



**Testimony of
Children's National Medical Center
Presented by Jorge C. Srabstein, MD**

**Before the
Maryland General Assembly's
House Ways and Means Committee**

**HB 199
Public Schools - Bullying and Cyber-Bullying - Policy and Disciplinary Standards**

**HB 206
Education - Student Bullying - State and School Policy**

**HB 546
Local Boards of Education - Harassment and Intimidation in Schools**

**HB 732
Bullying, Harassment, and Intimidation - School Policy**

February 20, 2008

Madam Chairwoman and members of this Committee, I am Jorge Srabstein, M.D., a child and adolescent psychiatrist and Medical Director of the Clinic for Health Problems Related to Bullying at Children's National Medical Center (Children's) located at its Montgomery County Regional Outpatient Center. I also serve as Coordinator for the Coalition for the Prevention of Bullying and Related Health Risks, an emerging community organization comprised of educational, health, and youth organizations, among others, in Montgomery County.

Thank you for the opportunity to testify in support of HBs 199, 206, 546 and 732.

Children's commends Delegates Rice, Riley, Kaiser and Stein for their leadership in introducing these important bills, and I am pleased, on behalf of Children's, to offer support. Children's also applauds Delegate Luiz Simmons and Senator Nancy King for their leadership in passing the Maryland Safe Schools Reporting Act of 2005, which has been pivotal in the development of public awareness and discourse about the problem of school bullying.

Bullying is a very toxic form of abuse prevalent along the lifespan on a global scale. It occurs not only in schools, but over the Internet and cellular phones, in the neighborhood, summer camps, at home between siblings, as hazing among young adults, and at the adult workplace. Bullying is a very urgent public health issue as it has been linked, during the last two decades, to hundreds of deaths due to suicide, accidental injuries and homicide. Both bullies and victims are at high risk of suffering from an array of very serious health, safety and educational risks, including suicidal attempts, injuries requiring hospital stay or surgery, drug and alcohol abuse, runaway episodes, serious absenteeism and poor academic performance.

I would like to submit the following recommendations for anti-bullying legislation, which are based upon my several years of clinical experience, research and advocacy work to prevent health risks related to bullying. Anti-bullying legislation based on public health concerns should:

- 1) **Protect** all children and adolescents attending public and private schools, as well as those who have been placed in residential facilities or correctional institutions.
- 2) **Contain** an explicit and inclusive research-based understanding of bullying, including its link to public health risks such as injuries and suicide.
- 3) **Prohibit** bullying as a matter of public health principle, with the recognition that zero tolerance by itself is not an effective preventive measure unless accompanied by improvement in the school psychological environment.
- 4) **Allocate** necessary funds to require that each school district implement a research-based school wide prevention and intervention strategy involving all students, school staff, parents and the community. This program should offer awareness to the entire community about the nature of bullying and its health risks; promote mutual respect and improved interaction among school peers; and enhance community empathy, sensitivity and tolerance to diversity.
- 5) **Support** detection and reporting mechanisms of bullying incidents.
- 6) **Require** school intervention to preclude recurrence of a bullying incident or the emergence of connections to health, safety or educational risks. This should preferably be based not upon punitive measures, but rather upon counseling the perpetrator to become sensitive to the harm caused to the victim, followed by a process of “restorative justice” by apologizing to the victim and establishing a positive future interaction, while appropriate support is given to the victim.
- 7) **Promote** referrals to health providers of students who are unable to stop bullying in spite of school intervention and for the bullies and victims who are suffering from health or educational risks.

- 8) **Involve** the participation of public health officials to promote community understanding of the health problems linked to bullying, to provide guidelines for the detection of health problems, and work with school authorities to conduct periodic assessments of the prevalence of bullying and its health correlates.
- 9) **Implement** regular assessment of the occurrence of bullying and associated health risks. To achieve this goal, it would be advisable to include questions about bullying and related symptoms to an already existing data collection program such as the Youth Risk Behavior Surveillance.

Thank you for the opportunity to testify, and I would be happy to answer any questions.

Background

Children's National Medical Center, a 283 bed not-for-profit academic medical center, has provided hope to sick children and their families throughout the Washington metropolitan region for more than 135 years. Located just three miles from the Maryland border, Children's annually devotes nearly 60% of its inpatient care to children from Maryland. With five outpatient centers in Maryland and specialty care services provided in eight Maryland locations, Children's is proud to provide high quality pediatric primary, specialty and emergency care to Maryland's children and families.

Definition of Bullying

Dan Olweus, a pioneer in the field of bullying research, first described the characteristics of bullying: "a student is being bullied or victimized when he or she is exposed, repeatedly and over time, to negative actions on the part of one or more students." He

also recognized three types of bullying behaviors: physical aggression (hitting, kicking, pushing); verbal harassment (threatening, teasing, calling names, making faces or dirty gestures) and indirect/relational mistreatment (ignoring somebody or leaving him/her out of things on purpose). We should include the action of “daring” somebody to perform a dangerous, illegal or inappropriate action, as a form of bullying. In this situation the victim, under the threat of losing approval among the members of a group, carries out an action that may be inappropriate or dangerous. The conceptual understanding of bullying varies according to developmental stages and cultures.

Prevalence

Physical, verbal and relational mistreatment among peers, or between subordinates and superiors, happen at all different stages of life. It can occur as early as kindergarten, usually predominates in middle school with some decline in high school. It should be noted that bullying also occurs in college, among young soldiers, prison inmates and throughout adulthood at the workplace.

Nansel et al. estimated that 30% of US adolescents, in grade 6-10, were involved in bullying incidents, sometimes several times a week, as bullies and/or victims.

Bullying among adolescents has been documented to occur in at least 60 countries, representing at least 250,000,000 adolescents. Nine percent of European workers (12 million people) claimed to have been subjected to intimidation (bullying/mobbing).

Cyber-bullying

The death of Megan Meier has prompted attention to a new version of bullying: cyber-bullying. In October 2006, Megan Meier, a teenager in Missouri, committed suicide after receiving messages on her MySpace Web page that could be classified as bullying.

Cyber-bullying is defined as cruelty to others by sending or posting harmful material using the Internet or a cellular phone. Cyber-bullying differs from the more traditional forms of bullying in that it can occur at any time, its messages and images can be distributed instantaneously to a wide audience, and perpetrators can remain anonymous, often making them difficult to trace. Although research is scarce, studies have found that approximately 30 percent of students in grades six through eight reported they recently had been cyber-bullied or had cyber-bullied another person at least once. Research also shows that girls are about twice as likely as boys to be victims and perpetrators of cyber-bullying and that the most common method of cyber-bullying is through instant messaging, followed by chat rooms, e-mails and messages posted on websites.

Bullying and Public Health Risks

There is a growing recognition of the serious public health risks associated with bullying along the lifespan. Adolescents who are involved in bullying as victims and/or as bullies are at high risk of suffering frequent physical and emotional symptoms, including eating disorders, suicidal attempts, injuries requiring hospital stay or surgery, abuse of over-the-counter medications, alcohol and drug abuse, daily smoking, runaway episodes, carrying weapons to school, serious absenteeism and poor academic performance. Workers who are subjected to bullying at the place of work are more prone to be absent from work

because of sickness, and also suffer from cardiovascular disease, including hypertension, cerebro-vascular disease, myocardial infarction, depression and post traumatic stress disorder (PTSD).

Prevention

In 1983, Olweus developed the first bullying prevention/intervention strategy. He was able to reduce the prevalence of bullying by 50% over a period of 18 months. The Olweus Bullying Prevention Program became the prototype of subsequent effective “whole school” programs. For these programs to be successful, they require the participation of all segments of the community. His program recommended a “zero tolerance” to bullying that in itself is not effective unless accompanied by a marked improvement in school climate that fosters peer support, mutual respect, better interaction, and enhanced sense among the victims of “security at school, greater self confidence, and a feeling of being liked and accepted by at least one or two fellow students.” Positive behavioral discipline should help the bullies to “have fewer aggressive reactions to the environment and assert themselves in more socially acceptable ways.” Primary bullying prevention, as school intervention, may be limited in its capacity to preclude only 50% of bullying episodes. Therefore, it is necessary to implement ongoing detection and medical referral of those students who are unable to stop bullying, in spite of school intervention, as well those bullies and victims who are suffering from health, safety and educational risks.

Professional Organizations' Anti- Bullying Policy Positions

The American Medical Association has taken the public health leadership in acknowledging the serious implications of bullying by identifying it as a set of “complex and abusive behavior with potentially serious social and mental health consequences for children and adolescents.” The AMA advises physicians to be “vigilant for signs and symptoms of bullying and other psychosocial trauma and distress in children and adolescents; (b) enhance their awareness of the social and mental health consequences of bullying and other aggressive behaviors; (c) screen for psychiatric co-morbidities in at-risk patients; (d) counsel affected patients and their families on effective intervention programs and coping strategies; and (e) advocate for family, school, and community programs and services for victims and perpetrators of bullying and other forms of violence and aggression.” The Society for Adolescent Medicine issued a position statement on bullying and peer victimization, stating that bullying is not acceptable and needs to be prevented; requiring health care providers to be familiar with signs and symptoms of bullying and their sequelae and to provide, together with school personnel, “leadership and education to community organizations” on interventions and referrals related to bullying. It also supported the efforts of the National Bullying Prevention Campaign of the U.S. Health Resources and Services Administration.

The American Academy of Pediatrics also recommends that pediatricians should advocate for bullying awareness by teachers, educational administrators, parents and children, coupled with adoption of evidence-based programs.

The American Academy of Child and Adolescent Psychiatry presented congressional testimony calling attention to the problem of bullying, and several psychiatric organizations have sponsored international symposiums on bullying and health related risks.

Anti-Bullying Public Policy

As of June 2007, 35 states have enacted anti-bullying legislation that intends to protect the safety of students enrolled in public schools. State policies vary widely, although many incorporate at least one, if not more, of the following components to address bullying: a statement prohibiting bullying; a definition of bullying; state-level support; school intervention strategies; individual reporting and immunity; public school reporting; parental rights; teacher and staff training; prevention task forces and programs; and integrated curriculum instruction. Legislation should:

1. Clearly define the risks associated with bullying in schools and its link to mortality, should clearly prohibit bullying; and
2. Require implementation of prevention programs, and should provide funding for prevention activities.

Between 2005 and 2007, nine states enacted legislation explicitly targeting cyber-bullying. Most legislation directs schools to enact anti-bullying policies as described above and also include electronic forms of bullying in state statutes defining bullying. Children's encourages the General Assembly to enact legislation that includes cyber-bullying in its anti-bullying statutes.

Children's Anti-Bullying Prevention Efforts

For the past several years, Children's has supported efforts to prevent bullying throughout the Greater Washington metropolitan region. In my role as Medical Director of Outpatient Child Psychiatry at Children's Regional Outpatient Center in Montgomery County, I have developed clinical expertise, performed research, and engaged in advocacy work in an effort to alleviate the serious public health risks linked to bullying. This work has led to the development of a Coalition for the Prevention of Bullying and Related Health Risks, which was conceived as a volunteer partnership of representatives of the Montgomery County PTA, educational, health, professional, civic, youth, business, labor, religious, and government organizations. The main goal of this initiative is to take steps that will prevent the occurrence of adolescent death linked to bullying. More specifically, it will: 1) promote the understanding of bullying and its association with health risks; and 2) advocate for the implementation of public and private policy and programs for the prevention of bullying along the lifespan. The Coalition held its first meeting in January 2008 and was attended by representatives of 35 public and private organizations and agencies.

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