



**Testimony of
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**Senate Bill 353
Task Force on Public Health Risks Linked to Bullying
Senate Education, Health, and Environmental Affairs Committee
Maryland General Assembly**

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Madam Chairwoman and members of this Committee, I am Jorge Srabstein, MD, a child and adolescent psychiatrist and Medical Director of the Clinic for Health Problems Related to Bullying at Children's National Medical Center's (Children's National) regional outpatient center located in Montgomery County. I also serve as Coordinator for the Coalition for the Prevention of Bullying and Related Health Risks, a community volunteer partnership of educational, health, and youth organizations, among others, in Montgomery County. Thank you for the opportunity to testify on behalf of Senate Bill (SB) 353. Children's National commends Senator Nancy King for her leadership in introducing this pioneering legislative initiative, and I am pleased, on behalf of Children's National, to offer support.

The actual dimensions and repercussions, in the State of Maryland, of the serious health risks associated with involvement in bullying incidents, is not yet known. However, if we extrapolate from national data of prevalence, we could estimate that approximately 37,000 Maryland adolescents in grades 6-10 may suffer from a combination of emotional and physical symptoms associated with their participation in bullying, as victims and/or as perpetrators. This group of symptoms includes depression, anxiety, insomnia, irritability and a least one or more physical symptoms such as headaches, stomachaches, backaches or dizziness. These warning signs may lead to pediatric outpatient visits costing approximately \$2.6 million per year. Furthermore, these students are at high risk of suffering from self inflicted, accidental or perpetrated injuries costing approximately \$59 million per year in emergency room and inpatient care. Beyond the economic health costs, bullying is associated with many safety and health risks such as running away episodes, school absenteeism, carrying weapons, alcohol and drug abuse, and, most significant, approximately five deaths in the state per year due to suicide.

Of course, the statistics I cite highlight the prevalence of bullying and the urgent public need to address the issue. However, bullying becomes a very personal issue when a child in our communities becomes a tragedy of these acts. Exactly one year ago, an 8-year-old third-grade boy at Robert R. Gray Elementary School in Capitol Heights, Maryland, was found dead in a Fairmount Heights home. He allegedly hanged himself because of bullying at school. According to news reports, one day prior to this tragedy the boy told his mother that some boys were going to "jump him" after school.

How can we prevent this significant and urgent human and economic loss? All anti-bullying statutes so far enacted in the United States have placed the responsibility of prevention solely upon education policy makers and administrators without requiring a public health input. The objectives of SB 353 reflect a long tradition of close cooperation among Maryland public health and education officials to ensure the health and safety of students through physical examinations, immunizations, blood lead testing, hearing and vision screening, among other measures included in Title 7, Subtitle 4 of the

Maryland Annotated Code. Most importantly, though, SB 353 places a unique responsibility upon the Secretary of Health in the prevention of disease and mortality as outlined by Article 18 of the Maryland Code.

Bullying is a very serious psychosocial stressor which has significant medical and psychiatric antecedents and consequences. This bill is the first legislative initiative of its nature to fully recognize the toxicity of bullying while requiring a consensus expert review of its regional morbidity and mortality, as well as recommendations for a bullying preventive public health policy.

Children's National Medical Center respectfully urges the Committee to give a favorable report to SB 353. Thank you for the opportunity to testify, and I would be happy to answer any questions.

Background

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). The action of "daring" somebody to perform a dangerous, illegal or inappropriate action should also be included 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, occur at 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 percent of US adolescents, in grades 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 million adolescents. Nine percent of European workers (12 million people) claimed to have been subjected to intimidation (bullying/mobbing).

Health and safety risks associated with bullying

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 workplace 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 PTSD.

It is estimated that 9.5 percent of US students in grades 6-10 suffer from a combination of physical and emotional symptoms associated with their participation in bullying as bullies and/or as victims. This includes depression, irritability, anxiety, insomnia and at least one or more physical symptoms such as headaches, stomachaches, dizziness and backaches. 44 percent of these students suffer from self injuries, and only 1/3 of these students may consult with a physician, which may lead to inpatient care. In addition, 49 percent of students with symptoms related to bullying may suffer from accidental or perpetrated injuries leading to an emergency room consultation with 17 percent requiring a hospital stay. The ratio of attempted suicides treated by health professionals to suicidal deaths is of approximately 945 to 1 for adolescents ages 11-15 in the United States.

Estimates of bullying related health costs in Maryland

Based upon national data of incidence of bullying-related morbidities, it is estimated that 37,000 Maryland adolescents in grades 6-10 may suffer from physical and emotional symptoms associated with their involvement in bullying as victims and/or as bullies. This health concern may lead to a pediatric consultation with an average cost of \$70, resulting in an annual cost of \$2.6 million. 13 percent of these students (4,900) may inflict self-injuries leading to emergency care at an average cost of \$560 per emergency room visit, resulting in an estimated annual cost of \$2.7 million. Subsequent inpatient admission, at an average cost of \$5,800 dollars per hospital stay, will result in an annual cost of \$28.4 million. Furthermore, 49 percent of students(18,130) suffering from bullying-related psychosomatic symptoms may experience accidental or perpetrated injuries requiring emergency room care at an annual cost of \$10.1 million per year, and 17 percent of these adolescents (3,080) may require a hospital stay resulting in an estimated annual expenditure of \$17.8 million.

Prevention

In 1983, Olweus developed the first bullying prevention/intervention strategy and was able to reduce the prevalence of bullying by 50 percent 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 is 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 percent 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.

Health professionals have the unique responsibility of promoting the development of community initiatives for the prevention of bullying and related health problems. This effort needs to include ongoing programs with elements of primary; second and tertiary prevention. These programs should

be supported and monitored by a public health policy with a strategy aimed at developing a whole community awareness about bullying and the related health risks; prohibiting bullying and developing emotionally and physically safe environments, in schools and workplace settings.

Professional organizations' anti-bullying policy/position:

The American Medical Association (AMA) has been a leader in the public health arena 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 has advised 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 has 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 Health Resources and Services Administration.

The American Academy of Pediatrics has also recommended 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, along the lifespan.

Anti-bullying Public Policy

More than 38 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. All anti-bullying statutes so far enacted in the United States have placed the responsibility of prevention to be solely shouldered by education policy makers and administrators without requiring a public health input. Public health policy needs to mandate the monitoring, detection and reporting of bullying incidents; provide guidance for school intervention and offer guidelines for medical consultation.

Children's National and its anti-bullying prevention efforts

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 National 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 National is proud to provide high quality pediatric primary, specialty and emergency care to Maryland's children and families.

For the past several years, Children's National has supported efforts to prevent bullying throughout the Greater Washington metropolitan region. In his role as Medical Director of Outpatient Child Psychiatry at Children's National's Regional Outpatient Center in Montgomery County, Dr. Srabstein has 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 development of a Coalition for the Prevention of Bullying and Related Health Risks, which was conceived as a volunteer partnership of representatives of different community sectors. 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.

In 2008, Dr. Srabstein testified in support of House Bill 199, which adds the terms "bullying" and "cyberbullying" into existing statute concerning school policies to report harassment. The bill also requires schools to establish a policy prohibiting bullying (and cyberbullying). Children's National commends Delegates Craig Rice, Dan Riley, Anne Kaiser, and Dana Stein for their leadership in enacting this bill. In addition, Children's National applauds Delegate Luiz Simmons and Senator 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.

In addition to his legislative advocacy, Dr. Srabstein participated in an ad hoc working group providing support to the Maryland State Department of Education in the development of a Model Bullying Prevention Policy.

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