health, and the limited empirical work on public-private partnerships in general appears in peer-reviewed journals that are often not read by program implementers. Successful case studies described on websites or in news articles help illuminate how public-private partnerships have been used to change the current system and make improvements over time, but more-rigorous pre-post longitudinal studies (with or without control groups) are needed to better understand how public-private partnerships are meeting stated objectives and goals, incurring or exceeding expected costs, and sustaining improved outcomes over time. Although the program representatives we talked with in veteran behavioral health described numerous successes attributable to multiple factors, there are few published reports or peer-reviewed articles available to determine how the partnerships have objectively fared in terms of goal attainment, let alone the processes leading to positive outcomes. Additional research on public-public and private-private partnerships would also be beneficial, shedding light on how these partnerships have helped address

veteran behavioral health issues in their own right and how public-private partnerships can improve on outcomes obtained by single-sector partnerships.

Adopt a Continuous Quality-Improvement Framework into Public-Private Partnerships

An essential next step for public-private partnerships in the veteran behavioral health arena is to implement a continuous quality-improvement framework that relies on regular data collection, review, and data-driven action to determine whether such partnerships increase capacity to provide quality and cost-efficient care. This can first be done through evaluation of the current partnerships to learn how these approaches are being administered, how they are meeting organizational goals, and how they are affecting consumers, communities, and the partners themselves. Most of the partnerships described by the interviewees do collect data. However, it is unclear whether the right types of data are consistently being collected, and whether the data are utilized to their full potential once collected.

Programs typically collect data on “process” measures (e.g., the number of individuals served) for their own internal purposes, but they might or might not collect data on outcomes (e.g., whether those being served are experiencing improvements in areas of need—that is, whether they are being helped as a result of the program). We recommend that programs consistently collect outcome data related to behavioral health and related goals (e.g., reduced symptoms, improved functioning, placement in permanent housing, long-term employment). Furthermore, we recommend that once appropriate outcome data are collected, they be used for both quality improvement and program evaluation.

Programs might build internal capacity for evaluation, or the partnerships themselves might consider partnering with an academic or research institution or consulting agency to conduct independent, objective evaluations of outcomes for public release. We caution that an evaluation plan spanning two institutions might be particularly challenging, since it might involve coordination of data systems and staff; it might also necessitate engaging government agencies that oversee services on the ground to arrange for the necessary information sharing. To further support evaluation efforts, several agencies, including civilian (e.g., the Substance Abuse and Mental Health Services Administration) and DoD (e.g., the Defense and Veterans Brain Injury Center, the Defense Centers of Excellence, the VA), have promoted or developed metrics to describe the coor-

dination and integration of services across medical specialties (including behavioral health) that could lay the foundation for similar metrics that might be useful in describing the strength and utility of behavioral health–focused partnerships.

Make Clear Funding Allocations to Evaluate Programs and Obtain Data to Support Future Sustainability Efforts

While data collection is important, decisions to fund program evaluation and research efforts should be discussed during the development stages of a public-private partnership to ensure that there is adequate funding dedicated to objectively evaluating the success of the program. Objectively measured success can support applications for further funding to continue the efforts of the program and meet the long-term goals of the partnership.

Expand on Established Community-Based Public-Private Partnerships

As described within this report, success stories do exist for public-private partnerships in the veteran behavioral health field. For example, the VHA and DHHS are partnering with local communities to improve access to care services for veterans in those particular communities. While promising at the local level, there is also a place for public-private partnerships expanding beyond individual communities to tackle issues on a regional and national level. That is, in addition to communities partnering with local VA sites, the VHA at the federal level could partner with regional and national private organizations to increase access to care for veterans and their families by using successful models at the community level to improve and expand on the reach of the public-private partnership. Likewise, targeted communities might be small and rural and thus require targeted efforts to address access to care barriers among those in remote places (e.g., the use of telemedicine and integrating specialty behavioral health care into primary care settings) (Brown et al., 2015). However, the approaches that can be used to reach out to rural veterans (e.g., telemedicine) might also be attractive to veterans in large cities. Proximity to care does not directly translate to receipt of care. Thus, a partnership between the VHA and DHHS in urban communities where there are large concentrations of veterans (e.g., San Diego, Houston, and Miami in the 25 Cities Initiative) could promote use of approaches traditionally meant for remote populations.

Encourage Organizations to Seek Out Public-Private Partnerships to Meet Their Goals

There has been a clear call for public-private partnerships from researchers and experts in veteran behavioral health, federal agencies, and President Obama himself. Indeed, the call for such public-private partnerships comes from the public side, regarding how the private sector can alleviate some of the federal burden or address veterans' needs that are not being met by federal agencies (e.g., involving community providers to address long wait times at some VA clinics). However more encouragement of public-private partnerships from the community organizations themselves might help those in the private sector see the benefit in pursuing such partnerships. Learning from others' successes through media attention can help encourage organizations to seek out their own public-private partnerships to meet their goals. Having a more formal forum where staff and leaders from successful and developing public-private partnerships can share stories, provide or seek advice, or receive feedback on new ideas can provide a supportive network where organizations can learn from each other about how best to establish and sustain partnerships. The key components discussed in this report represent an important starting point for public-private partnership development, but directly reaching out to the staffs of organizations on both sides of public-private partnerships might provide even more direction and encouragement toward partnership development. Collecting and reviewing both interview and survey data from both partners might provide a more in-depth portrayal of how each sector views the partnership and the factors that it attributes to its success.

Lastly, it will be important for public-private partnerships to develop in areas beyond homelessness, employment, and care for the critically ill—areas where most public support and

federal efforts are targeted. There is a place for public-private partnerships in many areas related to veteran behavioral health, including, among others, transition preparedness, early access to care (i.e., *prevention* in addition to *intervention*), and the creation of culturally competent and clinically sound care among providers in the community. Partnerships focused on prevention, early intervention, and clinical care can follow our proposed key components and next steps to establish and sustain efforts.

CONCLUSION

An increasing number of veterans and their families are struggling with behavioral health problems; addressing these concerns is a national priority. The creation and expansion of public-private partnerships have been suggested as methods to help overcome barriers to care and meet the needs of this population. Much can be learned from successful public-private partnerships, both within and outside the veteran behavioral health area. The intent of this report was to inform how the field considers public-private partnerships by reviewing their current evidence base and then offering nine key components that characterize effective partnerships. We recommend additional study of the key components, as well as the evaluation of established and developing public-private partnerships to assess key outcomes. We call for the broad dissemination of key findings to fill current evidence gaps. We also encourage policymakers in the federal government (including the VA and DoD) and in private entities to work together to develop evidence-informed public-private partnership models, and then evaluate them to effectively expand behavioral health services for veterans and their families.

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