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Home Visits to Mothers with Children Between the Ages 0 to 4 Years: A Mental Health Intervention Strategy in Emerging Countries

Marcela Aracena, Consuelo Undurraga, Esteban Gómez,
Loreto Leiva, Ariela Simonsohn and Pilar Navarro
*Pontificia Universidad Católica De Chile,
Chile*

1. Introduction

According to recent investigations both in Chile and other countries, mental health of mothers show a special vulnerability during the post-partum period. This is an especially disturbing knowledge, because of the relevance of the first three years of life in the posterior development of children. The connection between the mental health of the mother (→ mother-son/ daughter relationship→ attachment style→ regulation of the child experience→ development of the brain cyto-architecture→) and the present and future mental health of the child is solidly established, based on a large amount of empirical and multidisciplinary evidence (Shore, 2001). Strengthening and parental skills of the mother, especially in the first upbringing stages are then a priority focus of action for health policies in every country.

This chapter focuses on linking the need of support that many families require in terms of the mental health of parental figures -especially the mother- and mental health of infants, with a promising intervention strategy in natural context, the home visit. So, it is a chapter with an emphasis on the practical side of supporting mental health, that intend to communicate an analysis both from an investigational view and an implementation of Home Visiting generated by a research team of Pontificia Universidad Católica de Chile starting 2003, in three consecutive projects financed by the “Fondo Nacional de Desarrollo Científico y Tecnológico” (National Fund for Scientific and Technologic Development) - FONDECYT, a national institution responsible for financing investigation in Chile.

This work is useful in two different aspects: (a) it provides a systematization of our knowledge regarding home visits, and effect on health and early childhood in an emerging country; and (b) it is a reflection regarding the challenges of implementing this type of programs.

2. Home Visits to mothers with children between the ages 0 to 4 years

Home Visiting is an ecologically sensitive strategy for the delivery of various services, aimed at supporting and strengthening families in their own home, through regular meetings with a home visitor (Aracena et al., 2011).

The focus of home visits are diverse, including the prevention of child abuse and neglect, Promotion of child development, strengthening parenting skills and a secure attachment and knowledge and use of formal/informal networks (Kotliarenco, Gómez, Muñoz & Aracena, 2010). Interventions in home visits are also diverse (McNaughton, 2004): information delivery, evaluation, promotion of breastfeeding and child development, counseling, referrals, monitoring, social support and family therapy.

Home visiting is considered an experience involving actors from different functional areas such as information provision, direct support and/or practical aid to the family. Participating educational agents (professionals or non-professionals) can play different roles such as friend, teacher, role model, among others (Gracia, 1997).

In Chile, the Ministry of Health [MINSAL] (2008) proposed that the home visit should be developed according to four categories: (a) reproductive cycle of the family, (b) risk factors and protective factors, (c) contingent health problems, (d) family crisis. But currently, there is not a unified model of home visitation that guided the practice, and in fact, that is precisely one of the most important challenges for the future.

In the last decade, it has been published several systematic reviews and meta-analysis about the effectiveness of home visiting (Elkan et al., 2000, 2001; Kearney, York & Deatrck, 2000; Kendrick et al., 2000; Sweet & Appelbaum, 2004; Russell et al., 2007; Lagerberg, 2000; Nievar, Van Egeren & Pollard, 2010), which have generally proved effective for various purposes, but with a range from low to moderate effect size. Among the findings of these reviews, notes that home visits delivered by nurses impact the psychological well-being, perceived social support, repeated pregnancies rates and alcohol use, mother-infant interaction (in various outcomes), and in parenting skills (such as parental discipline, attitudes related to child abuse, parental expectations about parenting and child behavior and learning stimulation), with mixed results, as rates of real child abuse and neglect have proven very difficult to change.

On the other hand, there are fewer results in social skills, employment, re-education, health and child development, and use of health services (Kearney, York & Deatrck, 2000; Lagerberg, 2000; Kendrick et al., 2000). Cognitive development in children with low birth weight or preterm may be positively influenced by home visiting programs, particularly when performed in combination with a program of early stimulation in the neonatal unit.

Regarding postpartum depression, it appears that significant improvements can be achieved in home visits by nurses using counseling once a week, for 6-8 weeks (Lagerberg, 2000). These results showed by reviews, have been partially supported by the meta-analysis of Sweet and Appelbaum (2004). Also, in a systematic review and meta-analysis of 12 studies using the HOME instrument (Caldwell & Bradley, 2001), there was a highly significant effect, suggesting that home visitation is effective in improving the quality of home environment as assessed by this instrument (Kendrick et al., 2000).

In the field of mental health care, international research have shown the effectiveness of home visits as an intervention strategy of mothers and infants within highly vulnerable environments. A recent review of this issue (Kotliarenco, et.al., 2010), summarizes the characteristics of the most effective programs of home visits around the following axis: (a) building a trust relationship between the visiting agent and the mother; (b) focusing on modeling the mother-infant interaction; (c) start during pregnancy; (d) extensive duration; (e) specific training for visiting agents.

Regarding, who perform these visits; it is possible to identify different educational agents: professionals and non-professionals. Even when the favourable effects of home visits have been recognized, there are still divergences regarding the characteristics considered as adequate for the agents participating in such programs since different profiles are needed depending on the objectives of the intervention. The role of the educational agent has great importance since it helps build a space for support and control for the mothers, fathers or care providers and validates a space for the experience of maternity. The educational agent therefore acts as a cultural and social mediator and constitutes a model which facilitates the vicarious learning for the mother (Olds, 1997). Therefore, it is really important to discuss the inclusion of professional vs. non-professional visitors, their training, experience, skills and supervision (Elkan et al., 2000, Olds, et al., 2004, Nievar et al., 2010).

Research carried on by Olds and his team in the United States, has concluded that home visit has different effects depending on the characteristics of the visiting agent. The women visited by community monitors, compared with a control group, showed better mental health and more parental sensitivity to their children. On the other side, women visited by nurses presented a longer interval between the birth of their first and second child, lower level of family violence, and their children showed a better level of language and behavioral adaptation. In both cases, women visited achieved a better learning environment for their daughters and sons (Olds et al., 2004). Additionally, a review on the subject showed that outcomes obtained by paraprofessionals are similar to professionals (Kendrick et al., 2000).

A recently published meta-analysis on moderators of improvements in maternal behavior using home visiting programs, with 35 studies and a $N = 6.453$ (Nievar et al., 2010), reveal that programs with more frequent visitation had higher success rates, with two visits per month predicting a small, substantive effect, while intensive programs (with at least three visits per month) were more than twice as effective as were less intensive programs. It is interesting for the discussion on the professional/paraprofessional controversy, the finding of this meta-analysis that home visiting programs using nurses or mental health professionals as providers were not significantly more effective than were programs using paraprofessionals.

The literature on cost-effectiveness of home visiting in early childhood has shown preliminary findings indicating that it is cost-effective, with net income at rates ranging between \$6,000 and \$17,200 per child, in the United States (Aos et al., 2004). In Chile, there are indications that the home visit implemented by community workers (non-professionals) would be cost-effective with respect to mental health outcomes of mothers. Thus, Aracena et al. (2009) reported that the incremental cost compared with the effectiveness of a program for teenage mothers using home visit, gives a cost of \$13.5 per unit of effectiveness (measured as a decrease of one point in the Goldberg questionnaire). The study concludes that significant gains are obtained investing \$40 per teen in a total period of 15 months.

3. Interventions

In the this section, we describe in some detail the results of two research projects about home visit in Chile, seeking to illuminate some of the topics that constitute the frontier of knowledge about the relation between intervention and outcomes in vulnerable families using this strategy.

Both investigations evaluate the cost-effectiveness of home visiting performed by community monitors to young women under 20 years old. In the first case, research focused on Centros de Salud de Chile (Chilean Health Centers), a State organization. In the other hand, in the second case, the investigation was framed in a non-governmental organization managed by the Church as opposed to an intervention provided by a Health Care Center. Methodology details of every investigation can be reviewed in the Figure 1 which follows.

	Cost-effectiveness of Home Visiting to teenage mothers associated to Health Centers (2003-2005)	Cost-Effectiveness of Home Visiting of teenage others associated to Health Centers and NGOs (2007-2009)
Objective	Evaluate cost-effectiveness of a home visit program compared to the regular program in two health centers in Santiago, Chile oriented to teenage mothers.	Evaluate the maintenance of effects in time and without additional intervention and also the cost-effectiveness of two home visit programs to teenage mothers by comparing them with each other and with regular programs in Health Centers for mothers with children younger than 4 years old, in Santiago, Chile.
Design	Experimental, clinical trial type controlled and randomized.	Mixed, quasi-experimental: a study for the evaluation of the maintenance effect in a group under intervention previously compared to other groups under intervention and all of them with a control group.
Sample	Control Group: 50 pregnant young women. Experimental Group: 50 pregnant young women.	Control Group: 140 pregnant young women. Experimental Group: 123 pregnant young women.

Intervention	Control Group: standard intervention of health centers. Experimental Group: they also received home visits from the 3 rd trimester of pregnancy up to the 12 th month of life of the child. Experimental Group: The program targeted young women who conceived their first child between 14 and 19 years of age. It involved community participation in the implementation of the program through health educators who conducted the home visits under the guidance of nurse-midwives from the local health center. The program sought to: (a) encourage the young woman's development of her identity as a woman, adolescent, and mother, (b) help her develop life plans, (c) reinforce her parenting skills, (d) promote basic health care practices for both mother and child, and (e) strengthen the adolescent's relationships with those around her.	Control Group: standard intervention of health centers. Experimental Group 1: highly standardized home visit program, edited in a manual and intensive (average of 12 annual visits). Experimental Group 2: low standardized and low intensity home visit program, non-edited in a manual (6 annual visits average). Experimental Group 1 The program targeted young women who conceived their first child between 14 and 19 years of age. It involved community participation in the implementation of the program through health educators who conducted the home visits under the guidance of nurse-midwives from the local health center. The program sought to: (a) encourage the young woman's development of her identity as a woman, adolescent, and mother, (b) help her develop life plans, (c) reinforce her parenting skills, (d) promote basic health care practices for both mother and child, and (e) strengthen the adolescent's relationships with those around her.

		<p>Experimental Group 2</p> <p>The core component were voluntary monitors linked to the Catholic Church NGOs who participated in training processes and support to pregnant young women or women with infants between 0 to 2 years old. This work was developed around three components: home visiting, training workshops and communication actions, being the first one our principal axis. Visits were performed according to needs established jointly with the mother from the pregnancy until the child reached 2 years old.</p> <p>All mother-child pairs received routine assistance from all traditional programs performed by the primary medical assistance system of Chile.</p>
<p>Instruments</p>	<p>Evaluation of the mothers</p> <ol style="list-style-type: none"> 1. Evaluation of physical health. Made by the medical team throughout the adolescent's pregnancy, in the post-partum period and during lactation, with prenatal check-ups and treatment for illness. 2. Evaluation of mental health. The Chilean adaptation of the Goldberg's General Health Questionnaire was used. This test allows for the detection of mental disorders of a neurotic origin as well as some personality and psychophysical disorders, indicating the presence and severity of symptoms (Araya, Wynn, & Lewis, 1992). 3. Evaluation of family function. This evaluation was carried out using the questionnaire 'What's YOUR family like?' developed by the Pan-American Health Organization (1992) and validated in Chile by Rodríguez et al. (1995). It includes 25 questions containing 132 items measuring family function, structure, processes of interaction, stressful events and potentially risky behaviors for the adolescent's health (Rodríguez, et al., 1995 en Hidalgo & Carrasco, 2002). 	<p>Evaluation of the mother</p> <ol style="list-style-type: none"> 1. Evaluation of physical health. Made by the medical team throughout the adolescent's pregnancy, in the post-partum period and during lactation, with prenatal check-ups and treatment for illness. 2. Evaluation of mental health. The Chilean adaptation of the Goldberg's General Health Questionnaire was used. This test allows for the detection of mental disorders of a neurotic origin as well as some personality and psychophysical disorders, indicating the presence and severity of symptoms (Araya, Wynn, & Lewis, 1992). 3. Evaluation of family function. This evaluation was carried out using the questionnaire 'What's YOUR family like?' developed by the Panamerican Health Organization (1992) and validated in Chile by Rodríguez et al. (1995). It includes 25 questions containing 132 items measuring family function, structure, processes of interaction, stressful events and potentially risky behaviors for the adolescent's health (Rodríguez, et al., 1995 en Hidalgo & Carrasco, 2002). 4. Satisfaction with life: the satisfaction with life scale was taken from the questionnaire developed by the Panamerican Health Organization (1992) and validated in Chile by Rodríguez et al. (1995). 5. Psychosocial welfare: it was measured through the inclusion of the educational system after the delivery.

	<p>Evaluation of the children</p> <p>1. Evaluation of physical health. The medical team's examination of the children included: (a) regular well-baby checks; (b) visits for illnesses; and (c) kinesthetic consultations. The frequency of key illnesses among the children (and their mothers) was determined by examining the health center's medical records.</p> <p>2. Evaluation of psychomotor skills children younger than two years old. As part of the periodic control within the health centers, nurses evaluated children using the Psychomotor Development Scale (EEDP). This scale, designed in Chile by Rodríguez, Arancibia and Undurraga (1974), measures the psychomotor development of children aged 0-2, showing a general score that differentiates between normal development and children at risk. It also allows for the establishment of a profile of development in relation to the chronological age, including 4 areas: motor, language, social skills and coordination.</p> <p>3. Evaluation of indicators for child abuse. These evaluations were completed by the health center's social workers throughout the duration of the program.</p>	<p>Evaluation of the children</p> <p>1. Evaluation of physical health. The medical team's examination of the children included: (a) regular well-baby checks; (b) visits for illnesses; and (c) kinesthetic consultations. The frequency of key illnesses among the children (and their mothers) was determined by examining the health center's medical records.</p> <p>2. Evaluation of psychomotor skills (children younger than two years old): It was measured through the Psychomotor Development Evaluation Scale from 0 to 24 months. This scale, designed in Chile by Rodríguez, Arancibia and Undurraga (1974), measures the psychomotor development of children aged 0-2, showing a general score that differentiates between normal development and children at risk. It also allows for the establishment of a profile of development in relation to the chronological age, including 4 areas: motor, language, social skills and coordination.</p> <p>3. Evaluation of indicators for child abuse. These evaluations were completed by the health center's social workers throughout the duration of the program.</p> <p>4. Evaluation of psychomotor skills (children older than 2 years): It was measured through the Battelle tool (Newborg et al., 1988). This tool evaluates 5 domains of development: motor, cognitive, adaptive, communicational and social development. It has also a Spanish version and standardization for the Spanish speaking US population.</p>
	<p>Cost measurement.</p> <p>Costs related to health care, as well as administrative and logistical costs, were taken into account. To identify and measure these expenditures, the registries of both health centers were consulted regarding any costs related to the adolescents and their children. The cost of primary care services in the neighborhood in which the study was carried out was used as the point of reference for standard expenditures.</p>	<p>Cost measurement.</p> <p>1. Use of micro-costing technique for each intervention.</p> <p>2. Interview to know about the program, group meeting for the determination of unitary costs, frequency of use.</p> <p>3. Estimation of different calculation scenarios through the awareness criteria (a) cost discount rate, (b) Results discount rate, (c) Intervention standardization: only home visiting in both groups (excluding all other components of the program associated to the NGO (d) Calculation of incremental cost in regard to control.</p>

Effectiveness Analysis	Results were recorded in descriptive terms, using frequency, percentages and measures of central tendency. Differences between the experimental and control groups were measured using inferential terms: (a) nonparametric tests, such as comparison of proportions, Fisher's Exact Test and Chi-square (with or without Yates' correction for continuity); (b) parametric tests, specifically ANOVA, Student's <i>t</i> -test and MANOVA, according to the levels of measurement and specifications required by each test.	Sets and every group were descriptively analyzed. Parametric tests were performed (ANOVA, Student's <i>t</i> -test and MANOVA, according to the levels of measurement and specifications required by each test) and also non-parametric tests (Chi-square test)
Cost-effectiveness analysis	In order to evaluate the cost effectiveness of home visits versus the standard treatment provided at the health centers, the following elements were analyzed: (a) unitary costs of each program, (b) effectiveness, and (c) an analysis of incremental cost-effectiveness.	As for the cost-effectiveness analysis, we use an incremental analysis approach which permits us to determine costs and incremental effects of interventions in the study and to compare them with those of the regular programs.

Fig. 1. Home visits to mothers with children between the ages 0 to 4 years old: Results.

3.1 Main results: Compared analysis

3.1.1 "The relationship between a non-professional home visitor and the mother is the key" (results of the research 2003-2005)

This project evaluated the cost-effectiveness of an implemented Home Visiting program compared to the regular program provided by Health Centers to teenage mothers in a high biopsychosocial risk district. The sample included 50 young women in the experimental group which received Home Visits from the third quarter of pregnancy until the 12 months of the child as an average along with the regular programs in Health Care Centers. Control Groups included 50 young pregnant women receiving only the State Health Care Centers programs of the State of Chile.

Among conclusions we can highlight: (a) a better level of mental and nutritional health and compatibility between maternity and the tasks proper of the stage of life cycle reached by the young women receiving home visits, compared to teenagers in the control group; (b) a higher level of development of language in children of teenagers in the experimental group compared to the children in the group who didn't receive visits. Finally, when evaluating cost-effectiveness, the home visits program turned out to be more cost-effective in terms of mental health (Aracena et al., 2009).

Achievements obtained by teenagers in the experimental group can be attributed to the interaction between the young women and the monitor. This interaction represented a space of dialogue, company and orientation where the experience was valued and the skills were recognized. All these tools permit the young women to put into words and elaborate their thoughts and emotions associated to the maternity and their teenage phase and lead them to gain control over the events of their life making them capable to handle difficulties and profit opportunities. It also translated not only into less anxious-depressive

symptomatology but also in the incorporation of the maternity adequately in their life projects and their stage in the life cycle along with self-care behaviors which impact in a better nutritional status compared to those women in the control group. It also favoured the interaction between young women and significant people leading to a higher development of language in their children.

It is worth to mention this is the first experimental study, controlled and randomized clinical trial performed in Chile and South America to evaluate the cost-effectiveness of an educational strategy addressing the teenage pregnancy globally. Results supported the need to continue this line of work and also to work with cost-effective community agents, profiting the resources of the community and approaching the public health service to their members. We can also mention the improvements obtained in the levels of mental health of the young women who received home visits which translated into benefits both at personal and family levels and medium and long term savings for the Chilean health system.

3.1.2 “Non-professional staff can have significant outcomes on parents” (results of the research 2007-2009)

The objective of this project was to evaluate the persistence of effects over time, with or without additional intervention, and the cost effectiveness of two programs of Home Visiting (the first, associated to Health Centers and the second, associated with an NGO) for teenage mothers (with different psychosocial risks), comparing them against each other and with the regular programs of the health centers for mothers with children under 4 years. The sample consisted of 263 families referred to the different studies.

The results at 12 months of life for children indicate that in the first program, women have better mental health and nutrition and their children better indicators of language. For the second program, women have better adherence to the school when their child is 12 months old (Aracena, et al. 2011). In this study, the non-professional staff showed better outcomes on parental-family variables.

The results of this project are not surprising since international evidence have already shown the highest effect from the visits performed by non-professional staff in the variables associated to parents. On the contrary, a marginal effect is found in the children and we must highlight the role of health professionals in this area. A doubt arises in this point of the study. It is possible that the effect in the early child development was lower because of the nature of the intervention (not focused on a direct work with children) and the high impact of other variables associated to child development and that were not measured in the study. It is also possible this is an effect of the underpowered design of the study given the size of the sample.

Home visits performed by non-professionals have a direct impact on teenagers according to the content developed in every model (more mental health vs. more networks) and an indirect impact on their children. It poses a question regarding the indirect mechanisms more adequate to impact the development of children and the value of emphasizing such aspects in the visits or definitely propose a parallel visit model focused on working with children, which has demonstrated to be useful in other latitudes and performed by professionals.

These results show the effectiveness and importance of home visits as intervention strategies to improve the biopsychosocial welfare of teenage mothers and their children in a context of poverty. In the other hand, it demonstrates the relevance of including community (non-professional) resources as a potential value in countries with few professional resources to assist the children and families.

Results after 48 months indicate no differences can be observed between the experimental group and the control group or between women or children. Controversy exists about the meaning of an immediate effect than later dilutes in time. This dilution can reflect not a lack of effectiveness of the intervention but the sustained effect of other negative stimuli after the end of such intervention. It can happen when mothers finish an intervention and enter a poor environment. Ramey and Ramey (2006) propose the principle of continuity of educational support. This principle indicates that the effects of an intervention dilute in time if no educational support to maintain learned attitudes and behaviours are in place.

Considering the previously described effects, this intervention permitted the awareness of the importance of a stable protocol for every home visit and the need of continuity in such programs in order to maintain the effects found in children 12 months old.

3.1.3 Home visits and its contribution to mental health: two necessary premises to consider for an effective implementation

3.1.3.1 At a theoretical-empirical level

Regarding the theoretical-empirical background of Home Visiting, it is necessary that those evaluating the possibility of using this strategy as a prevention strategy in mental health must have updated information as the one we have previously presented.

From the point of view of our line of investigation there are two array lines that must be addressed at this level: (a) strengthening the relationship as a mechanism of change and (b) the figure of the community monitor as a possible alternative for Latin-American countries, need to be understood not only at a conceptual level, but also set into the characteristics and challenges of its implementation in the local reality. Otherwise, it is impossible to break the dichotomy between theory and practice, and the proposal to strengthen the home visit as a tool for the promotion and intervention in mental health is weakened.

3.1.3.2 At an implementation level

The experiences of research previously described have generated an endless source of learning, at an implementation level which will be described in detail using the ecological scheme of Bronfenbrenner (1987), because this knowledge has different levels and compromise different actors in each of these levels.

4. Principal lessons regarding the implementation of Home Visiting in an emerging country

4.1 The socio-political national context

The projects presented were implemented in different moments of national contingency, which determine the diverse possibilities and also the diverse limitations for each project. As an example, the current project (2010-2012) initiates in a context of government change,

after being in power for 20 years another political coalition (the one that led the country into democracy). This event determines big changes in the social environment, and more concretely in the public administration, creating situations of uncertainty about the stability/change of political and technical responsible officers, the ones that will have influence on the work of implementation of home visiting; and a big public policy like this one, must count with the support of the national, regional and provincial health administration system. Everyone was needed, but no certainty was granted.

4.2 The institutional context, national level

Influenced by the dynamic of political change, the context of central administration shows a particular dynamic, in which important changes in political responsibility are observed, slowing down the access to local Health Centers in an institutional culture that follows the central guidelines dictated by the national central level.

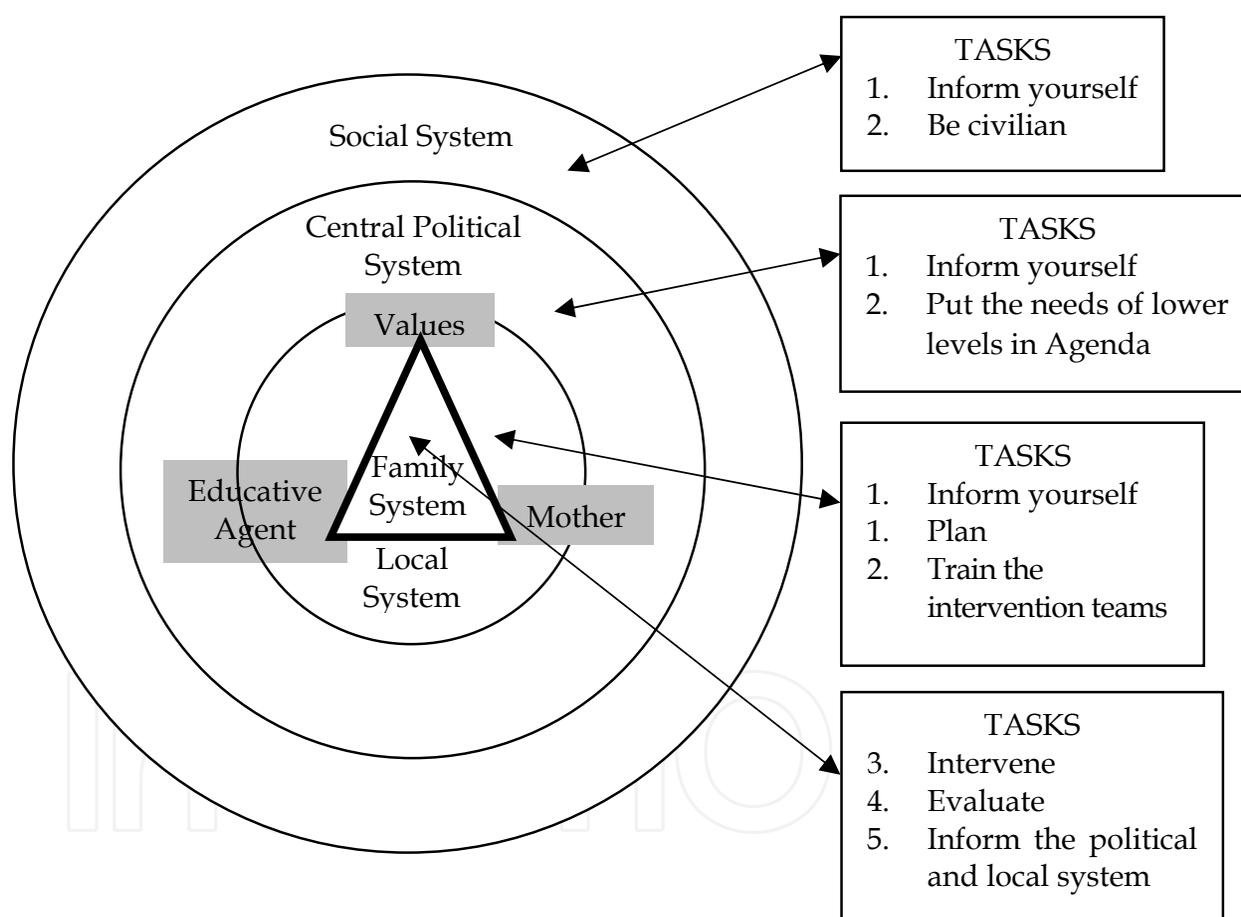


Fig. 2. Intervention Levels Diagram.

4.3 The institutional context, local level

In Chile, Health Centers depends -in terms of general guidelines- of central level, but in terms of administration, of "Municipalidades" that represents the local structure of government. The present research program has demonstrated that, although it is important, to enter the system, to count with the agreement and facilitation of central level, it is

absolutely necessary to work with local responsible officers in their different levels ("Corporación municipal", directors of Health Centers). Although the officers of the central administration could facilitate the realization of the home visits if the officers of local government and the directors and operators of Health Centers are not receptive to the initiative (for different reasons, including overload of work, lack of staff, among others), it is impossible to implement home visits of quality.

It is in this context, at this level, that it is necessary a special care about the administrative aspects. These refer to the elements that allow the management of the project or intervention, partially or totally. Among the administrative aspects, it is important to consider the human, economics and material resources, beside the "time" resource -the most valuable and scarce one- to implement home visitation. Each one of these must be attended according to the specific needs that home visits require in each local context.

The human resource must meet certain characteristics. For home visits, it is necessary to evaluate with whom will be possible to count on to implement the home visits in the institution. International literature reports that the professionals could have a differential response in contrast to paraprofessionals, but the evidence is controversial to date (Nievar et al., 2010; Kotliarenco et al., 2010). So, it is relevant that the human resource could be dimensioned considering the goals proposed for the home visiting intervention.

The economics and materials resources, such as the availability of a vehicle or money for the transportation to deliver the home visits, are important elements to consider when making a budget. It is important too, to document in the programs how and to whom these resources will be delivered, and how the staff directly involved in the intervention will access it.

About the "time" resource, it is necessary to consider the real amount of time of the implementation of home visits, in line with the specifications stipulated in the design of the program (objectives for the work with the families, distance to access the home). In the case of present visits that offers Health Centers in Chilean National Program of Health, this service consider -for each center- the meeting of an interdisciplinary staff, planning and schedule of the Visit, and its recording and evaluation. All of this, including the home visit itself, must be accomplished in a frame of 90 minutes (MINSAL, 2008).

The administrative considerations can be prioritized according to the clarity that it has of the service -in this case home visits- inside the institutional mission, allowing generating the required space.

In brief, and considering the elements previously explained, it can be stated that in order to successfully implement the home visits, it is necessary: to consider the reality of the national context; to contact and inform to national responsible officers about the advantages of the intervention and coordinate it with already existing policies; to solicit that they inform to local representatives, using the appropriated mechanisms, about the importance and meaning of the initiative.

At local level it is necessary, besides having the central authorization, to inform to each one of the persons responsible for the benefits of the initiative; to articulate it with the local policy; to assume administrative aspects and the training of the agents of intervention, by they professionals or persons of the community.

Everything that has been previously stated, as is evident, implies important resources, resources that are consequence not only from a technical and ethical compromise with the scientific evidence available, but also from a political compromise with the mission and vision, from a shared eagerness for the families, and the mental health and wellbeing of each one of their members.

4.4 Micro level intervention

Home Visits are performed at a level we can call micro level. Since it is inserted into a local and domestic context, it cannot be understood as an isolated unit but, according to Bronfenbrenner (1987), as receiving and providing mutual influence from and to such contexts. Home Visits are performed within the family environment, being generally present the pregnant woman/mother and the visiting agent. It is developed within the intimacy of a particular family with a family culture of its own. The visited family agrees to open the door and receive an agent it generally does not know whose function is to help it prepare for the delivery and raising of a son or daughter. To adequate the intervention to this reality is absolutely necessary to increase the possibility of success. In order to analyze this space more clearly we will be using the following axis concepts: Mission or Vision, Competences of the Visiting Agent and Quality of Service.

4.4.1 Mission and vision

Mission and vision are key elements of the strategic planning. Objectives determined derived from mission and vision to guide the intervention, Home Visits in this case (Stanton, Etzel & Walke, 2004). Thus, the mission provides a consistent guide to make important decisions.

In the other hand, the vision is defined as the future situation the institution desires to reach. Its purpose is guiding, controlling and encouraging the organization as a whole to reach the desired status (Quijado, 2003).

The strategic vision has the purpose of describing proposed future strategic scenarios according to the interests and objectives of an institution and with the purpose of obtaining evidence to determine the necessary projections to reach it through the protection of their freedom of action (op cit).

In such sense, Cuadra (2011) concludes it is necessary for the "sense of the intervention" to be transparent; it means that concepts or visions supporting the intervention are clearly stated both for the managers and the people performing the intervention and the users. According to the author, it permits a coherent and strategic look of the work to perform.

Cuadra also highlights the importance of providing technical and emotional support to the agents performing the intervention since it is an element favoring a responsible and effective practice (op cit).

It is important to point out that our research team focuses in the educational aspect of the Home Visiting, which considers the Visit as an educational situation, a privileged relationship between the woman (pregnant woman/mother or care giver) and the educator (visiting agent). The relationship between them is the privileged focus that triggers the expected changes. Therefore, this Home Visiting is a specific intervention centered in

connections. It means, focused in the particular link between the pregnant woman/mother and the visiting agent. Evidently, it involves certain conditions.

4.4.2 Competences of the visiting agent

When defining in depth the competences necessary in a visiting agent, no matter it is a professional or not, Hodkinson and Issit (in Delamare Le Deist & Winterton, 2005) emphasized that the competences focus requires a perspective beyond the activities related to care services involving knowledge, comprehension, values and skills that: "live in the person performing an activity" (p. 39). Cheetman and Chivers (1996) identified five interconnected competences:

- Cognitive competences: theories and concepts, implicit knowledge obtained through experience. "The know-how".
- Functional competences: those aspects the person should be capable of doing or demonstrate.
- Personal competences: characteristics proper of a person and related to a good performance.
- Ethical competences: having a set of personal and professional values and the skills to make decision according to such set.
- Meta-competences: the skills to deal with uncertainty and also a constant learning and reflection. It is important to consider that every one of these competences must be put into practice since competences can only be defined in action, it means, cannot be reduced to resources (skills) but to the extent they move in contexts (Cuadra, 2011).

Since the relationship is the core element, the way the agent presents and establishes the relationship, it means how this agent privileges his/her "know how to be" (Cabello, 2008) is more important than its knowledge. Therefore, the way the agent sees itself and establishes a relationship determines to a great extent the construction of common meanings between the agent and the pregnant woman/mother. As Krause (2000) highlights, in the field of clinical interventions, it facilitates the work and lead to success. In this sense, when the agent is a member of the community, a common construction is easier since participants of Home Visits share the same daily world.

Monitors or community agents, in the other hand, have stated in studies performed by this team (Cabello, 2008; Cuadra, 2011), that cognitive competences are less relevant than interpersonal and instrumental competences. They have identified personal, interaction and organizational skills as the most relevant to achieve a significant relationship with the users (Cabello 2008; Cuadra 2011, Navarro, 2005).

As a resume, from the experience of our investigational team, it is possible to state that the competences necessary for the success of Home Visits point to certain personal characteristics of visiting agents that lead to an easier and significant relationship with the pregnant woman/mother (Simonsohn, 2011; Cuadra, 2011; Cabello, 2008). This relational context will be the lowest level to start a continuous training process with educational agents through regular supervisions, support manuals or didactic material that make learning easier. Opportunities of training and constant supervision are then essential in order to achieve such required competences and ensure the success of interventions (Cuadra, 2011).

4.4.3 Quality of service

Home Visiting is an intervention but is also a service provided to community. In such sense, it must be a service of quality and such quality must be evaluated. Quijado (2003) highlights that elements of quality of service being evaluated are subjective and depend on the diversity of people receiving such services. From this perspective, the author highlights five elements the users frequently evaluate:

- **Tangible elements:** the appearance of the premises of the organization, its staff and equipment being used. In the case of Home Visiting, there are no tangible assets. In the case of projects reported, tangible material involved educational worksheets the visiting agent gives the pregnant woman/mother. The report of the community agents clearly highlights its importance. For them, having support materials to deliver the pregnant woman/mother makes easier to have a specific reason to justify a visit. In the other hand, for the professionals, having these materials involves and is a benefit itself. (Simonsohn, 2011).
- **Fulfilling promises:** it involves to correctly and timely rendering the agreed service. In such sense, planning and making the visit turns into a form to validate the service by providing it the importance it deserves. In Home Visiting focused on a relational aspect, this is a fundamental issue since it makes possible to develop trust, the basis to establish an adequate relationship.
- **Attitude of service:** frequently users do not think the ones providing them a service are willing to listen to them and solve their problems or emergencies in a convenient way. This is a core aspect in relational Home Visits: the visited person must feel visible and listened and feel that she and her concerns are the ultimate objective of the service. These elements have turned to be the most relevant in projects developed in Chile according to the monitors and users evaluated (Cabello, 2008; Cuadra, 2011; Simonsohn 2011). In the other hand and considering Home Visiting as a service of the Comprehensive Child Protection System “Chile Crece Contigo”¹, and therefore a strategy connected to other services, when one person does not feel welcomed and supported, this situation can motivate a rejection to other experiences making more difficult to establish a relationship between the users and the Health Care Center (op cit).
- **Competence of the staff:** competences required by the educational agent must be different. For the users it is important the visiting agent is competent and can correctly assist it; if it is polite, if he/she knows its institution and the services it provides both tangible and not tangible. But for the user it is also important to trust the knowledge of the agent in order to receive an effective support if the visited mother so requires (Cuadra, 2011).
- **Empathy:** Quijado (2003) defines empathy as the capacity to be accessible for the other: ranging from the establishing an easy contact, to use a clear language and be empathetic with the other, making him/her feels pleasant and important. This characteristic has

¹ The Child Protection System “Chile Crece Contigo” is a local program offering a comprehensive system of high quality interventions and social services to support the child and the family and lead them to develop their potential, it involves children from 0 to 4 years old (Ministry of Health, 2008)

been already highlighted as essential for the visiting agent. In this sense, Hiatt et al. (1997), points out the importance of common experiences as an aspect permitting to establish and maintain a relationship with the users and increase the self-effectiveness feeling.

5. Conclusion

Home Visiting, as described previously, appears to be a valid intervention strategy and work in vulnerable sectors. It permits to approach the concrete reality these people lives into; it shows availability and access from agents working in this environment. We know both professional and non-professional agents are effective in different aspects.

It is important to highlight that according to advances in our knowledge, non-professional agents are most likely to open vulnerable families to the knowledge the system can provide (Nievar et al., 2010).

In order to be effective, these agents must have certain characteristics, mainly from a relational point of view but also in terms of commitment with the system and public policy.

Also, the relationship established between the educational agent and the pregnant woman/mother is fundamental. It is important to consider the relational aspect of Home Visits both for the selection of potential field worker and for training and support purposes (Simonsohn, 2011; Cuadra, 2011). It is necessary that visiting agents are not only competent in prevention or care services for the pregnant woman or the mother and child, but also in recognizing and developing competences that lead to the establishment of a positive relationship with the person they visit.

It is also fundamental that such educational agent is clearly convinced of the usefulness of the Home Visiting as a valid intervention to reach the proposed objectives and of course the support and same conviction by the institution offering this service.

Once people is convinced about the effectiveness of Home Visiting with clear objectives and they believe the visited person is capable of improving her conditions and the institution has political, administrative, methodological support and necessary materials and of course it shares this conviction, the first stage for a good development of the intervention is all set.

It is interesting to highlight the fundamental importance of incorporating a supervision based on reflection, an element not considered or left aside in most systems. As Cuadra (2011) points out, it permits to generate a space of technical and emotional support both to professionals and monitors, and favour a responsible and effective practice. This previous aspect makes the practice easier and also permits to level up cognitive competences, to detect training needs, to analyze cases, to promote self-care and team work among visitors, and others.

Within such context, supervision must be regular, collaborative and based on reflection. Regular as a part of the institution as a valid space; collaborative, in the sense of ensuring that all subjects participating in this type of supervisions are assuming responsibilities and finally, reflexive in the sense that it constitute a space for respect that incorporates the

making, feeling and thinking and permit the system to observe and learn about itself (Cuadra, 2011).

Therefore, we can point out that within the context of an emerging country and an environment of vulnerable families, Home Visiting appears as an opportunity in the prevention and care of mental health when fulfilling certain specific characteristics. Home Visiting permits the system to intervene in hard access family environments, to directly know the reality of the family and to implement self-care strategies for the mother and child, a finding which has been reported by mothers in a study performed in Chile (Navarro, 2005).

Nevertheless, there are still many questions. The current investigation project implemented by Universidad Católica de Chile is trying to answer some of them. The areas where more information is needed regarding home visits and health and early childhood are: (a) an optimum number of visits connected to the expected results; (b) perceptions of the visiting agent about its role; (c) more effective practices when visiting mothers, especially those visits focused on building a work alliance; (d) theoretical framework, contents and models; (e) use of professional, paraprofessional and non-professional staff; (f) cost/effectiveness relation of home visit programs.

In emerging countries such as Chile, it is especially important to study different methods that could result pertinent both for the socio-cultural characteristics of the context and the low economic and technical resources available (Kotliarenco et al., 2010). Home visiting is therefore, a new, high impact strategy requiring not only a theoretical view regarding who, how and which model is necessary to perform such interventions but also a strategic view on how to implement this alternative in countries which intervention form in mental health is preferably associated to clinical-hospital environments.

The decision of working in Mental Health with Home Visiting requires at least two basic elements to start with. In one hand, a clear vision of the group and purpose to perform interventions with this strategy and in the other hand to size the political-administrative logistics such Home Visiting execution demands.

Home Visiting as a strategy for mental health is a great challenge but an excellent opportunity in emerging countries such as Chile.

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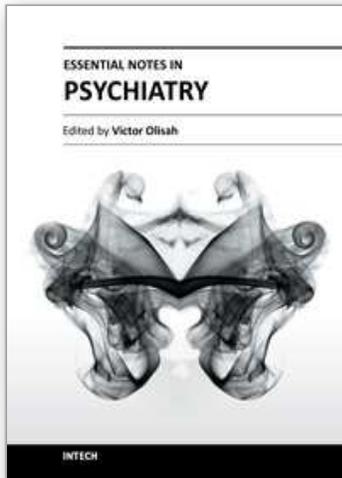
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