出國報告（出國類別：國際會議）

『國際自殺防治協會第 27 屆世界大會』與會報告

服務機關：國立暨南國際大學
輔導與諮商研究所
姓名職稱：蕭富聰助理教授
派赴國家：挪威
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摘要

蕭富聰助理教授至挪威奧斯陸參加『國際自殺防治協會第 27 屆世界大會』，本次國際會議共計有來自將近 60 個國家超過 900 位相關領域的研究者與實務工作者與會。蕭富聰助理教授除了在會議中口頭發表研究論文 Process and outcome evaluation of Taiwan Suicide Prevention Hotline: A preliminary study 以及壁報發表研究論文 Reaching the target population: A descriptive analysis of Taiwan's National Suicide Prevention Hotline and the Taipei Lifeline database，並在會議期間與國內外專家學者多有互動交流，包括香港賽馬協會自殺研究與防治中心知名學者葉兆輝博士（Paul Yip）、國際生命線台灣總會理事長陳宇嘉博士、馬偕紀念醫院自殺防治中心方俊凱醫生等人。

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目的

國際自殺防治協會是自殺領域首屈一指的國際非政府組織，致力於自殺防治學術研究與實務工作之精進與推廣，並且與世界衛生組織有正式公務上關係。國際自殺防治協會每二年舉辦一次世界大會，此次『第 27 屆世界大會』由挪威國家自殺研究與防治中心協辦，在挪威奧斯陸舉行，會議期間有 23 場主題演講、超過 300 篇研究論文發表，共計有來自將近 60 個國家超過 900 位相關領域的研究者與實務工作者與會。蕭富聰助理教授此次與會的主要目的是進行二篇研究發表，並希望能進一步加深與國內外相關領域學者專家的專業連結。

過程

『國際自殺防治協會第 27 屆世界大會』於 9 月 23 日開始會前工作坊，9 月 24 日下午 4 點正式開幕，協會主席 Lanny Berman 在致詞時引用最新的研究資料破除自殺領域裡一個常見的迷思—自殺個案為精神疾患所苦的比例約在 60%~80%，遠低於過去認為的 90%，顯示過去以醫療和公共衛生領域為主的自殺防治相關處遇確有不足。

所有與會發表的學者專家於 24 日晚間在諾貝爾和平獎頒獎廳接受奧斯陸市長晚宴（見圖一左），蕭富聰助理教授於宴會中結識國際生命線台灣總會與馬偕紀念醫院自殺防治中心一行人，包括生命線理事長黃裕舜、生命線輔導理事長陳宇嘉博士、生命線秘書長何振宇、馬偕醫院方俊凱醫師、馬偕醫院胡仁潔護理師等（見圖一右），對於國內的自殺防治與處遇進行深入的討論與交流，蕭富聰助理教授當場獲邀參加『第 14 屆亞太地區電話諮商國際大會』。

圖一、開幕式晚宴

圖二、壁報與口頭發表研究論文

蕭富聰助理教授於 25 日上午 10:30 至下午 4:30 壁報發表研究論文 Reaching the target population: A descriptive analysis of Taiwan's National Suicide Prevention Hotline and the Taipei Lifeline database（見前頁圖二左），向世界各國學者專家與實務工作者介紹台灣衛生福利部自殺防治熱線《安心專線》的服務普及性以及待改進的地方，壁報內容請詳見附錄一。蕭富聰助理教授亦抽空與其他壁報發表者互動學習，得知美國和澳洲已結合社群網站臉書和即時通訊軟體 WHATSAPP 服務青年和青少年族群，而蕭富聰助理教授壁報發表的研究亦發現國內 30 歲以下族群對熱線電話服務的使用率偏低，因此藉機向美國和澳洲學者請教相關作法。

蕭富聰助理教授於 26 日下午 4:30 至 6 點口頭發表研究論文 Process and outcome evaluation of Taiwan Suicide Prevention Hotline: A preliminary study（見前頁圖二右），向世界各國學者專家與實務工作者介紹台灣衛生福利部自殺防治熱線《安心專線》志工協談技術與成效分析，與會人士對台灣自殺熱線推動以實徵研究為基礎的本土化實務工作感到印象深刻，PPT 內容請詳見附錄二。

此次會議五天期間共有 23 場主題演講以及超過 300 篇研究論文發表，蕭富聰助理教授把握機會參與多場演講以及壁報與口頭論文發表，深化學習各國在自殺防治領域的最新發展與發現，馬偕紀念醫院自殺防治中心的壁報發表介紹如何從一般門診篩選自殺高風險的高齡者（在台灣，高齡者族群自殺率遠高於其他年齡層），另外包括韓國的自殺率遠高於其他已開發國家（台灣人在羨慕韓國經濟成長的同時，並不知道韓國有很多嚴重的社會問題）、限制自殺工具的取得（例如香港在捷運裝設安全門以預防臥軌/跳軌、香港在部分高樓架設安全網以預防跳樓、中國農村集中管理致命性農藥）、自殺行為在人際間的傳染性（可以協助篩選高風險族群並提供預防性服務）、辯證行為心理治療對自殺未遂者的治療（對於反覆自傷個案的治療成效較傳統心理諮商佳，但是嚴謹的實徵研究仍非常不足）、透過社群網站和即時通訊軟體服務青少年和青年族群。

國際自殺防治協會有感於各國年輕學者在學術研究方面可能面臨種種的挑戰，會議期間於 26 日、27 日中午安排二場『與大師午餐』活動，邀請 6 位國際知名學者（一場次 3 位）與年輕學者分享他們的研究經驗以及對未來趨勢的看法。蕭富聰助理教授把握機會，二場次全程參與，結識香港賽馬協會自殺研究與防治中心知名學者葉兆輝博士（Paul Yip），葉博士非常讚賞蕭富聰助理教授對自殺熱線的歷程與成效分析實徵研究，口頭邀請日後有機會至香港賽馬協會自殺研究與防治中心參訪。

『國際自殺防治協會第 27 屆世界大會』於 9 月 28 日閉幕，閉幕式邀請 3 位分別來

印度、澳洲、加拿大的自殺防治工作負責人分享實務工作的創新作法與研究工作的未來趨勢，並宣告 2015 年『國際自殺防治協會第 28 屆世界大會』將在加拿大蒙特羅舉辦。

心得與建議

自殺防治在世界各國都是重要的公共衛生議題，而國際自殺防治協會是自殺領域首屈一指的國際非政府組織，致力於自殺防治學術研究與實務工作之精進與推廣，此次會議有 23 場主題演講、超過 300 篇研究論文發表，共計有來自將近 60 個國家超過 900 位相關領域的研究者與實務工作者與會。蕭富聰助理教授在會議期間與學者專家多有交流互動，從中得到許多寶貴的學習與想法，分述如下：

一、最新的發展與知識—自殺防治實務工作與實徵研究發展日新月異，最新焦點已經從社會或個人層面危險及保護因子、轉向至創新和有效的處遇方法，包括限制自殺工具的取得（例如香港在捷運裝設安全門以預防臥軌/跳軌、香港在部分高樓架設安全網以預防跳樓、中國農村集中管理致命性農藥）、自殺行為在人際間的傳染性、辯證行為心理治療對自殺未遂者的治療、透過社群網站和即時通訊軟體服務青少年和青年族群；

二、拓展學術人脈、強化國際學術能見度—會議期間與國內外專家學者多有互動交流，包括香港賽馬協會自殺研究與防治中心、國際生命線台灣總會、馬偕紀念醫院自殺防治中心等代表，除了獲得葉兆輝博士邀請日後有機會至香港賽馬協會自殺研究與防治中心參訪，並獲得生命線台灣總會邀請參加『第 14 屆亞太地區電話諮商國際大會』；

三、未來實務工作與研究想法—青少年和青年族群已逐漸捨棄傳統電話通訊、轉向使用社群網站和網路通訊軟體，蕭富聰助理教授也證實這點，換句話說，熱線服務需要轉型和改變以因應時代轉變。生命線台灣總會雖有意開展新服務，但是其 5 年時程規劃緩不濟急，蕭富聰助理教授已和新竹市生命線協會洽談合作發展網路和即時通訊軟體的自殺防治協談服務。

大型國際學術會議對於專業成長與學習非常重要，不僅能交流各國最新的實務作法和研究發現，更可以協助建立堅實的學術人際網路。蕭富聰助理教授此次申請國家科學委員會補助會議期間食宿遭駁回，所幸有本校的新進助理教授研究計畫獎勵金補助才得以成行。值此國家財政困難之際，不論政府預算或企業私人捐助都是僧多粥少、競爭激烈，但是蕭富聰助理教授仍呼籲政府和校方能更加重視並補助教師與研究生參與研究以及出國參與大型國際會議。畢竟台灣欠缺天然資源，人才就是台灣最重要的資源，所以人才的培育養成絕對是最重要的投資，即便短時間內不容易見到成效，日後絕對是台灣

能長遠發展的重要力量。

附錄一

Reaching the Target Population: A Descriptive Analysis of the National Suicide Prevention Hotline and the Taipei Lifeline Database

Fortune Shaw [1], Kai-Yu Chu [2], Wen-Hsien Chiang [2], Yi-Fang Chang [1], Li-Chuan Chen [1], Pei-Wen Chen [1], Hui-Chun Cheng [1], Chen-I Li [1], Shing-Li Shih [1]

[1] Graduate Institute of Guidance & Counseling, National ChiNan University
[2] Taipei Lifeline Association

Objectives: Established in 1969 and then undertaking the National Suicide Prevention Hotline from the Department of Health since 2009, the Taipei Lifeline Association has provided much-needed counseling services for hundreds of thousands of callers each year. The purpose of this descriptive study was to answer a simple yet important question: Did the service reach the target population?

Methods: Archival data from the National Suicide Prevention Hotline and the Taipei Lifeline 2009-2011 Database were used to summarize the demographic characteristics and counseling issues of the callers. The findings were then compared to government data drawn from the National Statistics and the Taiwan Suicide Prevention Center.

Results: Overall, more and more people with suicide ideation and/or suicide plan or who were taking actions to kill themselves were willing to call the hotlines (from 6,012 in 2009 to 11,875 in 2011). The hotlines were also able to intervene more and more acute suicide crises (from 143 in 2009 to 475 in 2011). However, contradicting to the fact that the suicide rate for males was two times higher than that for females, 56.1% of the calls were made by females. Young adult and middle-aged females were more likely to call the hotlines for family, intimacy, emotion, and marriage related issues; while young adult and middle-aged males were more likely to seek help for issues related to mental illness, substance abuse, financial crisis, and sex, which are similar to the national suicide statistics. Inconsistent with the national statistics that more than 40% of mature adults committed suicide for physical health problems, only 6.3% of elders sought help for concerns related to physical health. Last, people in urbanized areas with lower suicide rates were more likely to use the hotline service than those in rural areas with higher suicide rates.

Conclusion: The suicide prevention hotline service did reach the target population, especially among those in young adulthood and middle age. More effort, however, is needed to promote the service among males, physical ill elderly, and rural people.

附錄二

Process and Outcome Evaluation of Taiwan Suicide Prevention Hotline: A Preliminary Study

Fortune Shaw — National Chi Nan University
Wen-Hsien Chiang — Taipei Lifeline Association

The Taiwan's National Suicide Prevention Hotline

- The Taipei Lifeline Association has been undertaking the 24/7 toll-free National Suicide Prevention Hotline (NSPH) from the Department of Health, Taiwan since 2009.
- 61,284 calls to the NSPH in 2009, 71,781 in 2010, and 68,303 in 2011.
- Intervened 143 individuals in the process of a suicide attempt during of right before the call in 2009, 375 in 2010, and 475 in 2011.

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Research Questions

- Would the NSPH service improve callers' mental state and decrease their suicidality during the call?
- Would the NSPH helpers use different types of helping behavior for non-suicidal callers, suicidal callers, and acute suicidal callers?
- Would helpers' helping behaviors be associated with changes in callers' mental state and suicidality?

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Methods

- The *Suicide Risk Assessment of NSPH* was used to classify callers into non-suicidal, suicidal, and acute suicidal groups. A total of 300 anonymous phone records (including 100 acute suicidals, 100 suicidals, and 100 non-suicidals) were drawn from the NSPH 2009 database.
- The *Helper Behavior List*, modified from the Helper's Response List (Daigle & Mishara, 1995; Mishara & Daigle, 1997; Mishara et al, 2007a, Mishara et al., 2007b), was used to code NSPH helper's behaviors.

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Methods

- The *Modified Mental State Rating Scale* (MSRS), based on the works of KaLafat and colleagues (2007), King and colleagues (2003), and Mishara and colleagues (2007b), was used to evaluate callers' level of emotional disturbance at the beginning and at the end of the call.
- The *Modified Suicide Risk Scale* (SRS), based on the work of Gould and colleagues (2007), was used to evaluate callers' suicide risk at the beginning and at the end of the call.

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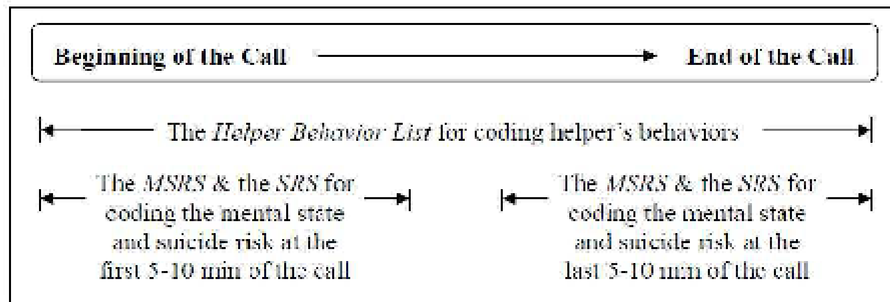
Methods



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Results

The Group Means and Standard Deviations of MSRS1, MSRS2, SRS1, and SRS2

Scales	MSRS1	MSRS2	SRS1	SRS2
Group	Mean (*SD*)	Mean (*SD*)	Mean (*SD*)	Mean (*SD*)
Non-suicidal	13.72 (2.75)	11.33 (2.80)	10.93 (3.25)	8.88 (2.52)
Suicidal	18.57 (3.39)	14.82 (3.30)	19.87 (5.07)	15.49 (4.52)
Acute-suicidal	16.57 (5.29)	12.77 (5.36)	22.36 (6.11)	16.53 (7.75)
Total	16.29 (4.42)	12.97 (4.21)	17.72 (6.97)	13.63 (6.35)

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Results

[illegible]

Item	F1	F2	F3	F4	F5	F6	F7
disagreement with callers	.727						
value judgment	[illegible]						
confrontation	[illegible]	[illegible]					
providing personal solution	.442						
[illegible]	[illegible]						
[illegible]		[illegible]					
reflection		[illegible]					
[illegible]		[illegible]					
[illegible]		.407					
[illegible]		[illegible]					
[illegible]			[illegible]				
[illegible]			[illegible]				
[illegible]		[illegible]	[illegible]				
[illegible]				[illegible]			
[illegible]				.444			
emotional validation		[illegible]		[illegible]			
[illegible]				[illegible]			
[illegible]				[illegible]			
providing information					[illegible]		
[illegible]					[illegible]		
[illegible]					[illegible]		
[illegible]						[illegible]	
[illegible]						[illegible]	
[illegible]			[illegible]			[illegible]	
[illegible]							[illegible]
[illegible]							[illegible]
[illegible]							[illegible]

Note. [illegible]

The Relationship between Helper Behaviors and Caller Groups

Techniques	Caller Types	*Mean*	η^2	*F*	*p*	*Post Hoc*
F1. Non-Professional Behavior	Acute-suicidal	1.88	.02	3.30	.038	Acute-suicidal = Suicidal > Non-suicidal
	Suicidal	1.85				
	Non-suicidal	1.48				
F2. Active Listening	Acute-suicidal	5.47	.03	4.82	.009	Suicidal = Non-suicidal > Acute-suicidal
	Suicidal	7.33				
	Non-suicidal	6.68				
F3. Facts Gathering	Acute-suicidal	8.68	.12	19.48	< .001	Suicidal > Non-suicidal > Acute-suicidal
	Suicidal	11.84				
	Non-suicidal	10.47				
F4. Consolation	Acute-suicidal	2.26	.01	1.32	.266	
	Suicidal	2.84				
	Non-suicidal	2.39				
F5. Caller-centered Problem Solving	Acute-suicidal	2.34	.08	13.27	< .001	Suicidal = Non-suicidal > Acute-suicidal
	Suicidal	4.13				
	Non-suicidal	3.74				
F6. Helper-centered Problem Solving	Acute-suicidal	2.41	.05	8.37	< .001	Suicidal = Non-suicidal > Acute-suicidal
	Suicidal	3.74				
	Non-suicidal	3.64				
F7. Crisis Response	Acute-suicidal	1.19	.08	12.50	< .001	Acute-suicidal > Suicidal = Non-suicidal
	Suicidal	0.53				
	Non-suicidal	0.37				

The Effect of Helper Behaviors on Callers' Mental Status

Fixed Effect	0 *Coefficient*	1 *Coefficient*	2 *Coefficient*
MSRS at the End of the Call, γ_{00}	12.97 ***	12.97 ***	12.97 ***
MSRS at the Beginning of the Call, γ_{10}		0.56 ***	0.54 ***
F1. Non-Professional Behaviors, γ_{20}			0.04
F2. Active Listening, γ_{30}			0.05
F3. Facts Gathering, γ_{40}			0.14 *
F4. Consolation, γ_{50}			0.12
F5. Caller-centered Problem Solving, γ_{60}			-0.13
F6. Helper-centered Problem Solving, γ_{70}			-0.08
F7. Crisis Response, γ_{80}			0.32 [a]
Random Effect	*Variance Component*	*Variance Component*	*Variance Component*
MSRS at the End of the Call, u_{0j}	2.92 ***	0.14	0.20
Level 1 Effect, r_{ij}	15.83	11.13	10.88

* $p < .05$. *** $p < .001$. [a] $p = .056$.

The Effect of Helper Behaviors on Callers' Suicide Risk

Fixed Effect	0 *Coefficient*	1 *Coefficient*	2 *Coefficient*
SRS at the End of the Call, γ_{00}	13.63 **	13.63 ***	12.97 ***
SRS at the Beginning of the Call, γ_{10}		0.67 ***	0.66 ***
F1. Non-Professional Behaviors, γ_{20}			0.06
F2. Active Listening, γ_{30}			-0.02
F3. Facts Gathering, γ_{40}			0.23 **
F4. Consolation, γ_{50}			-0.05
F5. Caller-centered Problem Solving, γ_{60}			-0.25 *
F6. Helper-centered Problem Solving, γ_{70}			0.03
F7. Crisis Response, γ_{80}			0.[illegible] *
Random Effect	*Variance Component*	*Variance Component*	*Variance Component*
SRS at the End of the Call, u_{0j}	16.93 ***	0.01	0.00
Level-1 Effect, r_{ij}	28.96	18.72	17.79

$* p < .05$. $** p < .01$. $*** p < .001$.

Comments, suggestions, or feedback?

Fortune Shaw

ftshaw@ncnu.edu.tw

Graduate Institute of Guidance & Counseling
National Chi Nan University

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