Suicide Prevention
and Mental Health Training

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The University of Hong Kong

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TRAINING OBJECTIVES

- Epidemiology of suicide
- Risk and protective factors of suicide
- Suicide and mental illness
- Helping someone with emotional distress
- Mental health enhancement programs for students
About us

We dedicated to

- generate and advance knowledge in suicide studies through vigorous scientific research
- build evidence-based indigenous working models for people with suicide ideation, attempters, as well as survivors through community-researchers collaboration
- transfer skills and knowledge to front-line professionals through workshops, resource production as well as opportunity of practicum training
- contribute to the formulation of social and health policies in combating the problem of suicide
此專頁旨在為關注學生自殺的各界人士提供幫助。我們整理了青少年自殺風險因素、預警訊號、社區可以提供幫助的資源、如何與青少年傾談的技巧等，亦針對不同的人士（例如傳媒、網民、家長、學生、校長、老師等）提供具體的跟進建議。

http://csrp.hku.hk/wecare/
Centre for Suicide Research and Prevention - Facebook
https://www.facebook.com/hkucsrp
Epidemiology of suicide
Global epidemiology of suicide

- Over 800,000 people die by suicide every year, many more who attempt suicide

- Global mortality rate = 16 / 100 000 population

- One death every 40 seconds. For every suicide, there are 20-30 suicide attempts

- 15th leading cause of death in 2012

- For 15-29 years age groups: 2nd leading cause of death

- Each suicide has a serious impact on at least 6 other people

Source: WHO, 2014
The context of Hong Kong
Number of suicide death and suicide rate in Hong Kong, 1997-2014

Registered death date up to 31 July 2015 (n=845)
Estimation of suicide death in 2014 (n=893) by adjustment with year 2013
Factors that may have influenced recent suicide rates in HK

- Population ageing
  - The greater number of elderly people, who have higher suicide rates, the greater number of suicide

- Economic factors
  - Economic recession and unemployment (Chan et al, 2007)

- New suicide method
  - The epidemic of charcoal-burning suicide

- SARS in 2003
  - Elderly suicide rates in particular (Cheung et al, 2008)
FACT about suicide

• Suicidal people are often ambivalent. On one hand, they wanted to commit suicide to end their pain, yet on the other hand, they wanted someone to be there to help them and listen to them.

• People who suicide usually show warning signs and clues.

• Asking people about suicide will often make them feel understood and relieved.

• Depressed patients who now show improvement may in fact be more at risk.

• Not all suicidal patients are psychiatric. We need to watch out for non-psychiatric patients that may be suicidal.
Suicidal behaviors
Suicidal behavior:

- Suicidal ideation
  - Thoughts of killing oneself

- Suicide planners
  - A degree higher than suicidal ideation; a person plans his/her suicide before actually carrying it out

- Suicidal attempt
  - Failed or poorly executed act of killing oneself resulting in non-fatal outcomes

- Death due to suicide
Prevalence study

- A representative community sample of 2,220 participants aged between 15 to 59 years, and an additional booster sample of 511 participants aged between 15 to 19 (Cheung et al, 2004)

- Face-to-face interview

- Representative to a total of 4,759,000 people aged 15-59 years
Mental health and suicidality in Hong Kong

BGCA (2009)
- About 4.2% P.1 – P.6 students at critical range for anxiety and depression

Among 2,586 youth aged 15-24 (Yip et al., 2004),
The prevalence rates of suicidal ideation and behavior:
- 17.8% considered
- 5.4% planning
- 8.4% attempt once or above
- 1.2% required medical care

Among 2,220 respondents aged 15-29 (Cheung et al, 2004),
- Depressive symptoms: 9%(CES-D) (M:7.3% ; F:10.5%)
- Suicidal ideation: 6.2%
- Suicidal attempt: 2.0% (CSRP, 2005)
Evidence-based Interventions for Suicide
Two Approaches

Identification of patterns of suicide and suicidal behavior for groups or population with the aim of modifying the environment to prevent suicide

Public health approach

Identification of suicide risk and suicidal behavior in individuals with the aim of treating underlying causes

Individual-based (clinical) approach
Public health approaches to suicide prevention
Public Health Approach

Projects

High-risk individuals
- Volunteer mentorship: help young adults with DSH behaviour

Subgroups with risk factors
- Care for suicide survivor project
- Gatekeeper training program
  - Consulting for NGOs

The entire population
- Community-based suicide prevention programs
- School-based mental health enhancement programs
  - Limiting charcoal access
  - Suicide reporting recommendations

Tip of the iceberg
Indicated
Selective
Universal

Bottoms up approach

HKJC Centre for Suicide Research and Prevention

Projects

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The entire population
- Community-based suicide prevention programs
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  - Limiting charcoal access
  - Suicide reporting recommendations

HKU

THE UNIVERSITY OF HONG KONG
Public Health Approach: Aims

1. To create a protective environment
2. To change behaviors that put people at risk

Source: Yip, 2005
Mann et al. (2005). Suicide Prevention Strategies: A systematic review

HKJC Centre for Suicide Research and Prevention

A multifaceted approach

Figure. Targets of Suicide Prevention Interventions

SUICIDAL BEHAVIOR

Stressful Life Event  Mood or Other Psychiatric Disorder

Suicidal Ideation

FACTORS INVOLVED IN SUICIDAL BEHAVIOR

Impulsivity  Hopelessness and/or Pessimism

Access to Lethal Means  Imitation

Suicidal Act

PREVENTION INTERVENTIONS

A Education and Awareness Programs
  Primary Care Physicians
  General Public
  Community or Organizational Gatekeepers

B Screening for Individuals at High Risk

Treatment

C Pharmacotherapy
  Antidepressants, Including Selective Serotonin Reuptake Inhibitors
  Antipsychotics

D Psychotherapy
  Alcoholism Programs
  Cognitive Behavioral Therapy

E Follow-up Care for Suicide Attempts

F Restriction of Access to Lethal Means

G Media Reporting Guidelines for Suicide

Circled letters refer to relevant prevention interventions listed on right.
Suicidal behavior:

- **Suicidal ideation**
  - Thoughts of killing oneself

- **Suicide planners**
  - A degree higher than suicidal ideation; a person plans his/her suicide before actually carrying it out

- **Suicidal attempt**
  - Failed or poorly executed act of killing oneself resulting in non-fatal outcomes

- **Death due to suicide**
The role of teachers
Identifying risk factors

- Psychiatric Illness Co-morbidity
- Exposure to suicide
  - Impulsiveness
  - Hopelessness
  - Family History
  - Psychodynamics/Psychological Vulnerability
- Personality Disorder/Traits
- Substance Use/Abuse
- Severe Medical Illness
- Access To Means
- Life Stressors
- Suicidal Behavior

Suicide
Suicide and Mental Illness
Suicide and mental illness

For both developing and developed countries:

- A majority of people who died by suicide a diagnosable mental disorder

- Suicidal behavior are more frequent in psychiatric patients

Though most of those who commit suicide have a mental disorder, a majority of them have not see a mental health professional!!
From Hong Kong Psychological Autopsy Study

Suicide risk and protective factors (aged 15-59 years old)

1. **Presence of psychiatric disorder** 精神問題 (OR=28.67; p<0.001)
2. **Past suicidal attempt** 過去意圖自殺 (OR=24.78; p<0.01)
3. **Indebtedness** 債務 (OR=10.08; p<0.01)
4. **Unemployment** 失業 (OR=8.65; p<0.01)
5. **Never married** 從未結婚 (OR=7.29; p<0.01)
6. **Social support** 社會支持 (OR=0.27; p<0.001)

Suicide with psychiatric diagnosis and without utilization of psychiatric service

Yik-wa Law¹,²†, Paul WC Wong¹,²†, Paul SF Yip¹,²†

Abstract

Background: Considerable attention has been focused on the study of suicides among those who have received help from healthcare providers. However, little is known about the profiles of suicide deceased who had psychiatric illnesses but made no contact with psychiatric services prior to their death. Behavioural model of health service use is applied to identify factors associated with the utilization of psychiatric service among the suicide deceased.

Methods: With respect to completed suicide cases, who were diagnosed with a mental disorder, a comparison study was made between those who had (contact group; n = 52; 43.7%) and those who had not made any contact (non-contact group; n = 67; 56.3%) with a psychiatrist during the final six months prior to death. A sample of 119 deceased cases aged between 15 and 59 with at least one psychiatric diagnosis assessed by the Structured Clinical Interview for DSM-IV-TR (SCID I) were selected from a psychological autopsy study in Hong Kong.

Results: The contact and non-contact group could be well distinguished from each other by "predisposing" variables: age group & gender, and most of the "enabling", and "need" variables tested in this study. Multiple logistic regression analysis has found four factors are statistically significantly associated with non-contact suicide deceased: (i) having non-psychotic disorders (OR = 13.5, 95% CI:2.9-62.9), (ii) unmanageable debts (OR = 10.5, CI:2.4-45.3), (iii) being full/partially/self employed at the time of death (OR = 10.0, CI:1.6-64.1) and (iv) having higher levels of social problem-solving ability (SPS) (OR = 2.0, CI:1.1-3.6).

Conclusion: The non-contact group was clearly different from the contact group and actually comprised a larger proportion of the suicide population that they could hardly be reached by usual individual-based suicide prevention efforts. For this reason, both universal and strategic suicide prevention measures need to be developed specifically in non-medical settings to reach out to this non-contact group in order to achieve better suicide prevention results.
The majority of the suicide population had made no contact with psychiatric service before they died (Law et al., 2010)

Contact group - substantial attention
Non-contact group - ranged from 62% to 86% of suicide population (Vassilas and Morgan 1993, 1997; Pirkis and Burgess 1998; Appleby et al. 1999b; Andersen et al. 2000; Miller and Druss 2001; Manchester 2006; Ho, 2003; Hamdi et al, 2008; Law et al, 2010; Phillips, 2009 & 2010)
Suicidal behavior and mental disorders

- Onset of suicidal ideation is best predicted by depression

- However, depression does not predict further progression to suicide attempt

- Severe anxiety (PTSD) and poor impulse-control (conduct disorder, substance disorders) emerged as the strongest predictors of which ideators make suicide plan and attempts


Major Depression

- Clinical depression is marked by a depressed mood most of the day
- Symptoms present every day for at least 2 weeks
- Five (or more) of the following symptoms (DSM-5)
  - **Depressed mood** most of the day
  - Markedly **diminished interest** or pleasure in almost all activities nearly every day
  - Significant **weight loss** or gain (a change of more than 5% of **body weight** in a month)
  - **Insomnia** or hypersomnia (excessive sleeping) almost every day
  - Psychomotor agitation
  - **Fatigue** or loss of energy almost every day
  - Feelings of worthlessness or **guilt** almost every day
  - Impaired concentration and indecisiveness
  - Recurring thoughts of death or **suicide**
More information on depression

- Symptoms
- Causes
- Check point
- Treatment
- Sharing garden

www.depression.edu.hk
The CES-D is an epidemiological, not clinical tool.

http://www.depression.edu.hk/

## Risk Factors in Youth Suicide

### Table 3 Psychiatric disturbances and precipitating events in youth suicide

<table>
<thead>
<tr>
<th></th>
<th>Age 10-14 years</th>
<th>Age 15-19 years</th>
<th>Age 20-24 years</th>
<th>Chi-square for age</th>
<th>Chi-square for sex</th>
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<tbody>
<tr>
<td></td>
<td>Male n = 16</td>
<td>Female n = 9</td>
<td>Male n = 58</td>
<td>Female n = 56</td>
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<tr>
<td>Antisocial</td>
<td>4 (25%)</td>
<td>2 (22.2%)</td>
<td>12 (20.7%)</td>
<td>7 (12.5%)</td>
<td>8 (6.3%)</td>
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<td>Depressive</td>
<td>2 (12.5%)</td>
<td>3 (33.3%)</td>
<td>24 (41.4%)</td>
<td>18 (32.1%)</td>
<td>32 (34.4%)</td>
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<td>Psychotic</td>
<td>1 (6.3%)</td>
<td>0</td>
<td>16 (27.6%)</td>
<td>18 (32.1%)</td>
<td>36 (38.7%)</td>
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<tr>
<td>Illicit drugs</td>
<td>0</td>
<td>1 (11.1%)</td>
<td>7 (12.1%)</td>
<td>6 (10.7%)</td>
<td>9 (9.7%)</td>
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<td>Any psychiatric</td>
<td>5 (31.3%)</td>
<td>5 (55.6%)</td>
<td>47 (81%)</td>
<td>37 (66.1%)</td>
<td>70 (75.3%)</td>
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<td>Precipitating</td>
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<tr>
<td>events</td>
<td></td>
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</tr>
<tr>
<td>Family factors</td>
<td>4 (25%)</td>
<td>6 (66.7%)</td>
<td>8 (13.8%)</td>
<td>16 (28.6%)</td>
<td>7 (7.5%)</td>
</tr>
<tr>
<td>School factors</td>
<td>9 (56.3%)</td>
<td>1 (11.1%)</td>
<td>10 (17.2%)</td>
<td>11 (19.6%)</td>
<td>5 (5.4%)</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>1 (6.3%)</td>
<td>2 (2.2%)</td>
<td>10 (17.2%)</td>
<td>13 (23.2%)</td>
<td>14 (15.1%)</td>
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<tr>
<td>factors</td>
<td></td>
<td></td>
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<tr>
<td>Any precipitating</td>
<td>13 (81.3%)</td>
<td>7 (77.8%)</td>
<td>23 (39.7%)</td>
<td>33 (58.9%)</td>
<td>26 (28.0%)</td>
</tr>
<tr>
<td>events</td>
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</tbody>
</table>

* P < 0.05; ** P < 0.01; *** P < 0.001

- Academic pressure
- Mental illness
- Interpersonal relations (peer, friends)
- Break up in a relationship
- Conflict with family members
## Identifying risk factors

<table>
<thead>
<tr>
<th>Biological</th>
<th>Psychological</th>
<th>Cognitive</th>
<th>Environmental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression/ Anxiety</td>
<td>Low self-esteem</td>
<td>Rigidity of thoughts</td>
<td>Depressed parents</td>
</tr>
<tr>
<td>Puberty</td>
<td>Hopelessness</td>
<td>Stubbornness</td>
<td>Parental Unemployment</td>
</tr>
<tr>
<td>Hormonal change</td>
<td>Loss of identity</td>
<td>Egocentrism</td>
<td>Physical/sexual abuse</td>
</tr>
<tr>
<td>Chronic illness/ pain</td>
<td>High impulsivity</td>
<td>Extreme perfectionism</td>
<td>Domestic violence</td>
</tr>
<tr>
<td>Mental illness</td>
<td>High levels of stress</td>
<td>Poor problem-solving skills</td>
<td>Family history of suicide</td>
</tr>
<tr>
<td>Genetic factors</td>
<td>Fear of humiliation</td>
<td>Poor emotional management</td>
<td>Bullying/ victimization</td>
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<td></td>
<td></td>
<td>Immatureness</td>
<td>Poor social skills/relationship</td>
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<td>Access to means</td>
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<td></td>
<td></td>
<td></td>
<td>Social isolation</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Drug or alcohol abuse</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Relationship break up</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pregnancy</td>
</tr>
</tbody>
</table>
Lonely teenager + alcohol +...
Identifying warning signs

- Significant reductions of academic performance
- Expression of ideas about death and suicide (direct and indirect)
- Sudden change in mood
- Significant stress events
- Withdrawal from social relationships/school
- Physical symptoms
- High risk behaviors (misconduct)
Protective factors

Family
- Perceived parent and family connectedness
- Emotional support
- Stable living environment

Personal
- Self of worth
- Good social skills
- Good coping skills
- Help-seeking behavior/active seeking
- Impulse control
- Effective problem-solving skills
- Reduced access to means for suicidal behavior
- Responsibilities for others/pets
- Religious beliefs

Social
- Support from teachers and other relevant adults (social worker/ counselor)
- Positive relationship with peers or relevant people
- Social integration, e.g., sports team participation, church association

School
- Perceived connectedness to the school
- Extra support/adjustment for students with SEN
- Establishing a caring environment
Helping students with emotional distress
When do students need help?

- Students can be upset for any number of different reasons such as
  - Academic performance or stress
  - Receiving bad news
  - Family/sibling conflict
  - Peer conflict/ bullying
  - Relationship breakup
1. Thoughtful assessment to the situation

Assess the situation:
- What’s happening?
- Are there any crisis?
- Who else can be involved?

Check yourself:
- What shape you are in?
- How have you been affected by the situation?
- Can you handle the situation?
- Who else can be of help?
2. To let him/her know that you care

Skills to engage students

- Do observation first
  - Say what you notice from the student
  - You seem very upset now, may I hear more of your story and how I can be of help?

- Empathic support
  - Ask yourself “how would I feel if this happened to me?”

- Show them you want to hear their story
  - You feel you just can’t live with this pain
  - How is it like for you?
  - I may not be able to understand exactly how you are feeling now but I do care about you and want to help.
To let him/her know that you care

Good listening

- Give students time to talk
  - Be physically still and relaxed
  - Make eye-contact appropriately

- Acknowledging distress
  - “I can see that things have been very difficult for you lately.”
  - “I can’t imagine how you must be feeling but I can see that it is very distressing for you.”
To let him/her know that you care

Good listening

- Be calm and relaxed
  - If you are not calm you may not be much help to someone who is upset

- Be non-judgmental and accepting
  - Accept their response and feelings
  - Don’t argue with them
Things to avoid

- Avoid false reassurance
  - For example: “Everything will be okay”

- Don't ignore their feelings and tell them to suppress their feelings

- Don’t act shocked and this will put distant between you two.

- Don't say things like, "I know just how you are feeling, just the same happened to me".

- Don’t hurry the next action

- Don’t try to solve all the problems

- Don’t promise confidentiality
3. Respond quickly

- The best treatment is to make them feel better so keep listening and acting on what you hear

- Stay alert for further risks

- At the right timing
  - ask directly
  - move to the next step by providing options or alternatives thoughtfully and carefully

- Suggest where to get further assistance or referral such as
  - general practitioners
  - social workers
  - psychologist or psychiatrist
4. Do not forget your own needs

- Emotions that you may have
  - Fear
  - Anger
  - Frustration
  - Irritation
  - Sadness

- Provide such support may create or remind you of many other emotions

- Speak to someone you trust about how you feel and what you have done
Suicide Prevention Training

Suicide Intervention Skills Training

| Objectives: | Aims to develop participants’ knowledge and skills in respond to students with suicidal thoughts and threat. It helps enhance participants’ competency and sensitivity in suicide risk identification, assessment, and management of cases with suicide risks. |
| Learning outcomes: | Participants will learn: Effective suicide prevention strategies Risk and protective factors of suicide To conduct suicide assessment To formulate crisis intervention and treatment plan |
| Targets: | Social workers, counselors and guidance teachers |
Trust your intuition
If it feels wrong, it probably is.
Our Psychoeducational Programs
What we taught?

1. Introduction
2. Understanding your stress
3. Stress and depression
4. Goal-setting
5. ABC model
6. Identifying thinking errors
7. Cognitive restructuring skills
8. Understanding other’s feelings
9. Communication skills
10. Problem-solving skills
11. Anger management
12. Summary
Results for Pilot Study (QEF1, 2006-08)

- 4 participating schools, 410 F.2-3 students received training in 2006-08
- Intervention group (i.e. students received training): in general showed improvement in help-seeking attitude and self-esteem
- Students with higher depressive symptoms in pre-assessment: enhanced cognitive restructuring skills and support seeking behaviors but not significant in reducing the symptoms
- Published on Journal of Affective Disorders in 2012 (Vol. 142, pp. 106-114)
Web-based Mental Health Programme for Adolescents with Parental Involvement

- **Period:** Oct 2010 – Aug 2013 (launched in Sept 2012)

- **Goal:** To develop an **e-Learning curriculum** to enhance the mental wellbeing of adolescents and **strengthen the mutual communication** between parent and child

- **Target:** F.1-2 students and their parents (equivalent to Grade 7-8)
Integrated framework of mental health promotion

Mental Illness Prevention

Preventive Constructs

Mental Wellbeing

Mental Wellness Enhancement

Positive Constructs

# Structured e-learning Modules

- 8 e-learning modules for 12-week of learning

<table>
<thead>
<tr>
<th>Module 1</th>
<th>The Cognitive Model</th>
<th>Week 1 &amp; 2</th>
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<tbody>
<tr>
<td>Module 2</td>
<td>Self-esteem &amp; Strengths*</td>
<td>Week 3 &amp; 4</td>
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<tr>
<td>Module 3</td>
<td>Goal Setting and Goal Attainment</td>
<td>Week 5 &amp; 6</td>
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<tr>
<td>Module 4</td>
<td>Hope*</td>
<td>Week 7</td>
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<tr>
<td>Module 5</td>
<td>Communication Skills</td>
<td>Week 8</td>
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<tr>
<td>Module 6</td>
<td>Gratitude*</td>
<td>Week 9</td>
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<tr>
<td>Module 7</td>
<td>Problem-Solving Skills</td>
<td>Week 10 &amp; 11</td>
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<tr>
<td>Module 8</td>
<td>Review &amp; Application of skills</td>
<td>Week 12</td>
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</table>

*Concepts from Positive Psychology*
《DoReMiFa歷險記》網頁 www.doremifa.edu.hk
Program content

- 6 modules, 11 e-lessons and 8 classroom teaching

For self:
- Emotional management
- Cognitive behavioral model and ABC theory
- Problem-solving skills

For interpersonal relationship:
- Social and communication skills
- Empathy
- Gratitude
Results – comparison between intervention and control group (n=625)

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>Range</th>
<th>Pre-test</th>
<th>Post-test</th>
<th>Pre-test</th>
<th>Post-test</th>
<th>Time</th>
<th>Group</th>
<th>Time*Group</th>
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<td>Knowledge</td>
<td>0-11</td>
<td>7.55</td>
<td>7.70</td>
<td>7.34</td>
<td>7.99</td>
<td>0.15</td>
<td>-0.24*</td>
<td>0.52*</td>
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<tr>
<td></td>
<td></td>
<td>(1.06)</td>
<td>(1.37)</td>
<td>(1.24)</td>
<td>(1.34)</td>
<td>(0.27)</td>
<td>(0.04)</td>
<td>(0.00)</td>
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<td>Anxiety</td>
<td>0-18</td>
<td>7.44</td>
<td>6.15</td>
<td>5.83</td>
<td>6.10</td>
<td>-1.27*</td>
<td>-1.59*</td>
<td>1.51*</td>
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<td>(4.61)</td>
<td>(4.32)</td>
<td>(4.65)</td>
<td>(4.49)</td>
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<td>Negative</td>
<td>0-40</td>
<td>13.38</td>
<td>11.37</td>
<td>12.32</td>
<td>11.21</td>
<td>-2.02*</td>
<td>-1.23</td>
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<td>(8.40)</td>
<td>(8.16)</td>
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<td>Perspective Taking</td>
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<td>15.20</td>
<td>15.57</td>
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<td>-0.94#</td>
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<td>(4.93)</td>
<td>(4.58)</td>
<td>(5.96)</td>
<td>(5.05)</td>
<td>(0.06)</td>
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<td>Self-esteem</td>
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^Controlled for school, age and gender  *p < 0.05  #p < 0.1
Quality Education Fund Thematic Network (QTN) on Developing Students’ Positive Attitudes and Values
Goals & Objectives

Goal:

- To develop and promote evidence-based practices for developing students’ positive attitudes and values in schools

Objectives:

- To enhance teachers’ skills and understanding of the importance of theoretical framework, evidence-based practices and systematic programme evaluation

- To strengthen the knowledge and skills of teachers to develop, implement and evaluate programs for students

- To disseminate good practices to different schools for developing students’ positive attitudes and values

- To develop a strong school support network and promote home-school cooperation for developing students’ positive attitudes and values
Conceptual Frameworks

- Public health approach
- Biopsychosocial model
Bio-Psycho-Social model

- **“Bio-” dimension**
  - Enhances relaxation skills
  - Enhances awareness on body sensation
  - Promote healthy body image
  - Promotes cognitive competencies

- **“-psych-” dimension**
  - Enhances self-esteem
  - Fosters resilience
  - Promotes emotional competencies

- **“-social” dimension**
  - Promotes social competencies
  - Promotes parent-child relationship
  - Fosters pro-social behaviors
Project details in development stage (2015-16)

Form a school support network:

- **Core schools**
  - 3 primary sch
  - 3 secondary sch

- **Partner schools**
  - 20 sch

- **Network schools**
  - 25 sch
Content of Student Programs - Primary School

- 8-session universal program for P.4 or P.5 students

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Theme</th>
<th>Content</th>
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<tbody>
<tr>
<td>Bio</td>
<td>Brain-based learning</td>
<td>Brain-based learning and teaching strategies</td>
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<td>Stress management</td>
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<td>Attention</td>
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<td>Breathing exercise</td>
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<td>Psycho</td>
<td>Emotional Management</td>
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<td>Cognitive Restructuring</td>
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<td>Problem Solving</td>
<td>6-step problem solving skills</td>
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<td>Social</td>
<td>Communication</td>
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<td>Prosocial behaviors</td>
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<td>Appreciation of Self</td>
</tr>
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<td>Thankfulness toward others</td>
</tr>
<tr>
<td>Bio/Psycho/Social</td>
<td>Conclusion</td>
<td>Review and application</td>
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Content of Student Programs—Secondary School

- 8-10 sessions universal program for F.2 or F.4 students

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<tr>
<th>Dimension</th>
<th>Themes</th>
<th>Content</th>
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<td>Muscle Relaxation</td>
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<td>Mindful Yoga</td>
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<td><strong>Psycho</strong></td>
<td>Self-image</td>
<td>Impact of the media</td>
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<td>Distorted ideation of beauty and thinness</td>
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<td>Character strength</td>
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<td>Practice character strength</td>
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<td>Emotional management</td>
<td>Cognitive Behavioral Theory</td>
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<td>Problem solving</td>
<td>6-step problem solving skills</td>
</tr>
<tr>
<td><strong>Social</strong></td>
<td>Empathy</td>
<td>Accepting emotions and empathy</td>
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<td>Gratitude</td>
<td>Appreciation of Self</td>
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<td>Thankfulness toward others</td>
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<td>Communication skills</td>
<td>Active Constructive Responding Skills</td>
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Briefing session

Quality Education Fund Thematic Network (QTN) on Developing Students’ Positive Attitudes and Values

- **Goals:** To develop and promote evidence-based practices for developing students’ positive attitudes and values in schools

- **Targets:** primary and secondary schools

- **Date of briefing session:** May 6, 2016 (Friday)

- **Time:** 4:00 – 5:30 pm

- **Venue:** G.02, G/F, The Jockey Club Tower, Centennial Campus, Pokfulam, The University of Hong Kong (香港大學百周年校園賽馬會教學樓地下G.02室)