學校領導全校參與
建設精神健康
預防學生自殺

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25-1-2025

中心命題

1. 應對學生輕生問題刻不容緩
2. 學校必須有決心和方法應對
3. 要能夠有效預防學生自殺
4. 必須建設好校園精神健康
5. 而要建設好校園精神健康
6. 則學校必須領導全校參與

基本邏輯：A —> B —> C

A：學校領導全校參與

B：建設校園精神健康

C：有效預防學生自殺

#1 學校領導全校參與

Conditions for Successful Implementation of Suicide Prevention Programmes in Schools

(Modified from Wyn et al., 2000)

EDB. (2017). A Resource Book for Schools: Detecting, Supporting and Making Referral for Students with Suicidal Behaviours.

學校領導的必要性

1. 發展方向

   校園精神健康不是學校發展計劃其中一個關注事項，而是所有關注事項的重要基礎

2. 對應策略

   真正的對應策略不是一個一個獨立分割的工作措施，而是多個協調一致的措施組成一套整全架構

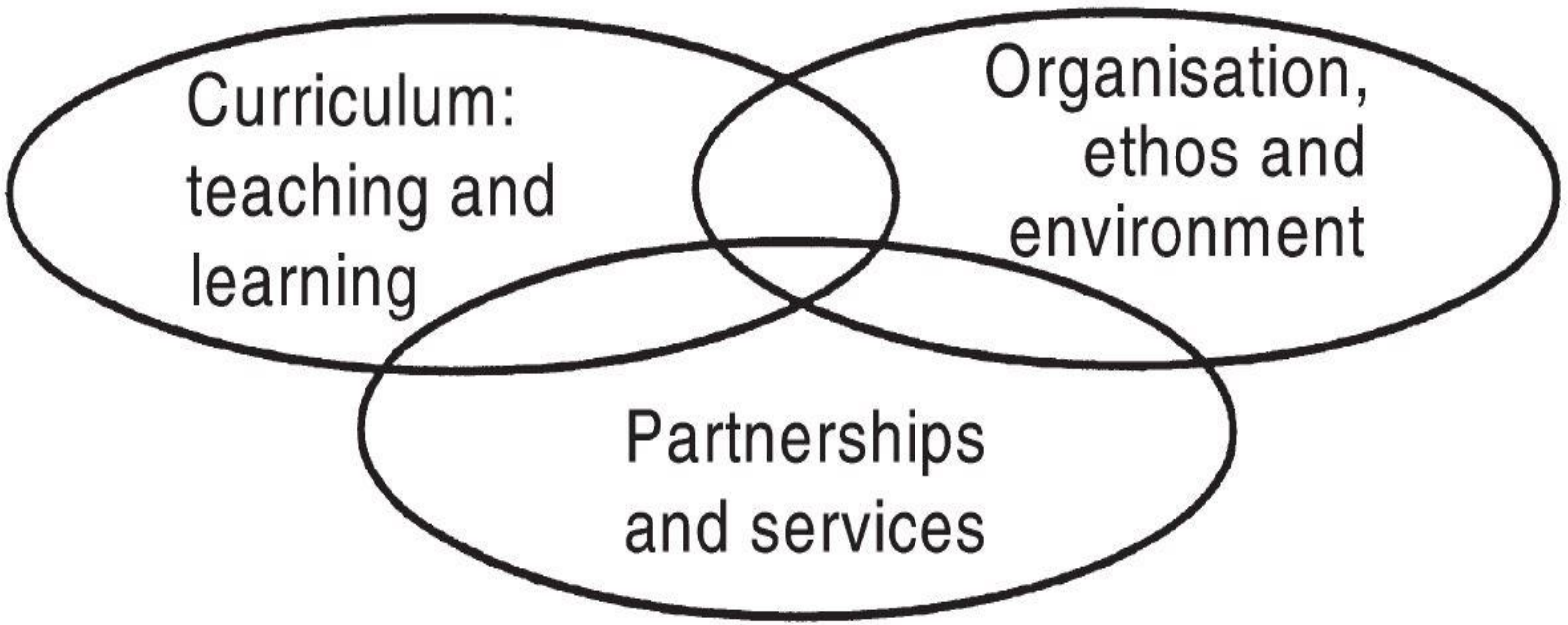
3. 配套資源

   最重要的資源是跨界別的社會網絡資源，其次是專業知識和人力資源

4. 推動能力

   學校領導是否有效很大程度上取決於真實行動的決心及其對持分者發揮的影響力

EDB. (2017). A Resource Book for Schools: Detecting, Supporting and Making Referral for Students with Suicidal Behaviours.



Common Components in Whole-School Wellbeing Promotion

Edwards, R., Byrne, J. & Grace, M. (2024). Enabling pupils to flourish: six evidence-based principles of whole-school wellbeing promotion.

Whole-School Approach To School Change for Mental Health

Wyn, J. et al. (2000). MindMatters, a whole-school approach promoting mental health and wellbeing.

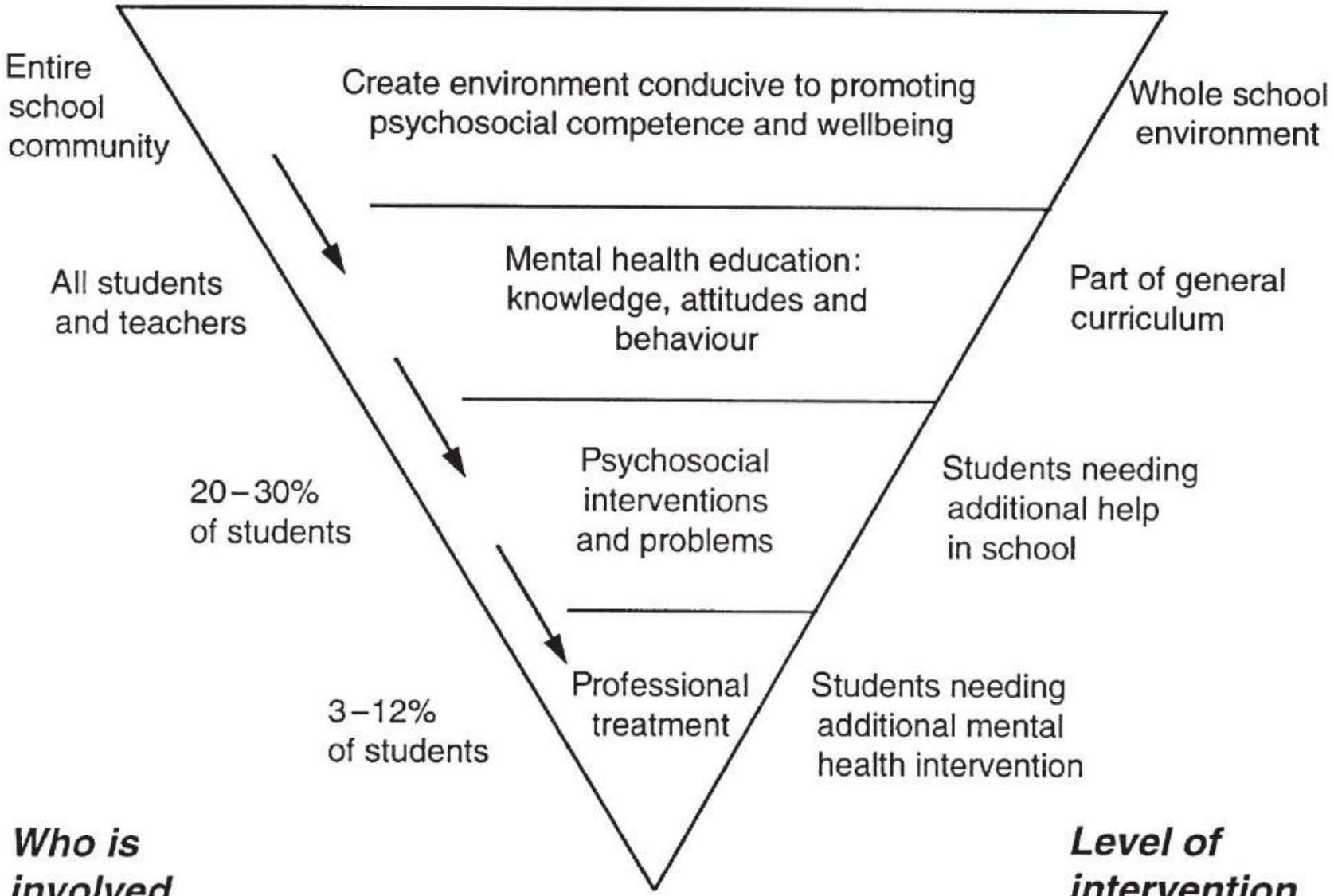


Figure 1. The World Health Organization's four-level, whole-school approach to school change.

全校參與的方式

1. 凝聚不同持份者

   包括教職員工、學生、家長、校董及社區人士

2. 建立共同目標

   以建設校園精神健康作為共同努力實現的目標

3. 制定學校政策

   有具體及清晰的政策，學校所有工作活動措施都與之貫徹一致

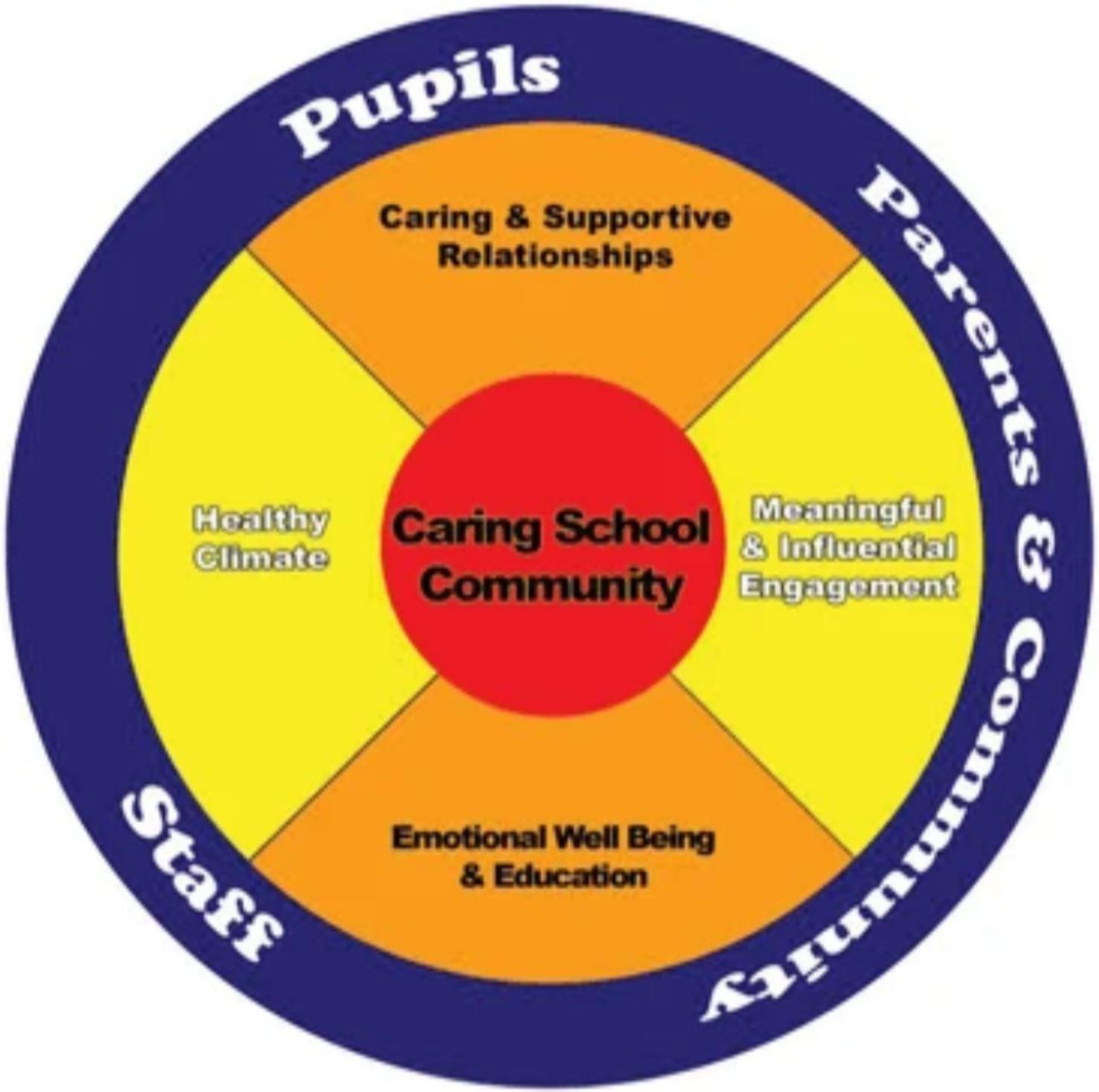
4. 連結不同範疇部門科組

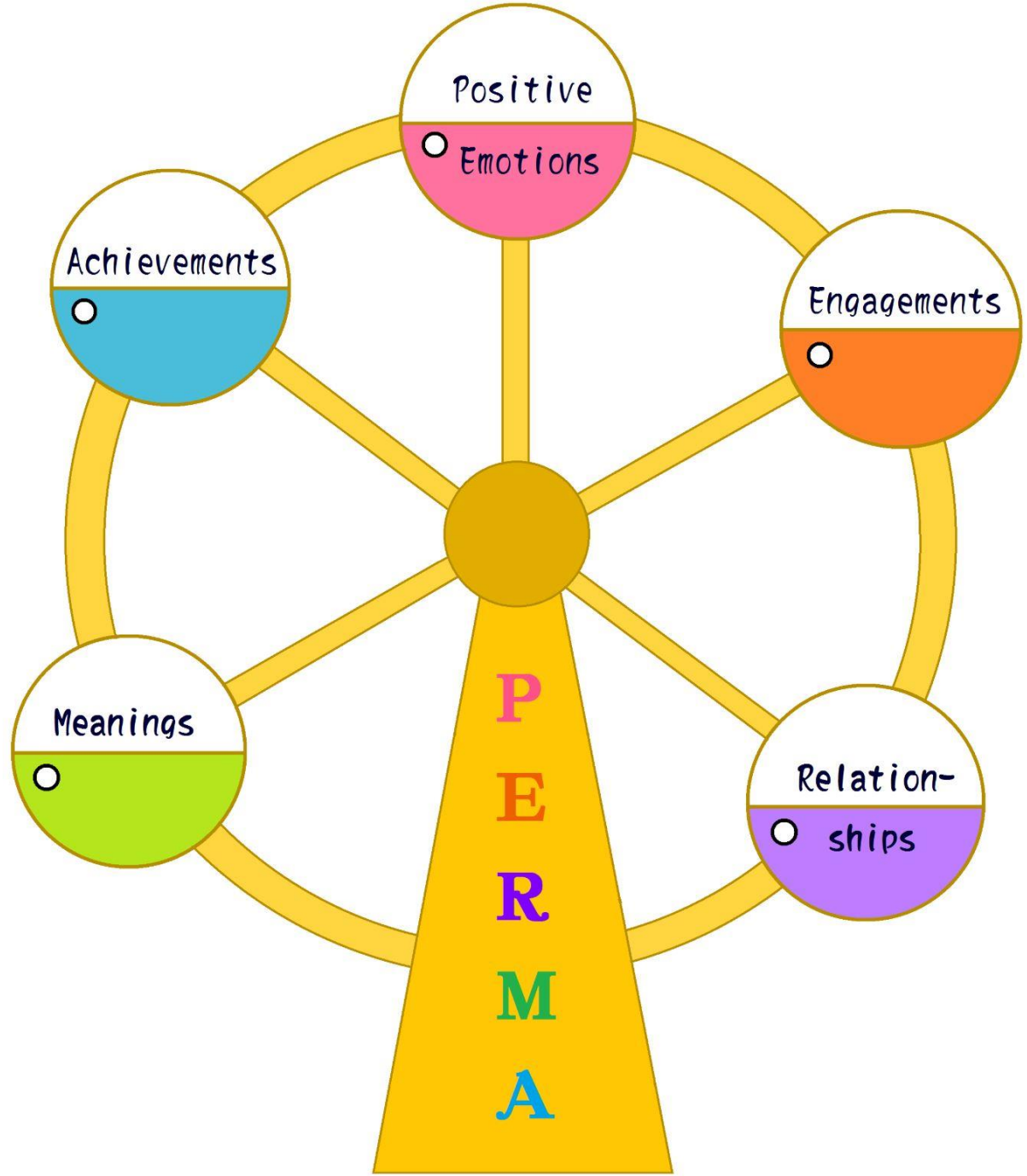
   包括學與教及學生支援各個部門、學科及組別

5. 融合正規、非正規及隱蔽課程的整體課程規劃

   涵蓋固定課時及非固定課時科本、跨科、級本及全級的各種學習內容和經歷

#2 建設校園精神健康


Pupils
Parents & Community
Staff
Caring & Supportive Relationships
Healthy Climate
Caring School Community
Meaningful & Influential Engagement
Emotional Well Being & Education


Positive
Emotions
Achievements
Engagements
Meanings
Relation-
ships
P
E
R
M
A

10 Healthy Habits For Students

Balanced Diet

Doing breakfast

Daily Exercise

Schedule tasks

Limited screen

Adequate Sleep

Overcoming Procrastination

Stress Management

Consistent Study routine

Stay Hydrated

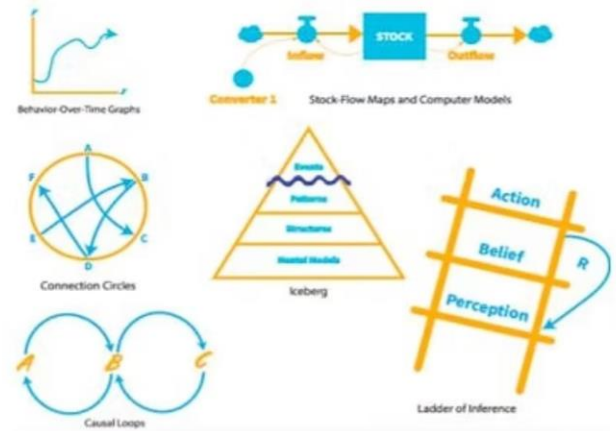

Self-Management
Managing emotions and behaviors to achieve one's goals
Self-Awareness
Recognizing one's emotions and values as well as one's strengths and challenges
Social & Emotional Learning
Social Awareness
Showing understanding and empathy for others
Responsible Decision-Making
Making ethical, constructive choices about personal and social behavior
Relationship Skills
Forming positive relationships, working in teams, dealing effectively with conflict


Problem Solving
Coping Skills / Emotion Management
Mental Health Literacy
Enhancing Resilience
Peer Relations
Family Relations
Mental Well-being / Positive Psychology
Self-Understanding

Compassionate Practices
(from established SEL models)

- Check-In
- Generative Social Field
- Ladder of Connectedness
- Mandala for Compassionate System Awareness
- Ways We Show Up
- Wheel of Emotions
- etc.

Systems Thinking Tools
(from Complexity Science & System Dynamics)



六個基本元素

1. 關愛文化 → 以人為本，建立彼此關心支持的關係
2. 正向教育 → 增強成就感及正向情緒
3. 健康生活習慣 → 平衡工作與生活、健康飲食、充足運動、休息與睡眠
4. 社會情緒學習 → 加深對自己和別人情緒的認識和調節
5. 心理韌性 → 加強抗逆能力，克服困難
6. 共感系統架構 → 結合身體、感知、關係、願景四種覺察與系統思維，建構能動的身心社靈健康

#3 有效預防學生自殺

The Public Health Model

WHO (2014). Preventing suicide: A global perspective.

數據監測及追蹤

1. APASO III

   心理健康(情緒、滿足感、生命意義、社交表現)、自我概念及學校氣氛等

2. 訓輔紀錄

   違規及欺凌行為

3. 社工個案

   學習、社交、家庭問題

4. 課堂觀察

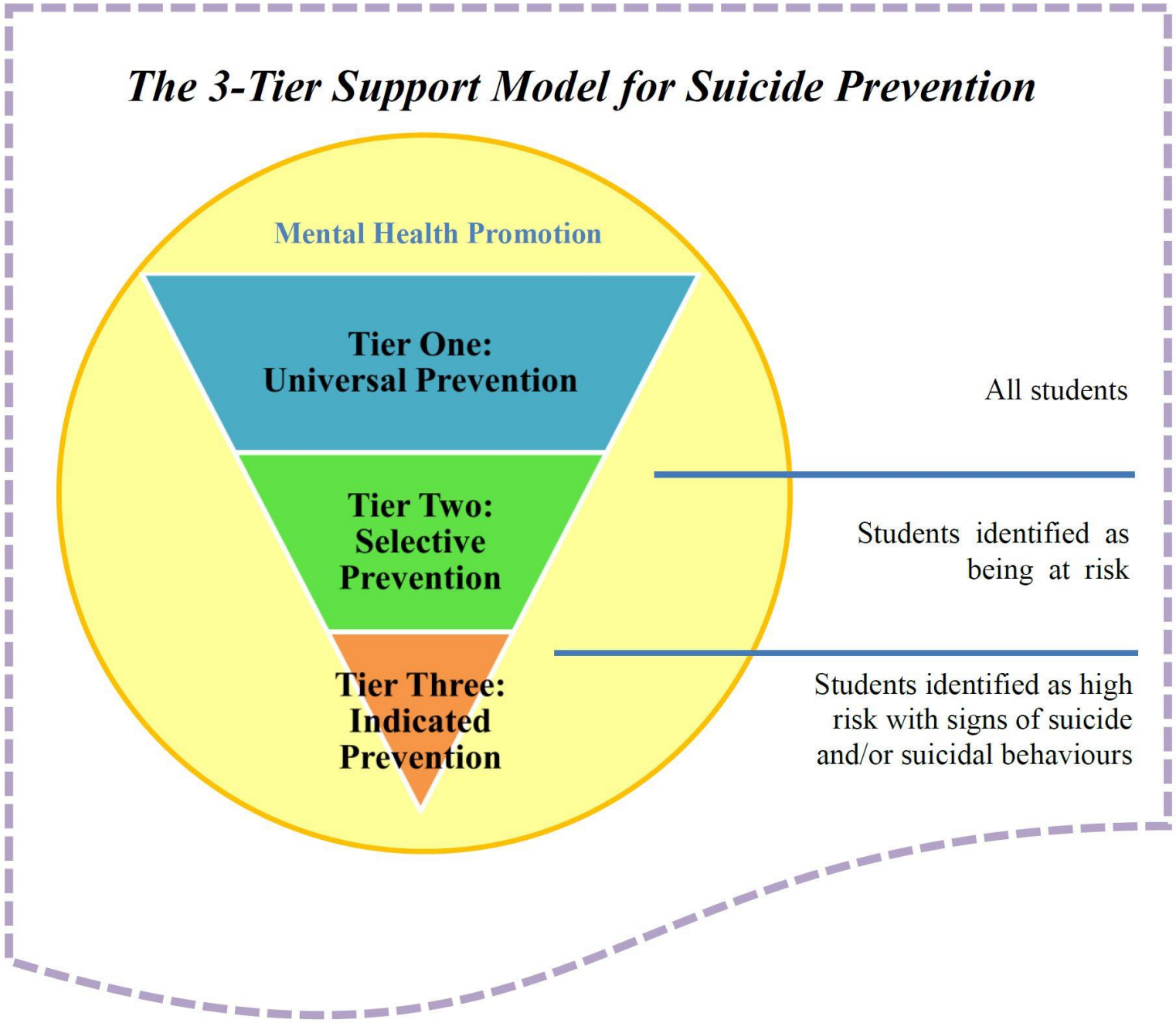
   異常表現

5. 家長聯繫

   電話、面談、社交媒體

The 3-Tier Support Model for Suicide Prevention (Adapted from World Health Organisation (2014). Preventing suicide: A global imperative.)

EDB. (2017). A Resource Book for Schools: Detecting, Supporting and Making Referral for Students with Suicidal Behaviours.



10 Common Myths about Suicidal Behaviours

WHO (2006). Preventing suicide: A resource for Counsellors .

Myth 1: People who talk about suicide will not harm themselves since they just want attention. This is **FALSE**. A counsellor must take every precaution when confronted with an individual talking about suicidal ideation, intent, or plan. *All* threats of self-harm should be taken seriously.

Myth 2: Suicide is always impulsive and happens without warning. **FALSE**. Death by one's own hand might appear to be impulsive, but suicide may be pondered for some time. Many suicidal individuals give some type of verbal or behavioural message about their ideations of intent to hurt themselves.

Myth 3: Suicidal individuals really want to die or are determined to kill themselves. **FALSE**. Most people feeling suicidal will share their thoughts with at least one other person, or call a crisis telephone line or doctor, which is evidence of ambivalence, not commitment to killing oneself.

Myth 4: When an individual shows signs of improvement or survives a suicide attempt, they are out of danger. **FALSE**. Actually, one of the most dangerous times is immediately after the crisis, or when the person is in the hospital following an attempt. The week following discharge is one in which a person is particularly fragile and in danger of self-harm. Since one predictor of future behaviour is past behaviour, the suicidal person often continues to be at risk.

Myth 5: Suicide is always hereditary. **FALSE**. Not every suicide can be linked to heredity and conclusive studies are limited. Family history of suicide, however, is an important risk factor for suicidal behaviour, particularly in families where depression is common.

Myth 6: Individuals who attempt or commit suicide always have a mental disorder. **FALSE**. Suicidal behaviours have been associated with depression, substance abuse, schizophrenia and other mental disorders, in addition to destructive and aggressive behaviours. However, this association should not be overestimated. The relative proportion of these disorders varies in different places and there are cases where no mental disorder was apparent.

Myth 7: If a counsellor talks to a patient about suicide, the counsellor is giving the person the idea. **FALSE**. A counsellor clearly does not cause suicidal behaviour simply by asking if patients are considering harming themselves. Actually, validation of the individual's emotional state and the normalization of the stress-induced situation are necessary components in reducing suicidal ideation.

Myth 8: Suicide only happens to "those other kinds of people," not to us. **FALSE**. Suicide happens to all types of people and is found in all kinds of social systems and families.

Myth 9: Once a person has tried to commit suicide, he or she will never try again. **FALSE**. In fact, *suicide attempts* are a critical predictor of suicide.

Myth 10: Children do not commit suicide since they do not understand the finality of death and are cognitively incapable of engaging in a suicidal act. **FALSE**. Although rare, children do commit suicide and *any* gesture, at *any* age, should be taken seriously.

Estimated Network of Suicidal Behaviour, and Risk and Protective Factors

Fonseca-Pedrero, E., et al. (2022). Risk and Protective Factors in Adolescent Suicidal Behaviour: A Network Analysis.

Note:

CYBERB = Cyberbullying victimisation;

BULL = Bullying victimisation;

CLIM = School climate/engagement;

SUIC = Suicide behaviour;

DEPR = Depression symptoms;

PROS = Prosocial behaviour; HIP = Hyperactivity;

PEER = Peer problems; CDT = Conduct problems;

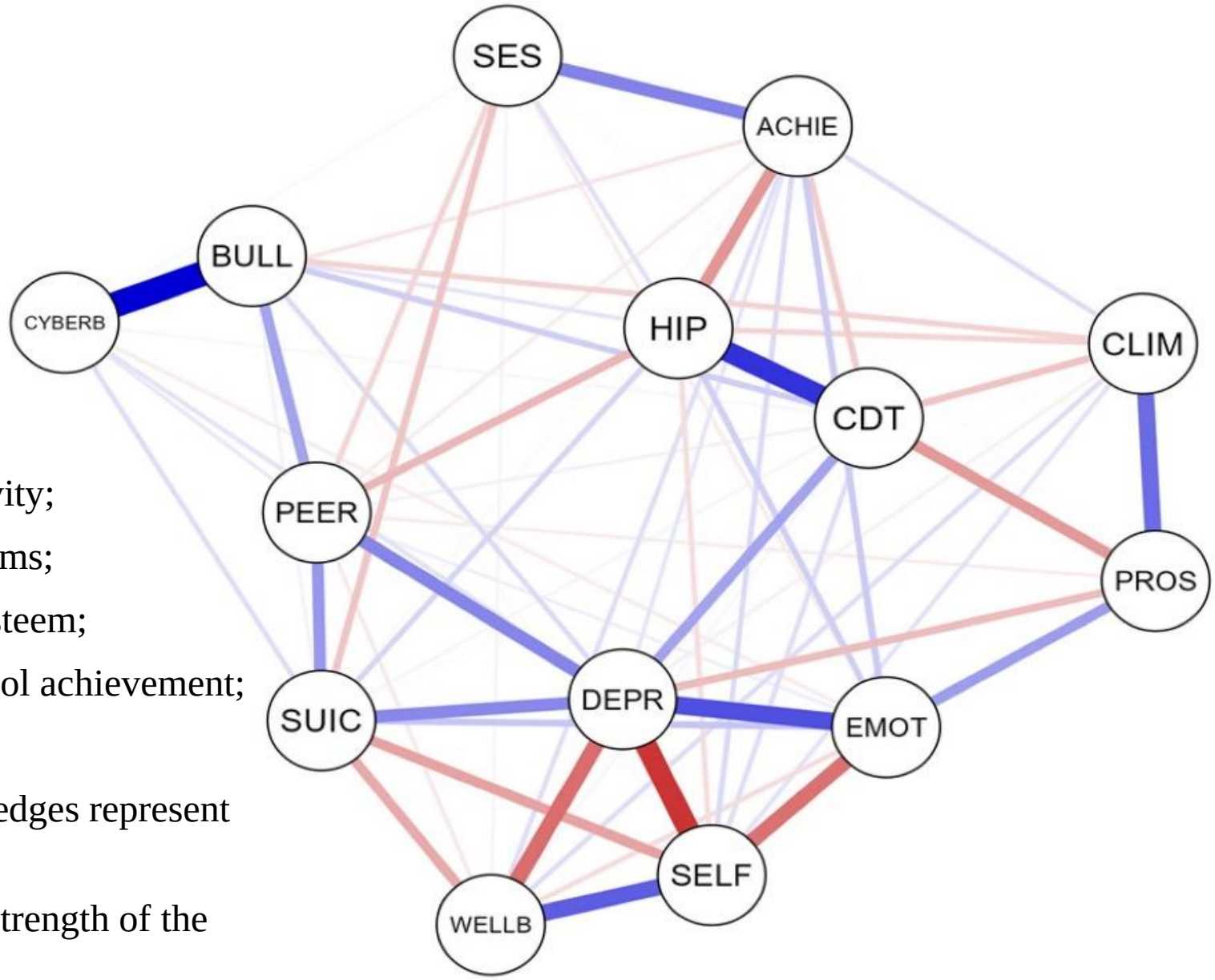
EMOT = Emotional symptoms; SELF = Self-esteem;

WELLB = Personal well-being; ACHIE = School achievement;

SES = Socio-economic status.

Blue edges represent positive associations, red edges represent negative associations.

Thickness and saturation of edges indicate the strength of the associations.



三級預防

1. 正確認識自殺問題及其迷思
2. 充分掌握自殺的保護因素及風險因素
3. 在校園精神健康的政策基礎上制訂三級預防的恆常機制及相關活動
4. 提供各種形式的學習機會，協助教職員工提升處理自殺的專業能力
5. 加強與外間專業機構的協作，包括教育心理學家、臨床心理學家及社會工作者等的到校支援

LIVE LIFE Cross-Cutting Foundations and Key Effective Evidence-Based Interventions

WHO (2021). Live Life: An implementation guide for suicide prevention in countries.

多元策略

1. 各級精神健康教育活動

   全年、分級、因應學生成長階段的不同主題

2. 及早識別及支援

   運用簡易的篩檢工具，找出有潛在風險的學生，與社福機構合作提供有針對性的課後或校外強化活動

3. 守門人及安全網

   改變師生對求助的固有觀念，加強求助和協助意識，培訓學生信任的老師及同學作為守門人

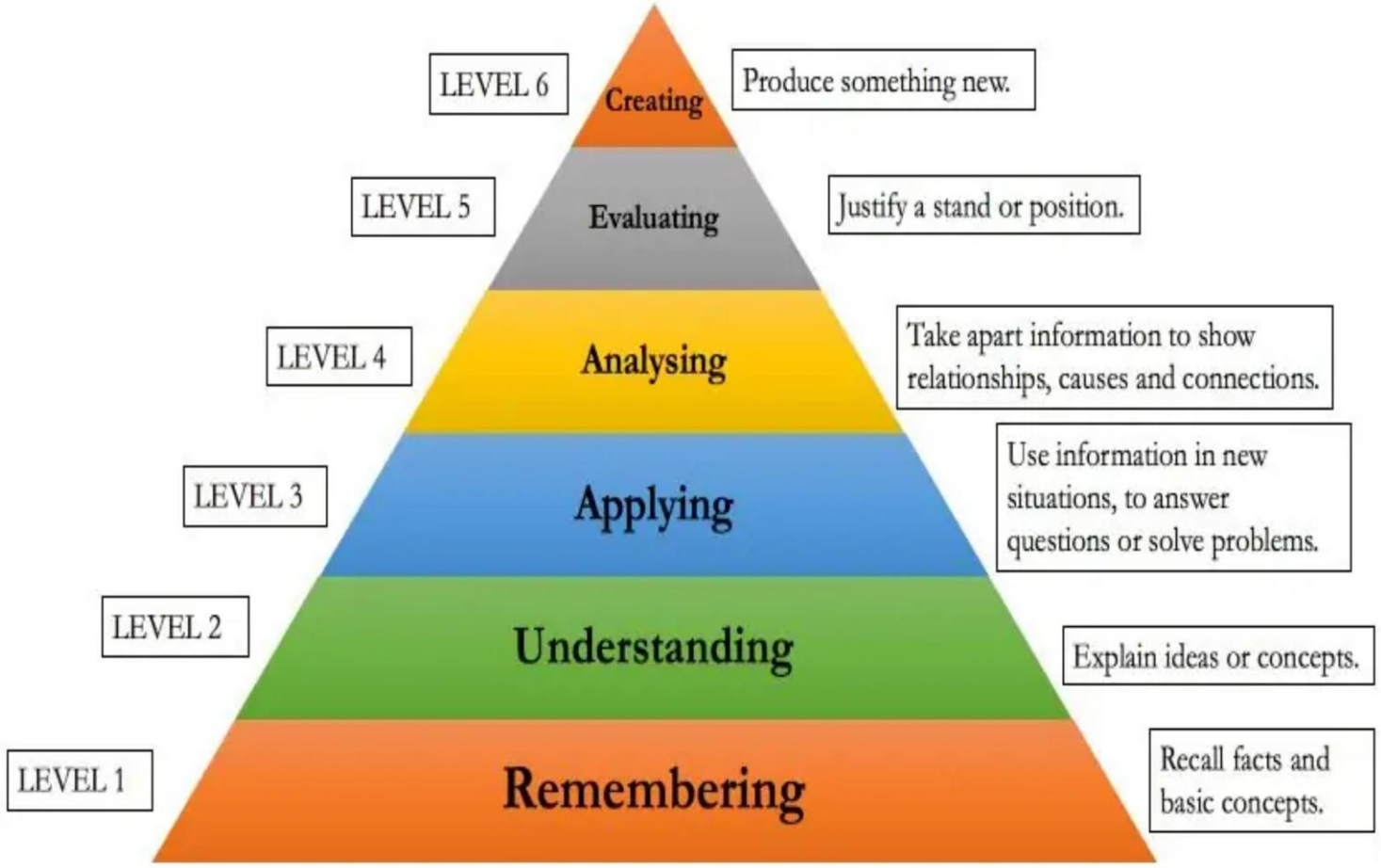
4. 家校社醫四方協作

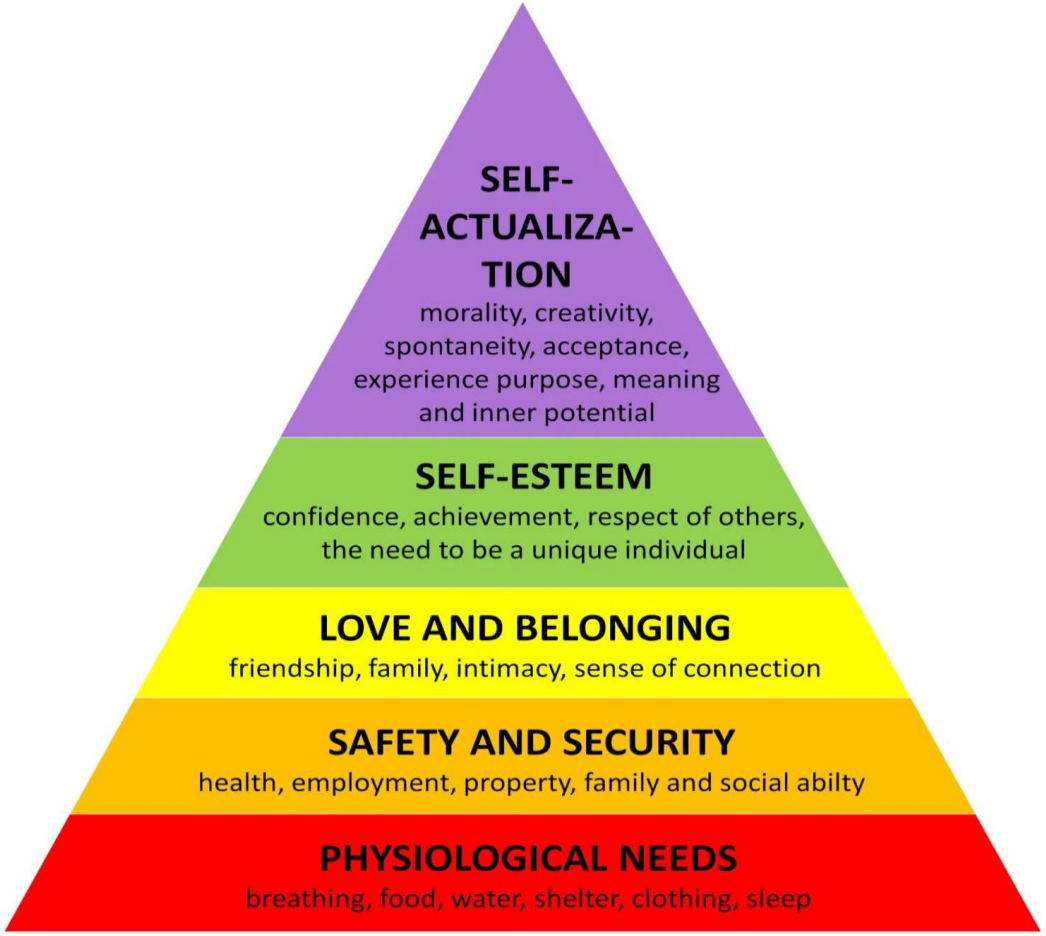
   建立緊密聯絡及充分合作的有效渠道和工作方式

5. 專業轉介

   爭取家長的信任，迅速轉介高風險學生予適當的專業人士協助緊急處理

Bloom vs Maslow





Well-Being and Workload: Human Needs Before Outcomes

Netolicky, D. M. (2020). School leadership during a pandemic: navigating tensions

Schools and systems are grappling with the tension between well-being and workload of students, teachers and parents. This can be framed as the **tension between Maslow and Bloom**, in which **Abraham Maslow's hierarchy of needs and Benjamin Bloom's taxonomy of learning** represent the importance of **balancing physical and psychological safety with learning and academic rigour**. In a time of global crisis, grief, trauma and instability, we need to consider **Maslow before Bloom** (Doucet et al., 2020). We should foreground health, safety, well-being and belonging first, before curriculum, pedagogy and assessment.

There can be no student well-being without teacher well-being (Hargreaves et al., 2019). Considering teacher well-being requires **leaders to support teachers through clear expectations and structures that take teacher needs and feedback into consideration** … educators' well-being is likely to prosper in environments that engage them in **deep and morally inspiring purposes** over which they exert **shared professional control; meaningful collaborative professionalism** that **brings them closer to each other and to their students** in **taking responsibility** for and achieving these transformational purposes; working in **multi-disciplinary teams** to respond to the **multiple diversities of their students** and when there is **external support from government and organizations**. Leaders of schools and system can work from this shared moral purpose, value teacher expertise and provide opportunities of meaningful collaboration in online, remote or physically distanced modes.

三種不同發展取向：Bloom vs Maslow

1. **Bloom > Maslow**
2. **Maslow > Bloom**
3. **Bloom < - > Maslow**