"The Role of Physicians in Bullying Prevention, Intervention & Follow-up"

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Profession of our distinguished audience

- Educator
- School Administrator
- School Nurse
- Physician
- Parent
- Other

About CHPDP
The Center for Health Promotion and Disease Prevention

- Public Health Team
  - Shiryl Barto, MEd
  - Karla Good, MSW
  - Charvonne Holliday, PhD
  - Matt Masiello, MD, MPH, FAAP
  - Allison Messina, MPH
  - Diana Schroeder, DNP, RN

- Health promotion initiatives regionally, nationally and internationally
- Signature partners with the Highmark Foundation on Bullying Prevention
- Largest implementation of OBPP
A person is bullied when he or she is exposed, repeatedly and over time, to negative actions on the part of one or more other persons, and he or she has difficulty defending himself or herself.

"any unwanted aggressive behavior(s) by another youth or group of youths who are not siblings or current dating partners that involves an observed or perceived power imbalance and is repeated multiple times or is highly likely to be repeated; bullying may inflict harm or distress on the targeted youth including physical, psychological, social, or educational harm."

Is the new definition of bullying better as compared to the historic version

- Yes
- No

If "no," why
  - Too specific
  - Too vague
  - Just don’t agree
A Look at Impact
Pennsylvania 2006-2012

49 Counties in Pennsylvania

2007 – Present
- 210,000 students (13%)
- 420 schools out of 3,280 (13%)
- More than 17,000 teachers
- Approximately 345,000 parents

Breakdown by School Type

- Urban 7%
- Rural 29%
- Suburban 47%
- Town 17%

Six year Initiative – Summary Results

- Significant decrease in students' self reports of being bullied
- Significant decrease in students' reports of bullying others
- Significant increases with regard to students' perceptions that teachers and other adults helped to stop bullying
- Students were less willing to join in bullying and more likely to try to help a bullied student
Successful Outcomes of a Large Scale, Public Health Based Bullying Prevention Initiative in Pennsylvania

Methods

The Olweus Bullying Prevention Program (OBPP), an evidenced-based program, was initiated with support and training by major foundations, states, and universities. The program itself includes clear rules and policies, peer relations, support and intervention for children who are bullied, and intervention with children who bully. Program components include peer education and 지자체, class meetings to discuss bullying and its consequences, and training for teachers and staff. The program was implemented in 214 schools in western and central Pennsylvania from 2008-11.

Results

From 2008-11, 214 schools in western and central Pennsylvania implemented the OBPP. It was a quasi-experimental study with an "extended" age cohort. Schools received support from a certified Olweus trainer and materials. A certified Olweus trainer provided support to the schools for the first 3 years of implementation. Classroom teachers and building leaders were trained in OBPP components. Committes (BPCC) to oversee OBPP implementation. Classroom teachers and building leaders were trained in OBPP components.

Key findings included:

- Significant decrease in students' reports of bullying and bullying others
- Significant decrease in students' self-reports of being bullied
- Increased likelihood of trying to help a bullied student
- Students were less willing to join in bullying and more likely to try to help a bullied student
- Odds Ratios ranged from 1.41 to 1.62, indicating that the program effects, which were systematically larger the longer it was implemented, were not due to historical effects but rather to the program effects.

Findings revealed many positive and systematic effects of the OBPP, including reduced reports of bullying. Prior to implementation, 16% of students (3rd-12th grade) were bullied at school, with 41-62% higher than after the intervention. (Figure 1) The odds of bullying others in the control (T0) condition was 14-25% higher than after the intervention. (Figure 2) Among students who reported they had been bullied or had bullied others, 80% of students who reported bullying others were likely to try to help a bullied student. (Figure 3) Students were less willing to join in bullying and more likely to try to help a bullied student. (Figure 4)

The data support the fact that evidence-based bullying prevention programs, when implemented as designed, can have significant positive impacts on bullying behaviors and students' perceptions that teachers and other adults helped to stop bullying. Students were less willing to join in bullying and more of implementation. Teachers were expected to conduct weekly classroom meetings with students and meet monthly as a staff to discuss the program. They were trained as a staff to discuss the program. They were trained in OBPP components. Teachers were trained to intervene and investigate when they witnessed or suspected bullying. Students were instructed to tell an adult at school and at home if they were bullied. Teachers were trained to intervene and investigate when they witnessed or suspected bullying. Students were instructed to tell an adult at school and at home if they were bullied.

Conclusion

The Olweus Bullying Prevention Program: Preliminary Findings From the Field and the Importance of Coalitions. Schroeder, B et al. Health Promotion Practice; July 2012 Vol. 13, No. 4. p. 489-495

The Role of a Health Care Foundation in a Statewide Bullying Prevention Initiative. Schroeder, B et al. Academy of Health Care Management Journal; Volume 8, Number 1, 2012. p. 32

In Print

School Cost Benefit: Each school could recover the cost of OBPP implementation if JUST TWO students were prevented from transferring or dropping out due to bullying.

Health Payer Cost Benefit:

Societal Benefit:
Does bullying really impact a child’s overall health?

- Minimal
- Moderate
- Large
Health Consequences of Bullying

- Headache 16% 6%
- Sleep problems 42% 23%
- Abdominal pain 17% 9%
- Feeling tense 20% 9%
- Anxiety 28% 10%
- Feeling unhappy 23% 5%
- Depression scale
  - moderate indication 49% 16%
  - strong indication 16% 2%

A long term consequence of bullying. Pick one.
- increased risk of tobacco use
- lower job function
- increased risk of illegal drug use
- relations to live in spouse/partner were poorer
- all of the above

School bullying and health
- J.F. Sigurdson, et al

- Prospective study – Norway
  - 14–15 y.o. age to 26–27 y.o. age
  - N= 2,464
  - Self reported on general health and psychosocial issues
- Classified as bullied, bully–victim, being aggressive toward others, non–involved
School bullying and health
- J.F. Sigurdson, et al

- Groups involved in bullying of any type in adolescence had an increased risk for lower education as young adults compared to those non involved
- Also, as compared to the non involved group, the group aggressive toward others had a higher risk of unemployment and receiving social support
- Those bullied and bully-victims had increased risk of poor general health and high levels of pain
- Bully victims and those aggressive toward others during adolescence had increased risk of tobacco use and lower job function as well as increased risk of illegal drug use

- Relations to live in spouse/partner were poorer among those being bullied

- *Involvement in bullying, either as a victim or perpetuator has significant social costs even 12 years after the bullying experience.*

- J.F. Sigurdson, et al. Is involvement in school bullying associated with general health and psychosocial adjustment outcomes in adulthood?
- Child Abuse and Neglect 38 (2014) 1607-1617

PEDIATRIC BULLYING SCREENING TOOL

With generous support from
Children and adolescents suffer physically and emotionally because of their involvement in bullying, yet few seek treatment or understand the connection between bullying and their health.

The AAP encourages pediatricians to become more aware of bullying, and to engage as professionals in this topic.

No current, formalized screening tool exists as a viable public health tool for pediatric healthcare providers.

This pilot provides a process & evaluation of a tool/procedure that will enable pediatricians and physicians to more thoroughly understand their school-aged patients’ role in bullying.

Why a Pilot?

- Study Size: >50 children per practice

- Practice In-Service Training:
  - Bullying (research, history of prevention, known health outcomes)
  - Instruction on survey

- General resources for patients and families

- “Thank You” library for participating practices

Process Evaluation of a Screening Tool

Bullying Experiences Screening Tool "BEST"

- A 10 question survey – “Test on the presence of bullying in and out school (Bull–M)”
  - An additional four questions about psychosomatic complaints were added
  - A likert scale (for ease of scoring), as well as a “For Office Use Only” box were developed where providers could capture information about the reason/type of visit and the BMI percentile of the patient
“Decision Tree” was developed

- Serves as an algorithm
- Allowed providers to analyze the score of the B.E.S.T. surveys
- Frames questions providers can ask their patients, based on their level of involvement in school-based bullying (whether as bully, target or bystander)
- Also recommends anticipatory guidance for providers to pass along to patients and their families, based on the BEST score, as well as suggested plans for follow-up interventions

Deployment

- After the in-service training, each practice began to administer the survey to patients in grades 3 through 12
- After completion, a staff member scored the survey and gave it to the physician, physician assistant or CNP who was conducting the office visit
- This provider, based upon survey score, discussed bullying involvement appropriately with the patient and family member(s), and provided guidance, resources and follow-up when needed

PA Bullying Prevention Toolkit
Debriefing focus groups

- After each practice had fulfilled the 50 survey mandate, CHPDP met with the staff members and physicians most closely associated with the pilot.
- During the 1.5 hour focus group, CHPDP staff collected qualitative data that was used to refine the BP screening process for future trials.
- A Survey Monkey was also sent to involved practice staff to collect additional quantitative data; the summarization of these data outcomes is promising.

Summary Outcomes

- Universally, the pediatric practices identified that the use of the BEST survey tool and the Decision Tree were very helpful, in that they enabled them to engage their patients in discussions about bullying in their schools and lives in a way that had not occurred previously.
- They found the process manageable and the survey tool easy to use with their patients.

Summary Outcomes

- The education received by providers and their office staff was critical in developing engagement about bullying and school safety between patients and their providers that had not occurred previously.
- All providers were better prepared to talk with their patients about the subject and felt there was more they could do to help their patient.
- Improved “connection” between the physical or psychosomatic complaints of children, and their experiences with bullying in schools.
Summary outcomes

- Positive comments on the Bullying Prevention Toolkit and other Highmark Foundation print materials.
  - These provided guidance for families and contain resources for proactivity
- The majority of providers have an interest in working to imbed the survey into their practices
- Clinicians indicated the time spent with patients during the survey and in follow-up conversation could be identified in ICD 9/10 codes

Recommendations

- Develop tools and resources in Spanish
- Consider a “Phase 2” educational session, with deeper information on bullying, laws, policies and prevention efforts
- Develop strategies for enhanced billing practices
- Help practices learn how to facilitate communications between families and schools
- Expand on the definition of bullying, to ensure that the parent and child understand what is being discussed
- Consider two versions of the survey tool – for younger and older children
- Pursue development of software for EMR use in the pediatrician office for institutionalization of survey use.
Next Steps

- CHPDP will begin a second pilot with 10 pediatric practices in the Spring of 2015
- Preliminary steps to publish results are underway

For additional information

www.chpdp.org

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