Home-School Partnerships:
A Behavioural-Community Approach to Childhood Behaviour Disorders*

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Although behaviour therapy with families has advanced understanding of family dynamics and effective intervention, parent training procedures continue to have limitations, with the most socially disadvantaged families usually the least likely to be the recipients of professional services. Schools, on the other hand, provide an available, community-based setting where parents could receive support. Here again, however, practical difficulties exist, with the families of children showing academic and behavioural problems often uninvolved in typical school programmes. To link home and school in a partnership for resolving children's behaviour problems, a home visitor protocol was designed that incorporated brief behaviour therapy strategies and the strengthening of communication between teacher and parent. While the referred children showed improvement, there were few variables which revealed significant differences between experimental and control children. There was some indication that teachers referred more problematic children to the active treatment group. Future research will explore how the protocol can be strengthened to provide effective mental health services via the natural ecology of the school.

Traditionally, behavioural treatments for childhood emotional disorders have not focused centrally on the family as a unit in a larger social ecosystem. The early classic papers in child behaviour therapy reported interventions conducted mostly in clinical, institutional settings (see Kazdin, 1978). In 1966, however, Hawkins, Peterson, Schweid, and Bijou described how parents could be taught to implement behavioural techniques to modify their children at home. By the late seventies there was an extensive literature on parents being trained in contingency management (for early reviews, see Patterson, 1971; Wahler 1976). In a few cases these procedures

were introduced in conjunction with teachers, on the grounds that changes achieved in one setting might not generalize to another (e.g., Patterson, 1974; Wahler, 1969). During the eighties there was continued widespread interest in both parent and teacher training, as the major context for implementing behaviour change in children (for a review of research in New Zealand, see Singh & Blampied, 1983). However, little consideration was given to the relationship or interaction between home and school settings.

In recent years, reservations have been expressed concerning the basic strategy of separate (even if parallel), direct training for parents and teachers. There concerns may be summarized as follows: (a) Wahler (1980) convincingly demonstrated that some parents — especially single, "insular" mothers with limited economic or social supports — were under too much personal stress to be capable of consistently practicing the parenting skills they had been taught. (b) Patterson (1974) and his colleagues conducted fine-grained research in homes and discerned complex interaction

patterns ("coercive traps") between parent and child, confirming the reciprocal or systemic nature of family influence. (c) There is often minimal agreement between parent and teacher regarding the nature or severity of the child's reported problem, suggesting that childhood behaviour disorders are at least partially phenomena of social construction, or reflect differences in standards, expectations, and rules (Simpson & Halpin, 1986; Tharp, 1989). (d) Behavioural repertoires are complex and treatment inevitably entails more than controlling behaviour through management techniques (Evans, Meyer, Kurkjian, & Kishi, 1988). (e) The discipline practices at home or school that are most effective, focus on democratic principles in an atmosphere of adult acceptance, not on artificial rewards and punishments (Maccoby & Martin, 1983).

Service delivery problems are closely connected to these theoretical issues. For example, the difficulties experienced by parents under stress can be translated into the practical problem that families in the greatest need of assistance are the least likely to be able to attend parent training. Differences in perception of a child's problem often seem to translate into conflict between parent and teacher, with each blaming the other for the child's difficulties. Providing individual family therapy is not cost-effective, and, because of inclusive educational policies, schools are being asked to work with an increasingly diverse, and in some cases more difficult, student body.

Many of these policy considerations have been confronted by psychologists having a community orientation (e.g., Cowen, 1983; Lutzker & Rice, 1987). Children's problems may represent less of a deficit inherent to the individual and more of a failure of the social environment (especially the school) to accommodate behavioural diversity. At the practical level, strategies need to be developed to modify environments and social systems so that behaviour disorders can be prevented or dealt with in a more natural context, not involving costly and unavailable mental health professionals. These requirements are particularly pertinent in situations where sophisticated clinical services might be limited, such as rural environments, poverty plagued inner-cities, or schools with large populations of ethnic minorities.

Home-School Partnerships

Given these considerations, we began some years ago to try to develop a prevention-oriented model of service-delivery that would build on the natural resources in the school and the family. There is a real need for models and programmes that focus on secondary prevention and help to ensure that emerging behaviour problems in young, primary school children do not escalate into the more serious problems so widely recognized in "at risk" youth, such as school dropout, educational failure, teenage pregnancy, drug abuse, and delinquency.

When educators have addressed these kinds of problems, they have tended to emphasize the value of early partnerships between home and school (Weiss, 1989). Home-school collaboration is widely cited as an important goal, and instances of the positive benefits for children when such partnerships have been created are regularly cited (Comer, 1984). One of the earliest stimulants for this approach came from the Head Start model. To enhance children's cognitive development, centers were established where mothers and fathers would feel comfortable in coming to learn new parenting skills. In some of these enrichment programs, individuals were sent to the home itself to assist parents in the natural context. Home visitors were able to model basic skills of child rearing, as well as monitoring psychological progress in the youngster, and encouraging the parents to implement simple instructional procedures. In New Zealand, parents have been taught seccessfully to serve as remedial reading tutors for their own children, often in collaboration with school personnel, resulting in substantial gains in reading ability (Glynn & McNaughton, 1985).

Early in our programmatic efforts to link home and school more effectively, we introduced the home-visitor model as a way of involving those families who were typically hard for school personnel to reach. Evidence from both interviews and an anonymous questionnaire (Okifuji & Evans, 1991) indicated that some parents are not simply uninvolved with their childrens' education, but are actively averse to interacting with the school. There are various reasons for this, usually tied to negative experiences of school when they were children, and feelings (often justified) that they are unwelcome in the school. A home-visitor

represents a much more neutral, unofficial contact than having to visit a teacher or principal. Originally we asked our home-visitors to visit both families that ostensibly had no problems with the schools as well as families of children who were problematic from the teacher's standpoint. But since the difficulties experienced by this latter group were so serious and so intricate, it was soon decided to concentrate our efforts on those children who were indentified by teachers as showing behavioural signs that would predict more serious problems with school adjustment.

The purpose of this report is to evaluate the home-visitor model that evolved, thus permitting an appraisal of a family-oriented behavioural strategy that attempted to fulfill some of the criteria of a community intervention. The focus of the programme was to link family and school in an effective communication, thereby providing a foundation for problem solving in the future. Data from the first year of the project have already been analyzed (Evans, Okifuji, Engler, Bromley, & Tishelman, 1991); the present report presents the findings from a second year, attempting both to replicate previous findings and to extend our understanding of behavioural interventions executed in the everyday environments of home and school.

Method
Setting
The study took place in conjunction with a small city (population 60,000) school district. The city has areas of severe urban poverty, mixed with more affluent middle and higher income suburban areas. It faces steady economic deterioration with the gradual decline of manufacturing industries and the influx of immigrants as well as people from rural areas and larger cities seeking social services. The public education system has seven elementary schools, two middle schools, and one high school, with a total enrollment of about 7,000 students. The four elementary schools with the most significant indicators of social and educational need (numbers of families on public assistance, lowest standardized achievement test scores, highest absentee rates) participated in the project. In addition to the program to be described, other supports were provided to the experimental schools, such as staff development for teachers in conjunction with university faculty, a small grants program to encourage teacher innovations in curriculum and instruction, and support for activities to foster parent participation.

Participants
Young children at risk for serious educational failure on account of behavioural problems were the subject group for this investigation. However there was no direct contact with these children and the real "targets" of the intervention were parents and teachers. Two cohorts of students and their parents were selected — one experimental group and one control — on the basis of teacher referral early in the school year. Teachers from three schools referred children to the experimental group; teachers from a fourth school, similar in terms of demographics, referred children to the control group. Referral was made on the basis of one or more of the following criteria: (a) poor academic performance, especially in reading and mathematics; (b) disruptive or difficult to manage conduct in the classroom; (c) indications of social withdrawal and/or emotional difficulties with peers; (d) chronic absenteeism or tardiness. It was made clear that referral to the project should precede and hopefully be a substitute for, referral to special education services, however it was also ensured that participation in the project would not exclude any children from other school programs to which they might be entitled.

After the referral was made, the parents were contacted, invited to participate, and their informed consent carefully secured. Parents in the experimental group were told the nature of the programme and the activities involved, while parents in the control group were told that various measures would be requested and that they would get a small reward (an educational toy) for participating, with no services promised. The teachers in the control group were informed that their participation was being requested for evaluation purposes and that they were a comparison group which would not receive the programme. The demographics of the two groups are described in more detail in Table 1. As can be seen the groups were not perfectly matched on a number of variables, however none of the differences were statistically significant. Of 39 students in the experimental group, 4 (10%) were referred for academic problems only, 14 (36%) were referred for behavioural/social problems, and 21 (54%) were referred for both academic and conduct problems. Of 14 students in the control group, 2 (14%) were referred for academic problems, 6 (43%) were referred for behavioural/social problems, 4 (29%) were referred for both, and 2 (14%) were referred for absenteeism.

Measures
Demographic data on each family were collected at the beginning of the programme. Additionally, teachers and parents were independently asked to indentify the child's specific problems and rate the seriousness of each one from 0 (no problem) to 4 (very serious). The same problems were re-rated at the end of the school year to obtain post treatment

Table 1. *Demographics of children and families in each group (percentages in parentheses).*

	GROUP	
	EXPERIMENTAL	CONTROL
SEX		
Male	26 (64.1)	3 (21.4)
Female	13 (33.3)	11 (71.4)
GRADE		
Readiness Kinder	3 (7.7)	4 (28.6)
Kindergarten	25 (64.1)	5 (35.7)
Pre 1st	2 (5.1)	2 (14.3)
1st	7 (17.9)	2 (14.3)
2nd	2 (4.2)	1 (7.1)
RACE		
African-American	7 (18.0)	3 (21.4)
Caucasian	28 (71.8)	10 (71.4)
Hispanic	0	0
Bi-racial	4 (10.3)	0
PRESCHOOL EXPERIENCE (Yes)	31 (79.5)	13 (92.9)
FAMILY STATUS		
Married	12 (30.7)	5 (35.7)
Single	17 (43.6)	6 (42.9)
Step family	3 (7.7)	1 (7.1)
Living with others	7 (18.0)	2 (14.3)
MOTHER'S EMPLOYMENT STATUS		
Full-time	9 (23.1)	1 (7.1)
Half-time	5 (12.8)	1 (7.1)
Unemployed	25 (64.1)	12 (85.7)
FATHER'S EMPLOYMENT STATUS		
Full-time	14 (35.9)	2 (14.3)
Half-time	8 (20.5)	4 (28.6)
Not applicable	17 (43.6)	8 (57.1)
PUBLIC ASSISTANCE (Yes)	21 (53.8)	11 (78.6)
MOTHER'S EDUCATIONAL STATUS		
Less than high school	13 (33.3)	4 (28.6)
High school graduated/GED	15 (38.5)	7 (50.0)
More than high school	9 (23.1)	2 (14.3)
FATHER'S EDUCATIONAL STATUS		
Less than high school	5 (12.8)	2 (14.3)
High school graduate/GED	9 (23.1)	2 (14.3)
More than high school	9 (23.1)	0
Not applicable/no data	16 (41.0)	10 (71.2)

measures. At the end of the year, teachers and parents were also asked to indicate whether the students improved in academic and behavioural/social domains and whether home-school communication seemed to have been enhanced in each case.

Report cards for each student were collected at the end of the school year. These revealed students' academic standing in reading, mathematics, work habits, and personal growth, as well as days absent and whether the student was promoted to the next grade. Instances of referral to special education services at any time during the year were obtained from school records

Procedure

Each home visitor was randomly assigned responsibility for approximately half of the students in each group. One home visitor was a former elementary school teacher with a Master's degree in education, the other had a Bachelor's

degree in education. Neither had had formal counseling experience, but both were very familiar with the district and lived in the neighbourhoods served by the schools.

Once referral was made, the home visitors contacted the teacher and collected information regarding her (all teachers were women) perception of the child's problems. Independently — without discussing the teacher's concerns in anyway — the home visitor next visited the family, and collected information about their assessment of the child's difficulties, if any. After these two visits the home visitors and a doctoral student in clinical psychology developed a "diagnostic profile" for each case, under the supervision of an experienced clinical psychologist.

Assessment

The diagnostic profile was based on a functional analysis of each problem indentified by parent or teacher, and was not a diagnosis according to any child psychiatric nosology. Each problem mentioned was placed in a logical matrix, ordered hierarchically according to whether the concern could be subsumed under some more general complaint. For example, if the teacher reported that the child was "noncomplaint" and the parent reported that the child "refuses to do his homework when he comes back from school", the latter complaint would be listed under the former, more general concern, whereas if the parent had reported that he "never does what I tell him to do", then that would be the exact equivalent of noncompliance, with teacher and parent agreeing as to the complaint. Hypotheses were generated as to the possible cause of any complaint. In this example, if the mother had also reported that she works in the evening and her boy-friend allows the child to do anything he wants, then that concern would be listed as superordinates, and probably causal, to the more specific complaints listed.

Sometimes, teacher and parent would have very different perceptions. The teacher might describe the child as "sassy, rebellious, defiant, and aggressive". The mother and the father might report that the teacher disliked their child and that she was very strict with him and picked on him all the time. They openly criticized the teacher in front of their son, but they themselves used harsh disciplinary procedures and physical punishment. The superordinate category might be lack of positive discipline skills in these parents, and few reinforcements available from the teacher at school, with more effective communication between home and school being the overall need, subsuming both of the other required changes. The general strategy for these assessment profiles is described in more detail in Evans (1985). Where

Table 2: *Example of problems identified by at least one person (teacher or parent) and the number of students presenting with the problem.*

PROBLEM	GROUP	
	EXPERIMENTAL	CONTROL
Academic failure	17	6
Noncompliance	14	4
Disruptive/Hyperactive	19	6
Physical aggressiveness	10	4
Verbal aggressiveness	4	0
Lack of or inappropriate social interaction	12	5
Enuresis/Encopresis	3	0
Frequent tantrums	3	1
Lying	2	0
Stealing	2	0
Moody/Overreacts to teasing	6	0

causal variables had to be hypothesized in the diagnostic profile, additional information relating the possible functions of the problem would be sought during subsequent home visits or interviews with the teacher. When specific problem behaviours were identified and agreed upon by both parent and teacher, these would always be targeted directly if they resembled the common "symptoms" of childhood psychopathology. This was because we wished (a) to demonstrate that the problems addressed by this model were just as complex and severe as those seen in the typical clinical setting, and (b) to monitor the presence of severe syndromes that might require referral to a mental health facility for more intensive intervention. Examples of the types of psychopathology symptoms exhibited by children in the two groups are provided in Table 2.

Treatment

Interventions designed by the home visitors followed logically from the diagnostic profiles. Certain broad principles guided the design of intervention: (a) Many of the families were highly dysfunctional and had numerous social and economic problems. It was assumed that a minimal intervention approach could not realistically change major family problems. Thus a customary goal was to find some strategy for insulating the child from the worst of the problems, usually by ensuring that the teacher, the school, or other responsible adult was involved in positive and constructive interactions with the child. (b) Suggestions for parents were very direct and simple and again were designed for the best possible "ripple effect." For instance, if the household was so chaotic that there was nowhere for the child to be able to do homework, practical suggestions such as having a reserved spot at the

Table 3: *Mean percentages of satisfactory grades in each marking period (standard deviations in parentheses).*

CATEGORY	GROUP	
	EXPERIMENTAL	CONTROL
Reading		
1	50.62 (38.34)	64.33 (24.14)
2	59.11 (32.70)	77.22 (22.81)
3	61.35 (32.43)	81.44 (24.21)
Maths		
1	54.68 (35.15)	60.00 (43.59)
2	54.28 (34.95)	80.00 (20.00)
3	55.57 (35.40)	73.67 (26.76)
Work and Study Habits		
1	51.25 (28.10)	95.00 (10.00)
2	55.00 (32.27)	95.44 (9.99)
3	63.73 (30.65)	94.00 (11.95)
Personal Growth		
1	61.97 (30.71)	91.56 (13.44)
2	69.61 (32.86)	93.56 (8.57)
3	74.41 (32.38)	92.56 (12.96)

kitchen table, using the local library, or enlisting the help of a friendly neighbour, would be proposed to the family. Individual suggestions of this kind were always followed up on the next visit to see if they had been implemented. (c) The home visitors spent a considerable amount of time listening to parental problems and concerns, which they would respond to with practical advice and suggestions. (d) Whenever possible the home visitors recommended strategies that would enhance the cognitive development of the children, such as parents reading to the child explaining rules rather than using punishments, praising the child for trying harder at school. (e) The major recommendations to both parent and teacher were for them to make contact, get together if possible, resolve any conflicts that may have developed between them, and to make an effort to understand each others' needs and concerns more clearly. The home visitors facilitated such interaction by arranging meetings acting as a go-between, explaining family limitations to the teacher, and joining in meetings as a mediator.

In the case of the more tangible behaviour problems that both parent and teacher agreed upon, more explicit interventions were designed. These were based on a conceptualization of child behaviour therapy that has been described in detail elsewhere (Evans, 1989). Briefly, the approach argues that in treating any childhood behaviour problem there are four components that must be present simultaneously in any plan. They are: (a) ecological change — modifying the environment so that eliciting stimuli or setting events are reduced; (b) implementing simple, natural, negative consequences for when the problem behaviour does occur, and reinforcing the child when it does not occur; (c) teaching an adaptive, replacement behaviour that is similar in function but more socially acceptable, and (d) long-term prevention, whereby the more general skill deficits or motivational needs revealed by the undesirable behaviour are addressed.

Based on our experience of how much time it takes to contact and meet these families, the number of home visits was limited to six per family, spread out over about half the school year. The visits often lasted much longer than the scheduled hour, and other contact (such as on the phone, or brief meetings at the school) was encouraged as needed. The control group received only the first and last visit, which were typically devoted to completing the various measures required for evaluating the outcome.

Results

Attendance and Academic Improvement

There was a total of 181 school days during the year. The mean days absent was 17 (SD=13) for the experimental group and 15 (SD=15) for the control group. The difference was not significant.

Most students received report cards three times during the school year; a few students
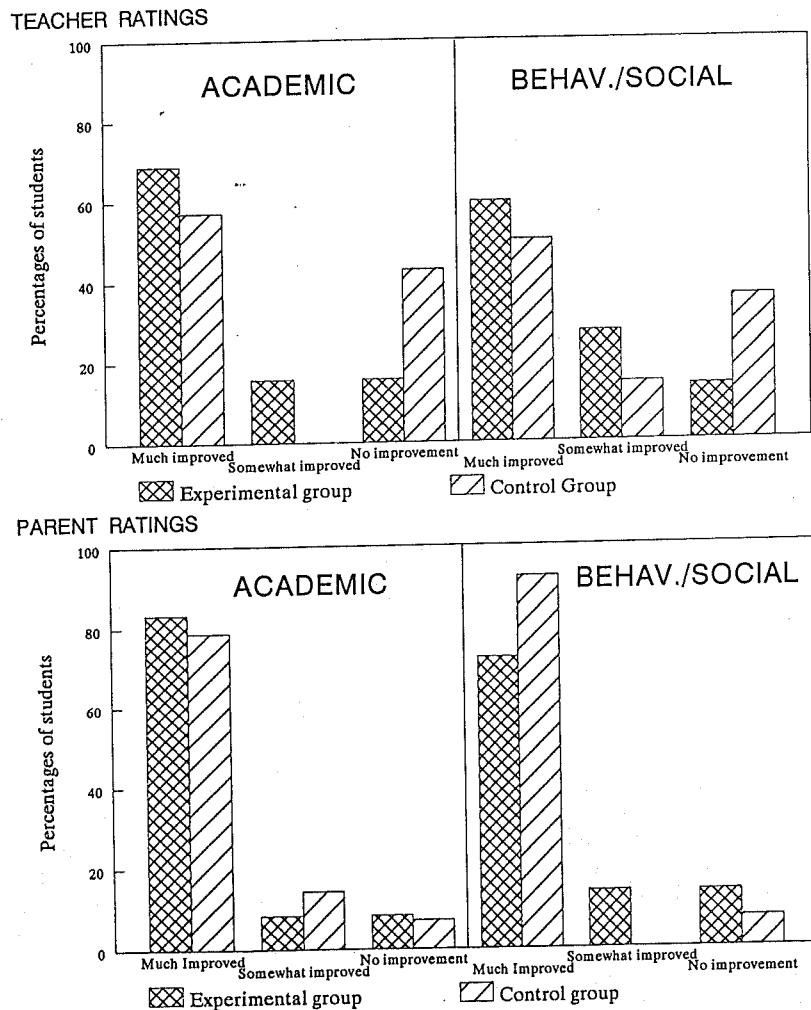
TEACHER RATINGS

PARENT RATINGS

Fig. 1. Improvement ratings by teachers and parents on how much children improved
in academic and behavioural areas in each group.

received grades 4 times and in these cases we analyzed only the second, third, and fourth grading periods. Changes in academic achievement were calculated for the categories reading, maths, work habits, and personal growth. The dependent measure was the percentage of specific items within each category that were rated as "satisfactory" or better by the classroom teacher. The percentages for both groups can be seen in Table 3. Overall, the students in the control group received higher percentages of the satisfactory grades. However, in work habits, the students in the experimental group showed significant improvement compared to those in the control group, $F(2, 84) = 3.62, p<.04$.

As a result of their grades, 23 students (61%) in the experimental group and 13 (93%) students in the control group were promoted to the next grade at the end of the school year. The difference between those proportions was not significant, $X^2(1) = 3.62, p<.06$. In addition, more students in the experimental group were referred for special educational evaluation by their teachers. Twelve students (32%) in the experimental group underwent the first special educational evaluation whereas no students in the control group did. This was a significant difference, $(X^2(1) = 3.87, p<.05)$.

Global Judgements of Improvement — Teachers

Figure 1 shows the percentage of children in each group rated by their teachers as unimproved, somewhat improved, and much improved in academic and social/behavioural areas. Generally, a larger proportion of students in the experimental group than in the control group was rated as somewhat or much improved, however those differences were not significant, $X^2 (2) = 5.41, p < .07$.

Global Judgements of Improvement — Parents

Figure 1 also shows the parents' responses, which were coded in the same manner as for teachers. The parents in the two groups did not differ significantly in terms of rating their children's improvement in academic and social/behavioural areas; a majority of the parents in both groups rated their children as showing much improvement.

Pre/Post Assessment of Improvement on Specific Targets

Based upon the ratings of the problematic behaviours identified at the beginning of the school year, an index of the total severity of specific problems was calculated by summing the seriousness rating of all problems into one score. Since parents and teachers perceived problems independently, each student had pre- and post-treatment scores rated by his/her parent, and pre- and post-treatment scores rated by his/her teacher. Figure 2 shows the changes in the severity scores over time. ANOVA's (Group X Time) were performed for the teacher- and parent-ratings. The analyses revealed that although both parents and teachers indicated improvement for both groups, the students in the experimental group improved significantly more than those in the control group: $F(1,48) = 8.80$, $p < .005$ for parent estimates, $F(1,47) = 11.18$, $p < .003$ for teacher estimates.

Quality of Home-School Communication

At the end of the school year, parents, teachers, and home visitors independently judged whether the quality of home-school communication had improved. Fifty six percent of the teachers in the experimental group and 50% in the control group rated that home-school communication improved.
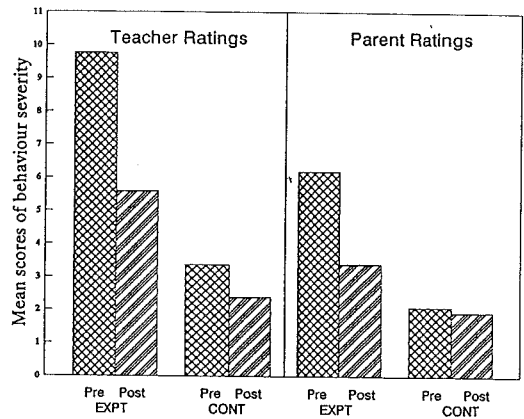

Fig. 2. Mean scores on Behaviour Severity Index as a function of group, time and rater.

Eighty four percent of the parents in the experimental group and 93% in the control group rated home-school communication as improved. The home visitors rated 68% of the experimental group as showing improvement in communication, and 21% in the control group.

Figure 3 shows how many parties agreed on improvement in home-school communication for each group. As can be seen, there was greater agreement for the experimental group than for the control group. However, the difference was not statistically significant, $X^2 (3) = 4.29$.

Discussion

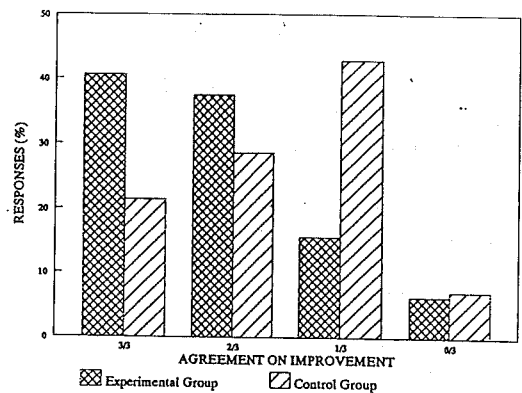Taken together, the results show that the home visitor program had a positive impact

Fig. 3. Agreement on improvement in quality of home-school communication among teacher, parent, and home-visitor.

on children referred by their teachers for significant academic and behavioural problems. However students in the control group were also rated as improved and the experimental group's outcome was significantly superior only on one report card evaluation and parents' and teachers' ratings of improvement in specific target behaviours. It must be noted with respect to the latter index, that the problems in the control group were considered less severe to begin with.

It seems likely that teachers referring students to the home visitor program tended to select their most problematic pupils. Teachers referring to a program they knew to be a "no treatment" comparison group were probably reluctant to refer children with the more serious needs. This is the classic problem that arises with nonrandom assignment, yet sometimes the realities of applied research make desirable methodologies difficult to achieve.

The results regarding referral to special education and the retention of the children (not promoting them to the next grade) were especially disappointing. In the previous year's results, none of the children in the experimental group were retained, and the number placed in special education programs was significantly less than for the control group. It has recently been the district's stated policy not to retain students, since the research literature indicates this practice does more harm than good. In the present results, however, a considerable percentage of the pupils was retained. Either school policies are not being well implemented, or the children referred during this project year were substantially more challenging than in the past.

To consider this latter possibility, we went back to the individual protocols and looked at the circumstances surrounding those children for whom the intervention seemed to have minimal results. It was possible to categorize these families according to three general factors that interfered with the home visitors' efficacy. First, there were many parents whose own personal problems were so significant that the home visitor was obliged to address these needs, rather than being able to focus on the child. Examples of families in this category were (a) a single teenage mother with four young children who

was herself failing high school and who had no financial or social supports; (b) a mother with paranoid disorder who was not receiving any mental health services; (c) very passive parents with mild mental retardation, whose own parents dominated family decision making and undermined efforts to effect change.

Second, there were practical and logistical problems that prevented the home visitor from implementing even simple change strategies. Examples from this category of problem were: (d) a father who had custody of the child was sent to prison during the intervention period, and the mother who had had no previous contact with the child became the primary caregiver; (e) a mother who worked from 3.00 pm until 11.00 pm, and although the primary caregiver, she saw the child only at weekends; (f) an immigrant family who spoke very little English and whose cultural traditions emphasized the frequent use of physical punishment.

The final broad category of limitation was one in which the clinical team judged that the child really needed more intensive, individual evaluation and mental health services. Examples were: (g) the child of an alcoholic mother, who appeared to have previously unrecognized fetal alcohol syndrome; (h) a child who had been sexually and physically abused living with ineffectual foster parents.

Clearly, the cases handled by the home visitors during the project year were quite complex. We were dealing with families in considerable distress. And yet these are not atypical of the kinds of family circumstances that are pervasive in public education in the United States, and doubtles other countries as well. It is arguable that children and families with this degree of difficulty will need much more intensive delivery of mental health services. Thus the home visitor model could be restricted to more benign problem areas where a prevention model has a chance of success. Future research will investigate whether aspects of the home visitor protocol (e.g., more frequent contact with consultants, a greater number of visits, more cooperation from teachers and other school personnel) can be enhanced so that its impact will be more powerful.

Finally, let us return to the matter of

families, to which this special issue of the journal is dedicated. We did not utilize family systems principles in the design of these interventions. In the majority of cases the "family" member we were influencing was the child's mother, who was usually the primary caregiver. The mothers were often leading difficult lives, with erratic relationships, economic hardship, and few personal opportunities. The intent of our programme was to provide them with some sort of support that would benefit the child, even if their own circumstances could not be enhanced. It is our contention that schools should represent an environment that sustains contructive, appropriate behaviour. Too often however, it seemed the very children in need of the greatest support from the normalized environment of the school, were the least likely to receive such encouragement. Teacher attitudes towards the referred children were often negative. The home visitors reported numerous instances in which teachers showed much greater understanding of and caring for a pupil once there had been some positive contact with the child's family. Similarly, many parents indicated that the home visitor experience was one of the first constructive encounters they had had with the education system. Thus the general principles of teachers working positively with families to understand and remedy children's behaviour disorders continues to seem to us to be a valuable adjunct to (if not a replacement for) more traditional therapies with children and families.

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