

How to change student behaviour

Michael Tunks

The recent National PBIS conference in Cairns was a great success with some very strong messages for PB practitioners – messages directed mainly at the behaviour of adults and teachers, not students. Dr Terry Scott, Professor of Teaching and Learning at the University of Louisville, delivered a keynote address and this article will attempt to summarise his excellent presentation (you can download his slide presentation at www.pbis.org), a quote: “Student behaviour won’t change until adult behaviour changes.”

Zig Ziglar was fond of saying, “The definition of insanity is doing the same thing over and over again and expecting different results.” PBIS is a system for changing adult behaviour in ways that produce the highest probability of student success. It’s really all about probability! What is the simplest way to make a difference in a student’s success/failure ratio? If we can help a student be successful in 80% of practices/trials/situations then the chances increase that the student will continue with the successful behaviour in other settings. So we need to ask ourselves, How do we set up students for success in the classroom, or playground or any other setting? Or are we inadvertently putting students into situations where there is a high probability of them failing? Student behaviour won’t change until adult behaviour changes.

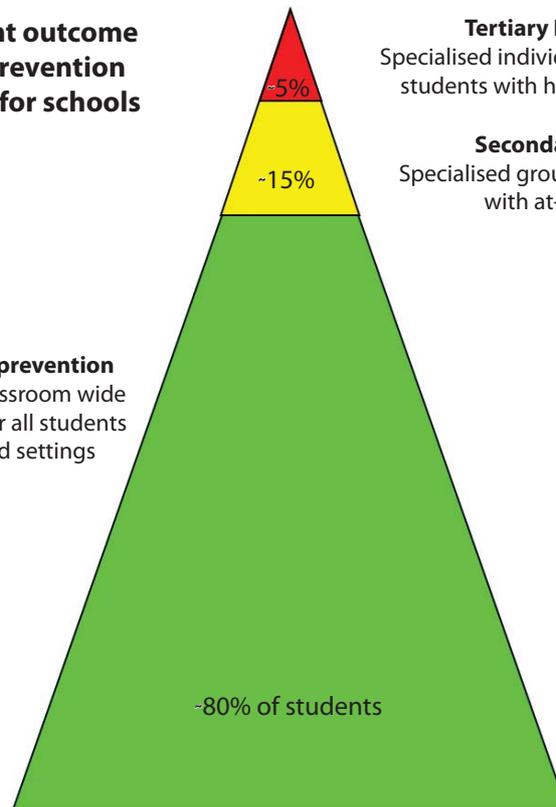
The PBIS triangle provides a means of depicting the prevalence of escalating behaviour in a school setting. Dr Scott used a medical analogy to refresh our understanding of the triangle:

Imagine a fever epidemic is affecting your students. Early detection is essential as, at its worst, if a student’s temperature rises to 42°C or more the only effective treatment is brain surgery. How would you protect your student population? What measures would you put in place to detect students at risk and how would you help them?

One solution might be to take the temperature of each student as they enter the classroom each morning. A reading of 37°C is normal and the student is OK. Anything higher and treatment may be required. In the way we may be able to ‘catch’ a student in the early stages but surely we can do more than this? Can we do anything to help our students reduce their chances of contracting the fever in the first place? How about inoculation? What is the simplest way to make a difference in a student’s success:failure ratio? How about chicken soup?

Student outcome and prevention model for schools

Primary prevention
School/classroom wide systems for all students staff and settings



Tertiary Prevention
Specialised individualised systems for students with high risk behaviour

Secondary prevention
Specialised group systems for students with at-risk behaviour

Chicken soup is simple to make, easy to administer and helpful in many cases. Why don’t we give our students a daily dose of chicken soup to help keep them healthy! (Read: why don’t we instruct our students in successful behaviour – every day?)

Now that we are doing something constructive to help our students, what is our criterion to tell us if the chicken soup isn’t working? If we detect a student with a temperature of 39°C we need a second tier of support. Chicken soup hasn’t been enough for this student so something stronger is required to combat the fever and stop it escalating to surgical intervention.

We consult with the parents and decide to administer a dose of Panadol to help return the student to full health. What else could we do to help this student? What other resources could we tap? Now is the time to do everything in our power to safeguard this student’s health. What can we do for this student who is displaying fever symptoms to increase their success:failure ratio? (Read: what interventions can we put/have in place that can be implemented quickly for students displaying Tier 2 behaviours?)

If a student’s temperature continues to rise

in spite of our chicken soup and Panadol then we need to call in the experts. We need a doctor to prescribe and administer more powerful interventions – perhaps antibiotics. So at this top tier of intervention we have exhausted our knowledge and resources and need seek the expertise of dedicated professionals.

We cannot offer to be complacent about early interventions. If we would act promptly and be cognisant of preventative actions in a medical crisis are we as proactive with the behaviour situation at our school? Behaviour problems can threaten the future of our students and a huge responsibility lies with us as educators to provide learning environments that increase the probability of success for our students. **ET**



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