Determining the Feasibility of Incorporating a Bullying Involvement Screening into Pediatric Office Visits

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Abstract

Background Bullying is a serious problem that can lead to short and long-term physical and mental health problems. Many healthcare providers are reluctant to screen patients for bullying involvement because they lack education and training on bullying prevention. The objective of this study was to determine if pediatric healthcare professionals would find a bullying screening process useful.

Methods A training was developed by certified bullying prevention specialists to teach healthcare providers about bullying prevention, associated health effects, and how to utilize a validated screening tool in their practices to determine adolescents' involvement in bullying and possible related health events. Eleven pediatric practices participated.

Results At project end, providers and staff completed a survey (n=66) and participated in focus group to document their experience with the project. Results demonstrated that: 1) the bullying prevention training, survey process, survey tool, and related educational materials were beneficial; 2) a need and desire exists to incorporate the tool into future pediatric visits; 3) healthcare professionals believe they have a responsibility to help patients who have been bullied.

Conclusion The survey tool and process show promise for increasing healthcare providers' knowledge about bullying prevention and likelihood of screening their adolescent patients' for bullying involvement. The project showed the screening tool was a beneficial way for providers to engage their adolescent patients and families in conversations about bullying.

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Introduction

Bullying is a serious problem that affects youth socially, academically, physically and psychologically. Bullying, retaliation and its consequences can lead to community conflict, short and long-term physical and mental health problems, and is part of a larger phenomenon of violence in schools and communities (1). Bullying is a form of youth violence that is often overlooked or misunderstood. Being bullied by peers is the most frequent form of abuse encountered by children; much higher than abuse by parents or other adults (2). According to 2015 Youth Risk Behavioral Surveillance System Survey, nearly 20% of students reported being bullied on school property and over 15% said they were electronically bullied over the past 12 months (3).

Bullying or being bullied, in or away from school, is consistently related to four violence-related behaviors: carrying a weapon, carrying a weapon in school, frequently fighting, and/or being injured in a fight (4). Children who bully others are three times more likely to have multiple criminal convictions by their early 20's, have higher self-reports of drug and alcohol use, and hold beliefs that support violence (5;6). Research indicates that childhood bullying is a risk factor for later criminal offending, and being the bully increases the probability of adverse outcomes later in life (7).

The health issues experienced by children, whether participating, being targeted or witnessing bullying behaviors, are significant. Headaches, stomachaches and sleep problems are some of the health problems these children may face (8). Anxiety, depression and other mood disorders are significantly associated with children who are bullied in school (9),

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and to a lesser extent, bystanders to the bullying. Victims and perpetrators of bullying are at increased risk of self-harm, self-inflicted, accidental and perpetrated injuries, and alcohol/drug abuse as well as attempting or completing of suicide (10-14). Studies indicate that bullied students are at least two times more likely than non-bullied peers to have psychosomatic problems (11).The consequences of bullying extend into adulthood with a significant association between childhood bullying behaviors and later psychiatric morbidity, including chronic depression and suicide (15).

Role of Healthcare Providers in Bullying Prevention

The significant health impact of bullying on individuals and society mandates a multifaceted approach that begins in an exam room (16). Healthcare providers play a critical role in bullying prevention, as many psychosomatic and psychosocial health problems follow an episode of bullying victimization (9). However, the effects of bullying are rarely obvious, and it is unlikely that a child will present to a physician with a chief complaint related to bullying (17). Providers are frequently the first to see the physical and/or emotional impacts of interpersonal violence among youth and need to remain vigilant for the possibility that a child is being affected by bullying (18). The potential negative health, psychological, and educational consequences of bullying experiences are significant and providers need to establish whether bullying plays a contributing role (9).

In 2005, the AAP launched Connected Kids: Safe, Strong, Secure, to help pediatricians integrate violence prevention strategies into routine child health visits. Their 2009 Policy Statement: Role of the Pediatrician in Youth Violence Prevention encouraged pediatricians to address the threat of youth violence (which includes bullying) within four domains: clinical practice, advocacy, education, and research, and to take an active role in its prevention (19). Yet neither has led to widespread changes in the exam room around the topic of bullying prevention.

Even though medical professionals can bring critical expertise to bullying prevention, too often it is not included in "violence against children" conversations in the exam room even though it is one of the most common form of violence that children can experience (20). Pediatricians should ask about bullying when school age children present with unexplained psychosomatic and/or behavioral symptoms, demonstrate signs of depression or talk about self-harm (17). Even with the AAP's clear recommendations, pediatricians still reported they felt ill prepared to screen for and manage forms of violence other than child maltreatment (19). Providers have limited professional education about bullying, which leads to inadequate assessment and intervention (19). Further, clinicians cite numerous barriers as to why they often don't offer these preventative services such as: lack of knowledge/confusion about guidelines or available tools, lack of time, belief that he/she can't effectively deliver the recommended services, belief that the delivery of services will lead to the desired outcome, and/or lack of motivation to change the practice (21). This data suggest that pediatricians want more training and structure when it comes to preventing youth violence, including bullying, but evidence-based screening and intervention strategies for providers remain limited (22;23).

Screening for bullying exposure is a reasonable first step. For example, patients who demonstrate signs of anxiety, depression, or social withdrawal should be routinely screened by clinicians to determine the patient's potential involvement in bullying as these symptoms can be related to peer victimization (24). If bullying is identified as a patient concern, clinicians should then assess for any associated physical/psychosomatic health complaints (24). In addition, when screening indicates, clinicians should provide patients with counseling using evidence-based responses, referral to mental health professionals, provide educational resources, and/or advocate for appropriate school follow-up (18;25). Pediatricians can help limit the adverse consequences of bullying through this early detection coupled with effective intervention (26).

Research Objectives

This study examines the feasibility of using an in-office bullying screening tool. The tool was administered to youth in grades 3-12 during office visits at eleven pediatric practices in Pennsylvania over a 15-month period. The objectives were to:

1) determine the effectiveness of a bullying prevention training module for providers that focused on understanding the issue of bullying and the health related consequences;
2) help pediatric practices address bullying issues with their patients and families and provide appropriate guidance and resources;
3) determine the feasibility of pediatric offices' ability to use a validated screening tool to screen patients for exposure to bullying and related health effects; and
4) explore the willingness of practices to continue the screening process after the pilot period.

Methods

Project Description

Prior to the project's start, a literature review was conducted and focus groups were held with three volunteer medical practices to learn their thoughts about why healthcare providers are reluctant to screen patients for bullying involvement during office visits. These sites self-identified: 1) a lack of professional expertise and comfort in assessing bullying-related health issues, and 2) the need to be able to start and manage conversations with their patients about bullying in a time-efficient, but beneficial way as barriers to more comprehensive bullying experience screening. Providers indicated a desire for a screening tool that was easy to administer and score, and a clearly defined procedure to interpret results and provide relevant, appropriate follow-up strategies. These issues and concerns were addressed in the development of the training module and the methodology of survey utilization.

Intervention: Providers' Training

A 90 minute bullying prevention education training module was developed and delivered by experienced bullying prevention trainers to pediatric practices prior to the start of the study. Physicians and healthcare staff who had direct contact with patients (physician assistants, nurses, nurse practitioners, psychologists, receptionists, medical aides, and social workers) completed the training. Staff who were unable to attend in person could call-in. Staff who did not interact directly with patients did not participate in the project.

The training covered the widespread and complex issues related to bullying with a specific focus on the health consequences, best practices in responding to children involved with bullying, and current research related to bullying and the role of the clinician in bullying prevention. Participants were taught how to utilize and score the survey tool, how to use the "Decision Tree" (Figure 1) to determine what follow-up was needed, how to provide effective counseling, and when to give additional bullying prevention resources or recommend follow-up services to patients/ families. The screening tool, parent resources and recommendations for anticipatory guidance were developed based on best practices.

The Bull-M, a validated 10-item questionnaire, was used to screen patients for bullying involvement. It focused on twelve common bullying behaviors and students' and peers' participation in these acts (23). Questions one through nine relate to students' involvement in bullying in a variety of school settings, either as the bully or as a target, and types of bullying experienced. The 10th question queries whether the four most likely health consequences of bullying (headaches, stomachaches, loss of appetite and/or sleep problems) were experienced. For this project, the Bull-M's 10th question was deconstructed into 4 separate health questions to better capture specific health outcomes. This resulted in a 13-question survey which was then re-titled the "Bullying Experience Survey Tool" (BEST).

Study Procedures

Juvenile patients were required to sign an assent form granting permission to participate in the study, and parents/caregivers signed an informed consent indicating their willingness to allow their child to participate as required by the IRB. Consent/assent could be withdrawn at any time. No incentives were offered for patients, but participating pediatric practices received 100 children's paperback books to distribute to any patients after the study ended.

Patients in grades 3-12 were offered the BEST survey regardless of the type of visit (i.e. well-check, sick visit, chronic disease management), and 414 surveys were completed during the 15 month study period. Receptionists gave patients and parents/caregivers the assent and consent forms at check-in to review and ask questions before the medical visit. If consent and assent were provided, the medical assistant gave the patient the survey in the exam room to complete before the pediatrician entered the room. Parents/caregivers were instructed not to help with the survey unless their child had difficulty reading. The survey asked participants to indicate their grade level and gender.

Using a 5-point Likert frequency scale, the survey asked subjects to indicate how frequently (never, rarely, sometimes, often or everyday) they participated in bullying others or were targets of bullying themselves. The medical assistant scored the survey and reported the total score which indicated the patient's involvement in bullying to the healthcare provider. For each question, the score ranged from 0-4, with the highest possible score on the nine bullying questions being a 36. A higher score indicated a higher level of bullying exposure. Bullying prevention literature related to health consequences suggests low, moderate or high levels of exposure to bullying correlate to health consequences (26). The same scoring method was used for the health-related questions. The health effect score ranged from 0-16. A higher health effect score suggested a possible health consequences secondary to bullying that needed to be explored by the provider during the visit.

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Figure 1 Decision Tree CHP
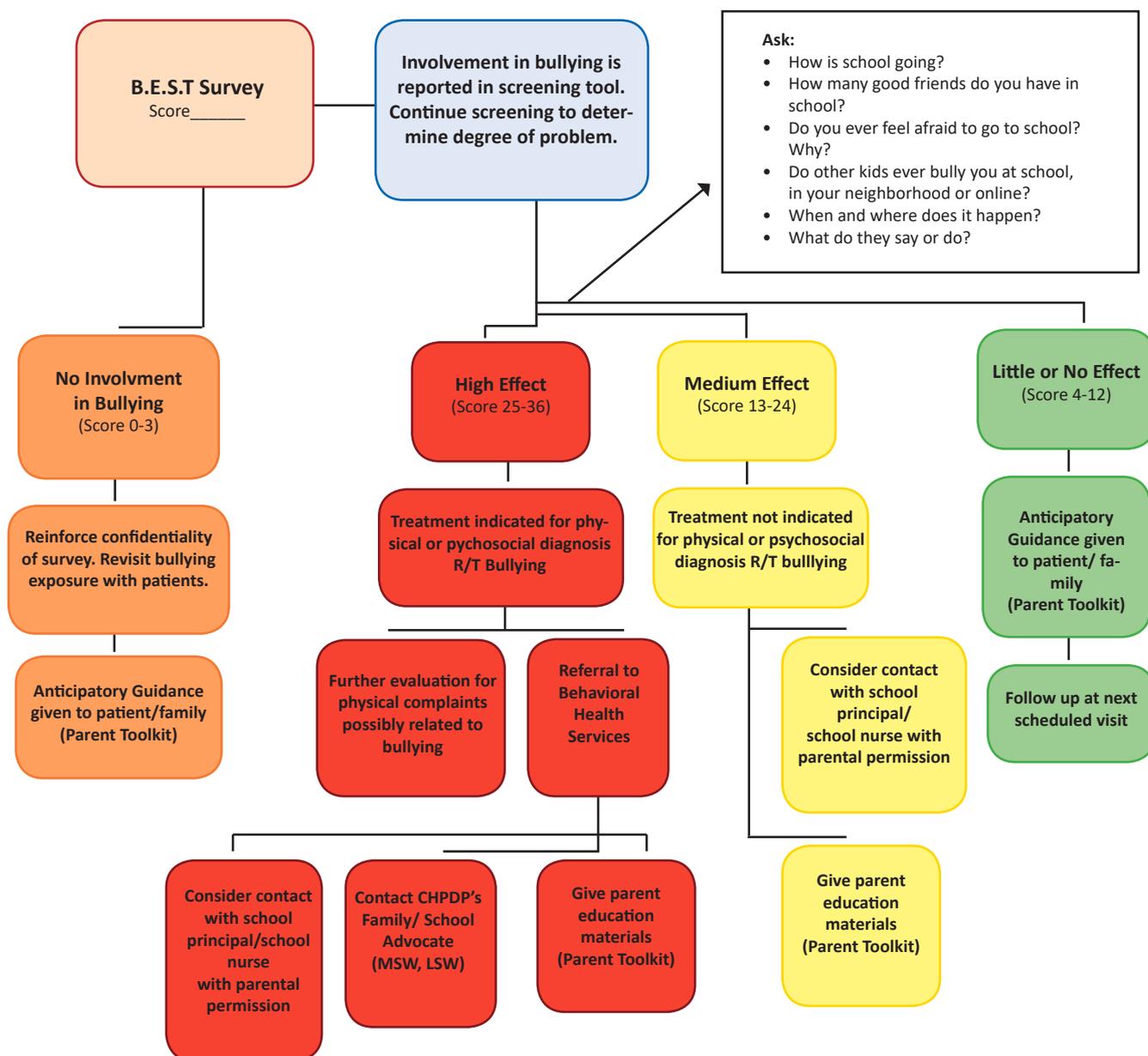
To help providers understand the survey's score, a Decision Tree (Figure 1) was created to reflect four levels of bullying exposure (Table 1). To make the Decision Tree easy for providers to use it was color coded to reflect different bullying experience levels. Once the survey score was calculated and the corresponding level of effect identified, the provider utilized the Decision Tree to determine what counseling and anticipatory guidance was indicated (Table 1), what patient resources should be given; and if any mental health professional referrals were recommended.

In addition, any patient who scored a 4 or higher received the "Pennsylvania Bullying Prevention Toolkit" (http://www.safeschools.info/content/BPToolkit2014.pdf) to help their parents understand and deal with the effects of bullying. The Toolkit addresses issues such as cyberbullying, tips for parents, understanding what to do about bullying, the difference between bullying and conflict, healthcare providers' roles, and the schools' role (27). The Decision Tree and any provider notes were included in the patient's medical record for follow-up as needed.

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Table 1 Summary of Decision Tree Anticipatory Guidance

	No Involvement in Bullying Score 0 -3	Little or No Effect Score 4-12 (Green coded)	Medium Effect Score 13-24 (Yellow coded)	High Effect Score 25-36 (Red Coded)
Anticipatory guidance given to the patient/family.	x	x		
Bullying Prevention Toolkit resources provided. This Toolkit provides additional information on numerous topics related to bullying		x	x	x
Provider prompted to consider contacting the patient's school principal and/or school nurse, with parental permission.			x	x
Provider provided families with a toll-free bullying prevention consultation line (as indicated)			x	x
Providers prompted to refer the patient to behavioral health services (social worker and/or family/school advocate as indicated).				x
Provider to evaluate patient for physical effects possibly related to bullying.				x

Intervention: Online Survey and Focus Group Follow-up

After the project period, 17-question Healthcare Provider and Staff Online Survey was administered to healthcare providers and staff who had direct contact with patients. Follow-up focus groups were conducted to collect additional information about participants' perceptions and overall experiences with the project, including the healthcare provider training. Six focus groups were held in the geographic areas of the participating pediatrician practices. Practices were selected based on their ability to attend the scheduled focus group dates. Table 2 lists the focus group questions.

Results

Sixty-six Healthcare Provider and Staff Online Surveys were completed (n=33: Medical providers: 12 physicians, 12 nurses, 4 nurse practitioners, 4 physician assistants, 1 psychologist; n=31 office workers: Medical Assistant/Office Manager/Rooming Assistant, and 2 who did not indicate their profession). One survey was incomplete and excluded from the total. Survey responses are summarized in Table 3. This data indicated that most respondents "strongly agreed" or "agreed" that healthcare professionals play an important role in bullying prevention, and that although professionals feel they should address this issue, over 1/3 of respondents were not asking their patients about bullying prior to this project. Six-seven percent (67%) of respondents felt that participation in the pilot project enhanced their practice, and if the BEST tool or simil-

Table 2 Focus Group Questions

1. What do you feel are common adverse health outcomes for children who are victims of bullying?

2. What do you feel are common adverse health outcomes for children who are bullies or bully-victims?

3. In general, how do you think other healthcare providers address bullying when it is affectting their patients?

4. How do you and your staff address bullying when it is affecting your patient?

5. What were your experiences with the BEST?

6. What were your experiences using the Decision Tree?

7. Was the training helpful in guiding your discussion with patients and their family members?

8. What would you change about the BEST or Decision Tree model?

9. Did patients/parents require further information or services after taking the BEST?

10. If yes, what types of information, referrals or treatment were given?

11. What was the families' reception to the follow up resources that were given to them?

12. Did the Decision Tree help you give consistent information to patients?

13. Is there anything else you would like to add?

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Table 3 Health Care Provider and Staff Survey Responses (n=66)

Beliefs About Adressing Bullying	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	No Response	n
I believe that health care providers play an important role in bullying prevention.	0 0.0%	6 9.1%	1 1.5%	38 57.6%	21 31.8%	-	66
I believe that health care providers should assist schools and communities in doing more to prevent and stop bullying.	1 1.5%	2 3.1%	0 0.0%	35 53.9%	27 41.5%	1	65
Bullying should be addressed during physician visits with school aged children.	0 0.0%	3 4.6%	1 1.5%	34 51.5%	28 42.4%	-	66
I address bullying with my school aged patients and their families during routine visits.	3 5.6%	18 33.3%	2 3.7%	24 44.4%	7 13.0%	12	54
I feel that time spent talking with patients and their families about bullying is beneficial.	1 1.6%	4 6.6%	1 1.6%	28 45.9%	27 44.3%	5	61
Parents are often aware of their child's exposure to bullying.	7 10.6%	30 45.5%	3 4.5%	23 34.8%	3 4.6%	-	66

Perceptions about BEST and resources

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	No Response	n
The BEST tool was easy for patients to use.	0 0.0%	4 6.7%	1 1.7%	40 66.7%	15 25.0%	6	60
The parent/patient feedback about the BEST tool was positive.	0 0.0%	6 10.5%	0 0.0%	43 75.4%	8 14.0%	9	57
The BEST tool was a beneficial guide to identify bullying involvement among patients.	0 0.0%	5 8.6%	0 0.0%	38 65.5%	15 25.9%	8	58
The use of the BEST tool and Decision Tree helped identify correlations between bullying exposure and patients' symptoms.	0 0.0%	8 14.3%	2 3.6%	38 67.9%	8 14.3%	10	56
The BEST tool allowed me to collect accurate information regarding patients' experiences with bullying.	0 0.0%	8 13.8%	0 0.0%	42 72.4%	8 13.8%	8	58
The Decision Tree was useful in helping the provider determine appropriate interventional strategies, education and follow-up based on the findings from the BEST tool.	0 0.0%	8 14.5%	2 3.6%	33 60.0%	12 21.8%	11	55
The bullying prevention resources given to families were found to be beneficial.	0 0.0%	7 12.7%	2 3.6%	35 63.6%	11 20.0%	11	55
The bullying prevention resources assisted me in providing guidance and support for bullying issues with my patients.	0 0%	9 16%	2 4%	35 64%	9 16%	11	55

Perceptions about Project	Agree	Disagree	Neither Agree nor Disagree	No Response	n
Participation in this project enhanced our practice	40 67%	9 15%	11 18%	6	60
If the BEST Tool was available I would use it to screen school age children as part of a routine office visit	42 71%	10 17%	7 12%	7	59
After the project I am comfortable discussing bullying with my patients (very comfortable or comfortable)	48 80%	12 20%	- -	6	60

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Table 4 Focus Group Results

Provider Training Feedback	Benefits/Barriers to use of BEST Survey Tool	Benefits/Barriers to use of Decision Tree	Clinical Challenges to Continued BEST Implementation	Changes in Clinical Practice as a Result of Pilot
Preexisting Knowledge: -Providers unaware of volume of patients negatively affected by bullying	None of the practices felt that the survey tool was too long or too cumbersome to use	Most often used by practitioner vs. office staff members	*Reimbursement Issues:* -Bullying related discussions created extended time with patient/family that currently is not reimbursable.	All practitioners identified change in understanding of health consequences of bullying and bullying prevention best practices.
Feedback About Training: -Training raised awareness about bullying related issues -Increased participants' skill level in talking with patients about bullying	Consistent feedback regarding time to talk about bullying and reimbursement is-sues.	Difficult to use at first, but easier with additional use. Over time, rubric easier to use	*Time Constraints:* -Practitioners felt that 1.5 hours of training was insufficient but had difficulty identifying additional time to train.	Willingness to incorporate into existing EMR for ease of use if that became an option.
Additional Training Requests: -How to differentiate bully vs. bullied -More in depth information about bullying and health consequences	All practices reported no negative feedback from child or parent regarding survey tool.	Practitioners felt that it was a guideline to assist with next steps.	*Provider Suggestions:* -Offer CME for training -Consider placing screening tool within EMR for ease of utilization. -Provide enhanced reimbursement strategies to use for extended time with patients.	-Utilization of bullying prevention resources to help parents better interact with schools regarding bullying.
Training Recommendations: -Separate content into two trainings: 1. Bullying in general 2. Utilization of BEST survey and Decision Tree -More training on Decision Tree use	Two practices recommended "pre-screening" assessment with shorter survey to minimize time utilization.	Some felt that the Decision Tree needed to be easier to use.	*Provider Suggestions:* -Develop resources for Spanish-speaking patients. -Need for additional mental health/behavior health services for patients experiencing high levels of bullying	Willingness to utilize BEST survey in same fashion as depression screening inventory **IF** billing issues can be resolved.

ar survey was available, 71% indicated that they would like to use it to screen for bullying. Eighty percent (80%) of respondents indicated they were "comfortable" or "very comfortable" discussing bullying with patients as a result of the project and 86% agreed that the tool helped to identify correlations between bullying exposure levels and symptoms. Interestingly, 42% said they have shared what they learned with others in their profession.

At the end of the pilot, six focus groups were held and each lasted approximately 45 minutes. Responses (n=42) were recorded and transcribed and a qualitative analysis was completed. The results of the qualitative analysis were grouped into five categories: provider knowledge about bullying, perceptions about the

BEST tool and the Decision Tree, clinical challenges with screening, and planned clinical changes as a result of the project. The focus group responses supported the APA survey findings that healthcare providers are aware of the child's vulnerability to bullying, but they lack knowledge, skill, and competence to respond in a therapeutic and consistent fashion. Responses from the focus group are summarized in Table 4.

Discussion

All adults who are in contact with children need to understand the psychological, physical and academic consequences of bullying, and have the ability to intervene appropriately and effectively when they see or suspect a child is being bullied. Previous studies indi-

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cate that healthcare providers currently do not have the tools and/or necessary training to meet these needs, which results in their reluctance to broach the subject. To optimize the clinical encounter, previous research has shown that promising clinician-focused strategies to improve delivery of preventive services include screening and decision support tools (22).

This project demonstrates that a bullying screening tool and related training can provide healthcare professionals with the necessary skills and information to provide effective assessment and intervention. It also demonstrates that healthcare providers and staff want to address bullying issues with their patients, and when given the proper tools and training, they are willing to do so. The study also indicates that those in physician extender roles such as physician assistants and/or nurse practitioners may also be utilized to effectively address the subject of bullying with patients. Interestingly, 42% of participating healthcare providers and staff said they shared what they learned with others in their profession which may reflect their comfort with new knowledge. If effective bullying prevention strategies and screening tools are to be adopted on a wider scale, more professionals need to share what they know and encourage others to advocate for these tools.

It is important to note that practitioners did not feel that the screening process was challenging to implement or that it took too much time to incorporate into their daily practice. The data collected indicated that providers felt the training and survey tools were effective, that the project built capacity within their practices to address bullying, and that the screening tool was easy to use and something they would like to continue to use, especially if it were a reimbursable service. These findings suggest that if this screening process was available on a larger scale to healthcare providers many practices would adopt.

However, a significant barrier to a larger-scale implementation of this screening tool is the issue of reimbursement for the screening and counseling time within an office practice and the lack of its incorporation into an electronic medical record (EMR). Bullying prevention screening and its subsequent counseling requirements are at best only partially reimbursed by health insurance companies. Reimbursement systems need to be modified to foster this screening process. Additional work and research is needed in this area, but given the correlation between bullying and health consequences (9) it is important that providers and insurance companies consider including bullying prevention screening as a reimbursable service. Doing so would allow healt-

hcare providers more time and flexibility to hold conversations with all their patients about bullying and not just the ones who are negatively affected by it. It would also enhance awareness of the correlation between exposure to bullying and its health consequences as they evaluate their patients.

Limitations

Limitations of this project include that surveys of patients and staff relied on self-reporting and included all office staff that had direct contact with the patient, regardless of their role or ability to address the bullying-related issues. While it is important to survey all staff involved in implementing the project to understand whether or not the actual screening method worked in the clinical setting, questions specifically about the content of the screening tool and utilization of the Decision Tree would be better asked only of those who directly counseled patients and families, and questions about survey implementation be directed to the office staff. The pilot was a relatively small convenience sample. Future studies are needed to determine if the screening would be as effective in a larger setting and to study the effects of the bullying prevention resources for patients and families.

Conclusion

Healthcare providers play a critical role in bullying prevention, but many lack education and resources to do so effectively. The pilot project demonstrates that using an evidence-based screening tool together with specialized training, appropriate anticipatory guidance, follow-up referrals when indicated, and bullying prevention resources was an effective method of increasing healthcare providers' capacity to address bullying issues in their practices. Creating safe and caring places for youth involves a comprehensive and coordinated effort on the part of all adults who come into contact with children, including healthcare providers.

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