



Evaluation of the Wesley LifeForce General Practitioner Suicide Prevention Training Program

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December 2019

The Suicide Prevention Skills Training Program for General Practitioners has been accredited as Continuing Professional Development (CPD) by:



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1 Introduction

Suicide is a key mental health issue in Australia today. The current reported rate of suicide in Australia is 12.2 per 100,000 population (2018).

The previous National Mental Health Priorities and strategies have identified suicide prevention as a key health target.

Over the last three years there has been specific emphasis on suicide prevention, and the Towards Zero initiative currently has bipartisan political support and is being championed by both the Prime Minister and the Health Minister. It is also a Council of Australian Governments (COAG) state and federal target initiative. Implementable programs such as Wesley LifeForce Suicide Prevention Training provide a practical and scalable training option in this area of practice in primary care.

This evaluation is to assist Wesley Mission in further developing and potentially promoting this existing program more widely.

Wesley LifeForce Suicide Prevention Training has been occurring since 1995. Since 2014 General Practitioner (GP) programs have been running through key local GP organisations. First through Divisions of General Practice, then through Medicare Locals and most recently through Primary Health Networks. No other widely available courses are available with this preventative focus currently.

The program has undergone various updates through that time, but the core of the program has remained the same.

The core of this program is the 'SALT' principle (See, Ask, Listen, Tell or Take), which improves a doctor or allied health team member's ability to provide a framework in which they can support a person with suicidal ideation.

The training focuses on the development of personal resilience in the individual as well as giving a framework to the clinician and their team, allowing them to feel comfortable in asking about possible suicide ideation.

The program also reinforces the clinical need for teamwork and provides clinicians with the ability to be supported by the practice team in dealing with a patient exhibiting suicidal ideation.

The ability to work as a team has been recognised as very beneficial and is the focus of lived experience advocacy in the area of suicide prevention and post suicide attempts.

The program occurs over a six-hour workshop comprising two sessions that could be provided consecutively (preferred) or separated in time.

Within the program, the key 'red flags' that can be associated with suicide are enumerated and discussed. Also discussed are the triggers and tipping points of individuals.

The benefits of this training, apart from learning the theory of how to react and what to ask, is how to practically deal with the situation that you find yourself in. To improve confidence, participants can practically implement the skills in a safe environment with role play and feedback.

Adult learning principles support this approach, and it is clear that a significant number of opportunities to intervene with a patient who has suicidal ideation are lost. This happens when a person they consult is not alerted to the 'signs' and hence, does not open the conversation.

This evaluation has focused on participants over the last two-year period.

2 Methodology

The evaluation population were past participants of Wesley LifeForce Suicide Prevention Training from 2017 and 2018.

The initial proposed methodology was to conduct an email questionnaire, collate the responses, including the comments, then proceed to some one-on-one interviews and focus groups.

The questionnaire totaled 14 items ranked on a Likert scale or free written answer, with a comment section for most items, and a general question for further comments. Basic demographics were sought, and an assurance of anonymous attribution was given. A brief letter of explanation and introduction to purpose was included with the questionnaire.

The questionnaire appears in Appendix 1 of this report.

A total of 100 participants were eligible for inclusion in the sample group. Initial questionnaires were emailed in the second week of June 2019. The questionnaire was resent to non-responders after two and four weeks. Six email addresses were no longer active, so were excluded from follow up.

The initial response rate to the first email was promising and quick, with a three per cent overall response rate in the first 72 hours. At the end of the first week, a total of seven responses were received. Unfortunately, no further responses were forthcoming despite the two follow up emails.

At that point, a change in methodology was instituted, and the investigator resorted to directly calling the eligible participants at their workplaces. This process took some time.

A total of 103 participants were contacted directly, having been picked at random from the list provided. Randomisation occurred by drawing names from a hat with all names included. This process led to 29 participants for the evaluation questions (a positive response rate of 28 per cent to direct contact). This response was surprisingly positive from previous experience but provided the necessary numbers to make the evaluation worthwhile and was time consuming.

Up to three calls were made to contact the potential survey participants.

Once contact had been made with these calls, a 20-minute time block was negotiated with the consenting participant at a time of their choosing to conduct the interview.

These interviews occurred mainly during lunchtimes or after hours. The interviews were completed in early October 2019. The original questionnaire was used as the basis of the discussion at that interview contact, and the responses were recorded for analysis. Qualitative analysis was used for the comments with thematic analysis being undertaken for the comments received. Quantitative items were analysed via a percentage and graphing approach. A total of 35 respondents to the evaluation was achieved (35 per cent of the total eligible cohort). This was regarded by the evaluator as being a sufficient sample size.

As part of the interview, participants were asked if they would consent to further follow up. None indicated a willingness to be contacted again. Respondents did wish the program well.

Participants were formally thanked at that time on behalf of the evaluator and on behalf of Wesley Mission. Participants were given the investigator's contact details in case they wished to add to the discussion or contact the investigator for any reason. To date, no further contacts have been received by the investigator.

3 Results

3.1 Overview

The results section will largely follow the structure of the questionnaire as posed to the participants.

Each area will have a thematic section, which will discuss the statements and thrusts of the participants when the question was discussed in more depth with them. The quantitative data will be shown graphically, and a discussion and analysis of the results will be included. Qualitative analysis and comment will follow the quantitative measures and will generally follow a thematic approach.

Over the evaluation period, 100 participants completed the training package. The initial questionnaire was sent to the email addresses as provided. A six per cent return of email (six in number) with the email no longer in use occurred. This was checked, and a further email sent with the same response. Within 72 hours, three participants had responded, and at the end of one week, seven participants had responded to the email questionnaire. However, despite several follow up emails, no further email responses were received.

The overall aim was to have a 30 per cent response rate to make this evaluation robust. After telephone interviews, the total final number of responses for analysis was 35 (see Methodology section for selection criteria).

3.2 Demographics

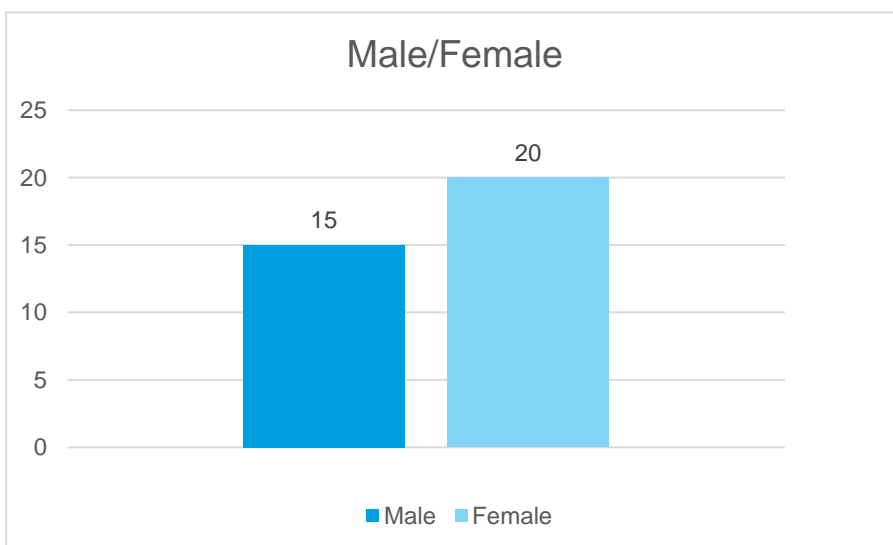
The final response sample size of 35 was 35 per cent of the possible respondents.

3.2.1 Male and female

The sample was comprised of 15 male (43 per cent) responders and 20 female (57 per cent) responders (see graph 1).

A total of 36,930 GPs are working in Australia (Health Workforce data 2017/18 – Health of the Nation report, RACGP 2019), of which 46 per cent are female and 52 per cent are male. Overall, this sample may represent the commonly held view that with the approximately 35 per cent presentation rate to GPs of mental health issues (BEACH data 2012), female practitioners are more likely to be approached than their male counterparts for these issues.

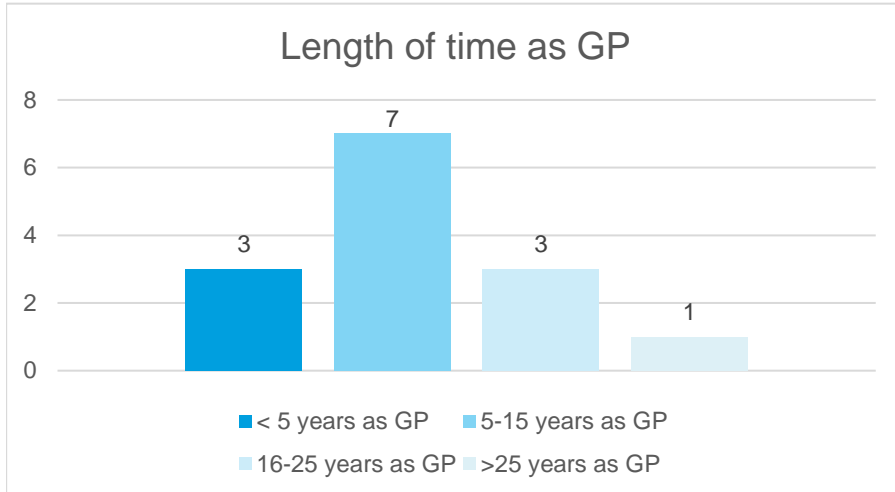
Graph 1



3.2.2 Length of time as a General Practitioner (GP)

Age ranges or years of practice were not asked for specifically in the initial survey. However, from the interview group (28 responders), 14 did mention their length of time in practice (Graph 2). Essentially this suggests that the responders were an appropriate cross-section of general practitioners and represented the various levels of practice experience across the lifecycle of a practitioner.

Graph 2



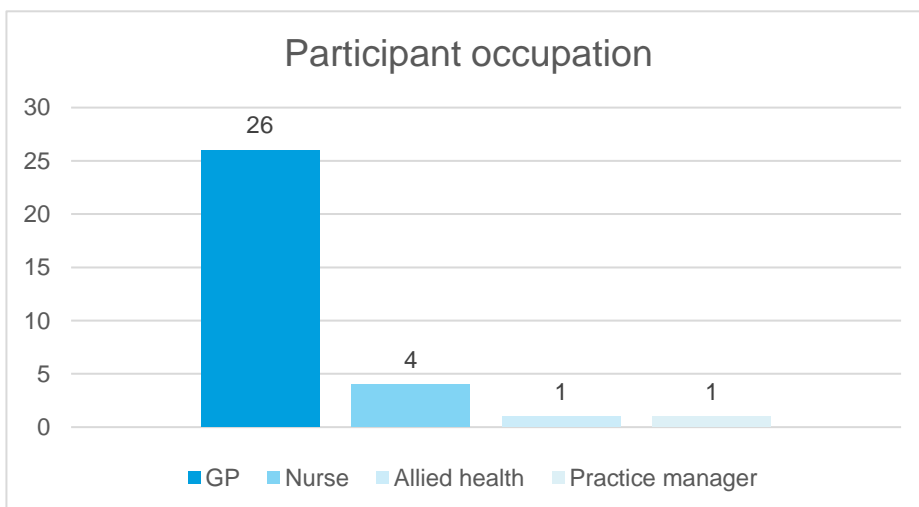
3.2.3 Participant occupation

This cross-section would also be consistent with the lifelong learning cycle with younger GPs relying on their training organisations for their training needs. Those with five to 15 years of experience looking actively to expand their knowledge base, depending on their practice needs.

As the program is also open to practice team members, the qualification/title of the responder was requested.

As shown in Graph 3 below, a majority of participants were GPs. However, approximately 12 per cent of the sample were practice nurses. The allied health member was a social worker, and a practice manager also responded.

Graph 3



3.2.4 Number of practice team members

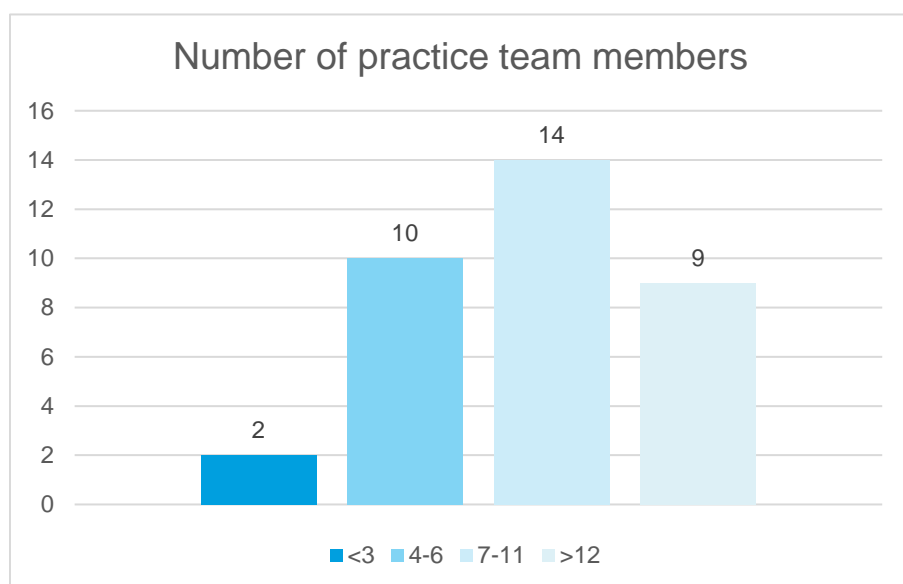
The practice team size was also requested (see Graph 4).

The tendency for General Practice over the last 20 years has been to move to larger practice sizes for many reasons, including the need for adequate staffing to provide comprehensive community care but also to facilitate team-based care. Most general practices are now between six and 12 GPs and staff. It is also true that much larger practices are becoming more common.

The practice locations of the doctors were not asked for, due to privacy, and as such, it is not possible to say if there is a metropolitan, outer urban, large rural, small rural or remote distribution in this demographic. However, it is true that some of the participants did list rural locations in contacts, but these were not looked at in terms of the record for analysis.

The team member numbers of the GPs in the survey, again suggest that this is a representative survey of current GP workforce. The fact that four respondents were practice nurses allowed increased relevance to the team-based themes in the analysis.

Graph 4



3.3 Questions relating to Wesley LifeForce Suicide Prevention Training

In this section, the analysis will follow the sequence of the questions as asked of participants.

Was Wesley LifeForce Suicide Prevention Training helpful?

This question was general in nature and the response overwhelmingly positive.

Ninety-seven per cent of respondents found the training positive (85 per cent strongly agree, and 12 per cent agree).

One responder said that the program was neither helpful or unhelpful. When asked, they stated they already used a similar type approach with patients with suicide ideation and did not get much new assistance from the course.

On the other side of the ledger, positive themes were grouped around new and practical information, a program that could be used in my practice and a positive learning experience generally.

Some examples of comments were:

“A great program that I learned a lot from.”

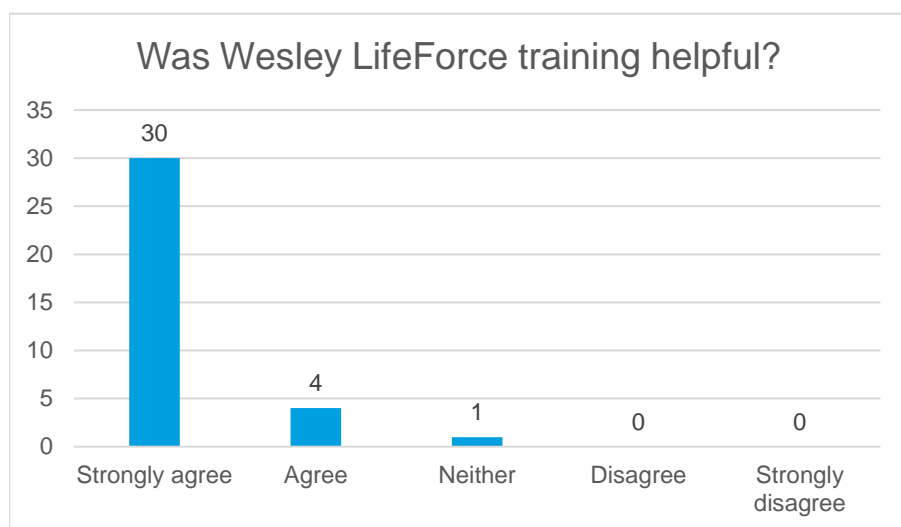
“... would recommend this to all GPs and particularly to GP registrars.”

“Best practical program I have attended.”

“I learnt a lot and it has changed the way I practice.”

“I looked forward to implementing this in my practice.”

Graph 5



3.3.1 I use the principles in my day-to-day practice

This question elicited a strongly positive outcome.

Sixty-six per cent of respondents strongly agree and 29 per cent agree to the question. Five per cent neither agree nor disagree to using the technique.

Most respondents were complimentary about the logic of the approach and the ability for it to fit to their clinical practice.

The respondents who responded ‘neither’, both stated that they would not use the approach as it did not fit their consulting style. One responder suggested that they had used an approach over many years based on cognitive behavioural and goal-based approaches and was happy with that approach.

That responder did state that the principles of the program were logical and somewhat similar to what they did already. They felt that if someone did not have a working approach already to dealing with suicidal ideation in a patient, this program would equip them with a good approach that was readily usable.

Of the positive responders, the main issues were the logical nature of the approach, the ability of the approach to be used after the workshop, the fact that they had some practical role play to consolidate the approach in their minds and that the approach would not take a large amount of time within the consult to perform.

Some comments were:

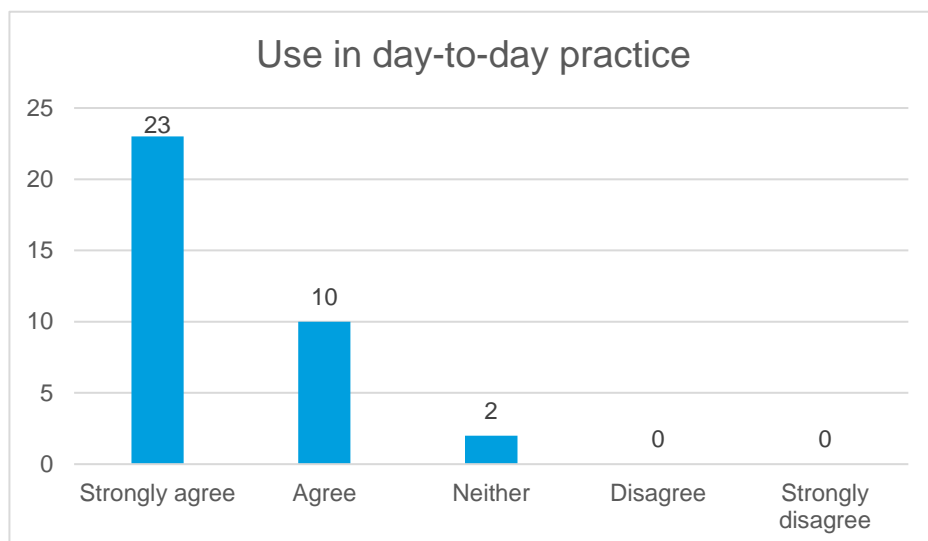
“Overall, this approach was logical and I easily incorporated it into the way I practice.”

“I like this technique and am using it in normal consultations as well.”

“The approach has worked well for me. I needed to use the technique a few days after the workshop and was amazed how well it worked. I have continued to use it. I have discussed it with some of my colleagues.”

“I have used the approach a lot, particularly in those with bad depression and it does work well. I am pleased I did the training.”

Graph 6



3.3.2 How recently have you used the technique you learned?

In fact, 77 per cent had used the technique in the last three months.

This indicates that the respondents found the technique helpful and were incorporating it into their everyday practices.

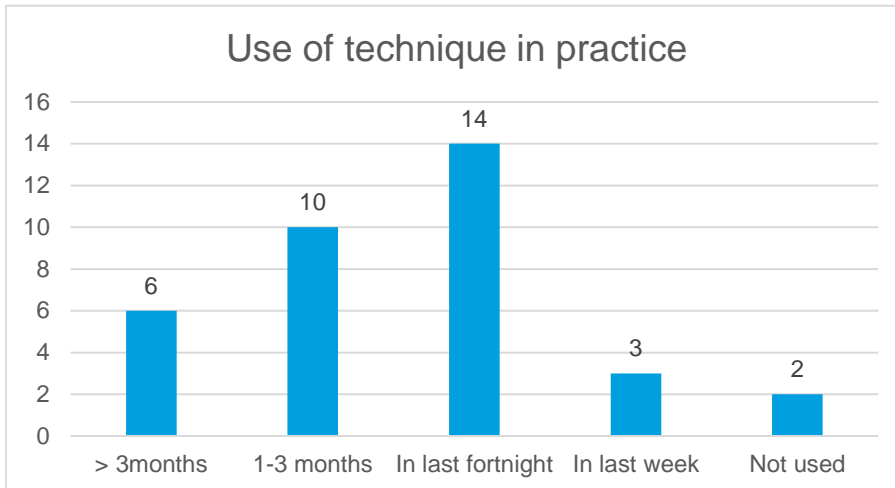
On discussion with respondents, the high level of usage of the technique was because respondents were using the technique in more than just those with suicidal ideation.

This is a positive outcome.

Overall patients were reported to respond positively to the technique. Respondents stated that the technique worked well in those with forms of depression, but some had some difficulties when trying to utilise the technique on patients, who in fact had issues with lack of insight. This is consistent with the technique.

The two respondents who had not used the technique, found it did not suit their clinical style and hence, they did not use it themselves, although they felt it probably would suit most practitioners – just not them.

Graph 7



3.3.3 Wesley LifeForce Suicide Prevention Training provided me with additional skills when dealing with patients with suicidal ideation.

In this question, the responses were positive (see Graph 8). Ninety-seven per cent felt the training had provided additional skills (71 per cent strongly agree, 16 percent agree).

One respondent felt that it did not aid them. That responder had been in practice for some time and felt their technique was working well. They did suggest that the technique “seems to have merit but is not for me”.

Some comments made were:

“Great addition to my skills.”

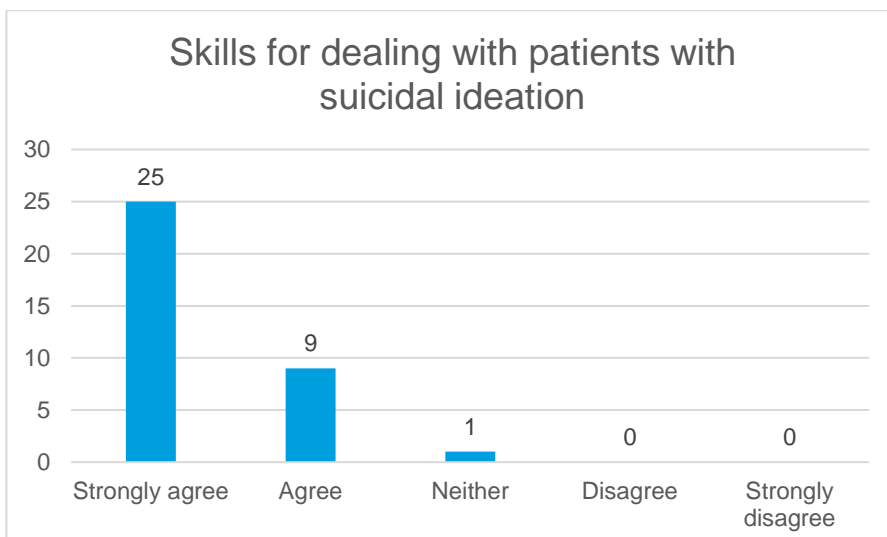
“I have been able to use these skills often and they are easy to use.”

“This works well.”

“Recommend these skills to doctors I teach. They do work.”

“This has helped my depressed and suicidal patients a lot and has been a good building block for my approach to their care.”

Graph 8



3.3.4 The SALT principles I have learned have been beneficial in my clinical practice.

This question focused on the core element of Wesley LifeForce Suicide Prevention Training and how it was perceived.

The SALT process was discussed with respondents. This was a positive response (see Graph 9).

Like previous questions, the one non-positive response was due to that practitioner having their own approach to dealing with this clinical situation and did not feel they needed to change.

Overall, the theme analysis of the discussions was that SALT was a straightforward, logical and simple to remember framework.

SALT was seen by practitioners as something they had not come across in their earlier training and that the mnemonic was easy to memorise and readily useable.

Again, practitioners commonly stated that they found the SALT approach worked well within the consultation and did not take excessive time to perform. It also provided the consultation with a goal, that could then be monitored in follow up and future consultations.

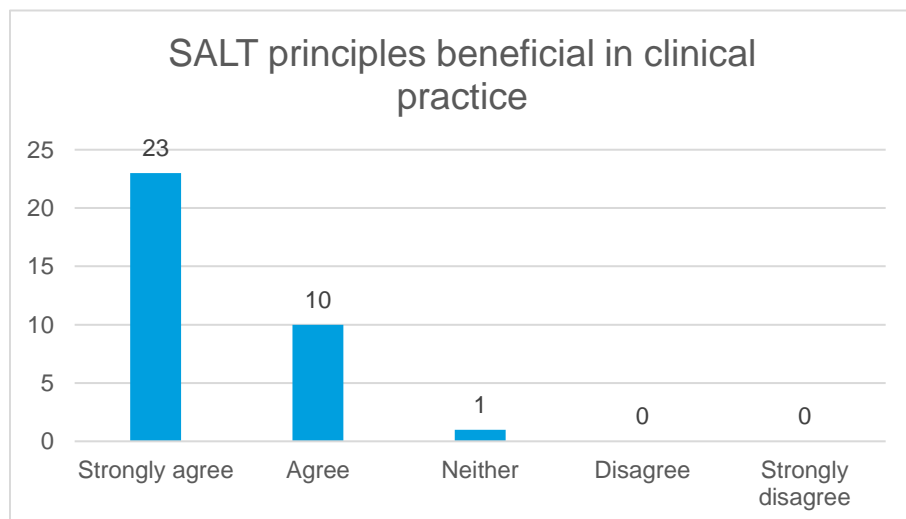
As in previous questions, the comments elicited were positive, such as:

“I wish I had been taught this simple logical approach earlier.”

“Like the HEADSS mnemonic for adolescents, SALT has provided me with a good framework in dealing with a patient who may be suicidal.”

“I have always found dealing with a patient who is suicidal challenging. This technique has helped make me feel more comfortable.”

Graph 9



3.3.5 How useful were the SALT principles when used clinically?

This question provided overwhelming support for the usefulness of the SALT principles (see graph 10).

Comments made include:

“A great addition to my abilities.”

“I needed practice, but it has been good to use.”

“I have limited specialist support in this area, and this has provided me with more confidence to open the discussion around suicide and depression with my patients.”

“It has been good, but I rarely see people with suicide problems in my practice.”

“I would have liked some more practice or access to videos to watch to feel more confident in using this.”

When asked about benefit to you as a practitioner (Graph 11), a strong positive was recorded. Those that were unsure stated that they felt that they were not confident with the technique and needed more practice. They have however, persisted with the technique and value it.

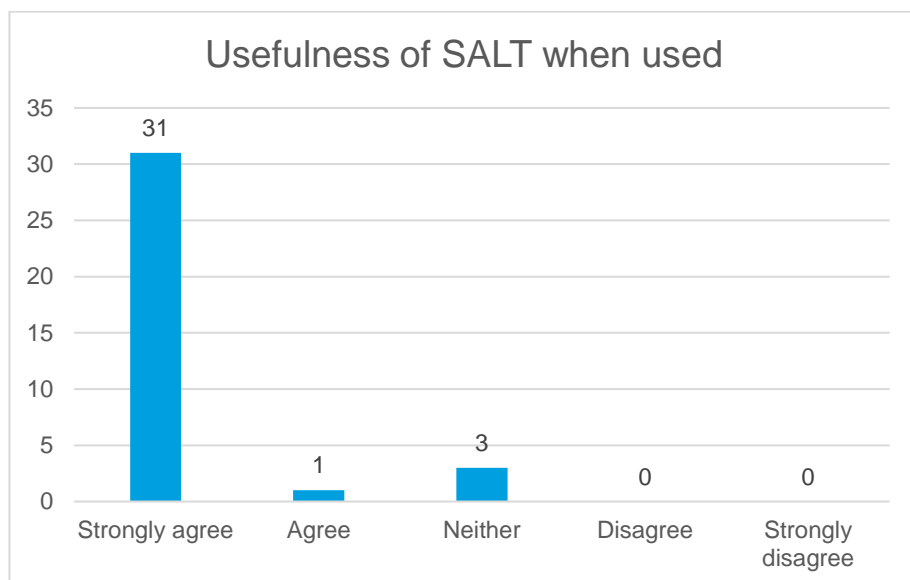
When asked about the difference the technique had made to the patients they had used it on, again the response was positive.

The comments considered that the more the technique was used by the practitioner, the better and easier it became. This is a common finding with any technique that takes time to master. The positive thing in the responses was the fact that the practitioners were happy to persist and utilise this approach as they perceived it as helpful.

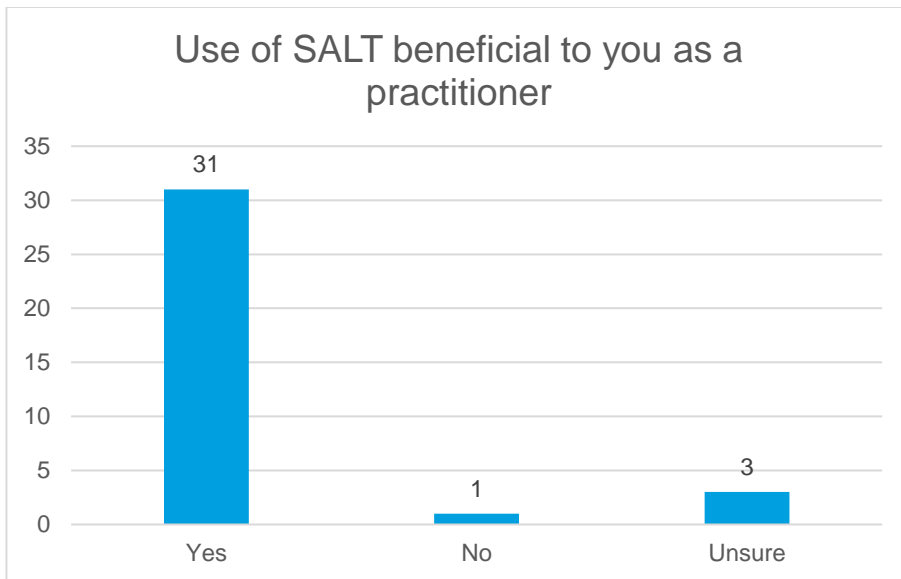
The comments about the patients who appeared not to be helped were of interest. The practitioners who felt this commented that the patients they used the technique on (in each practitioner’s cases), were found to have problems with their clinical insight as time went on. The cases were a first presentation of schizophrenia and another with a severe bipolar disorder. The practitioners commented that the patients benefitted at the time of the consultation but did not progress and ended requiring specialist psychiatric care.

Most of the practitioners did comment that they felt that they did not know of other simple frameworks in this area, and hence this was very helpful.

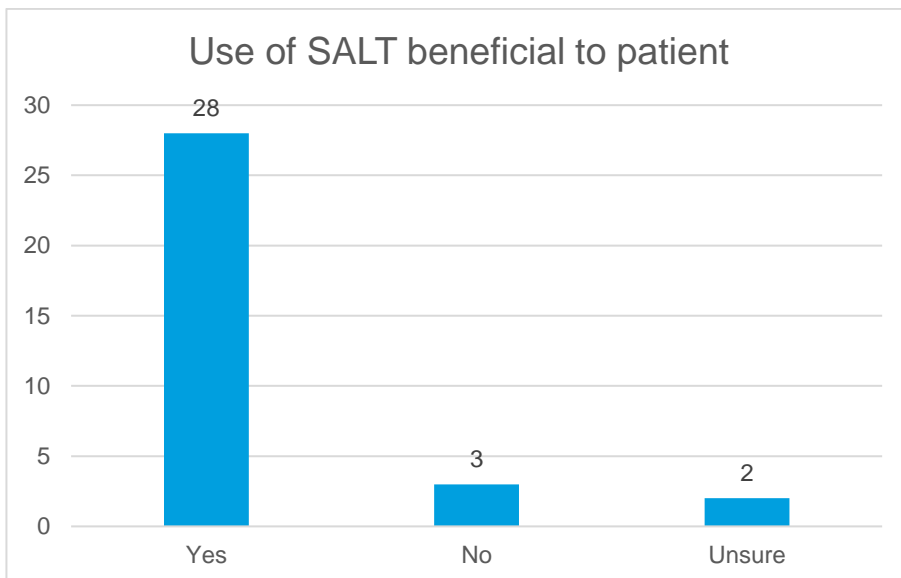
Graph 10



Graph 11



Graph 12



3.3.6 Was Wesley LifeForce Suicide Prevention Training translatable to your practice team?

As noted in Graph 13, this was split in response.

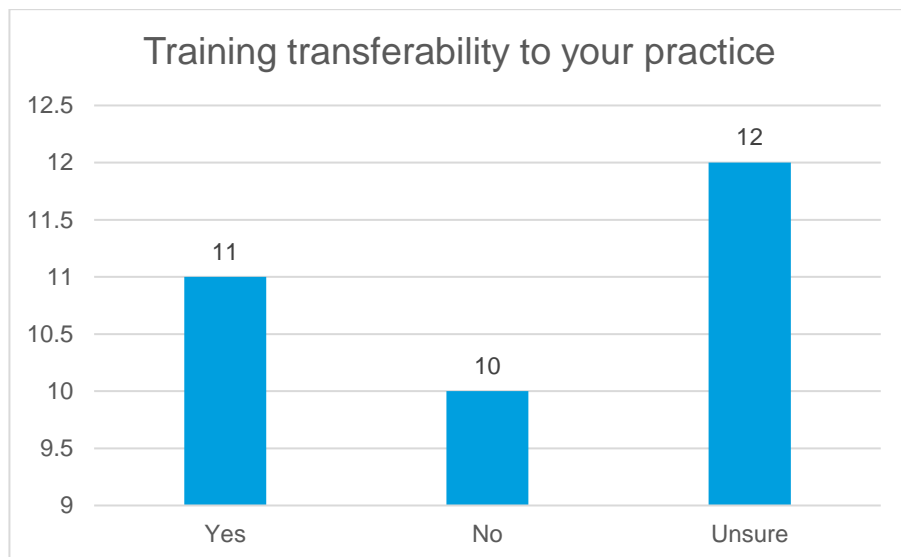
Thirty-one per cent felt that it was translatable (this included the nurses and practice managers in the sample). Twenty-nine percent felt that it would not translate to the wider practice team. The largest response was 40 per cent who felt unsure about the question.

In discussing this question, non-positive respondent GPs felt they were not teachers and as such, did not have the skills to train others (40 per cent). Thirty per cent of respondents felt that the skills were individual, so they would not be helpful for the skills to be known by the primary care team. Twenty per cent did not have a team in their practice and 10 per cent felt their team members did not have the clinical ability to use this technique.

The practice nurses included in the analysis were all positive that it would enhance the team in their practice and be a good baseline technique, so that the team could better know what all members were attempting in this area of practice.

This will be discussed further later in the report.

Graph 13



3.3.7 Suicide resources known

When asked about their knowledge of resources for suicide prevention, most struggled to identify many resources available to them apart from local Mental Health Crisis teams (CAT), and emergency departments.

Many practitioners discussed the difficulty of obtaining semi-urgent and urgent appointments with psychiatrists privately, without going through emergency departments or CAT.

When asked about local pathways to care, 70 per cent of respondents acknowledged that they might look up Health Pathways from their local Primary Health Network (PHN). Only 20 per cent knew whether their PHN had a suicide prevention pathway documented.

Twenty per cent of respondents had heard about suicide 'buddy' programs, but either did not know whether they were available locally or how to access them if they did. One respondent identified the Beyond Blue buddy program but lamented that it was not available for him to refer to. The rest of the respondents did not know about these programs or about peer worker supports.

Ten per cent of the respondents noted suicide prevention resources to be available at the Commonwealth Department of Health website, two per cent named the Mind website.

Beyond Blue, Lifeline and charities such as Vinnies, Salvos and Anglicare were named as possible community resources.

For younger people, Headspace and the Kids Helpline were suggested as options by about 60 per cent when asked about child and youth resources.

It was interesting to note that specific PHN programs and resources were only mentioned by two respondents.

3.3.8 How could the program change?

This section had 90 per cent of respondents suggesting no need for change to the program and they were comfortable with it as it is.

Twenty per cent did suggest that, given that they enjoyed it and found it helpful, the program should be more widely available and more advertised.

Some 15 per cent of these respondents also suggested more emphasis could be placed on active role play to cement their comfort with the technique.

The other 10 per cent of respondents had various suggestions for the course into the future.

Of these, the main themes were some takeaway resources, including 'cheat sheets' that could sit on their desk, so when using this technique they could easily refresh their memory. Also, possible access to videotaped 'gold standard' consults, where they could model behaviour and possibly follow up workshops for those who wished for refreshers.

4 Conclusions

The Wesley LifeForce Suicide Prevention Training has been overwhelmingly supported by this evaluation.

The questions discussed were extremely positive to the program. Participants found the course excellent and few felt the need for the program to be changed.

Overall the participants found both the techniques taught and format of delivery enhanced their patient contact outcomes. They also found the techniques to be directly and indirectly helpful when consulting in other areas and also to their patients.

The respondents felt that the SALT technique was a positive addition to their clinical tools and that it benefitted patients.

Some felt that the option for more practice with the technique would have been helpful to them.

Interestingly, some respondents suggested that their confidence at opening the conversation with the patient around suicidality had become less stressful (not easier). This is interesting as the possibility that doctors do not open the conversation in this area has been postulated by some as a reason for doctors not being aware of a patient at risk.

The fact that the participants all virtually found the technique both acceptable and easy to utilise in their clinical practice, also provides a good push to advertise this program more widely.

The participants remembered the mnemonic (SALT) and felt it to have been very helpful both to them as clinicians and more importantly, to the outcomes of their patients. Although this is a subjective view, it should be noted in a positive sense for the benefit of the program.

The comment from two participants that the technique had made practice in areas of reduced specialist services easier should be noted as a success.

As with all techniques, a small minority did not use the technique as they were more comfortable with what they currently use.

This is not unexpected but the participants who did say this, also commented that they felt the technique had a lot of merit. One stated it would have been good to have been taught it many years ago as they would not have struggled to develop their skills in this area as much.

The ability to involve the primary care team in the training was recognised by some, but this potential benefit was not obvious to many participants.

Clinicians found that the principles also applied to patients with significant depression and was useful in these cases. This is a beneficial by-product of the training and warrants noting.

On the other side, the limitation of the approach to those patients with poor insight into their condition and thoughts should be noted.

The fact that little else is known and available in this area of clinical practice suggests that this education would be a high priority if it were more widely available and advertised.

Wider promotion of this program would be beneficial, particularly given the upcoming Towards Zero report, which will likely be looking for training programs to support its work. This should include organisations such as Mind and Beyond Blue, where this program may have beneficial bedrock status and reinforcement for their programs.

Comments that the technique was particularly useful if it had been taught to them early in their careers, even as a GP registrar, should be noted as a potential area for expansion.

In relation to the training of the primary care team, the cohort questioned were not confident that they would be able to train the others in their team. Mostly, this was due to the belief that they would not have the skills to teach the technique, which could be true. But also, some were unclear about potential benefits of the whole team having this training so that working as a team could be more effective and delegation of roles and support might be undertaken. Practice nursing staff were particularly enthusiastic about such an approach.

This could be addressed in the training package, perhaps.

Overall, the knowledge of resources locally for patients with suicidal ideation was largely limited to the emergency programs for patients. Although outside the scope of Wesley Mission's training program, this is an interesting finding that could be followed up by Primary Health Networks with some local education for their primary care teams.

5 Recommendations

The results of this evaluation have been very positive ones and the recommendations reflect this. Most recommendations are designed to move the program forward as well as to further enhance aspects of it as it currently stands.

Some recommendations are around the current environment and how this program might better interact with this environment moving forward.

5.1 Recommendation 1

That Wesley LifeForce Suicide Prevention Training should continue to be delivered and that its reach to participants needs to be increased.

5.2 Recommendation 2

That a review of the training program content looks at the possible timing within the program to allow for additional time doing role-play practice of the techniques taught. That a section on when the technique may need to be followed up particularly closely to make this program's safety a gold standard.

5.3 Recommendation 3

Consideration should be given to developing some further takeaway resources for participants such as desk reminder charts of the SALT principles as an aide de memoire, and a templated practice-based form that could be filled out by a practitioner with local services and pathways in this area of practice.

5.4 Recommendation 4

Consideration should be given to developing a small video series based on 'gold standard' type demonstration consultation modules that could be utilised as a teaching aid. Perhaps it could be offered to participants to watch after training to consolidate skills and increase confidence.

5.5 Recommendation 5

Ensure that the program is continuing professional development (CPD) compliant for the 2020 – 2022 RACGP and ACRRM triennium.

(This may support Recommendation 2 with possible need for increased time allocation within CPD).

5.6 Recommendation 6

That a specific team training program be offered to primary care/GP teams. This could be as an additional unit or a delivery mode to larger practices or a specific add on trainer accreditation for interested clinicians.

5.7 Recommendation 7

That the program be reviewed for possible use as a training package for peer workers who may work in this area of suicide prevention and support.

5.8 Recommendation 8

That this program be reviewed with respect to making it associated with compliance with the General Practice Mental Health Collaboration's (GPMHSC) training requirements for doctors to be eligible for those doctors to be able to access the Better Access to Mental Health Initiative. This could take the form of a modular pathway module or as an additional CPD type module.

5.9 Recommendation 9

That this program be actively promoted to GP training organisations around Australia to be utilised in training syllabuses of GP registrars. This fits with four of the five RACGP curriculum domains, namely Communication Skills, Applied Knowledge and Skills (mental health) and potentially the Professional and Ethical domain and Medico-Legal domain. This is dependent on emphasis and modification of some content of the program, such as discussions of mandatory reporting and managing admission for the patient.

5.10 Recommendation 10

Consideration be given to developing links with the Australian Practice Managers Association and the Royal Australian College of General Practitioners (RACGP) state-based faculties to copromote and deliver this program more widely.

5.11 Recommendation 11

That this program be actively promoted to the Primary Health Networks (PHNs) and community health organisations as a training opportunity for their members.

6 Appendix 1 - questionnaire

Dear Colleague,

I am writing to you today as I have been asked by Wesley Mission to conduct an external evaluation of the Wesley LifeForce General Practitioner (GP) Suicide Prevention Training program.

My name is Dr Morton Rawlin. I am a GP and have research interests in mental health and suicide prevention in general practice and strategies at a national level to reduce suicide in Australia.

I have been provided with your details by Wesley Mission as a participant in this program over the last three years.

At the end of this email are some questions that I would appreciate you answering in a reply email to me. The questions should take five to 10 minutes.

These answers will be used to evaluate the usefulness of the program to you and how it has been used in your practice. Questions will also check your thoughts about the program as a whole and its good points and your views on areas where it might be improved.

Your answers will be kept confidential and comments will not be identified to any individual. Wesley Mission and I sincerely appreciate your taking the time to complete this questionnaire.

I found the Wesley LifeForce Suicide Prevention Training helpful				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree

Please expand

.....

.....

.....

I use the principles from the Wesley LifeForce Training in my day to day practice				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree

Please describe how

.....

.....

.....

How recently have you used the techniques that you learned in the Wesley LifeForce Training?			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
More than 3 months	1– 3 months	In last fortnight	In last week

The Wesley LifeForce training provided me with additional skills when dealing with patients with suicidal ideation				
Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree

Please describe how

.....

.....

.....

The SALT principles I have learned in the Wesley LifeForce training have been beneficial in my clinical practice.				
Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree

In what way?

.....

.....

How useful were the SALT principles when used clinically?				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not at all helpful	Not helpful	Neither helpful nor unhelpful	Helpful	Very helpful

Please describe

.....

.....

.....

If helpful was this beneficial:

for you as the practitioner

for the patient outcome

Thinking back to the program:

What would you have liked more emphasis on?

.....
.....
.....

What would you have liked less emphasis on?

.....
.....
.....

Was the Wesley LifeForce Suicide Prevention Training translatable to your team?				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree

How have you used the program’s principles with your practice team?

.....
.....
.....

How many members are in your practice team?

What resources have you found useful in suicide prevention?

.....
.....
.....

Demographics

I am:

Male

Female

I am:

Medical practitioner

Nurse

Allied Health

Do you have any further comments you would like to add?

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.....

Thank you for taking the time to respond

Dr Morton Rawlin – GP (Lead Investigator)