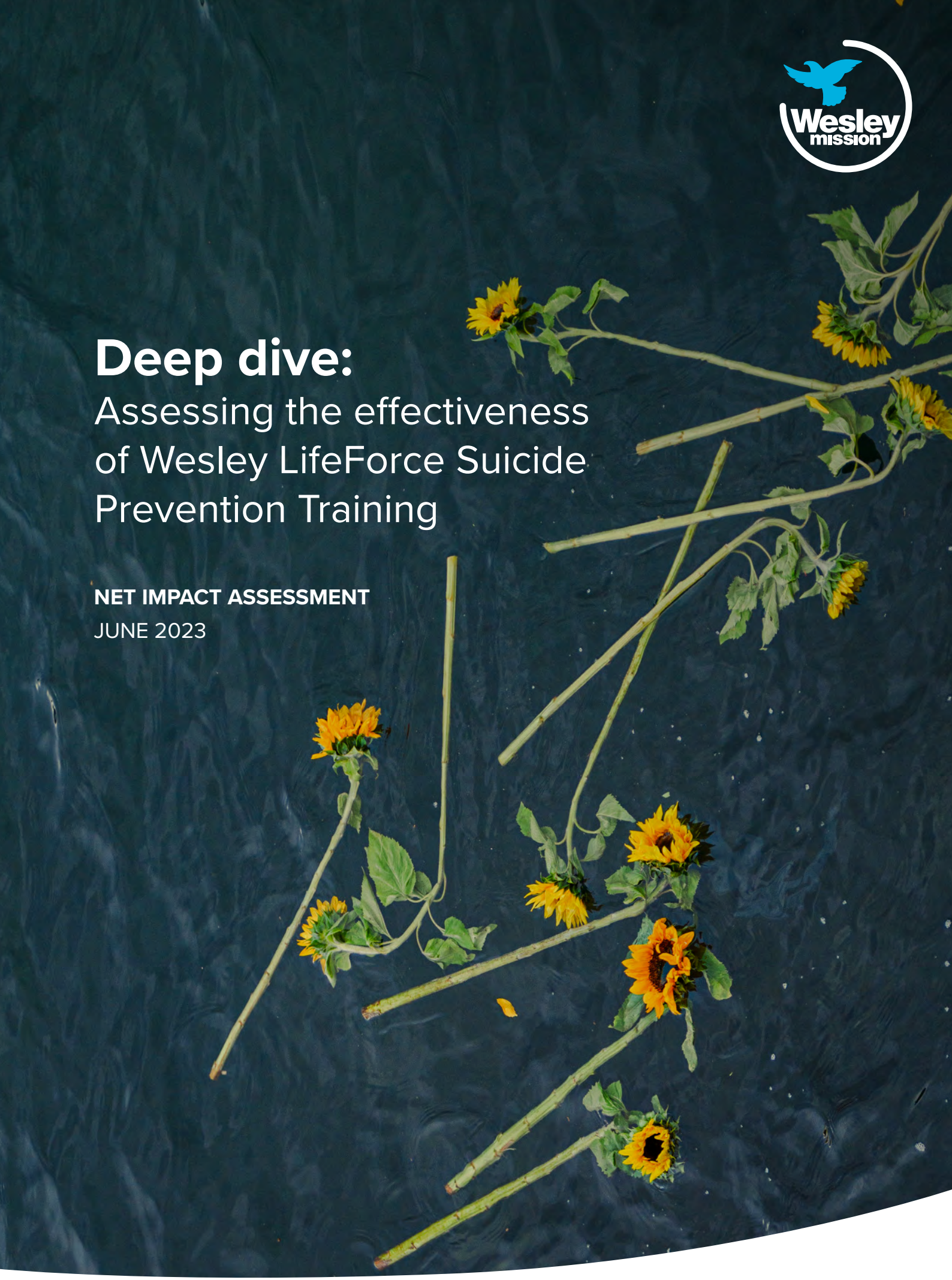

Deep dive:
Assessing the effectiveness of Wesley LifeForce Suicide Prevention Training

NET IMPACT ASSESSMENT

JUNE 2023

Doing all the good we can
because every life matters

Foreword

Suicide is a growing concern for Australians and has a profound impact on individuals and communities.

Since 1995, Wesley LifeForce has worked to enhance individual resilience and self-help skills, as well as build community strength and capability in preventing suicide.

This study aims to assess the effectiveness of Wesley LifeForce Suicide Prevention Training delivered to community gatekeepers who identify and support people at risk of suicide. The three main objectives of the study are to:

1. Assess the effectiveness of the training for gatekeepers.
2. Measure the impact of training on gatekeepers' knowledge, attitudes and skills, specifically focusing on the success of the S.A.L.T method.[1]
3. Evaluate the success of implementing recommendations from the 2019 Australian Institute for Suicide Prevention and Research study.

Catalyst Consultancy & Research conducted telephone interviews with 75 participants and online surveys with 189 participants, based on questions developed by Wesley Mission researchers and Wesley LifeForce staff. Additionally, pre- and post-training surveys from 2020–22 were reanalysed to assess intermediate and long-term impact on gatekeepers' knowledge, attitudes and skills.

Thanks to open and honest feedback from participants, we now have greater insight into the quality of our training and the specific areas where we can make improvement.

I'm delighted to share that 82 per cent of participants were extremely satisfied with our training. We also learned that investment in the knowledge of suicide issues and risk indicators can improve awareness among gatekeepers.

I'm strengthened by these results and look forward to working together to offer an even more effective service.

My sincere thanks go out to all participants, whose valued feedback will help us save more lives from suicide, as well as Wesley Mission and Wesley LifeForce staff and Catalyst Consultancy & Research for their professionalism and insight.

In mission together,

Rev Stu Cameron
CEO and Superintendent

Citation: Wesley Mission and Catalyst Consultancy & Research. June 2023. Deep dive: Assessing the effectiveness of Wesley LifeForce Suicide Prevention Training. Sydney.

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Background – Suicide in Australia

Suicide is a critical public health concern. In 2021, suicide was one of the leading causes of death in Australia and claimed 3,144 lives[2]. Males accounted for 75 per cent of these cases. The daily average was about nine suicides, translating to a rate of 12.0 per 100,000 people.[3] The median age for suicide fatalities was 44.8 years, significantly younger than the 82-year old average for all causes of death.[4] Consequently, each suicide led to an average loss of 33.2 potential years of life. Among Australians, the age group most affected by suicide is those aged 15-24, where it accounts for over a third of all fatalities.[5] However, in terms of sheer numbers, adults aged 30-59 represent more than half of all suicide cases, with middle-aged and older males being especially impacted.[6]

Geographic disparities in suicide rate is evident: In 2021, New South Wales (NSW) reported the most suicide deaths with a count of 880, while the Northern Territory (NT) had the highest rate of 18.4 per 100,000 people.[7] This trend worsened in NSW in 2022, with suicide deaths rising to 963.[8] This variation may be partly due to the different proportions of urban, regional and remote areas in each territory and state, as suicide rates are typically higher in less urbanised locations.[9]

Suicide is a complex and multi-faceted issue, influenced by a range of interconnected factors.[10] These can include life circumstances, socio-economic status, individual history and mental health conditions.[11] Risk factors that may heighten vulnerability to suicide encompass experiences of high stress such as changes in employment status[12], trauma[13] and social isolation[14]. Mental health disorders, particularly depression and other mood disorders[15], prior suicide attempts[16], chronic illnesses, disability, drug and acute alcohol consumption[17], limited access to behavioural healthcare and inadequate psychosocial support are also significant contributors.[18]

Protective factors can mitigate the risk of suicide at individual, relational, community and societal levels.[19] Key resilience factors include strong social bonds, a sense of control and purpose in life, stable family environments, and life skills such as problem-solving, coping and adaptability.[20] Proactive help-seeking and a strong sense of connection to people, community and social institutions also help.[21] Access to high-quality, effective behavioural healthcare is another important safeguard.[22] Additionally, cultural, religious or personal beliefs that dissuade suicide can serve as societal protective factors, further reducing the risk of suicide.[23]

Suicide has a profound impact on individuals and communities, yet it is preventable.[24] Effective prevention strategies that operate at multiple societal levels and are tailored to specific demographics can significantly reduce suicide rates.[25] These approaches include gatekeeper training to recognise warning signs and foster resilience, as well as advocating for social change.[26]

Australian governments have embraced a comprehensive, systems-based approach to suicide prevention, ranging from individual to public health measures.[27] Implementing these strategies simultaneously amplifies their effectiveness. These plans focus on identifying and supporting those at risk, using evidence-based data for both implementation and evaluation. The ultimate goal is to enhance resilience and improve overall wellbeing.[28]

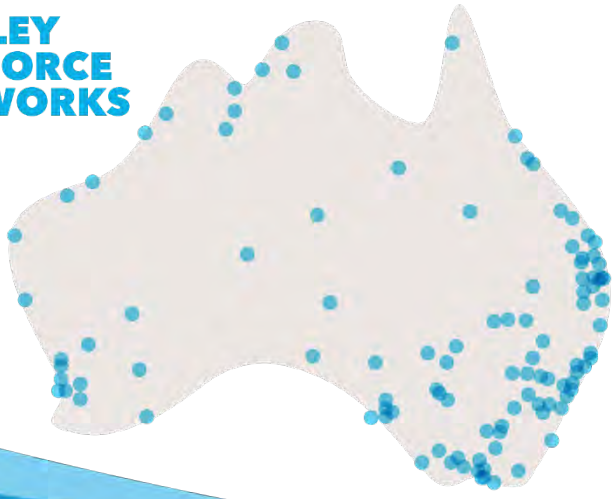
About Wesley LifeForce

Wesley Mission provides a wide range of community services and support programs to help individuals and communities in need. One of the significant programs is Wesley Lifeforce, which focuses on suicide prevention with the ultimate goal of achieving a zero-suicide rate in Australia.

Wesley Lifeforce places a strong emphasis on building individual resilience, by providing individuals with the necessary skills and resources to navigate life's challenges and stresses. This encompasses activities such as offering mental health education, crisis intervention training and promoting help-seeking behaviours. Wesley Lifeforce not only improves personal resilience and self-help abilities, but has also strengthened community capacity to prevent suicide.[i]

Through Wesley Lifeforce, more than 100 community suicide prevention networks have been established nationwide. These networks serve as valuable platforms for community members to establish service connections and create a supportive environment for those with personal experiences of suicide.[ii] By tailoring its approach to local needs, the program enhances community readiness and ensures easy access to services.[iii] Wesley LifeForce also supports at-risk individuals and grieving families through memorial events. These events raise awareness, honour lives lost and offer emotional support. Additionally, the program advocates for effective suicide prevention policies on a larger scale.

WESLEY LIFEFORCE NETWORKS



Wesley

LifeForce

Suicide Prevention Training

Wesley LifeForce offers a range of suicide prevention training programs, including the Gatekeeper Training Workshops. These workshops play a crucial role in the national Suicide Prevention strategy, aiming to educate and empower local communities and support those most at risk of suicide in Australia.

About community gatekeepers

Community gatekeepers are members of the community who are trained to identify and reach out to people experiencing suicidal thoughts or behaviours. Their role is to create safe spaces for open discussion, encouraging people to seek help from healthcare services and from their social networks of family and friends. Essentially, they initiate life-saving conversations, offering support and reassurance. [iv]

Community gatekeepers come from diverse backgrounds; they can be teachers, youth workers, clergy members, disability support staff, aged care workers, members of the community and sports coaches, among others. They are often on the front lines of public life, ready to provide timely intervention and support.

Gatekeeper Training Workshops

The Gatekeeper Training Workshops aim to equip the attendees with essential knowledge and skills to recognise and respond to suicide risks in Australia, guiding them to professional help.[v]

Targeted at community members without prior training, the sessions are advertised on Eventbrite, the Wesley Mission website and through email lists.

Typically led by a single trainer, the workshops offer both half-day and full-day options. In-person sessions accommodate up to 25 participants, while online sessions are limited to 20.

The facilitators are qualified in specialised suicide prevention training and update their skills annually. Most are accredited trainers, and many are certified counsellors. Each session features case studies, role-playing and open forums for discussion, along with an evaluation form for attendee feedback.

The workshops are anchored in the SALT method – See signs, Ask about intent, Listen, Take action – to train attendees in suicide risk identification and response. They cover:

- Understanding suicide: Prevalence, impact, and risk factors.
- Recognising risk: Warning signs and cues.
- Prevention: Effective communication and confidentiality limitations.
- Professional referral: Directing at-risk individuals to appropriate help.
- Self-care: Importance of the helper's wellbeing.

SAMPLE PROGRAM:

Wesley LifeForce Suicide Prevention Training Workshop

Overall training goals

Participants will have increased confidence in their ability to:

- Identify people who may be at risk of suicide
- Communicate appropriately with a suicidal person
- Ask a person if they are considering suicide
- Conduct a suicide intervention

Training outcomes

Session 1:

- Awareness of the requirements for classification of a death as suicide.
- Understand that suicidal ideation and planning are not linear processes.
- Knowledge of the occurrence and demographics of suicide in Australia.

Session 2:

- List common barriers to helping a suicidal person including your own beliefs and attitudes.
- Be able to identify risk and protective factors.
- Differentiate between risk factors and warning signs.
- Recognise the association between loss and suicidality.
- Understand the cascade of events that can lead to thoughts of suicide.

Session 3:

- Capability to be able to implement the SALT suicide intervention strategy.
- Identify national and local suicide prevention resources.
- Understand the importance of self-care and be able to implement self-care strategies.

Note: For a detailed understanding of the program, exercises and methodologies, please refer to the official Wesley LifeForce Suicide Prevention Training Workshop workbook

This comprehensive approach enables participants to identify suicide risks, engage in meaningful conversations and take suitable action, from referrals to emergency intervention.

The program's effectiveness is assessed using a variety of metrics including attendance, participant feedback, completion rates, pre- and two post-training assessments, as well as changes in community suicide rates. Past reviews confirm that the gatekeeper training aligns with international best practice.[29]

The latest evaluation by the Australian Institute for Suicide Research and Prevention (AISRAP) yielded 12 suggestions, with a standout recommendation to implement a fidelity checklist for trainers, considered the 'gold standard' for objectively assessing trainer impact.

About this study

This research aims to assess the effectiveness of the Wesley LifeForce Suicide Prevention Training workshops for gatekeepers. The study focuses on measuring participants' understanding, skills, confidence, and competence in suicide intervention. The three main objectives are:

Assess the effectiveness of the Wesley LifeForce Suicide Prevention Training for gatekeepers.

Measure the impact of training on gatekeepers' knowledge, attitudes, and skills, specifically focusing on the success of the SALT method.

Evaluate the success of implementing recommendations from the 2019 AISRAP study.

Evaluation methodology

1. A combined team of Wesley Mission researchers and Wesley LifeForce staff developed a questionnaire aligned with the study's objectives. An independent firm, Catalyst Consultancy & Research, were hired to conduct primary research. Catalyst gathered data through telephone interviews with 75 participants and online surveys with an additional 189 participants.
2. Wesley LifeForce Suicide Prevention Training (Wesley LifeForce Training) includes pre- and post-event surveys. Data from workshops conducted between 2020-2022 underwent secondary analysis to assess both immediate and long-term impacts on gatekeepers' knowledge, attitudes, and skills. The study also aimed to measure the effectiveness of the SALT method among participants within three months following the workshop.

Key findings and recommendations

Wesley LifeForce Training overall performance indicators

- Eighty-two per cent of workshop participants were extremely satisfied with the training.
- The quality and expertise of facilitators is a key driver of positive performance.
- Emotional support during training sessions is an important factor to ensuring participants feel supported and develop competency while learning skills.
- Evaluation scores and effect sizes improved from 2020 to 2022, suggesting that AISRAP training modifications may have positively impacted learning outcomes.

SALT in practice

- SALT is effective in providing participants with the necessary tools to feel effective when speaking to a person experiencing suicidal thoughts.
- Sixty per cent of participants feel able to use SALT method to link people needing intervention to professional help.
- Trained people play a critical role in the community, demonstrated by their assistance to approximately 2,500 people in accessing professional help.

Improvement opportunities

The feedback derived from the evaluation has identified several areas for potential program improvement. These include:

- Long-term knowledge of suicide issues could be improved.
- Investment in the development of knowledge of suicide issues and suicide risk indicators for participants would improve awareness amongst the graduates. This could be achieved through the use of quick reference guides as handout materials that could be later used in workspaces or other locations.
- Alternate options for inexperienced participants and those that have a superior knowledge base. Senior and experienced training participants reported wanting further training and resources. Perhaps this could be another course or an extended course for those who felt they needed greater proficiency to be achieved upon completion.
- Post course check-ins may help knowledge retention and development. Participants reported that their capabilities continued to improve over time with the use of new knowledge and skills developed through the training. Perhaps a refresher course or check-in post training to talk through real life cases could further cement new learning.

Objective 1: Insights into program effectiveness

Note: Participants completing the survey in full have undertaken the Wesley LifeForce Training in the past 24 months.

The topics covered in this section include:

- overall perceptions of training and support
- effectiveness of the SALT methodology
- impact of the training on capability
- confidence in ability to conduct an intervention
- knowledge of suicide issues
- most useful resources.

Overall perceptions of training and support

Table 1.1 indicates that 80 per cent of survey respondents completed the Wesley LifeForce Training within the last year, while 14 per cent completed it over a year ago. Those who had not yet completed the training were excluded from further analysis.

Table 1.1 Time since Wesley LifeForce Training completed

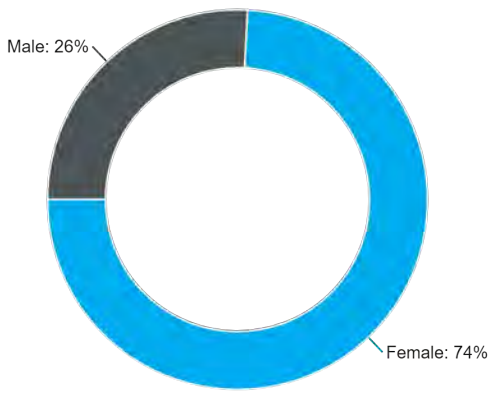
When was your training completed	%	Interviews
<6 months	23%	62
6-12 months	56%	149
1-2 years	12%	31
>2 years	2%	6
Yet to complete *–screened out*	6%	16
Total	100%	264

Many training courses assess knowledge immediately following the learning event, or soon after, but a key issue for real change is long term sustainability of knowledge and skill improvements. This study assessed those factors.

Socio-demographic characteristics of respondents

The respondents were examined for their socio-demographic characteristics to better understand the sample and potentially the usual participants in Wesley LifeForce Training. About three quarters of the respondents were female, which may suggest that the training predominantly attracts female participants. While acknowledging the possibility of response bias, this finding is significant considering male suicide rates are higher than female rates. The data suggests that the program could benefit from directing its advertising and recruitment efforts more towards men.

Figure 1.1 Sample composition: Gender



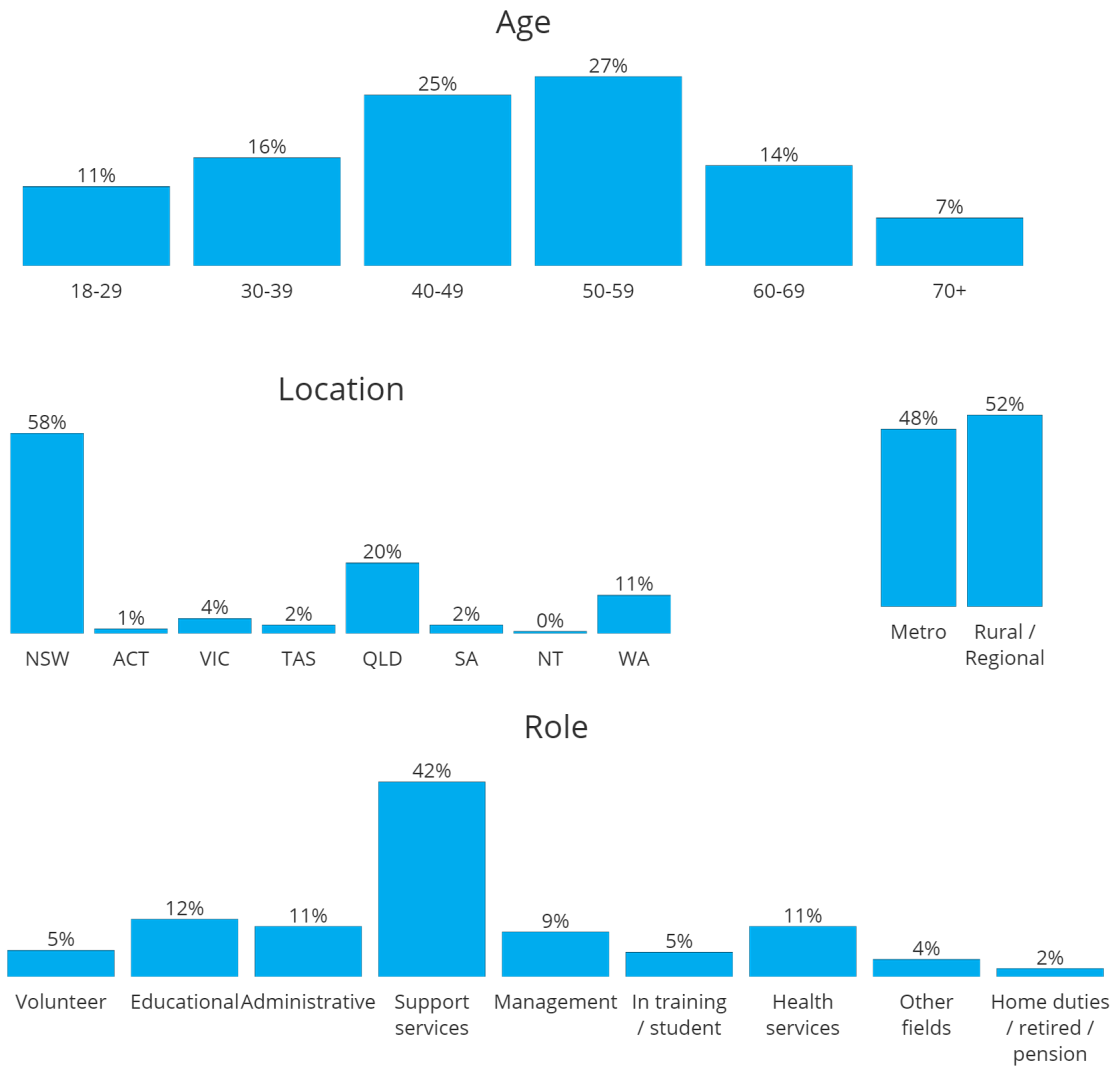
In terms of age, the majority of respondents were between 40-59, making up just over half the sample. Since suicide is a major cause of death in middle age, training focused on this group could be impactful, especially for peer-to-peer effects. However, older men also have high suicide rates, indicating a need to attract more participants from this demographic or people working with this age group to attend suicide prevention awareness training.

Geographically, most training courses were conducted in New South Wales (58 per cent), Queensland (20 per cent) and Western Australia (11 per cent), with other states and territories accounting for less than 9 per cent of the total. This disparity cannot be explained by population level, but rather reflects the availability and promotion of courses in these specific areas. More comprehensive promotion of courses in states and territories where training uptake is low, would better help to address suicide rates in those areas.

There was a large representation (over 50 per cent) from regional and rural areas which suggests good penetration into communities that are often underserved with these types of programs, but also that have high suicide rates (see Figure 1.4)

Over half of the workshop participants worked in health (11 per cent) or various support services (42 per cent) which is consistent with expectations.

Figure 1.2 Sample composition: Age



Overall satisfaction with Wesley LifeForce Training

The following section delves into participant satisfaction with Wesley LifeForce Training.

Feedback from participants about the quality of the training was very positive. The vast majority of respondents (82 per cent) rated the workshops as excellent. Here are some specific comments from participants:

> *"Very easy to understand, compassionate and effective trainer. Relevant information. Caring and safe environment to discuss the topic."*
>
> *"Information was provided in a clear and sensitive way. I also liked the opportunity to share stories."*
>
> *"It was tangible and practical. It gives you steps on how and what do if you come across someone who is intending to take their life."*

Figure 1.3 Overall satisfaction with Wesley LifeForce Training

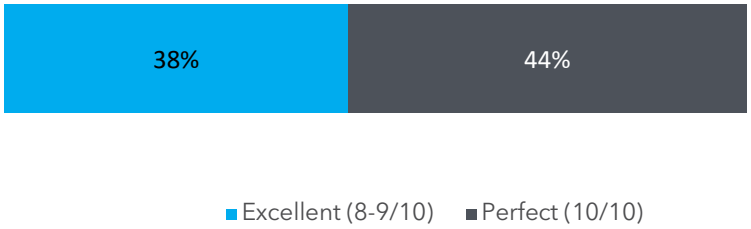
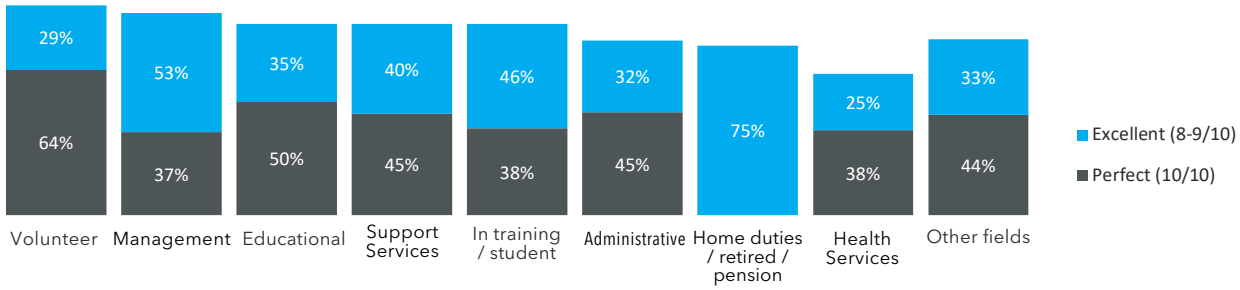
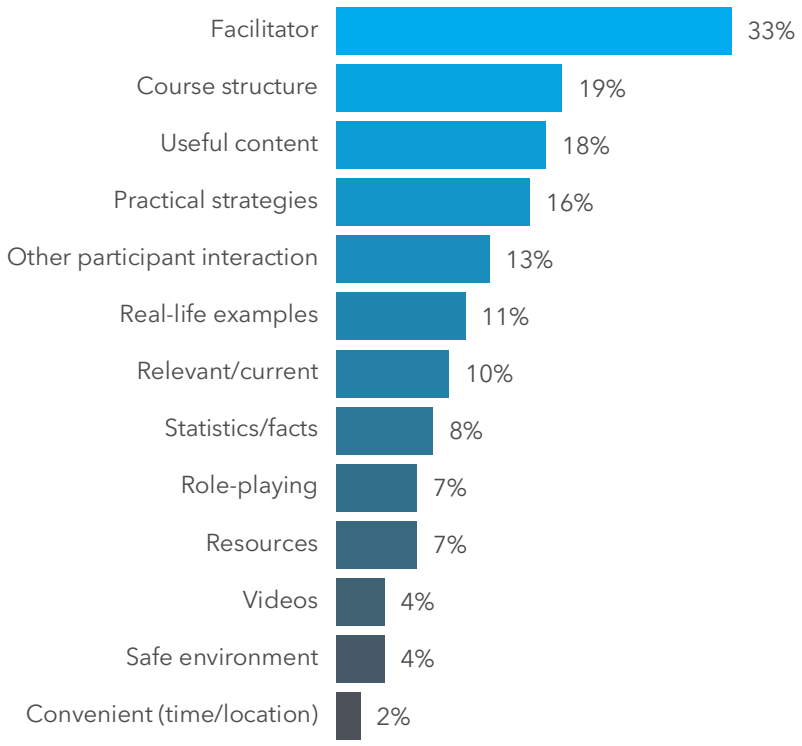


Figure 1.4 Satisfaction with training by role



Participants were invited to point out the training's strengths and could select multiple aspects. The quality of the facilitator was the primary issue identified (33 per cent), followed by course structure (19 per cent), content (18 per cent) and practical strategies (16 per cent). This feedback provides good support for the quality of the facilitators, but also highlights areas for improvements to bring greater balance to various components of the training.

Figure 1.5 What participants liked about the training?



Some of the specific comments from participants about the training included:

"I like hearing about the lived experience of the facilitator. I guess the normalisation of being able to talk about suicide. I also got some ideas on what words to use and the permission to talk about suicide. I now feel like it is not as taboo as a result of the training."

"I actually really liked the facilitator she did a great job. I found her very approachable and knowledgeable. She explained to us not to be afraid to ask the tough questions to assess if they are having suicidal thoughts and then help them through that."

"The presenter was excellent. I found the content appropriate, and there were video examples, concrete examples and techniques. There were examples of specific situations, one where a worker put the drugs down the toilet. We were able to talk things through to see it working. I guess what I took away was the idea that you have to have the conversation do not shy away from it.
I think if someone is at that point, I am now not scared to ask if they are suicidal. Instead of the old-fashioned belief that mentioning suicide it would put the idea in their head."

"I have done a few similar courses, and the one thing I did notice was the cross-section of people. They came from all walks of life, with a good mix of input from people with different life experiences. I find SALT to be very good, it is another mental health tool for my toolbox. I am a facilitator for a men's group so any other avenues to learn what to say and how to ask questions?"

Improvement suggestions

When queried on potential improvements for the course, by far the strongest suggestion was for more in-depth training (21 per cent), followed by similar preferences for role play (eight per cent), delivery method (seven per cent), and safer and more supportive environment (seven per cent).

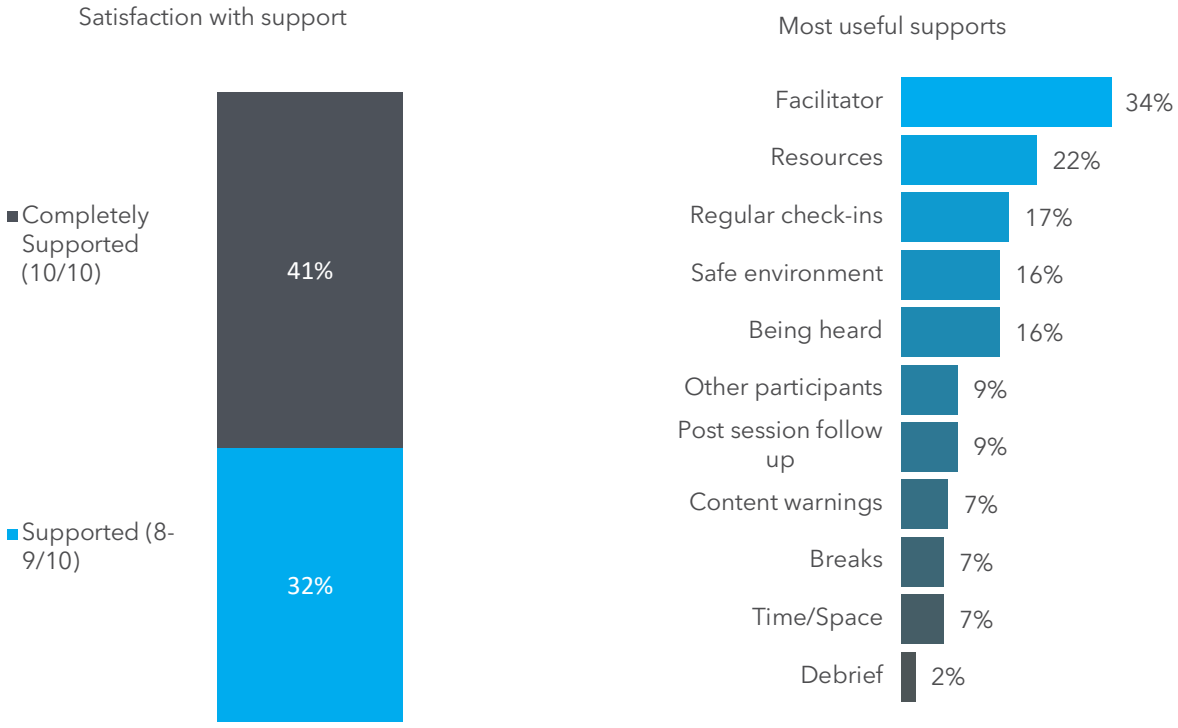
Figure 1.6 Improvement opportunities

What did you not like about the training, how could it be improved?

Perceptions of support

Participants were asked to identify the elements that they felt provided them with the most support during the course. Once again, the facilitator was nominated as the key resource for support (34 per cent) with other useful supports being: resource materials (22 per cent); check-ins (17 per cent); a safe environment (16 per cent) and the opportunity to be heard (16 per cent).

Figure 1.7 Support received during and after training



When asked for specific feedback about useful supports, participant mentioned:

"I found the trainer to be very supportive, she gave a signal, a thumbs up if we just needed to go to the bathroom or a thumbs down if we needed a break due to a trigger, etc. She would come out and check on you if you were ok. I believe there was a specific lifeline number for participants in the training."

"During the training, the lady was definitely available. We were advised a lot of times if anything triggers you can take time out."

"They provided us with a resource brochure. Whilst we were sharing our experiences, they advised we only share what we are comfortable with. They were very sensitive and put some preventative measures in place."

"The ability to practice self-care during the course. Also, the opportunity to have the training workbook with me after the course."

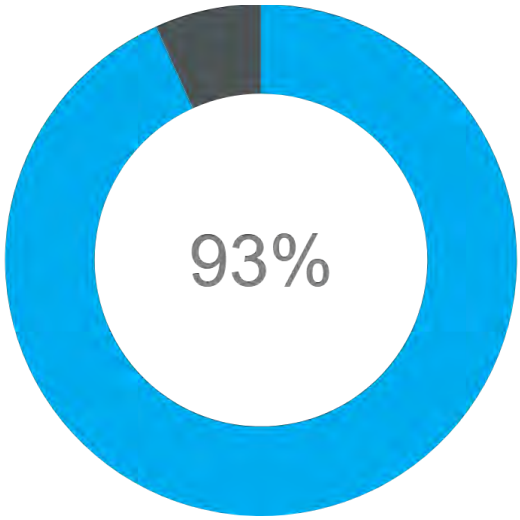
"They gave us a lot of information/contact numbers/websites etc for support which was handy to know."

"When we did the role plays, they said just if you feel comfortable continuing great if not, please let us know."

Content

Respondents were asked about the currency of content and its relevance.

Figure 1.8 Content current and up to date



Feedback indicated that 93 per cent of participants felt the training was up to date and incorporated all the current developments in knowledge of suicide prevention.

Participants were also asked to nominate the training materials that could be improved. From the collated feedback it was identified that:

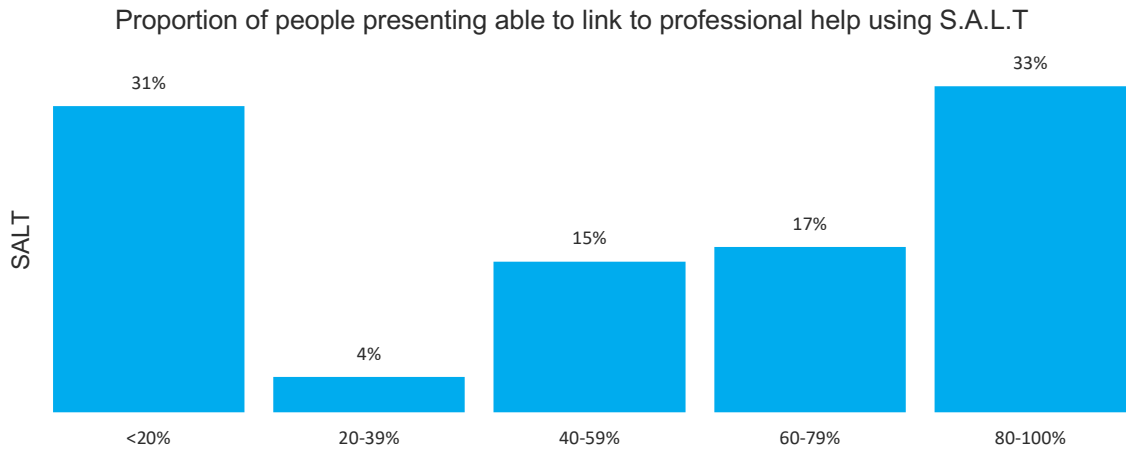
- here was a desire for more content relating to acute situations
- a guide for appropriate responses for different suicide related scenarios would be beneficial
- inclusion of practical case studies that would offer insight into how to handle situations involving suicide ideation
- multiple respondents felt the need for more content on Indigenous issues relating to suicidal thoughts and management.

SALT – its application and use

The workshop's primary strategy is the SALT approach, designed to empower participants to address people with suicidal tendencies. SALT stands for: See the warning signs, Ask about suicidal intent, Listen to the person, and Tell or Take them to the right help.

Participants practice this method through role-playing during the workshop. The workshop's success hinges on participants' ability to remember and apply the SALT approach.

Figure 1.9 Use of SALT in practice



Capability – intervention

Respondents were asked to reflect on the extent to which they felt they were able to provide suicide prevention interventions both before and after the training.

The data included below focuses on those who rated their confidence in their ability as "high", scoring between 8-10 out of a maximum of 10. Figures 1.10 and 1.11 below contrasts these perceptions before and after training, with grey bars representing perceptions of pre-training ability and the blue bars indicating post-training ability.

The increase in perceptions of ability increased substantially in every case with at least a doubling in the awareness for "referring a person with suicidal thoughts for help" (from 39 per cent to 80 per cent) to a four-fold increase for "developing a resource for raising awareness" (from 15 per cent to 62 per cent) and similar for "using the SALT intervention strategy" (from 18 per cent to 69 per cent).

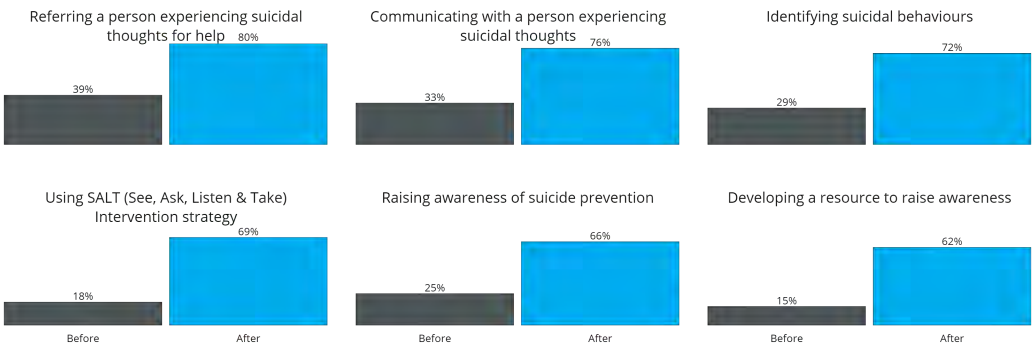
It's worth noting that for over 70 percent of respondents, this feedback was provided more than six months post-training, and so reflects long term learning and application of the material from the program. Several key parameters such as "identifying suicidal behaviours" along with "communicating with a person experiencing suicidal thoughts" and "developing a resource to raise awareness" continued to strengthen over time.

Percent rating their ability as 8-10/10 shown.

Key:

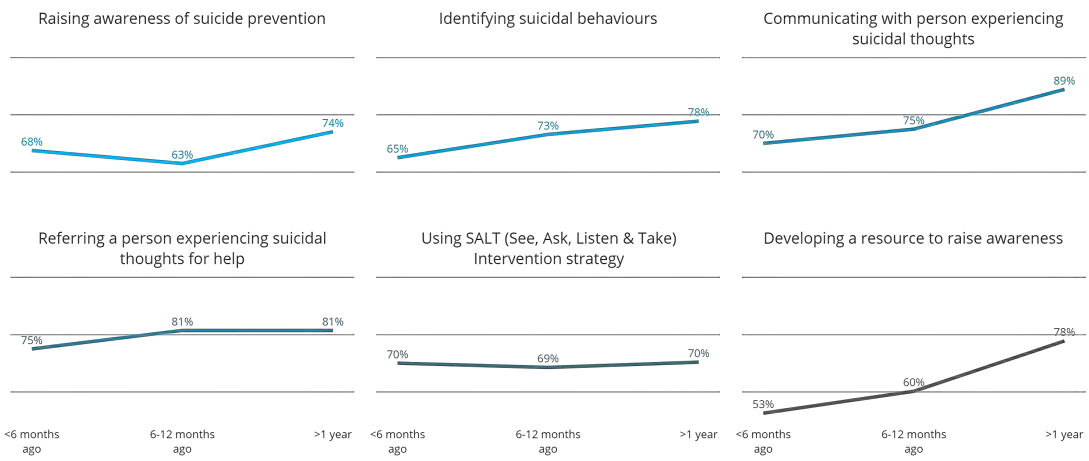
Grey = Before training Blue = After training

Figure 1.10 Ability to conduct an intervention before and after training



Ability to conduct all elements of an intervention is significantly higher after the training than before.

Figure 1.11 Ability to conduct an intervention after training by time since training

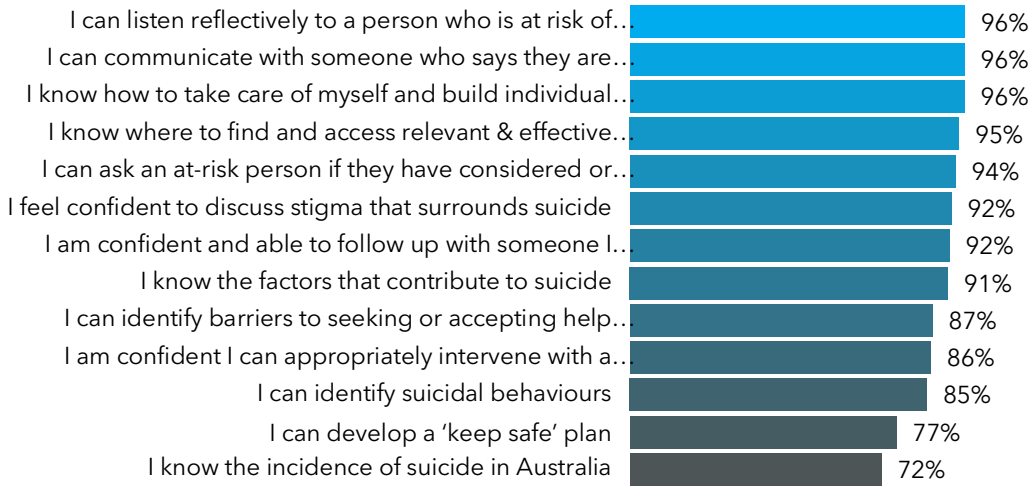


The increased ability to conduct an intervention is sustained over time and for most elements increases past a year, mostly likely due to practical implementation.

Respondents were asked about their confidence in their ability to undertake certain interventions with a person at risk of suicide. The feedback was especially encouraging with over 80 per cent of participants expressing confidence in their ability to undertake most of the identified actions, as detailed in the figure below. The strongest responses were for direct risk reduction actions for people thinking about suicide. The lowest score was a memory item for recall of the suicide rate, which would not have a direct impact on a person's ability to conduct an intervention.

The proportion who feel confident in their ability to undertake interventional tasks is shown below.

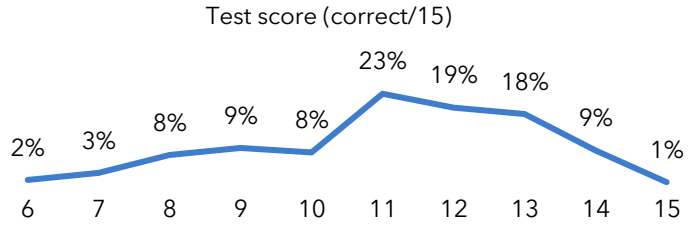
Figure 1.12 Perception of capability after the workshop



Most participants feel confident in their ability to undertake all actions following the training, with the ability to develop a 'keep safe' plan, and knowledge about suicide incidence being the few areas of relative weakness.

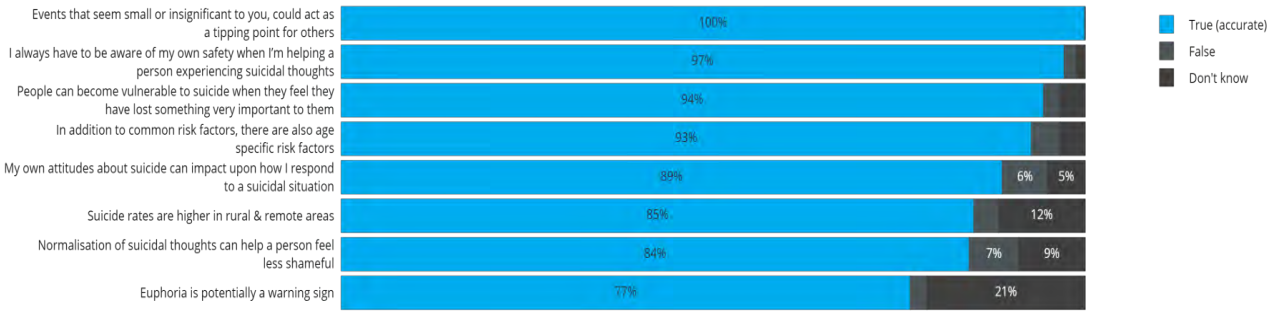
Knowledge of suicide issues

Figure 1.13 Knowledge test



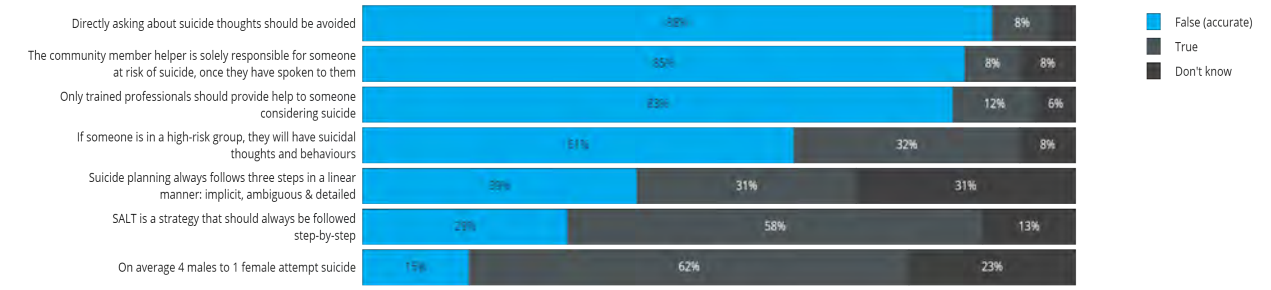
The survey included 15 true-or-false knowledge questions, with the percentage of correct answers displayed in two accompanying figures, where the correct answers are highlighted in blue. In 10 out of the 15 questions, 80 per cent of respondents identified the correct answer. The questions were originally developed to be an assessment of course content knowledge undertaken soon after the completion of training, so retention of knowledge by participants at significant lengths of time after the course is a positive sign of knowledge retention.

Figure 1.14 Knowledge of suicide issues post-training



Participants were asked whether each statement was true or false (the correct answer is shown in blue).

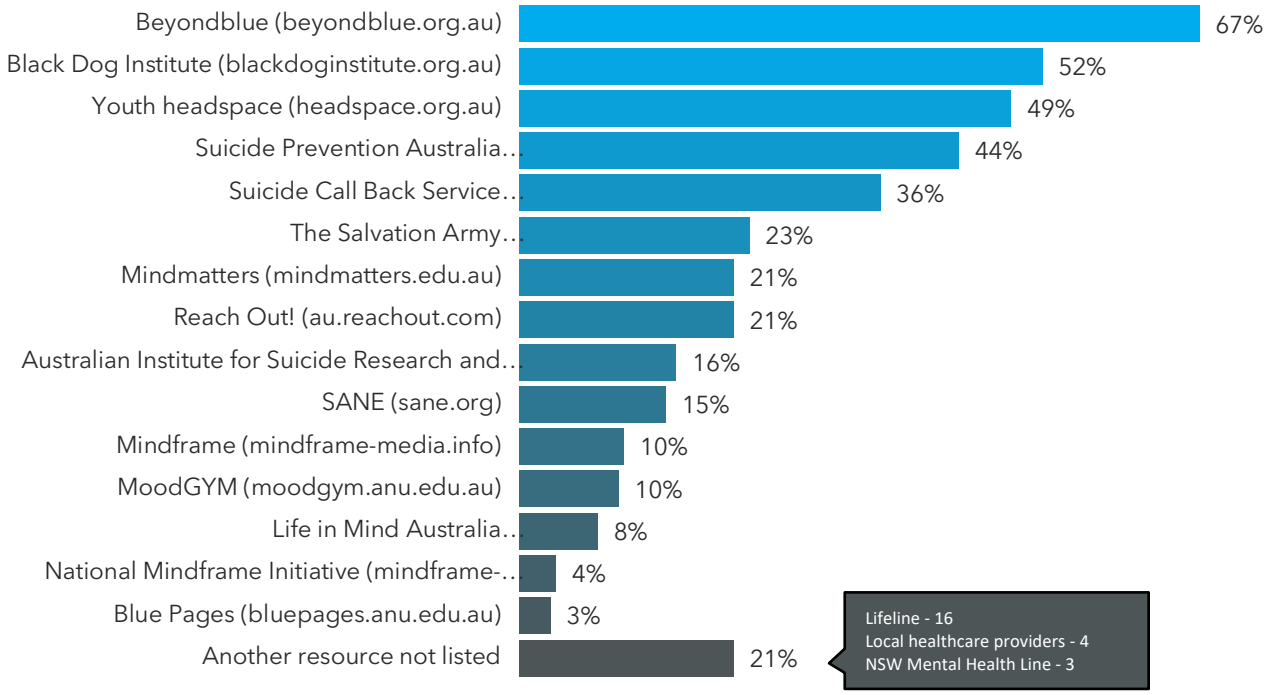
Figure 1.15 Knowledge of suicide issues post-training



The vast majority of training participants are able to accurately answer all but a few statements with the median score 11/15.

Resources

Figure 1.16 Resources used most frequently



Respondents were asked to indicate the three suicide or mental health resources that they used most frequently when undertaking a suicide intervention.

Beyond Blue, Black Dog, Youth Headspace, Suicide Prevention Australia and Suicide Call Back Service are widely used, but other resources are also important and used by more than half the respondents.

- Top five resources are used by 83 per cent of participants.
- Other resources are also used by over half the workshop participants (53 per cent).

Objective 2: Effectiveness of the training and success of SALT method

The analysis of records focused on assessing the immediate and ongoing effects of the training on: (1) enhancing gatekeepers' knowledge, attitudes and skills; and (2) impacting attendees exposed to the SALT (See; Ask; Listen; Take) approach. Data from Wesley LifeForce Training workshops, spanning January 2020 to December 2022, were cleaned and analysed in three stages:

1. Pre-workshop: Participants' baseline knowledge about the topic was assessed.
2. Post-workshop: The immediate effectiveness of the training on attendees' comprehension was evaluated.
3. Three-month follow-up: The long-term benefits of the training were assessed by evaluating knowledge retention, ability to identify people at risk, intervention effectiveness and outcomes.

Wesley LifeForce Training workshops attracted 4,597 participants nationwide during the three-year period. Approximately 43.5 per cent (2,001 participants) completed the training and shared their feedback through an online questionnaire. Three months later, a follow-up survey was sent, with 7.3 per cent of the trained participants (328 participants) responding.

Figure 2.1 Flow of training activities

Booking of training	➡	**Assess training**	➡	**Evaluate: Application of SALT method**
Pre-Training Evaluation		Post-Training Evaluation		3-month Evaluation
Responses (N_1=4,597)	➡	Post-Workshop responses (N_2=2,001)	➡	Responses (N_3=328)
Population (4,597)		43.5% of Population		7.2% of the population

Trainee feedback on select items (n=2001): Participants mainly rated the workshop highly, but identified skill practice and venue suitability as areas for improvement.

Figure 2.2 Flow of training activities

Item	Poor (%)	Average (%)	Good (%)	Excellent (%)	No response (%)
% Facilitator	0.01	1.2	15.3	83.4	0.1
% Group Activities	0.6	4.9	35.0	57.1	2.2
% Skills practice	1.7	9.3	45.7	41.7	1.5
% Venue location	0.6	4.9	35.0	57.1	2.2
% Venue suitability	1.0	5.1	35.7	55.6	2.6
% Support given during training	0.1	1.3	21.8	76.8	0.0
% Overall satisfaction with workshop	0.2	3.0	27.1	69.7	0.0
% Workshop meeting objectives	0.4	3.9	29.9	65.7	0.0

Impacts of training on gatekeeper knowledge, attitudes and skills

Three months after completing the training, 328 participants reported on their knowledge retention.

Figure 2.3 Knowledge/Understanding the incidences of suicide in Australia (n=328)

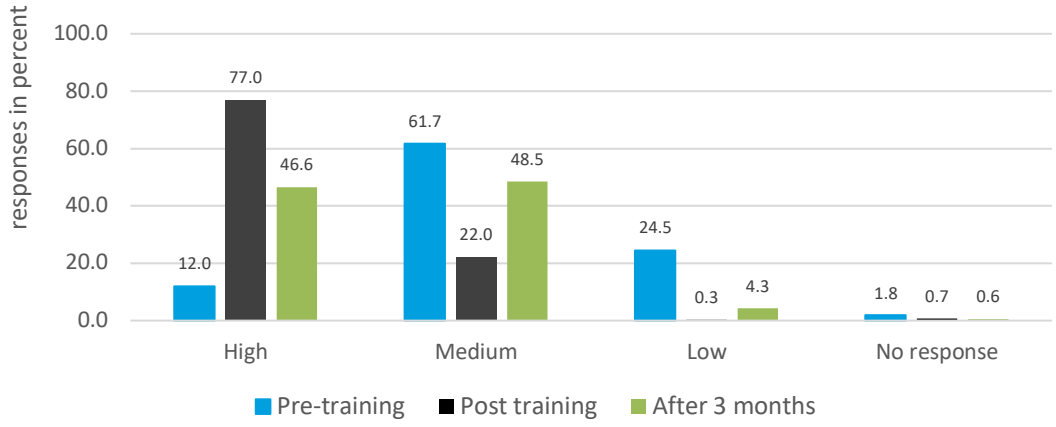
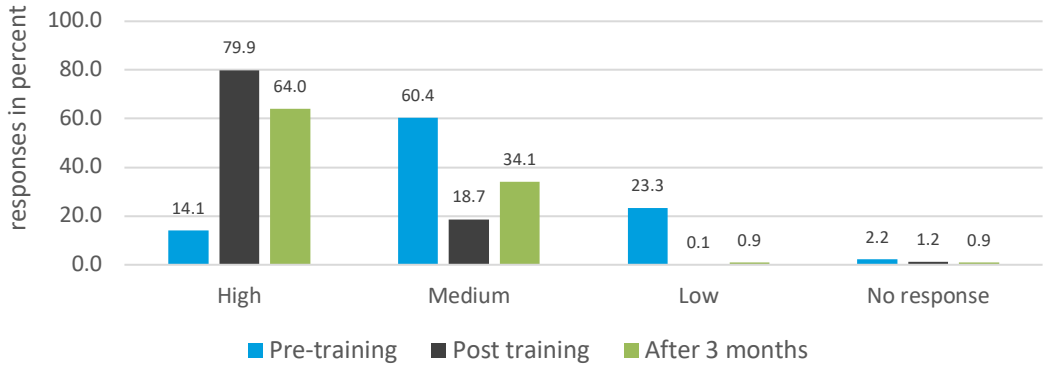


Figure 2.4 Knowledge/Understanding the factors that contribute to suicide in Australia (n=328)



In terms of understanding Australian suicide rates (Figure 2.3), the percentage of respondents with "high knowledge" increased from 12 per cent to 77 per cent right after training but decreased to 46.6 per cent three months later, suggesting a decline in knowledge retention. The "low knowledge" rate initially at 24.5 per cent, fell to 0.3 per cent immediately post-training and later rose to 4.3 per cent, indicating that a small number of workshop participants experienced incomplete retention.

Regarding the understanding of factors contributing to suicide (Figure 2.4), immediate post-training knowledge soared to 79.9 per cent but declined to 64 per cent after three months. The rate of "low understanding" initially at 23.3 per cent, dropped sharply to 0.1 per cent but increased modestly to 0.9 per cent, showing minor regression in some participants.

Continuous reinforcement post-training could help maintain and improve knowledge levels. Interestingly, while high knowledge of suicide rate dropped about 30 per cent from just after the workshop to three months later, the regression in understanding of suicide factors dropped by only about half that amount i.e.16 per cent indicating that improvements in awareness after training were more robust than improvements in knowledge.

Figure 2.5 Ability to identify an Individual who may be experiencing/exhibiting suicidal behaviour (n=328)

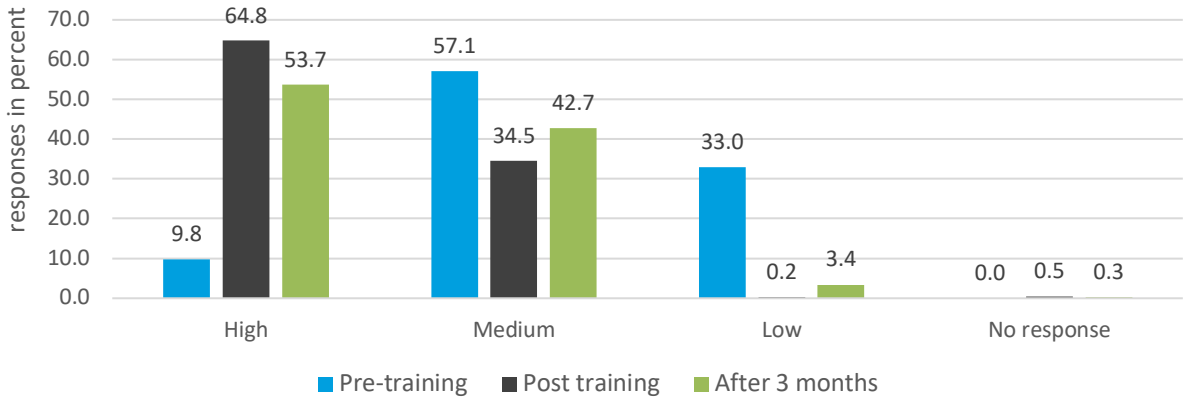


Figure 2.6 Ability to communicate appropriately with an individual experiencing / exhibiting suicidal behaviour (n=328)

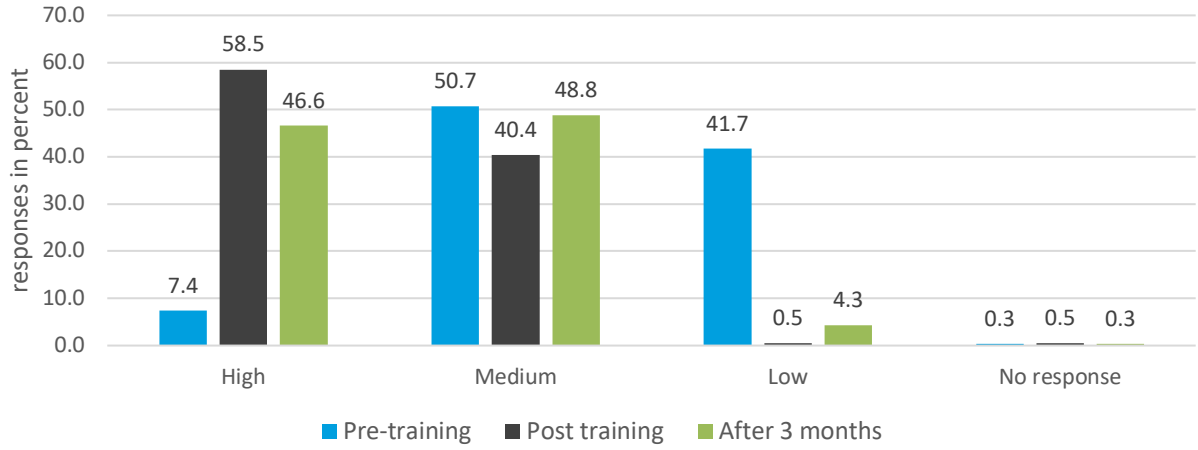
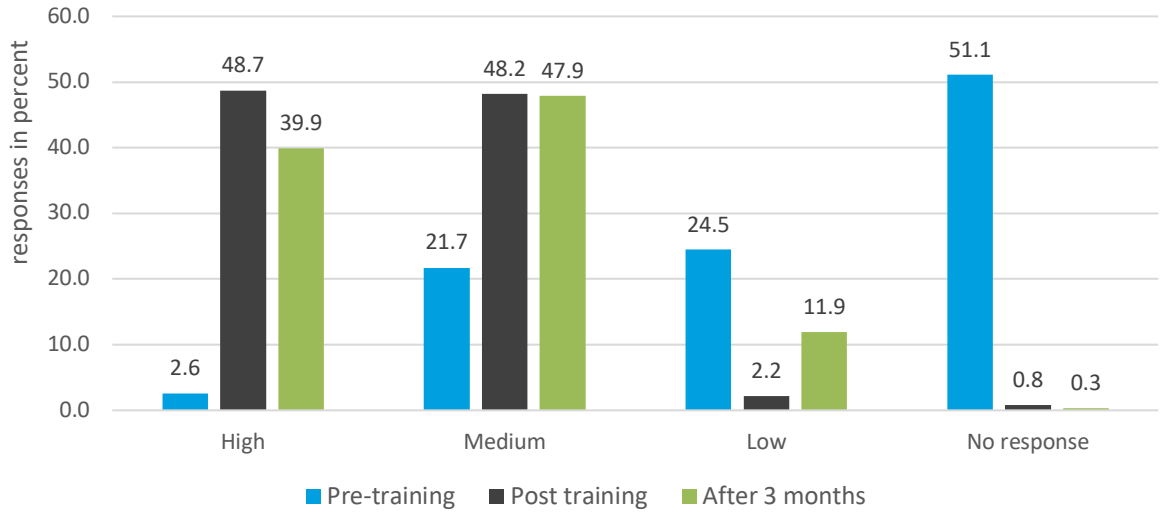


Figure 2.5 demonstrates the increase in participants' (n=328) ability to identify suicidal ideation and behaviour from a low 9.8 per cent pre-training to 64.8 per cent post-training. However, this declined slightly to 53.7 per cent after three months, implying the need for continuous reinforcement of the training. While there was a decline in the number of respondents who said their ability to identify suicide ideation was high three months after the workshop, the data indicates that these mostly moved to the medium assessment of capability. Similarly, almost all of the respondents who indicated that their ability to identify suicide ideation before the training was

low, were later found to be either high or medium in this parameter at both end of training and three months later, indicating good sustainability in these improvements.

Similarly, Figure 2.6 shows a boost in participants' skills in communicating with people experiencing suicidal distress. Initially those who perceived their ability to be high, rose from 7.4 per cent to 58.5 per cent after training, then slightly fell to 46.6 per cent three months later. Despite this decrease, there's an overall positive long-term effect as the vast majority of those who perceived their ability on this measure to be low before the training (42 per cent) remained at high or medium three months following training.

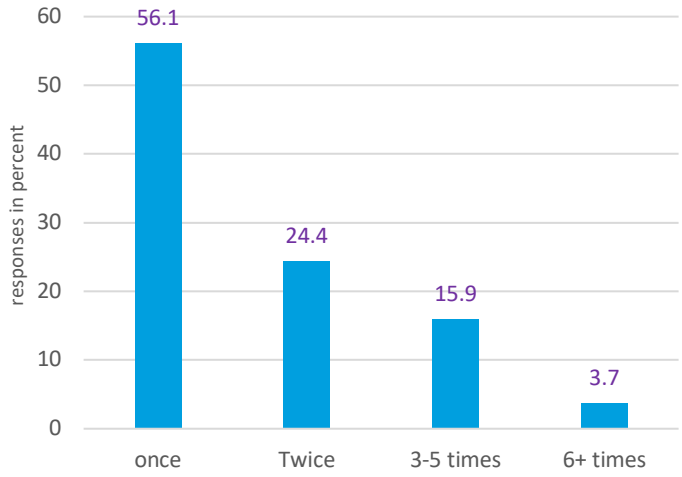
Figure 2.7 Ability to conduct a suicide intervention (n=328)

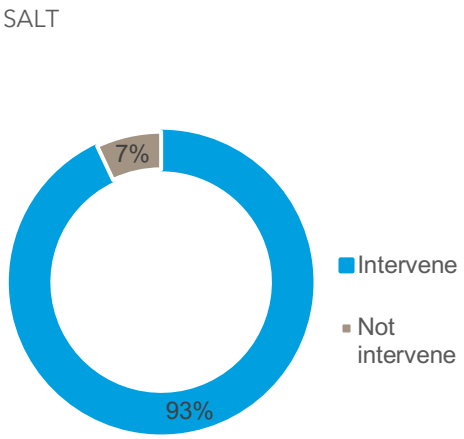


After training, 48.7 per cent of participants felt significantly more equipped to conduct suicide interventions, a figure that slightly dropped to 39.9 per cent after three months. Pre-training, 24.5 per cent reported low confidence, which reduced to 2.2 per cent post-training and then rose to 11.9 per cent after three months. The training's positive effect could potentially be sustained with more engagement and support for workshop participants in the period following the work.

Optimising the SALT method

Figure 2.8 Distribution of Successful Connections to Professionals for At-Risk Individuals



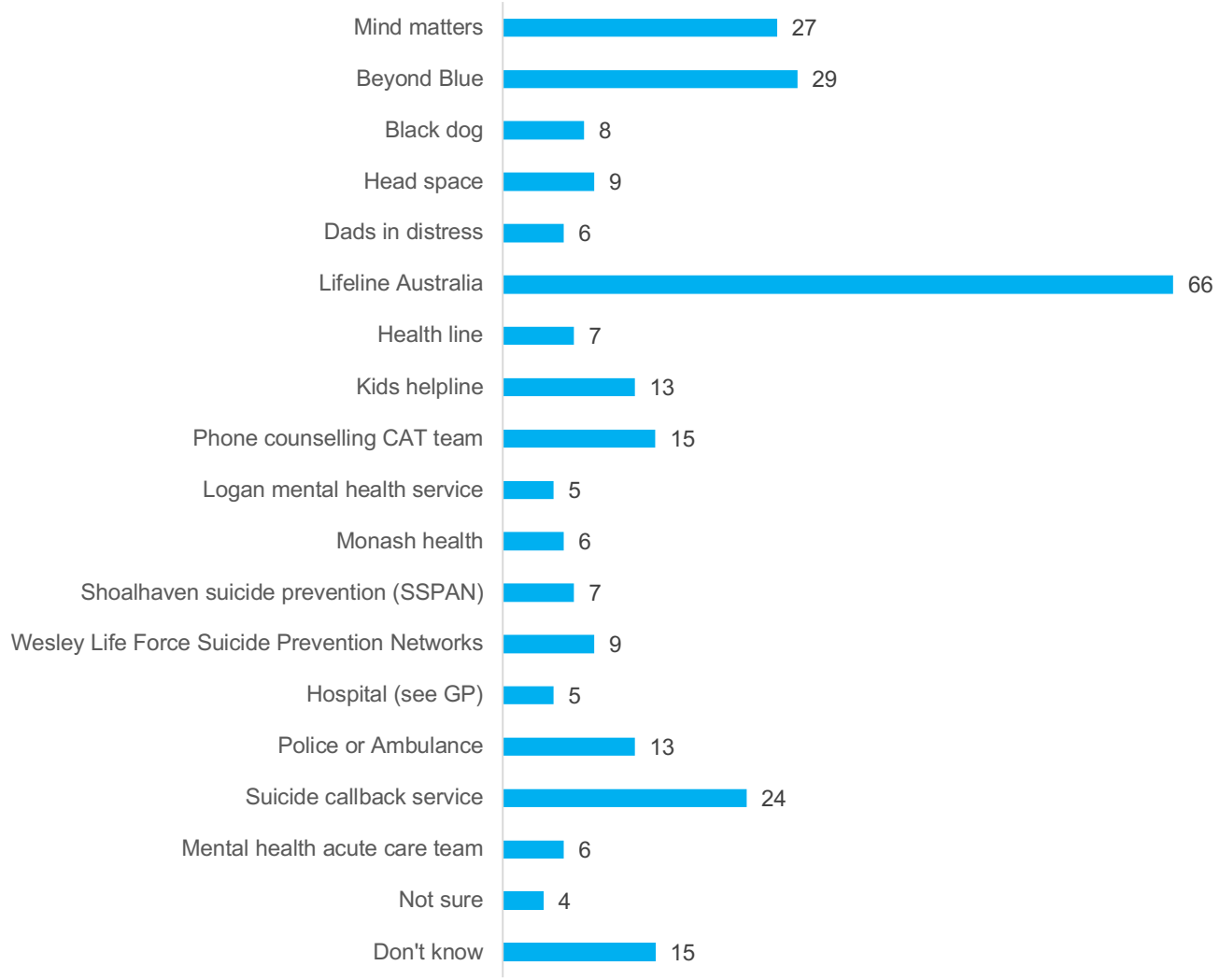


The SALT acronym (See; Ask; Listen; Take) is a crucial element of successful suicide prevention interventions. Following the three-month post workshop follow-up, a strong 85.4 per cent of participants could correctly recall the acronym. Those who remembered the acronym had a success rate of 93 per cent in interventions. Effective recall improves intervention success, corroborated by insights from participant interviews.

The SALT method is also highly effective in connecting at-risk people with professional help. Of the 100 respondents evaluated three months after training (representing 30.5 per cent of the 328 in the three-month post workshop sample), 82 per cent successfully utilised the method during crises, demonstrating statistical significance with a 95 per cent confidence level and a ±5 per cent margin of error. Participants most commonly made a single connection (56.1 per cent), while others made two (24.4 per cent), three to five (15.9 per cent), or six or more connections (3.7 per cent).

Directing people to available resources

Figure 2.10 Frequently mentioned resources and their frequency of mention: 3-months post-training (n=328)



Echoing participant interviews, resource analysis revealed increased awareness of mental health and suicide prevention services post-training. Participants recognised resources such as Lifeline Australia, Beyond Blue, Mind Matters and Suicide Callback. However, some respondents struggled to identify these resources, highlighting the need for ongoing awareness efforts or referral resources for suicide prevention services.

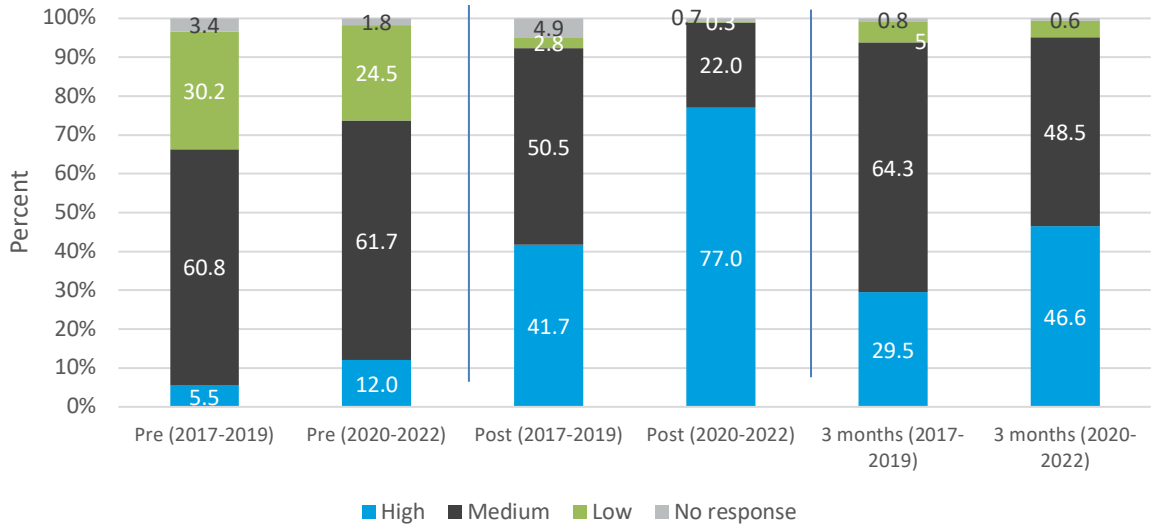
Objective 3: Impact of incorporating the 2019 AISRAP recommendations

This study further evaluated the effectiveness of incorporating recommendations from the 2019 AISRAP study into the Wesley LifeForce Training program. It compared two groups: (1) the 'pre-AISRAP-study group' with 1,227 participants from 2017-2019, and (2) the 'post-AISRAP study group' with 4,597 participants from 2020-2022. The focus was on respondents with significant knowledge gains, especially those advancing from low or moderate to high assessed knowledge levels. The study also measured the self-perceived knowledge level in each cohort, providing average scores. The 2019 AISRAP evaluation significantly influenced the training program's structure based on its key insights.

Analysis of self-perceived skills/knowledge level in each cohort

The data from 2017-2019 and 2020-2022 showed similar trends in self-perceived knowledge about suicide prevention.

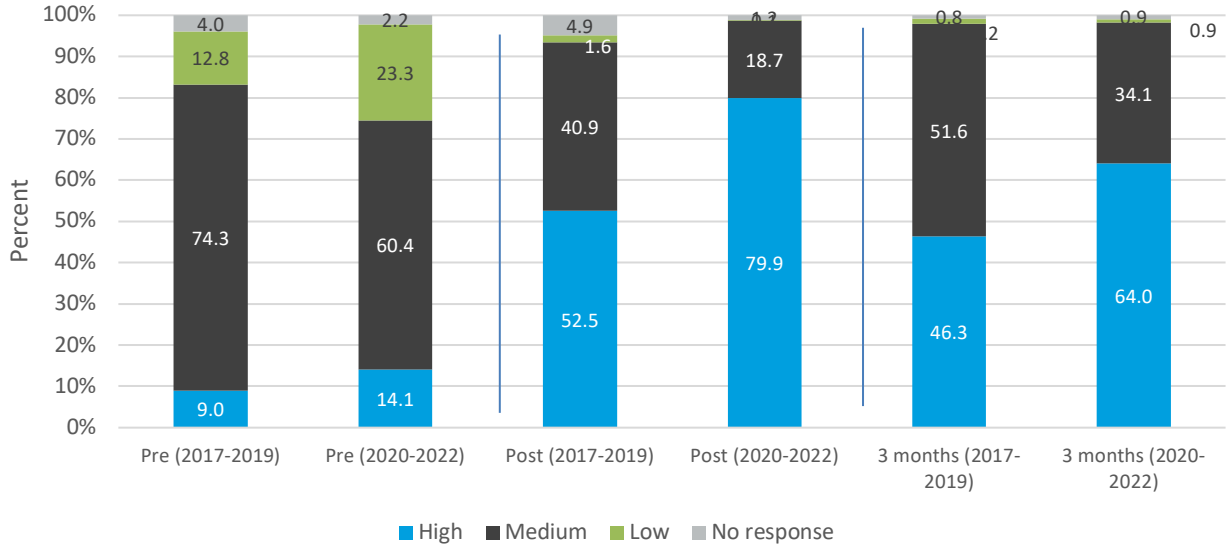
Figure 3.1 Knowledge/Understanding of incidences of suicide in Australia



In the 2017-2019 cohort, high knowledge on Australian suicide rates rose from 5.5 per cent pre-training to 41.7 per cent post-training, and then decreased to 29.5 per cent three months later. For the 2020-2022 cohort, the corresponding figures were 12 per cent for pre-training, 77 per cent for post-training and 46.6 per cent three months post-training.

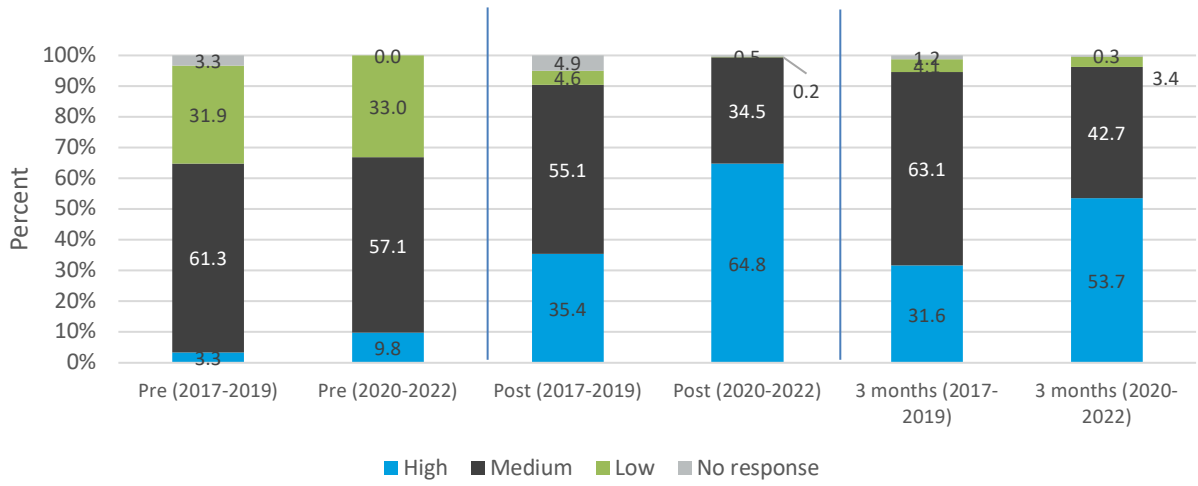
Similarly, low knowledge in the 2017-2019 group dropped from 30.2 per cent pre-training to 2.8 per cent post-training, and then slightly increased to 5.3 per cent after three months. In the 2020-2022 group, these numbers were 24.5 per cent pre-training, near-zero (0.3 per cent) post-training, and 4.3 per cent three months post-training.

Figure 3.2 Knowledge/Understanding of factors contributing to suicide in Australia



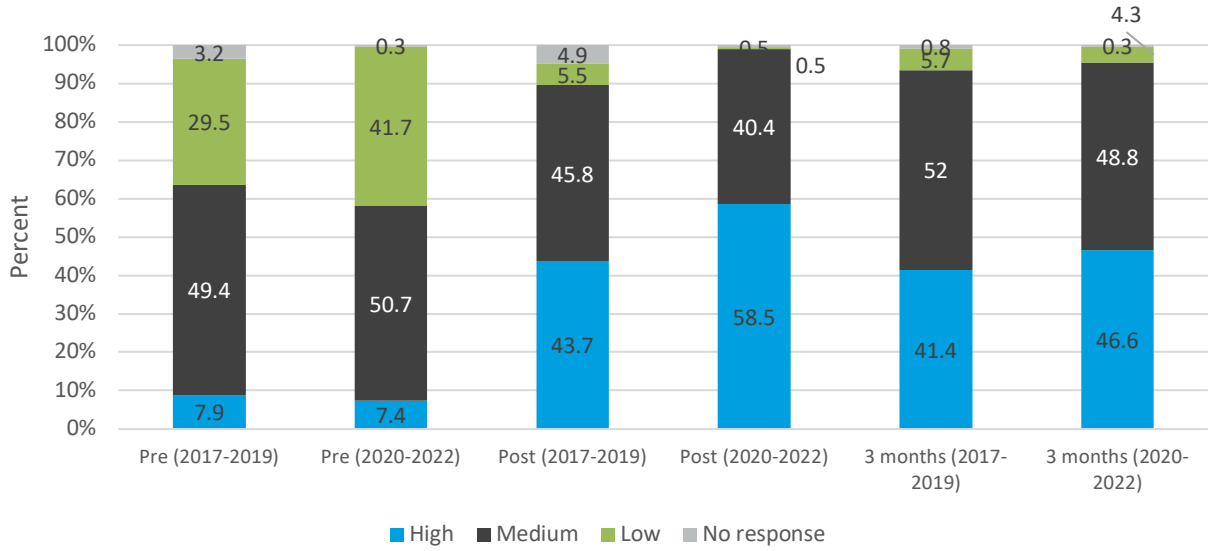
In terms of awareness of suicide factors, high knowledge rose from 9 per cent pre-training to 52.5 per cent post-training in the 2017-2019 cohort, then dropped to 46.3 per cent after three months. The 2020-2022 group saw an increase from 14.1 per cent pre-training to 79.9 per cent post-training, with a slight drop to 64 per cent after three months.

Figure 3.3 Ability to identify an Individual who may be experiencing /exhibiting suicidal behaviour



Participants' self-perceived ability to identify suicidal tendencies rose significantly post-training, from 3.3 per cent to 35.4 per cent for 2017-2019, and from 9.8 per cent to 64.8 per cent for 2020-2022 participants. This dropped slightly to 31.6 per cent and 53.7 per cent respectively after three months. The data illustrates that the updated training programs corresponded to substantially better outcomes for participants ability to identify people experiencing or exhibiting suicidal behaviour suicide.

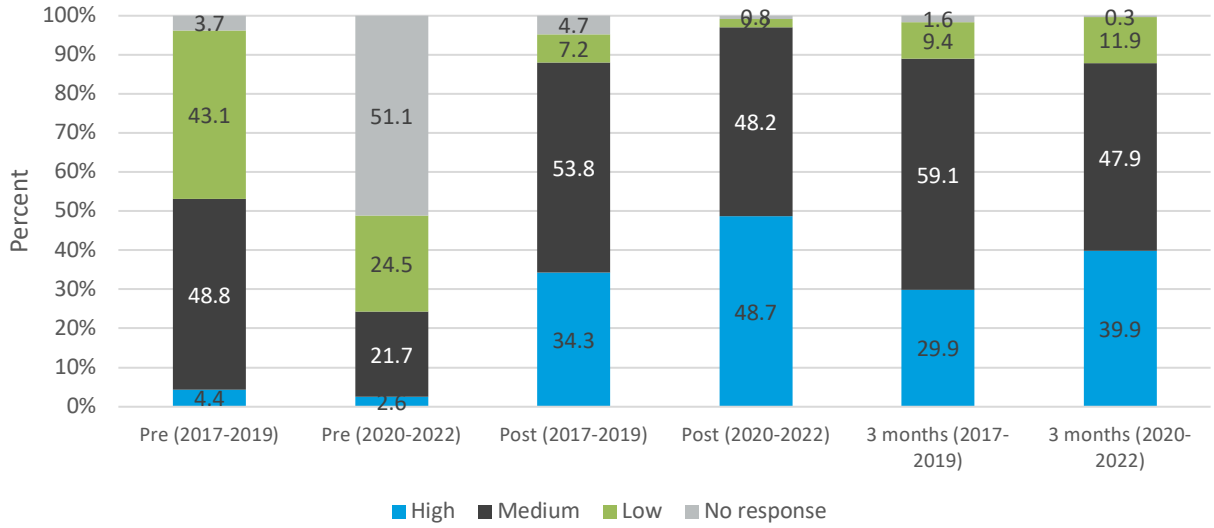
Figure 3.4 Ability to communicate appropriately with an individual experiencing /exhibiting suicidal behaviour



In both cohorts the training substantially improved participants' confidence to communicate with at-risk people. The 2017-2019 participants saw an increase from 7.9 per cent to 43.7 per cent, and 2020-2022 participants from 7.4 per cent to 58.5 per cent. These figures decreased slightly to 41.4 per cent and 46.6 per cent respectively after three months.

Before training, 29.5 per cent of 2017-2019 and 41.7 per cent of 2020-2022 participants reported low communication skills. These figures reduced to 5.5 per cent and 0.5 per cent respectively post-training, rising slightly to 5.7 per cent and 4.3 per cent after three months. The differences between the two cohorts was not substantial on this measure.

Figure 3.5 Ability to conduct a suicidal intervention

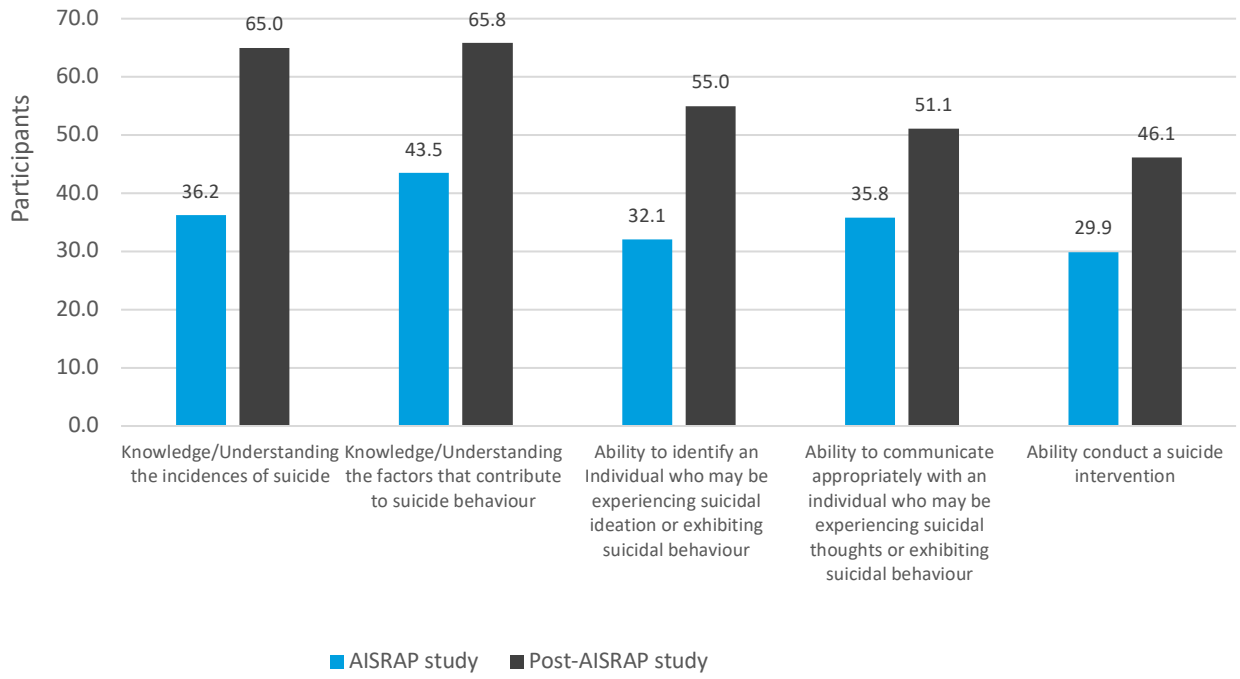


Before training, only 4.4 per cent of participants from 2017-2019 and 2.6 per cent of those 2020-2022 felt highly capable of performing suicide interventions. Post-training, these figures increased to 34.3 per cent and 48.7 per cent, respectively. Three months later, the percentages dropped slightly to 29.9 per cent for 2017-2019 and 39.9 per cent for 2020-2022 participants. The AISRAP updated program provided much better findings than the earlier training program. Interestingly, about half the sample of 2020-22 program participants did not respond to the pre-test question about their ability to conduct a suicide intervention, likely due to COVID-19 pandemic lockdowns that were taking place at this time, preventing people from coming together for organised activities.

Analysis of skill/knowledge level changes in each cohort

Additional analysis shows the training program conducted between 2020 and 2022 (post-AISRAP), significantly enhanced the participants' understanding of suicide prevention, outdoing the previous AISRAP group (2017-2019) in all areas. For example, post-AISRAP participants reported a 65 per cent increase in transitioning to high knowledge of suicide incidences in Australia, compared to a 36.2 per cent increase in the pre-AISRAP group. Improvements were noted across several parameters as indicated in the table below.

Figure 3.6 Change in trainees with perceived 'high knowledge' before and after training (2017-2019/2020-2022)



Analysis of skill/knowledge level changes in participants across three-time points: Mean response on 5 items (scale: 1-3) and overall rating

Figure 3.7 Post-AISRAP 2020-2022 Study cohort: Participant findings on 'high-level' knowledge and skills:

Items	Before Training	After Training	>3 months	T-test	P (95%CI)
Understanding the incidences of suicide in Australia	1.83	2.77	2.43	5121.67	0.000
Understanding the factors that contribute to suicide in Australia	1.94	2.81	2.64	5538.15	0.000
Skill in recognising an individual who is experiencing suicidal ideation or exhibiting suicidal behaviour	1.83	2.65	2.51	4740.86	0.001
Skill in communicating effectively with an individual experiencing suicidal thoughts or exhibiting suicidal behaviour	1.72	2.58	2.43	4535.46	0.001
Skill in performing a suicide intervention	1.59	2.47	2.28	4191.19	0.001
Overall Level of Skill/Knowledge	1.78	2.66	2.46	4111.12	0.001

Figure 3.8 AISRAP 2017-2019 Study cohort: Participant findings on 'high-level' knowledge and skills:

Items	Before Training	After Training	>3 months	T-test	P (95%CI)
Understanding the incidences of suicide in Australia	1.77	2.42	2.28	26.539	0.000
Understanding the factors that contribute to suicide in Australia	1.87	2.55	2.45	27.831	0.000
Skill in recognising an individual who is experiencing suicidal ideation or exhibiting suicidal behaviour	1.74	2.36	2.28	26.942	0.001
Skill in communicating effectively with an individual experiencing suicidal thoughts or exhibiting suicidal behaviour	1.65	2.45	2.40	27.054	0.000
Skill in performing a suicide intervention	1.69	2.34	2.30	28.722	0.000
Overall Level of Skill/Knowledge	1.74	2.42	2.34		

The effectiveness of the 2017-2019 and 2020-2022 training programs in enhancing participants' knowledge and skills in suicide prevention were further evaluated with tests of significance to assess whether differences were meaningful and not due to sample size of chance associations. The analysis, supported by t-tests and p-values, showed that the 2020-2022 training program was significantly more effective than its 2017-2019 predecessor.

This improvement was evident across various areas such as understanding suicide, identifying risk factors developing communication skills and suicide intervention proficiency. While both programs led to increased mean scores, indicating improved understanding and communication, the 2020-2022 participants exhibited more significant growth. There was a more notable growth in comprehension, understanding, identification, communication and intervention skills, despite a slight decline in scores three months post-training. This group demonstrated larger and more consistent improvements, substantiated by highly significant p-values (0.000 or 0.001).

Overall, compared to the 2017-2019 program, the 2020-2022 training program was more effective, producing higher post-training scores and achieving larger, more consistent improvements in participants' skills and knowledge related to suicide prevention.

Conclusion

This study sought to assess the effectiveness of Wesley LifeForce Suicide Prevention Training, and specifically the SALT method to gauge participants' improvements in understanding, skills, confidence and their ability to handle the complex responsibilities involved in suicide intervention.

The study had three main objectives:

1. Gain insights into the effectiveness of the Wesley LifeForce Training gatekeeper program.
2. Evaluate the impacts of training on gatekeeper knowledge, attitudes and skills, and ascertain the level of success achieved by the SALT method, implemented in Wesley LifeForce Training.
3. Assess the impact of incorporating the recommendations from the 2019 AISRAP study and determine the effectiveness of their implementation.

For the evaluation, a new survey was developed and sent to workshop participants who had completed training in the past two years to assess the sustainability of effects. The survey methods included both online questionnaires and phone interviews. The study also used pre-existing data collected for evaluation purposes at three stages: (1) before training; (2) immediately post-training; and (3) three months post-training. This historical data was reanalysed to compare results prior to the AISRAP, with workshops conducted after the AISRAP recommendations were implemented.

Objective 1

There was strong evidence that workshop participants were highly satisfied with the training, primarily attributing this to the quality and expertise of facilitators. Other factors contributing to participant satisfaction included the course structure, content and practical strategies. Factors participants mentioned that could be improved were more in-depth training, more role plays and other delivery methods as well as fostering a safer and more supportive environment during the workshops. In relation to content and practical strategies, participants also requested for more content relating to acute situations, advice on appropriate responses for different scenarios, role plays on how to handle situations involving suicide ideation and more content on Indigenous issues relating to suicidal thoughts and management.

The findings showed that the SALT method is effective in providing participants with the tools to feel effective when speaking to a person experiencing suicidal thoughts, with significant increases in key knowledge and skill sets essential for this task. While these improvements dropped slightly over time, there were considerable long-lasting benefits attesting to the sustainability of training impact. There was some evidence that benefits might actually strengthened over time, rather than diminishing which is often the case with knowledge and skill interventions.

The feedback has offered insights for improving long term knowledge retention. Suggestions included providing quick reference guides as workshop handout materials that could be later used in workspaces or other locations. Senior and experienced training participants could also benefit from an extended or additional higher-level course to satisfy their need for greater proficiency. Similarly, a refresher course or check-in post training to talk through real life cases, could further cement new learning.

The workshops had significant improvements on participant confidence in being able to conduct an intervention with a person at risk of suicide. After the workshop, participants' recall of suicide statistics was quite strong, though not as well as other aspects. However, this did not affect their ability to intervene.

Objective 2

With the reanalysis of the pre-existing questionnaires administered pre-workshop, post-workshop and three months later, the evidence was again, strongly in support of the positive impact of the SALT method incorporated in the training. The data illustrated that there was a considerable improvement immediately following the workshop and that these changes largely remained evident three months later.

Objective 3

The reanalysis of data from past surveys was used to compare courses conducted prior to the implementation of the AISRAP recommendations (2017-2019) with those conducted after the recommendations were incorporated into the training materials (2020-2022). The data showed that across all survey items in both time points, there was a significant and strong increase in key suicide prevention indicators following intervention, and while this generally dropped a little at three months, there was still a considerable advantage over pre-workshop measures. Importantly, workshops conducted after implementing the AISRAP recommendations exhibited a generalised better result at post-workshop and three months, than the pre-AISRAP workshops, highlighting the benefits of the updated program.

Endnotes

[1] Gatekeepers are trained in suicide risk identification and response using the S.A.L.T method – See signs, Ask about intent, Listen, Take action.

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review of risk factors associated to suicide attempts and completed suicides. *Neuroscience & Biobehavioral Reviews*, *127*, pp.193-211.

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For more information about this study contact:
Jim Wackett
General Manager, Wesley Communications & Advocacy
0448 415 546
jim.wackett@wesleymission.org.au

Wesley Mission
220 Pitt Street, Sydney NSW 2000
PO Box A5555, Sydney South NSW 1235
(02) 9263 5555
communications@wesleymission.org.au
wesleymission.org.au

CEO and Superintendent: Rev Stu Cameron
ABN 42 164 655 145

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