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Suicide and Life-Threatening BEHAVIOR

ORIGINAL ARTICLE

Designed and created for a veteran by a veteran: A pilot study of caring cards for suicide prevention

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Abstract

Introduction: This pilot study investigates feasibility and acceptability of Caring Cards, a suicide prevention intervention inspired by Caring Contacts and the Recovery Model, where Veteran peers create cards that are sent to Veterans recently discharged from a VA psychiatric hospitalization for suicide risk.

Methods: Caring Cards consists of: (1) a weekly outpatient group where Veterans (card makers) create cards, and (2) sending cards to recently discharged Veterans (card recipients). Feasibility for card makers was measured by attendance; acceptability (satisfaction) was examined. Card recipients were sent one caring card, one week post-discharge. Feasibility for recipients was measured by the percentage of Veterans that met eligibility and follow-up response rate; acceptability (satisfaction) was examined.

Results: Caring Cards is feasible and acceptable. The outpatient group had a higher attendance rate (81%) compared with other clinic groups. The percentage of eligible card recipients was 61%. Of these, 69% were reached for follow-up and 50% provided follow-up responses. Card makers and recipients both expressed positive experiences with Caring Cards.

Conclusion: Caring Cards is a low-intensity, feasible, and acceptable intervention with potential benefits for both Veteran card makers and recipients. Additional research is needed to determine the efficacy of Caring Cards as a suicide prevention intervention.

KEYWORDS
veterans, caring cards, suicide prevention

INTRODUCTION

From 2005 to 2016, Veteran suicide rates have risen 26% (Department of Veterans Affairs, 2018) despite increased prevention efforts. There is a great need to develop, evaluate, and implement interventions that prevent Veteran suicide. This is particularly true for the weeks following psychiatric hospitalization, as Veterans are at increased risk for suicide within the first 12 weeks post-discharge (Valenstein et al., 2009). Caring Contacts is a suicide prevention intervention (Motto & Bostrom, 2001) that has been widely used across a variety of settings, populations, and nations (Beautrias et al., 2010; Carter et al., 2005, 2013; Hassanian-Moghaddam et al., 2011), as well as with U.S. active duty servicemembers and Veterans (Comtois et al., 2019; Luxton et al., 2020) during this high-risk period. Relatively simple in design, Caring Contacts are short messages composed by hospital or research staff that express well wishes. Typically, Caring Contacts are

sent to patients post-discharge; however, they have recently been used with outpatients without a recent admission (see Comtois et al., 2019). Since its inception, Caring Contacts has taken many forms, including letters (Motto & Bostrom, 2001), postcards (Carter et al., 2005; Hassaian-Moghaddam et al., 2011), emails (Luxton et al., 2020), and text messages (Comtois et al., 2015, 2019; Larsen et al., 2017).

Empirical studies of Caring Contacts have yielded mixed results on suicide prevention. Some studies demonstrate reductions in outcomes such as suicide rates and re-hospitalization (Carter et al., 2005, 2013; Hassanian-Moghaddam et al., 2011), expenses associated with suicide (Carter et al., 2005, 2013; Denchev et al., 2018), as well as worst suicidal ideation and suicide attempts at 12-month follow-up (Comtois et al., 2019). The general efficacy and effectiveness of Caring Contacts have been supported by two systematic reviews and a meta-analysis (Luxton et al., 2013; Milner et al., 2015). However, some individual studies examining suicide-related outcomes such as current suicidal ideation, medical evacuation due to suicidal behavior, inpatient admissions (Comtois et al., 2019), suicide attempts, readmission, rate of readmission after initial enrollment (Luxton et al., 2020), and frequency of emergency department visits (Beautrias et al., 2010; Comtois et al., 2019) found no significant differences between Caring Contacts and usual care. Given this body of results, it is evident that Caring Contacts is a promising, low-intensity suicide prevention intervention with room for improvement.

To refine the use of Caring Contacts with Veterans, Veterans' preferences, such as message type (e.g., email, letter), content, and composer, were systematically examined (Reger et al., 2018). Results found the majority preferred monthly letters with patriotic imagery from providers they have previously met or worked with (e.g., mental health providers) (Reger et al., 2018). Importantly, Veterans also indicated interest in receiving a letter from an unknown peer (Reger et al., 2018), underscoring the potential value of combining peers and Caring Contacts.

We are aware of only two studies (unpublished) that have used Veteran peers to create Caring Contacts. The first is the present study (preliminary results were shared as a poster presentation under primary author's maiden name; see Schembari & Perivoliotis, 2018). The second (shared as an oral paper presentation; see Carter, 2019) used a non-clinical sample and focused on teaching Veterans at a local Vet Center how to write caring letters to peers. Across both studies, feedback from peer card makers/letter writers suggested their involvement was purposeful and personally helpful. Including peers as message writers may increase the efficacy and effectiveness of Caring Contacts for recipients, as well as benefit the peer composers.

There is strong empirical support for the use of the peers (i.e., persons with lived mental health experience) in mental health recovery (Repper & Carter, 2011). Peer involvement has demonstrated significant reductions in mental health relapse (Forchuk et al., 2005), isolation (Yanos et al., 2001), and self-stigma (Ochocka et al., 2006), as well as increases in hope (Davidson et al., 2006), empowerment (Corrigan, 2006; Resnick & Rosenheck, 2008), and involvement in and satisfaction with mental health care (Chinman et al., 1999; Hodges et al., 2003). Using their lived experience with mental health concerns, peers challenge stigmas, help patients integrate into their communities, and become more active participants in their own care (Chinman et al., 2015). Studies examining the use of Veteran peers in VA settings emphasize their role in the facilitation of mental health services (e.g., recovery groups, adjunctive support to mental health care) (Alicock et al., 2013; Jain et al., 2012; Resnick & Rosenheck, 2008), and as members of intensive case management teams (Chinman et al., 2015).

Caring Contacts offers a promising opportunity for the inclusion of peers as message writers. This is particularly true for Veterans, as their unique camaraderie may strengthen the intended support of the caring message. As such, the current study evaluates the feasibility and acceptability of a new, peer-centered Caring Contacts intervention called Caring Cards (see Ehret, 2020 for treatment manual; Schembari & Perivoliotis, 2018). Caring Cards is designed to both increase the efficacy of the messages received by Veterans to reduce suicide risk and reduce risk among a new population, the Veteran card makers themselves.

Inspired by Caring Contacts (Motto & Bostrom, 2001) and the Recovery Model (Davidson et al., 1997; Ramon et al., 2007), which promotes patient-centered care, stigma reduction, empowerment, hope, socialization, and independent functioning (Winsper et al., 2020), Caring Cards employs a novel adaptation of traditional Caring Contacts by utilizing Veteran peers with lived mental health experience as card makers (generators of both artistic and written content). In Caring Cards, Veterans compose messages of hope and unity by hand-making one-of-a-kind cards in a weekly outpatient group. These cards are then sent to their peers who have been identified to be at increased risk for suicide (e.g., post-discharge from a suicide-related inpatient stay). Caring Cards is unique in that it simultaneously targets two clinical populations and, is the only form of suicide prevention that was originally developed with Veterans with serious mental illness (SMI). This pilot study evaluated the feasibility and acceptability of the Caring Cards intervention in an open trial.

MATERIALS AND METHODS

Participants

Two distinct participant groups of Veterans, card makers ($n = 7$) and card recipients ($n = 18$), were included in this

study. All Veterans were receiving mental health services at the VA San Diego Healthcare System (VASDHS). The study was approved by local VA Human Research Protection Programs. Table 1 describes sample characteristics.

Card makers

Card makers were all active members or alumni of the VASDHS' Psychosocial Rehabilitation and Recovery Center (PRRC). The PRRC's inclusion criteria include the following: (1) a diagnosis of a primary psychotic disorder and (2) serious functional impairment, defined as a Global Assessment of Functioning score of 50 or below. Veterans are excluded from the PRRC if they exhibit behaviors that would significantly impair their learning or disrupt learning for other Veterans (e.g., due to a primary or untreated substance use disorder, serious personality disorder, or dementia). No additional inclusion/exclusion criteria were defined for participation as a card maker. Veterans were recruited to join the Caring Cards group by their PRRC treatment providers. The group was generally described as an opportunity to connect with others and give back to their Veteran peers struggling with mental health concerns by creating one-of-a-kind cards.

We examined feasibility (i.e., group attendance) and acceptability (i.e., satisfaction) outcomes for card makers from February 2018 to October 2019. Card maker satisfaction was examined at two time points, May 2018 ($n = 7$) and June 2019 ($n = 3$). Only unique responses were analyzed.

TABLE 1 Sample characteristics

	Card makers	Card recipients
	Percent (*n*)	Percent (*n*)
Gender		
Male	87.5% (28)	85.7% (36)
Female	12.5% (4)	14.3% (6)
Race		
American Indian or Native Alaskan	3.1% (1)	0.0% (0)
Asian	6.3% (2)	2.4% (1)
Black or African American	9.4% (3)	19.0% (8)
Native Hawaiian or Pacific Islander	3.1% (1)	2.4% (1)
White	68.7% (22)	66.7% (28)
Declined to answer	9.4% (3)	9.5% (4)
Ethnicity		
Hispanic or Latino(a)	25.0% (8)	26.2% (11)
Not Hispanic or Latino(a)	71.9% (23)	69.0% (29)
Unknown	3.1% (1)	4.8% (2)
Branch of Service		
Air Force	6.3% (2)	7.1% (3)
Army	43.7% (14)	45.2% (19)
Army National Guard	0.0% (0)	4.8% (2)
Coast Guard	3.1% (1)	2.4% (1)
Marine Corps	12.5% (4)	14.3% (6)
Navy	34.4% (11)	26.2% (11)

Card recipients

Card recipients consisted of Veterans discharged from the VASDHS' psychiatric inpatient unit from April 2019 to June 2019. Veterans were identified as potential recipients by the unit discharge coordinator based on the presence of a viable mailing address and telephone number. Veterans' electronic health records were reviewed for eligibility based on the inclusion criterion of admission due to suicidal ideation or behavior. Veterans provided verbal consent to answer follow-up questions about their experience receiving the card. Feasibility (i.e., percentage of Veterans who met eligibility criteria and the telephone follow-up response rate) and acceptability (i.e., card recipients' feedback) were evaluated.

Procedures: caring cards group

Specific procedures for the Caring Cards group are outlined in its treatment manual (Ehret, 2020). For the present study, the Caring Cards group met once per week for 90 min. Groups were facilitated by one to two PRRC staff and/or trainees (doctoral or Master's-level clinicians). Group members (card makers) were the creative decision-makers and received minimal guidance about card production. At the initial group meeting and upon the arrival of a new participant (Caring Cards is an open group and new participants were invited to join at any time), the rules (e.g., limits of confidentiality), format, and purpose of the group, as well as general rules for making cards (i.e., keep content neutral to sex, military branch, age, religion, and political affiliation, and no profanity), were reviewed.

Card makers were instructed to focus on using their lived experience to create and communicate positive messages for Veterans who had recently been hospitalized due to suicidal ideation/behaviors. To help elicit this, the facilitator asked Veterans to "think of a difficult time you experienced; what message would you have wanted to see that would have been helpful to you at that time?" Veterans collaboratively designed the card covers (see Figure 1) and generated all messages and artwork inside each card (see Figure 2); art supplies were provided. The phrase, "Designed and created for a Veteran by a Veteran," was printed inside each card; the

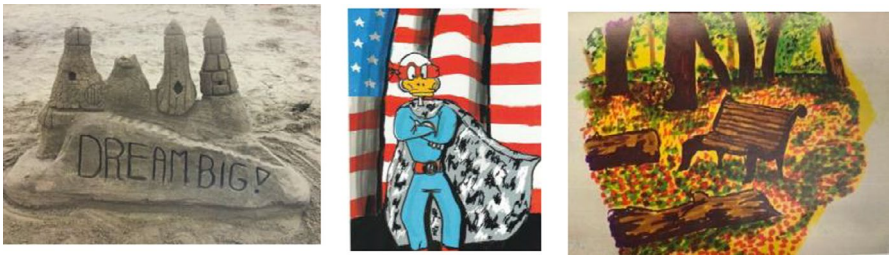

FIGURE 1 Examples of Veteran designed Caring Card covers [Colour figure can be viewed at wileyonlinelibrary.com]

FIGURE 2 Examples of Veteran created Caring Cards messages [Colour figure can be viewed at wileyonlinelibrary.com]

back contained local and national resources for mental health crises. All cards (blank cards with Veteran designed covers) were printed by the VASDHS' reproduction department.

Card maker feasibility (i.e., group attendance rates and number of Veterans served) data were extracted from VA electronic medical records. Acceptability (i.e., group members' feedback) of the group was surveyed at two time points. At each time point, participants were asked a mix of open and closed-ended questions: (1) *Would you recommend this group to other Veterans?*, (2) *Has this group positively impacted your life?*, (3) *How long would you like to stay in this group?*, and (4) *Do you believe this group should become a permanent offering in the clinic?* Veterans were also provided extra space to offer specific feedback about the group.

Procedures: sending cards and card recipient feedback

Card recipients were mailed one caring card approximately one week following their discharge. Each card was reviewed to ensure they did not contain inappropriate content (as defined above). A letter was included with the card, briefly stating the reason they were receiving the card (i.e., recent hospital visit) and who made the card (i.e., "a fellow Veteran"). The letter informed them that a provider would be calling them to obtain their feedback. The primary investigator's telephone number was provided. Card recipients' feedback was collected via telephone by a doctoral-level VA provider approximately 10 days after their card was sent. Veterans gave verbal consent to provide feedback and were asked 10 open-ended questions related to their experiencing receiving the card (e.g., impact of card on mental health recovery, positive and/or negative aspects of the card, desire to receive more cards, and/or be involved in creating cards). See supplemental materials for the full list of questions. Veterans' responses were transcribed verbatim. Three telephone attempts, within approximately two weeks, were made before a Veteran was determined to be unreachable.

Statistical analyses

Feasibility for the Caring Cards group was determined by calculating the attendance rates for all therapy groups that occurred in the PRRC during the same 18-month time period. A one-sample *t* test was used to determine whether the Caring Cards group attendance differed significantly from the other PRRC therapy groups that occurred during the same time period. For card recipients, feasibility data were calculated as the proportion of Veterans who met eligibility criteria and telephone follow-up response rate. Acceptability for card makers and recipients were examined based on Veterans' qualitative response to the satisfaction questions described above.

RESULTS

Sample description

The average age for card makers was 49.00 years ($SD = 14.25$), and card recipients were 44.79 ($SD = 15.34$).

Feasibility of the caring cards group

A one-sample *t* test determined the attendance rate of the Caring Cards groups was significantly different from the average attendance rate of the other PRRC groups that occurred

TABLE 2 Card makers' recommendations to other Veterans

Would you recommend this group to other Veterans? Why or why not?	
"Yes" responses	"No" Responses
"Because it allows for a safe, secure place to be with other Veterans going through like or similar life challenges that are not judgmental."	None
"We are given a chance to express kindness, compassion, hope that may help another Vet. The friendships that I established are absolutely life enhancing."	
"Helps to socialize with others."	
"Because it can be creative."	
"I have; it's fun and mentally helpful."	
"Group is great."	
"Yes, it's a very exciting part of my week."	

during the same 18-month time period. The Caring Cards attendance rate (81.0%) was significantly higher than the average attendance rate of the other groups (76.1%; $t(24) = 2.93$, $p = 0.007$). Note, this test considers the Caring Cards attendance rate as the population value since no there were no other Caring Cards groups in existence. Meaning, the significant finding is relevant to the context of the PRRC included in this study and does not necessarily generalize beyond this specific PRRC. Until more Caring Cards groups are deployed, and data are collected further inferential tests are not possible.

Acceptability of the caring cards group

Group members' satisfaction was surveyed at two time points (May 2018, $n = 7$; June 2019, $n = 3$). All 10 Veterans surveyed (100%) said they would recommend this group. When asked if the group has positively impacted their lives, the majority (90%) said "yes"; one Veteran did not answer this question; none said "no." The majority (90%) said they believed this group should be a permanent clinic offering. When asked how long they would like to stay in this group, the majority (50%) said "other"; four Veterans wrote in an undetermined amount of time (e.g., "forever," "ongoing") and one said, "not sure." Other Veterans indicated they would like to participate in the group for "more than 6 months" (10%), "4–6 months" (10%), and "1–3 months" (30%). None said they would like to stay in the group for "less than 1 month." Tables 2–4 report a sample of qualitative responses from the card makers surveyed across both time points.

Feasibility of sending caring cards

Over two months, a total of 78 Veterans were screened for inclusion and 48 were eligible (61%). A total of 46 cards were sent (two Veterans were hospitalized and discharged twice during this timeframe). Five cards were returned due to incorrect mailing addresses; five Veterans were readmitted to the hospital. We attempted to reach the remaining 36 for telephone follow-up. Of these, we reached 25 (69%) and collected follow-up responses from 18 (50%); six were unable to provide feedback due to not receiving their cards yet and one declined to respond.

Acceptability of sending caring cards

A total of 18 Veterans completed follow-up interviews. All respondents (100%) said receiving the card was a positive experience (see Table 5 for qualitative responses). A total of 14 (77.8%) said the card had an impact on their experience following discharge and recovery (see Table 6 for qualitative responses). A total of 16 (88.9%) denied any negative aspects to receiving the card; however, one Veteran questioned their privacy (i.e., asked if the card makers knew who they were; interviewer confirmed their anonymity) and another mentioned they felt some negative emotions, as receiving the card reminded them of their hospitalization. When asked if they had any suggestions for Caring Cards, eight Veterans (44.4%) said "yes"; see Table 7 for suggestions. The majority said they would like to receive additional cards (83.3%). Regarding the frequency of receiving additional cards, most suggested receiving them every few months/quarterly (50.0%), followed by monthly (35.7%), one suggested to send them "whenever possible," and another said to send them weekly. Only four commented on how long they would like to receive additional cards, with 50.0% suggesting more than one year and the other 50.0% suggesting less than one year.

All respondents (100%) recommended the VA continue sending these cards following discharge. When asked if they would like to make cards for other Veterans, the majority said "yes" (61.1%), followed by "no" (27.8%), and "unsure" (11.1%). The majority said they will keep their card (88.9%); one said they had thrown it away, and another said they were

TABLE 3 Impact on card makers' lives

Has this group positively impacted your life?	
"Yes" responses	"No" Responses
"Something to look forward to."	None
"Made friends."	
"Helped me start socializing again."	
"It has made me appreciate my life and freedom a lot more."	
"It has allowed me a first step into a group social life and time to reflect that I am not alone with my symptoms, negative experiences, troubles, upheavals, and successes in group and individual sessions."	

TABLE 4 Card makers' feedback

Please provide any specific feedback you have about the Caring Cards group.
Notable Responses
"[this group should be] mandatory because cards, crayons, and colored pens and pencils are a whole lot better than chemical treatments ('meds'), which are o.k. but not the best."
"I really enjoy the group a lot especially coloring cards for other Veterans who receive cards. I really look forward to the group at the beginning of the week."
"I love the group; I love the staff; I love the other Veterans."
"It is fun to draw and color and to write positive words."
"It has helps me step outside of myself."
"I'm putting a lot of myself into the cards and that's really helping me - by focusing on the cards it's helping me see I didn't make a mistake when I came for help."
"Brings Veterans closer."
"I've been hospitalized before; I can see how these [card] will help."
"Illustrated where you've been and how far you've come."

unsure if they would keep it. For those that said they will keep their cards, the majority said they will keep it forever or did not plan to get rid of it (37.5%), followed by 31.3% who said they were unsure. One said they would keep it for a few months; four did not comment on the how long they would keep the card. Lastly, all (100%) gave permission to be contacted in the future.

DISCUSSION

This pilot study indicated that Caring Cards is a feasible and acceptable intervention for both Veteran card makers and recipients. Over 18 months, the Caring Cards group had high attendance (81%), which was significantly greater than other groups within the same clinic. Acceptability of the Caring Cards groups was strongly supported. Group members shared positive feedback, highlighting themes such as connecting with other Veterans, establishing friendships, feeling safe, having an outlet to creatively express themselves, and personally benefitting from making the cards. Importantly, several of these reported aspects, such as feelings of belongingness, may mitigate suicide risk (Van Orden et al., 2010). Feedback was consistent with Veterans' responses to Carter's (2019) peer-centered caring letters pilot.

Overall, card recipients expressed strong positive experiences related to receiving their cards. Based on their qualitative feedback, several themes emerged, including feeling reassured and as though someone cared, experiencing improved motivation/behavioral activation, interest in making cards for other Veterans, desire to connect with the Veterans who made their card, and interest in receiving more cards emerged. Similarly to the card makers' qualitative responses, several of these reported themes may reduce suicide risk, such as feeling cared for and connected to others (Van Orden et al., 2010), as well as behavioral activation (Malone et al., 2000).

Feedback from the card recipients builds upon Reger et al., (2018) findings that Veterans are interested in receiving a caring contact from a peer and have positive feelings toward the inclusion of imagery with these messages. Reger et al., (2018) found Veterans had a slight preference toward receiving letters compared with postcards, greeting cards, and other forms of caring contacts. However, the option to receive a caring card (i.e., a one-of-a-kind, handmade card from a peer) was not available in that study.

Largely, sending caring cards is feasible; however, some barriers were noted, such as difficulty reaching Veterans by phone, cards not delivered before follow-up, and cards having been returned due to incorrect mailing addresses. Card recipients were not initially consented prior to being sent a card; it is possible not knowing they would receive a card and follow-up phone call contributed to follow-up challenges. The majority of card recipients regarded receiving a caring card as a highly positive and meaningful experience. Future studies should examine Veterans' preferences for Caring Cards versus traditional Caring Contacts.

Value of caring cards

Caring Cards has several strengths. Perhaps the most salient is its use of Veteran peers currently receiving mental health care. Although peers are widely used within VA, the inclusion of them in the creation of Caring Contacts is new. Caring Cards is the first intervention to combine peers and Caring Contacts with VA. The present study demonstrated that Veteran peers are highly capable of creating hope-filled cards, and the recipients

TABLE 5 Card recipients' positive experiences

Was receiving the card a positive experience? Why or why not?	
"Yes" responses	"No" Responses
"It made me feel like someone was thinking of me; that somebody cared."	None
"Yes, because it is reassuring that everything will be okay."	
"Yes, it was. It was positive because it showed concern, it showed care. Although I have my moments of depression, it gave me views in life that you know, that you guys care. And I appreciate that."	
"Yes. Just having another Veteran think of me, or write something nice like that, it said "take your wings and fly" with the VA symbol, it was really nice after being in the hospital, sort of like being cared for."	
"Very positive, I am a combat Veteran with PTSD, receiving the card let me know that they care about us, united."	

felt connected to and understood by their peers. Peer connection may be especially valuable for Veterans, who may believe civilians cannot understand their experiences; thus, the acceptance and support of other Veterans may be irreplaceable in their mental health recovery process.

Caring Cards is also unique in that it simultaneously benefits two populations at increased risk for suicide. Card makers reported experiencing personal gains and improvements in their mental health from being involved in the group, underscoring that Veterans with SMI, specifically schizophrenia spectrum disorders, can experience important benefits while also meaningfully contributing to the well-being of others. In addition, the positive experience of helping another Veteran may lead to reductions in self and societal stigma. Card recipients also reported strong positive experiences receiving the cards, highlighting feelings of being cared for and connected to their peers, as well as experiencing increased motivation and behavioral activation. Given these encouraging responses, Caring Cards may also improve Veterans' perceptions of VA care post-discharge, as well as increase satisfaction with VA services and improve VA mental healthcare engagement.

Furthermore, a recent editorial on suicide-specific interventions for military and Veteran populations identified four important aspects that current evidence-based suicide prevention interventions are lacking (Hoge, 2019). The Caring Cards intervention addresses two of these aspects—increased "community-based supports," (p. E2) and "reaching those that may not be willing or able to receive other mental health care" (p. E2). Veterans' responses in this study suggest that Caring Cards improved their sense of connectedness; a lack of connectedness has been posited as a contributing factor to increased Veteran suicide rates that Hoge (2019) also suggested should be prioritized. Even as a relatively new approach, Caring Cards' methodology is unique and targets a growing need for novel suicide prevention interventions.

Clinical implications

Caring Cards is a low-cost, highly scalable, and potentially high-impact intervention for suicide prevention and personal recovery among Veterans. Similar to Caring Contacts, Caring Cards is relatively simple to implement. The group does not require an advanced provider to facilitate it (e.g., doctoral-level). Indeed, in a recent quality improvement project, a social work trainee successfully developed and piloted a peer-led Caring Cards group, where current Caring Cards group members taught Veterans at the VASDHS' domiciliary how to create caring cards.

Furthermore, Caring Cards does not require a significant amount of funds or resources to implement. All supplies, including art supplies and card printing, and mailing costs were provided by VA. Since the development of this group in 2018, two additional VA San Diego clinics have started their own Caring Cards groups, indicating the ease of dissemination and implementation, as well as provider, Veteran, and VA support of Caring Cards. Although the present study demonstrates the use of a Caring Cards group within a VA PRRC, given the establishment of this group in other mental health clinics, there is strong potential for Caring Cards to generalize to other VA clinics, reaching new Veteran populations (e.g., general mental health, PTSD, substance use, inpatient, palliative care units).

Limitations

The present study has several limitations. First, the small sample size and use of one VA hospital greatly restrict the generalizability of these results. Larger studies will determine whether these results are able applicable to Veterans more broadly. Second, Veterans' responses may have been biased, as card makers and recipients may have responded favorably toward Caring Cards to please the data collectors. Finally, given our limited follow-up response rate for card recipients, it is possible the Veterans that were not reached may have provided different feedback from those who were.

Future directions

Establishing the feasibility and acceptability of Caring Cards was an important initial step. Further study is needed

TABLE 6 Card recipients' experience following discharge

Has receiving the card had any impact on your experience after being in the hospital and your recovery? Why or why not?	
"Yes" responses	"No" Responses
"Yes, because I have it on my fridge and I read it sometimes to give me more reassurance."	"No, I don't think so. It just something nice to get. Whoever it was who did the inside, I hoped it helped him. Or her! It gave me a smile but I don't think it was transformative, in any way."
"I mean, it did have an impact. I think it would have an impact on anybody who has common sense. It was card that was to be appreciated. You showed care, and concern. There was love. It was like having support."	
"It made me feel like I'm not alone."	
"It helped me with my recovery. It kind of boosted my feelings, or my… trying to find the right word… feeling like being a part of the family again. Like having brothers, or being a part of a group. There are times I don't feel like a Veteran, because I never deployed. so this brought me into that. It made me feel accepted."	
"Absolutely, considering that it's one of the first things I see in the morning. It's one of thing that's helps me get up in the morning. So it's made a big difference."	

TABLE 7 Card recipients' feedback

Please provide any specific feedback you have about this program.
Notable Responses
"This card can actually have a positive impact. I appreciate that you are healing the Veterans in the hospital and I hope it's helping."
"Great job, and great service. I'm alive because of you."
"I just liked it and it made a good impact on me."
"No, I think you guys are doing a great job, so keep up the good work."
"Not really, it was really nice and it caught me off guard; it was the most positive thing out of everything else. This was better than the post-discharge calls because I don't have to relive my experience at the hospital."
"Honestly, the simple fact that you started this program- it's made a big difference. Just on me! I can't say I can suggest anything, because it seems like the card message is personal in that sense- it's kinda like, I'm receiving a card from someone I don't know but they're willing to take the time out of their day because they've been there. I've been going through a lot of loneliness and pain- receiving a card made me feel less alone. A lot of that. It has me running every morning! It's helped me quite a lot. The running is definitely helping, and definitely one thing I could suggest- in the card, say 'go the get some sun'- the card had a sun on it with a smiley face, and it reminded me that I'd been indoors for several days, and my depression was getting worse, so it was a reminder that I'm probably getting pale and going outside and getting some sun is a good idea."

to understand the utility of Caring Cards as a suicide prevention intervention and determine its generalizability to other Veteran populations and VAs. Future empirical investigations of Caring Cards should also include large-scale, randomized controlled trials. Additional avenues worthy of study could address questions including the use of Caring Cards with non-clinical or non-Veteran populations (e.g., first responders creating cards for their peers), integrating technology (e.g., digital cards, virtual Caring Cards groups), exploring recipient preferences and suicide-related outcomes for traditional forms of Caring Contacts (i.e., general staff-written letters, postcards) compared with Caring Cards (i.e., peer-developed, one-of-a-kind cards), and examining Caring Cards as a tool for treatment engagement or re-engagement.

CONCLUSIONS

Caring Cards is a promising intervention that is feasible and acceptable; Veterans with mental illness experience Caring Cards as helpful, personally enriching, and beneficial to their mental well-being. Caring Cards may allow Veterans with mental health concerns to foster their own recovery by contributing to their peers' well-being, creating a dual intervention that benefits two at-risk groups simultaneously. In response to the Caring Cards intervention, both card maker and recipients identified experiences that may mitigate suicide risk, such as social connectedness (Van Orden et al., 2010) and improvements in behavioral activation (Malone et al., 2000). If efficacy is established, Caring Cards may be an enhanced alternative to traditional Caring Contacts.

DATA SHARING AND AVAILABILITY

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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CONFLICT OF INTEREST

The authors do not have any conflicts of interest to disclose.

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REFERENCES

Allicock, M., Haynes-Maslow, L., Carr, C., Orr, M., Kahwati, L. C., Weiner, B. J., & Kinsinger, L. (2013). Training veterans to provide peer support in a weight-management program: MOVE!. *Preventing Chronic Disease*, *10*(185), 2–9.

Beautrais, A. L., Gibb, S. J., Faulkner, A., Fergusson, D. M., & Mulder, R. T. (2010). Postcard intervention for repeat self-harm: Randomised controlled trial. *British Journal of Psychiatry.*, *197*(1), 55–60.

Carter, G. L., Clover, K., Whyte, I. M. et al (2005). Postcards from the EDge project: Randomised controlled trial of an intervention using postcards to reduce repetition of hospital-treated self-poisoning. *British Medical Journal*, *5*(331), 805–807.

Carter, G. L., Clover, K., Whyte, I. M. et al (2013). Postcards from the EDge project: 5-year outcomes of a randomised controlled trial for hospital treated self-poisoning. *British Journal of Psychiatry*, *202*, 372–380.

Carter, S. (2019). *Making a difference: Caring letters from peers. Oral presentation at*. American Association of Suicidology Annual Meeting.

Chinman, M. J., Allende, M., Weingarten, R., Steiner, J., Tworkowski, S., & Davidson, L. (1999). On the road to collaborative treatment planning: Consumer and provider perspectives. *The Journal of Behavioral Health Services & Research*, *26*(2), 211–218.

Chinman, M., Oberman, R. S., Hanusa, B. H., Cohen, A. N., Salyers, M. P., Twamley, E. W., & Young, A. S. (2015). A cluster randomized trial of adding peer specialists to intensive case management teams in the Veterans Health Administration. *The Journal of Behavioral Health Services & Research*, *42*(1), 109–121.

Comtois, K. A., Kerbrat, A. H., DeCou, C. R., Atkins, D. C., Majeres, J. J., Baker, J. C., & Ries, R. K. (2019). Effect of augmenting standard care for military personnel with brief caring text messages for suicide prevention: a randomized clinical trial. *JAMA Psychiatry*, *76*(5), 474–483.

Comtois, K. A., Kerbrat, A. H., & Holman, C. et al (2015). *Feasibility and acceptability of caring contacts via text: Increasing connection with active duty marines and soldiers to prevent suicide attempts and ideation*. Poster presented at the 48th Annual American Association for Suicidology Conferences; Atlanta, GA.

Corrigan, P. W. (2006). Impact of consumer-operated services on empowerment and recovery of people with psychiatric disabilities. *Psychiatric Services*, *7*(10), 1493–1496.

Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: A report from the field. *Schizophrenia Bulletin*, *32*(3), 443–450.

Davidson, L., Weingarten, R., Steiner, J., Stayner, D., & Hoge, M. A. (1997). *Integrating prosumers into clinical settings*. Consumers as providers in psychiatric rehabilitation. (pp. 437–455). Columbia: International Association of Psychosocial Rehabilitation Services.

Denchev, P., Pearson, J. L., Allen, M. H., Claassen, C. A., Currier, G. W., Zatzick, D. F., & Schoenbaum, M. (2018). Modeling the cost-effectiveness of interventions to reduce suicide risk among hospital emergency department patients. *Psychiatric Services*, *69*(1), 23–31.

Department of Veterans Affairs, Veterans Health Administration, Office of Mental Health and Suicide Prevention (2018). *Veteran Suicide Data Report, 2005–2016*.

Ehret, B. (2020). *Caring Cards to and from veterans: A treatment manual*. https://doi.org/10.31234/osf.io/uv6ak

Forchuk, C., Martin, M.-L., Chan, Y. L., & Jensen, E. (2005). Therapeutic relationships: From psychiatric hospital to community. *Journal of Psychiatric and Mental Health Nursing*, *12*(5), 556–564.

Hassanian-Moghaddam, H., Sarjami, S., Kolahi, A.-A., & Carter, G. L. (2011). Postcards in Persia: Randomised controlled trial to reduce suicidal behaviours 12 months after hospital-treated self-poisoning. *British Journal of Psychiatry*, *198*, 309–316.

Hodges, J. Q., Markward, M., Keele, C., & Evans, C. J. (2003). Use of self-help services and consumer satisfaction with professional mental health services. *Psychiatric Services*, *54*(8), 1161–1163.

Jain, S., McLean, C., & Rosen, C. S. (2012). Is there a hole for peer support delivered interventions in the treatment of Veterans with post-traumatic stress disorder? *Military Medicine*, *177*(5), 481–483.

Larsen, M. E., Shand, F., Morley, K., Batterham, P. J., Petrie, K., Reda, B., Berrouiguet, S., Haber, P. S., Carter, G., & Christensen, H. (2017). A mobile text message intervention to reduce repeat suicidal episodes: design and development of Reconnecting After a Suicide Attempt (RAFT). *JMIR Mental Health*, *4*(4), 1–9.

Luxton, D. D., June, J. D., & Comtois, K. A. (2013). Can postdischarge follow-up contacts prevention suicide and suicidal behavior? *Crisis*, *34*(1), 32–41.

Luxton, D. D., Smolenski, D. J., Reger, M. A., Relova, R. M. V., & Skopp, N. A. (2020). Caring e-mails for military and Veteran suicide prevention: A randomized controlled trial. *Suicide and Life-Threatening Behavior*, *50*(1), 300–314.

Malone, K. M., Oquendo, M. A., Haas, G. L., Ellis, S. P., Li, S., & Mann, J. J. (2000). Protective factors against suicidal acts in major depression: reasons for living. *American Journal of Psychiatry*, *157*(7), 1084–1088.

Milner, A. J., Carter, G., Pirkis, J., Robinson, J. O., & Spittal, M. J. (2015). Letters, green cards, telephone calls and postcards: Systematic and meta-analytic review of brief contact interventions for reducing self-harm, suicide attempts and suicide. *British Journal of Psychiatry*, *206*(3), 184–190.

Motto, J. A., & Bostrom, A. G. (2001). A randomized controlled trial of postcrisis suicide prevention. *Psychiatric Services*, *52*, 828–833.

Ochocka, J., Nelson, G., Janzen, R., & Trainor, J. (2006). A longitudinal study of mental health consumer/survivor initiatives: Part 3—A qualitative study of impacts of participation on new members. *Journal of Community Psychology*, *34*(3), 273–283.

Ramon, S., Healy, B., & Renouf, N. (2007). Recovery from mental illness as an emergent concept and practice in Australia and the UK. *International Journal of Social Psychiatry*, *53*, 108–122.

Reger, M. A., Gebhardt, H. M., Lee, J. M. et al (2018). Veteran preference for the caring contacts suicide prevention intervention. *Suicide and Life-Threatening Behavior*, *49*(5), 1429–1451.

Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health*, *20*(4), 392–411.

Resnick, S. G., & Rosenheck, R. A. (2008). Integrating peer-provided services: A quasi-experimental study of recovery orientation, confidence, and empowerment. *Psychiatric Services*, *59*(11), 1307–1314.

Schembari, B. C., & Perivoliotis, D. (2018). *Leave no one behind: Caring cards to and from veterans*. Poster presented at: The 41st Annual Wellness and Recovery Summit of the Psychiatric Rehabilitation Association; Denver, CO.

Valenstein, M., Kim, H. M., Ganoczy, D., McCarthy, J. F., Zivin, K., Austin, K. L., Hoggatt, K., Eisenberg, D., Piette, J. D., Blow, F. C., & Olfson, M. (2009). Higher-risk periods for suicide among VA patients receiving depression treatment: prioritizing suicide prevention efforts. *Journal of affective disorders*, *112*(1-3), 50–58.

Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner, T. E., Jr (2010). The interpersonal theory of suicide. *Psychological Review*, *117*(2), 575.

Winsper, C., Docherty, A. C., Weich, S., Fenton, S. J., & Singh, S. P. (2020). How do recovery-oriented interventions contribute to personal mental health recovery? A systematic review and logic model. *Clinical Psychology Review*, *76*, 101815.

Yanos, P. T., Primavera, L. H., & Knight, E. L. (2001). Consumer-run service participation, recovery of social functioning, and the mediating role of psychological factors. *Psychiatric Services*, *52*(4), 493–500.

SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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