

Positive Behavior Intervention and Support: Improving School Behavior and Academic Outcomes

Heather R. Reynolds

As a student, did you ever get into trouble for your behavior? For a number of students, the irritation and anxiety of being “in trouble” are a reality of school. Whether as a result of cultural differences, behavioral health challenges or just a lack of experience in a new setting, many students in our public schools experience these unpleasant feelings every day, in a place they are mandated to go. The stress this produces can further exacerbate school difficulties.

Schools are constantly looking for ways to improve outcomes for students, and over the years teachers and administrators have tried a myriad of interventions to improve students’ academic and social behavior. One strategy currently being employed in North Carolina is Positive Behavior Intervention and Support (PBIS). PBIS is an evidence-based framework for school improvement based on a structured problem-solving model [1]. Schools implementing PBIS are taught to collect and analyze data, especially data related to student behavior, in order to identify areas needing improvement. Once challenges have been identified, school teams work to identify, teach, and reinforce desired behaviors and to extinguish problem behaviors. Throughout this process, schools use their own data to inform the ongoing implementation of strategies and systems to improve school climate and academic performance. By improving student behavior, schools decrease disruptions in the learning environment, thereby giving teachers and students more high-quality instructional time. When PBIS is paired with the use of effective instructional strategies, schools experience improvements in student academic performance in addition to improvements in student behavior and overall school climate [2].

One of the hallmarks of PBIS is its emphasis on pro-

viding direct instruction regarding schoolwide behavior expectations. Rather than assuming that students arrive already in possession of the behavioral skills necessary to successfully function in a school environment, schools teach socially appropriate behavior to all students. When there is a uniform standard for behavior across school environments, consistency is improved, which further aids student success. Increased consistency and clear expectations serve to decrease anxiety and stress by making the environment predictable. Once school-wide behavior expectations are firmly established, schools are able to identify students who may need additional behavioral support to be successful. School teams identify the specific behavioral skills that students need to improve by reviewing data about these students’ behaviors. Once the particular skills are identified, school staff may provide differentiated behavior instruction, opportunities to practice the needed skills through role play, or additional cues or reminders to the students about when they should use particular skills. Such support may take any of a variety of forms, including behavioral instruction in small groups, more frequent behavior coaching from adults, or a highly specific individualized plan tailored to address the support needs of one student. This type of multitiered instruction is considered best practice in schools across the country.

Schools in North Carolina that have implemented PBIS have experienced changes in school climate and student outcomes that are in keeping with national trends for PBIS implementation [2]. PBIS schools have realized reductions in office discipline referrals (trips to the principal’s office for a behavior problem) and suspensions as well as improvements in academic performance [3].

There is a relationship between educational level and health for both chronic conditions and acute ones, but the magnitude of the relationship is generally greater for chronic conditions [1]. Among adults 25 years of age or older, an additional 4 years of education lowers 5-year mortality by 1.8 percentage points (from 11% to 9.2%); it also reduces the risk of heart disease by 2.2 percentage points (from 31% to 28.8%) and the risk of diabetes by 1.3 percentage points (from 7% to 5.7%) [5].

As we have noted, better-educated persons have lower morbidity from the most common acute and chronic diseases (heart condition, stroke, hypertension, high cholesterol, emphysema, diabetes, asthma, and ulcers) [5, 10]. Educational attainment has been shown to have a significant protective effect on the risk for stroke and myocardial infarction, independent of socioeconomic status and other cardiovascular risk factors. Researchers in the Department of Neurosurgery and Toshiba Stroke Research Center at State University of New York, Buffalo, evaluated

the relationship between education level (12 years or more of education versus less than 12 years) and the incidence of fatal stroke, ischemic stroke, intracerebral hemorrhage, and myocardial infarction [11] in a cohort of 21,443 United States adults who had participated in 1 of 2 large survey follow-up studies. During a mean follow-up period of 15.2 years, the risk for all fatal strokes increased in persons who reported less than 12 years of education; those with less education also had higher risks of myocardial infarction and of fatal intracerebral hemorrhage [11]. In combination with higher income, higher levels of education can also protect against risk factors for atherothrombotic (coronary, cerebrovascular, and/or peripheral arterial) disease: In a large multinational study, Goyal and colleagues [12] found that attained education level was protective against risk factors such as obesity, smoking, hypertension, and baseline burden of vascular disease in high-income countries such as the United States, but not in countries where income was low or moderate.

PBIS schools in North Carolina have documented reductions in suspension rates over a 7-year period [3, 7]. After office discipline referrals for 1 outlier school in North Carolina were removed, during the 2010-2011 school year the mean office discipline referral rate was lower in PBIS schools in North Carolina than in PBIS schools nationally [3-6]. For North Carolina schools implementing PBIS with high levels of fidelity, the average achievement rate on end-of-year academic performance measures was higher in 2011 than it had been at the same schools in previous years [3]. And in 2011 the average graduation rate for high schools that had been implementing PBIS for at least 4 years was higher than the statewide graduation rate, not only for the general student population but also for students with disabilities [3]. Other schools implementing PBIS have shown improvements both in overall academic performance and in closing the achievement gap for underperforming groups [3]. More than 40% of schools across the state have received PBIS training, and as this proportion increases, these data trends are expected to continue. As implementation spreads and improves, schools will become places where students can thrive and grow because they no longer need to worry about getting into trouble. NCMJ

Heather R. Reynolds, MS PBIS consultant, Exceptional Children Division, North Carolina Department of Public Instruction, Raleigh, North Carolina.

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Address correspondence to Ms. Heather R. Reynolds, Exceptional Children Division, North Carolina Department of Public Instruction, 6356 Mail Service Center, Raleigh, NC 27699-6356 (heather.reynolds@dpi.nc.gov),

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People with more education are less likely to have diabetes [5, 10]. Diabetes is especially common among disadvantaged groups, including persons without a high school diploma. A study by Reither and colleagues [13] using Utah data from the Behavioral Risk Factor Surveillance System between 1996-1999 and 2004-2007 found significant inverse associations between educational attainment and the odds of having diabetes. Women with a college education were found to be 27% less likely than women with a high school education to have diabetes. Well-educated men and women exhibit lower rates of diabetes than those with less education, and these disparities have not changed appreciably over the past decade [13].

Those with more education are healthier both mentally and physically. They are substantially less likely to report that they are in poor health or are experiencing anxiety or depression [5]. Having an additional 4 years of education lowers the probability of reporting oneself to be in fair or

poor health by 6 percentage points (from 12% to 6%) and reduces the number of days of work lost to sickness each year by 2.3 days (from 5.2 days to 2.9 days) [5]. Better-educated people report spending fewer days in bed or not at work because of disease, and they have fewer functional limitations [10]. In short, higher levels of education yield better health, and with each increase in level of education (eg, from high school to college, or college to graduate school), there appears to be a positive change in health status [5].

The fact that people who are better educated have lower morbidity rates from the most common acute and chronic diseases is due in part to the fact that education level and educational achievement play a role in determining what sort of job or career one has, which in turn directly correlates with one's financial or socioeconomic status. Education is perhaps the most basic component of socioeconomic status, because it shapes future occupational