FEASIBILITY OF PBIS IN A THERAPEUTIC GROUP HOME

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Purpose

The success of Positive Behavioral Interventions and Supports (PBIS) in typical schools has led to interest in PBIS among all types of alternative programs, including residential mental health treatment programs, juvenile justice programs, and alternative day school programs. The PBIS framework and essential features of each tier of support look much the same in these environments as in typical school settings. However, characteristics of alternative programs have implications for planning and implementation to effectively address the social, emotional, and behavioral needs of youth in these programs, while maintaining fidelity to the core features of PBIS. In this model demonstration report, we describe PBIS implementation in one small group home for adolescents with significant mental/behavioral health needs. Prior to PBIS, the program centered around individualized supports for each resident. The PBIS framework enabled the program to add Tier 1 supports to increase consistency throughout the home, and to use behavioral data to integrate supports across tiers. We report fidelity scores across years of implementation as well as informal data reflecting staff and youth perceptions of PBIS.
Conceptual, descriptive, and quantitative publications have illustrated implementation and lessons learned regarding PBIS data, systems, and practices in different types of alternative programs (e.g., Alonzo-Vaughn, Bradley, & Cassavaugh, 2015; Fernandez et al., 2015; Kumm et al., 2020; Lopez, Williams, & Newsom, 2015; Simonsen, Britton, & Young, 2010) across tiers of support (e.g., Ennis et al, 2012; Kennedy & Jolivette, 2008; Ramsey et al., 2017; Swoszowski et al., 2012). In addition to addressing behavioral needs of youth, PBIS has been used in a variety of alternative programs to address mental health needs of youth (e.g., Kumm et al., 2020) and to support youth during transitions (e.g., Griller Clark & Mathur, 2015; Jolivette et al., 2016).

Alternative program staff, and youth who attend those programs, report positive perceptions of PBIS (e.g., Jolivette et al., 2015; Kimball, Jolivette, & Sprague, 2017; Swain-Bradway et al., 2013). Finally, a few studies have documented fidelity of implementation and/or impact of PBIS on various behavioral and academic outcomes (e.g., Griller Clark & Mathur, 2015; Johnson et al., 2013; Sprague et al., 2020). In this report, we describe a multi-year effort to implement PBIS with fidelity in a small, residential group home for children and youth with significant mental/behavioral health needs. This effort is significant because traditionally, programs such as this are based largely on individualized treatment plans. Proactive practices focused on teaching and supporting positive behaviors through universal strategies often receive less systematic, formal attention than individually focused behavioral interventions.

The Raleigh Therapeutic Group Home is a small program that provides behaviorally and cognitively based therapeutic programming treatment to children and adolescents. Prior to adopting PBIS, the program primarily focused on individual treatment plans. While some program-wide elements were in place, most treatment practices focused on individual youth. With training and support from Mississippi’s State Personnel Development Grant and from the Center on PBIS, this program adopted, planned, and implemented Tier 1 PBIS supports for all youth in the program. In this report, we provide a summary

Key Takeaways

- PBIS can be implemented with fidelity in a therapeutic group home for youth with significant emotional/behavioral needs.
- Even in a program focused on individualized interventions for all youth, Tier 1 supports can help increase consistency and efficiency in supporting positive behavior.
- Behavioral data can help staff identify the most efficient supports to address youth needs.
- Staff and youth had positive perceptions of PBIS implementation and facility climate related to PBIS.

For a description of PBIS implementation in a secure, residential, juvenile justice program, please refer to PBIS in a Secure Juvenile Justice Setting.
of the Raleigh Therapeutic Group Home’s journey to PBIS implementation, including data documenting Tier 1 implementation fidelity from May 2016 - May 2022. We provide an overview of their rationale for adopting PBIS; training and technical support provided; and examples of Tier 1 core features. In addition, we provide fidelity data for one baseline year and six years of implementation. We also describe anecdotal indicators of staff and youth perceptions of PBIS.

**Program Description**

The Millcreek of Raleigh Therapeutic Group Home (Raleigh TGH) is a 10-bed congregate care home service provider for the Mississippi Department of Child Protection Services (MDCPS). Raleigh TGH serves adolescent males ages 12 - 21 years old who are in state custody and who have been recommended for therapeutic placement. Residents are referred from the MDCPS Therapeutic Placement Office and must have a psychological evaluation and recommendation for placement to receive therapeutic services. Residents receive individual therapy (minimum once per week), group therapy (Monday-Friday), and family therapy (minimum once per month). The program emphasizes a therapeutic milieu and provides opportunities for growth in social/life skills and independent living skills. While some school-aged residents attend public schools, most residents attend Raleigh TGH’s therapeutic day school, which is separate from the group home. Residents’ discharge is based on their permanency plan (determined by the courts) and their treatment progress.

Most residents are 15-18 years old. Racial demographics at the group home typically correspond with the state’s overall racial demographic, with occasional fluctuations. Most residents served have a special education classification (usually emotional/mental health disorders) and have been in acute care or psychiatric residential treatment programs. Because the group home receives referrals only from MDCPS, the residents have experienced some form of physical/sexual abuse and/or neglect. The group home staff structure consists of a program director, program coordinator/case manager, therapist, and direct care staff. They have a minimum ratio of one staff for every five residents but typically have three direct care staff scheduled for each shift (one of which is the supervisor or lead staff for that shift).

**Context**

The goal and purpose of the program is to provide a therapeutic placement for adolescent males who are in custody of the state. Most residents have had failed foster home placements previously or are at an age when foster placement is difficult to find. In addition, residents served have emotional and/or behavioral problems that make it difficult to place them in a regular or therapeutic foster home or in a regular group home setting. The program provides services for residents until they can discharge to a lower level of care (e.g., reunification with parent[s], placement with relatives, foster home, adoption) or find a more appropriate setting.
The Raleigh Therapeutic Group Home includes the following staff:

- Program Director (Master's Degree): oversees all aspects of the TGH program and carries a small caseload, providing therapy and case management services for select residents.
- Licensed Therapist (Master's Degree): oversees all aspects of therapeutic treatment, including developing individual resident treatment plans and behavior goals, and training staff on those plans and goals.
- Program Coordinator/Case Manager (Bachelor's Degree): assists the Program Director in implementing policies and procedures. Oversees Behavioral Health Associates (BHA's); schedules all resident personal and healthcare appointments, and recreation and leisure activities.
- Group Home Shift Supervisor (Bachelor's Degree) and Behavioral Health Associates (BHA) (High School Diploma or GED): attend to all aspects of residents' daily living needs.

**Why Did the Program Choose PBIS?**

The U.S. Department of Education and the Mississippi State Department of Education funded REACH MS (Mississippi's State Personnel Development Grant) in 2005, with PBIS as one primary focus area. By 2015, the Mississippi Department of Children's Protective Services and Department of Mental Health expressed interest in extending PBIS to alternative settings, specifically in implementing PBIS at a therapeutic group home (TGH) as a pilot program. Raleigh became the primary candidate program due to its location and stability among therapeutic group homes.

Selina Merrell, Ed.S., Director of REACH MS, contacted Valerie McCord, then Director of the Raleigh TGH, to invite their participation in Mississippi's new PBIS initiative. Ms. McCord initially expressed reluctance, not because of philosophical differences, but from concerns related to whether PBIS would negatively impact current programs, particularly with time needed for its implementation. Quickly, however, Ms. McCord realized that (in her words), “PBIS was in line with everything we were already doing, but it was a...more structured approach.”

Raleigh's existing behavior management program consisted of a level system that, theoretically, reserved higher (i.e., more advanced) standards for self-regulated behavior, more desirable privileges, and greater freedoms for youth who reached the top level (green) of 3-levels labeled “green,” “yellow,” and “red.” One of the needs Ms. McCord expressed was to improve the level system's effectiveness. She observed that the Raleigh TGH level system lacked meaningful distinctions among the incentives available at each level. For example, incentives available for the green (highest) and yellow (middle) levels had few, if any, meaningful differences to the residents. Also, Raleigh TGH lacked a consistent system for training staff and new residents on how the level system worked. Nor did the program solicit staff or resident feedback about what worked well or what could be improved. Finally, the program lacked data reviews related to major and minor misbehaviors for decision-making.
Timeline

Ms. Merrell acted as External Coach for the Raleigh PBIS initiative. In July 2015, she conducted a 2-day team training for the Raleigh TGH’s newly formed PBIS team. The Raleigh TGH used 2015 - 2016 as a planning year. During this time, the External Coach provided support through monthly visits to Raleigh PBIS Leadership Team meetings led by the Program Director as well as informal PBIS conversations with the Program Director. That technical assistance support continued through November 2020.

In 2021, Center on PBIS partners finalized a formal collaboration with the External Coach and the Program Director with the goal of establishing the Raleigh TGH as a model alternative programs demonstration site. Since that time, the Program Director and the External Coach have participated in regular meetings with Dr. Scheuermann and Michael Turner. They have participated in Center-supported activities, such as monthly Community of Practice meetings led by Center partners and have contributed to video products.

Tier 1 Systems and Practices

The Raleigh TGH PBIS team established a motto (“Together We Can”) and expectations for positive behavior for all areas and activities. The team posted expectations in appropriate areas throughout the home and summarized them in a teaching matrix. (See sample in Table 1.) The team implemented formal activities for teaching expected positive behaviors during therapy meetings and group meetings. Informal teaching occurred during activities throughout the day, including family team meetings.

<table>
<thead>
<tr>
<th>Living Skills</th>
<th>Be Cooperative</th>
<th>Be Respectful</th>
<th>Be Responsible</th>
<th>Be Safe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathroom</td>
<td>• Report problems or issues.</td>
<td>• Flush toilet.</td>
<td>• Use soap and water when washing hands and body.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Complete all bathroom activities in a timely manner.</td>
<td>• Give others privacy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Meetings Group</td>
<td>• Attend and participate in all community meetings.</td>
<td>• Keep all communication in community meeting confidential.</td>
<td>• Complete all assignments.</td>
<td>• Stay in community meeting until dismissed.</td>
</tr>
<tr>
<td></td>
<td>• Provide and accept all constructive feedback.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Van</td>
<td>• Take all personal items off the van.</td>
<td>• Use inside voice.</td>
<td></td>
<td>• Stay seated while van is in motion,</td>
</tr>
<tr>
<td></td>
<td>• Profanity prohibited.</td>
<td></td>
<td>• Keep seatbelts on at all times.</td>
<td>• Keep hands, feet, and objects to self.</td>
</tr>
</tbody>
</table>
The PBIS team designed a token system in which staff recognized youth for positive behaviors by giving “Caught You Being Good” tickets to youth who were exhibiting behaviors listed in the teaching matrix. The incentives associated with the “Caught You Being Good” system were different from, and unrelated to, the incentives associated with the level system. Residents could exchange tickets earned by choosing from an incentive menu. The PBIS team also tied a staff incentive system to the “Caught You Being Good” tickets: Staff earned prizes in a weekly drawing from all tickets distributed that week. (Staff wrote their name on tickets that they distributed.)

The PBIS team identified major and minor misbehaviors and created a flow chart for responses to misbehaviors in each category (see Figure 1). Both the major and minor categories included the consequence of moving residents to the previous level in the level system, with different criteria for each category. Consequences specified in the level system for major and minor behaviors were the same as those specified in the PBIS behaviors/consequences flow chart (Figure 1).

Finally, the PBIS team collected data on major and minor misbehaviors. Staff summarized data (average number of incidents per day per month), and disaggregated data by resident, location, time, and nature of the misbehavior. The PBIS leadership team used a Tier 1 Data Summary Form (see Table 2) each month as a prompt to disaggregate and analyze discipline data, and to link directly to action plans for problem areas. The PBIS team prepared and discussed data summaries in staff and resident group meetings to obtain input regarding action steps. The Raleigh TGH Director reported that after PBIS implementation, the PBIS team and other staff increasingly considered Tier 1 supports for action steps. This was a notable shift from focusing entirely on interventions for individual residents toward systems-level supports to benefit all residents. As part of the data review process, the Raleigh TGH team also updated their Action Plan monthly (see sample in Table 3).
Figure 1. Behavior Flow Chart

Behavior Flow Chart

Minor vs. Major Behavior

Minor Behaviors

- Defiance/disrespect
- Noncompliance
- Dress code violation
- Physical contact/horseplay
- Disruptive behavior
- Profanity/inappropriate language
- Contraband (non-safety)
- Leaving assigned area
- Lying/cheating
- Anger outburst
- Poor hygiene
- Late for bed
- Room unkempt
- Roaming around classroom/group
- Walking out without permission
- Minimal classwork or participation
- Criticizes peers in group
- Reacting negatively to feedback

Major Behaviors

- Fighting
- Verbal Aggression
- Physical Aggression
- Make threats to harm others
- Intimidating/bullying others
- Elopement
- Sexual acting out
- Refusal to take medication
- Self – harm
- Contraband (safety concerns)
- Suicidal gesture/attempt
- Gang affiliation display
- Destruction of property
- Truancy
- Theft/stealing
- Borrowing/lending/selling
- Betting
- Being in another person’s room
- Pulling fire alarm
- Refusal to attend group and or participate

Behavior Ceases

Minor Infraction Procedure:

Step 1 – Prompt expectation
Step 2 – Redirect
Step 3 – Process with resident
Step 4 – Incident documented
3 documented incidents in a day may result in a level drop.

RTGH Level System
Where do Your Behaviors Fit In?

Reinforce Appropriate Behavior

Major Infraction Procedure:

Step 1 – Document incident
Step 2 – Notify program director
Step 3 – Level drop
A major behavior infraction may result in a level drop.
<table>
<thead>
<tr>
<th>Table 2. Data Summary Form</th>
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</thead>
<tbody>
<tr>
<td><strong>Is There a Problem?</strong></td>
</tr>
<tr>
<td>How often are incidents?</td>
</tr>
<tr>
<td>• Trends?</td>
</tr>
<tr>
<td>• Compared to last year?</td>
</tr>
<tr>
<td>Total number of incidents/total number of days in the month</td>
</tr>
<tr>
<td>What are the problem behaviors?</td>
</tr>
<tr>
<td>• One, few, or many behaviors?</td>
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<tr>
<td>• Clusters of behaviors?</td>
</tr>
<tr>
<td>Where are the behaviors occurring?</td>
</tr>
<tr>
<td>• One, few, or many locations?</td>
</tr>
<tr>
<td>• Clusters of locations?</td>
</tr>
<tr>
<td>When are behaviors occurring?</td>
</tr>
<tr>
<td>• Compared to the schedule?</td>
</tr>
<tr>
<td>• Compared to the location?</td>
</tr>
<tr>
<td>Who is involved?</td>
</tr>
<tr>
<td>• Many or few?</td>
</tr>
<tr>
<td>Precise Problem Statement:</td>
</tr>
<tr>
<td>Feature</td>
</tr>
<tr>
<td>----------------------------------------------</td>
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<tr>
<td>1.1 Team Composition</td>
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<td>1.8 Youth feedback and acknowledgment</td>
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<tr>
<td>1.9 Staff feedback and acknowledgment</td>
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</tbody>
</table>
Fidelity

**Benchmarks of Quality Coach Rating Form**

Raleigh TGH initially used the Facility-wide Benchmarks of Quality Coach Rating Form, an instrument adapted from the Benchmarks of Quality (Kincaid, D., Childs, K., & George, H., 2010. Tier 1 Benchmarks of Quality [Revised]). The adapted version reflected the language and characteristics of residential settings. The External Coach and the Raleigh TGH PBIS team completed the Facility-Wide Benchmarks of Quality Coach Rating Form in July 2015 as a baseline assessment to guide initial planning. They then completed this assessment in subsequent years (2016, 2018, 2019, 2021) to capture implementation fidelity data.

Two factors contributed to early implementation fidelity. First, the 10-bed facility’s small scale helped to avoid some complexities with which larger programs must contend. Second, the program had existing behavior management practices, some of which became part of Tier 1 systems, data, and practices. The total score for implementation fidelity shows the program moved quickly from just below 50% at baseline, to just over 80% in Year 1 and maintained implementation fidelity over 90% in subsequent years.

**Facility-wide Tiered Fidelity Inventory**

In May 2021, upon the recommendation of partners from the Center on PBIS, Raleigh TGH began using the Facility-Wide Tiered Fidelity Inventory (FW-TFI, v 0.2). The FW-TFI was developed through a formal process of input from administrators and staff in alternative settings and experts in PBIS in alternative settings, followed by field-testing in alternative settings. (See Scheuermann & Turner, November, 2020 for description of the development process.) By comparison to results from the Facility-wide Benchmarks of Quality Coach Rating Form, Teams and Implementation subscale scores were lower (scoring 50 percent and 80 percent, respectively), while the total score reflecting implementation fidelity remained above the goal at 81.3 percent (see Figures 3 and 4). Reasons for the decreased scores tied to modified structure of the fidelity instrument and a higher threshold for scoring partial and full implementation in some elements, such as Teams.
Figure 2. Benchmark of Quality Scoring Trends by Subscales and Total Score

![Benchmark of Quality Scoring Trends by Subscales and Total Score](image)

Figure 3. Facility-wide Tiered Fidelity Inventory (v0.2) Scoring by Subscales and Total Score, May 2021

![Facility-wide Tiered Fidelity Inventory (v0.2) Scoring by Subscales and Total Score, May 2021](image)
Youth Perceptions

The program reported that youth surveys primarily focused on their perceptions of PBIS implementation (see Table 4). Youth surveys were comprised of 10 questions, administered during 2016, 2017, and 2019. (Surveys were not conducted in 2018, 2020, and 2021.) Responses were recorded on a 5-point scale ranging from Strongly Disagree (1) to Strongly Agree (5). For all questions except one, the averaged responses consistently fell between Agree (4) and Strongly Agree (5). The lone exception showing notable change over time involved the question, "Residents in this Group Home are expected to show respect for each other." Averaged responses increased from 3.6 (Neutral) in 2016 to 3.9 (nearly Agree) in 2017 and 4.7 (nearly Strongly Agree) in 2019.

Staff Perceptions

The program reported staff PBIS surveys to solicit staff perceptions of PBIS implementation and impact. Staff surveys were administered in 2016, 2017, 2019, and 2021. (Surveys were not conducted in 2018 and 2020.) Survey questions are shown in Table 4. Staff responded to each question using a 5-point scale ranging from Strongly Disagree (1) to Strongly Agree (5). Questions related to implementation included, “At least 80% of the staff use PBIS strategies on a regular basis.” Averaged responses moved from 3.1 (Neutral) in 2016 to 4.1 (Agree) in 2017, 3.8 (nearly Agree) in 2019, to 4.6 (nearly Strongly Agree) in 2021. Another question asked, “Did you teach the PBIS rules to your residents in context, as needed?” Averaged responses increased
from 3.6 (Neutral) in 2016 to 4.1 (Agree) in 2017, 4.1 (Agree) again in 2019, to 4.5 (nearly Strongly Agree) in 2021. Two questions reflected an interesting dynamic suggesting that as staff learned more about PBIS, their interest in acquiring deeper knowledge increased. One question inquired, “Do you feel that PBIS information and scheduled activities were communicated effectively with staff?” Averaged responses were 3.7 (nearly Agree) in 2016; 4.3 (Agree) in 2017; 3.4 (Neutral) in 2019; and 4.5 (nearly Strongly Agree) in 2021. Another question asked for an assessment of the following statement, “I feel additional training on behavior management and PBIS would be beneficial.” Averaged responses were 3.8 (nearly Agree) in 2016; 4.1 (Agree) in 2017; 4.1 (Agree) in 2019; and 4.4 (more strongly Agree) in 2021. The sense that staff received effective PBIS information and communication, and that additional training would be beneficial, both reached their highest scores in 2021.

Table 4. PBIS Youth and Staff Surveys

<table>
<thead>
<tr>
<th>Youth Survey</th>
<th>Staff Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>I understand the Group Home motto and expectations.</td>
<td>PBIS offers sufficient short- and long-term incentives for residents</td>
</tr>
<tr>
<td>Residents are reinforced/acknowledged for appropriate behavior.</td>
<td>I am familiar with PBIS and its components</td>
</tr>
<tr>
<td>I am expected to follow the expectations and rules at my Group Home.</td>
<td>I try to utilize PBIS language when interacting with residents</td>
</tr>
<tr>
<td>The expectations for behavior are posted.</td>
<td>At least 80% of staff use PBIS strategies on a regular basis</td>
</tr>
<tr>
<td>The expectations for behavior are enforced.</td>
<td>I prompt and/or teach the PBIS rules to residents in context, as needed</td>
</tr>
<tr>
<td>My Group Home has a plan for working with residents who do not follow the expectations.</td>
<td>I feel that PBIS information and scheduled activities are communicated effectively with the staff</td>
</tr>
<tr>
<td>In general, the environment at this Group Home is positive.</td>
<td>Overall, I feel PBIS has a positive impact on resident behavior</td>
</tr>
<tr>
<td>Residents in this Group Home are encouraged to show respect for each other.</td>
<td>I feel additional training on behavior management and PBIS would be beneficial</td>
</tr>
<tr>
<td>Staff take safety concerns seriously.</td>
<td>Overall, I feel that we praise appropriate resident behaviors more than we correct inappropriate behaviors</td>
</tr>
<tr>
<td>I feel safe at the Group Home.</td>
<td></td>
</tr>
</tbody>
</table>
Next Steps

The Raleigh TGH demonstrated the feasibility of implementing Tier 1 systems, data, and practices with fidelity in a small, therapeutic group home, and took steps toward evaluating youth and staff perceptions of PBIS, and institutionalizing PBIS for sustainability. To further strengthen current practices, we recommend focusing on the following goals.

1. Begin technical assistance for Tier 2, with attention to integrating data, systems, and practices with existing practices at Tiers 1 and 3. Many elements of intensified support are already in place but are not yet fully aligned. Nor is data-based decision making fully established as part of an overall tiered approach to support. For example, developing Tier 2 supports and establishing criteria for accessing those supports may further enhance the concept of tiered supports that is already in place. Establishing effective, systematic supports for Tier 2 also may help when youth who have more intensive needs are placed in the program. Sometimes other placement options are not immediately available, so having strong, integrated systems and practices at each tier may help these youth to be more successful while awaiting other placements.

2. Develop standard metrics for monitoring the impact of PBIS on overall youth behavior. Raleigh TGH has data systems in place for tracking major misbehaviors, but further refinement of data collected and analysis procedures will provide clearer indications of effects on youth behavior over time. In addition, these data and analyses will help guide PBIS decisions, particularly for Tier 1.

3. Strengthen and formalize certain aspects of Tier 1 systems, including staff input/communication, aligning the level system (expectations, incentives, and responses for misbehavior) with PBIS, and developing incentives and a hierarchy of responses for misbehavior that are independent from the level system.

As a final note, the positive youth and staff response to PBIS in the Raleigh TGH has led to Reach MS and Millcreek of Raleigh partnering on a PBIS initiative in two larger residential programs: one for adjudicated youth and another for youth with mental health needs.
References


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