Chapter 2
The Four Challenges of Home Visitation Programs: Alcohol and Substance Abuse, Intrafamilial Violence, and Mental Disorders

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The use of alcohol and other drugs is particularly serious in high-risk communities and is related to their availability and cost; therefore, consumption will be higher where they are widely available and have a low cost (Babor et al., 2010a, 2010b). The harms caused by alcohol are proportionally higher in low- and middle-income countries, partly, due to the lack of services and resources, including an absence of enforced policies, safe roads, electricity, health services, police presence, and safe leisure spaces (World Health Organization, 2011). The harms caused by alcohol increase where there are no policies in place, either at local or national levels to reduce access to alcoholic beverages, limit excessive drinking, sales to minors, sales to intoxicated people, or the marketing and promotion of alcohol products. One of the most important negative results of excessive drinking is violent and aggressive behavior, which can aggravate already existing violent situations in the family or in the community (Pan American Health Organization, 2010). The use of other drugs—especially stimulants, such as cocaine, crack, methamphetamines, and other related substances—is also associated with violence (World Health Organization, 2004). Home visitors may need training to recognize symptoms of alcohol and substance abuse and to convey clear messages about the dangers of excessive alcohol and drug use, and the available community services to reduce such problems.

Alcohol and stimulant drugs, in particular, are associated with violence, but intrafamilial violence occurs even when alcohol use or other substance use is not excessive (WHO/London School of Hygiene and Tropical Medicine, 2010). Often, this type of violence is prevalent in countries with more social and gender inequalities, where laws and policies are lacking for the prevention of violence and reduction of its impact on women and families, and in cultures in which violence is more accepted (WHO/Commission on Social Determinants of Health, 2008). As a result, in communities that do not offer equal access to education and employment for women and in which men have much more power than women, the risk of violence against women and children is greater and can be aggravated by the excessive

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use of alcohol (Pan American Health Organization, 2008). Home visitors are often the only persons who may witness intrafamilial violence, and in some cases home visitors could be at risk of violence.

Finally, when not treated, mental disorders—such as depression, schizophrenia, and other conditions—can interfere with the acceptance of home visitation programs and adherence to them. In the majority of countries, there are significant gaps in the treatment of mental disorders due to a lack of specialized services, services integrated in primary health care, or trained professionals and access to essential medicines (World Health Organization, 2010a, 2005b). The stigma attached to mental disorders prevents people—both men and women—from seeking help or discussing their emotions with health professionals, specialized or not (World Health Organization, 2010b; Room, 2005). For example, postpartum depression can lead the mother to neglect the child, underestimating or not interacting with their babies, which may result in developmental delays that could be avoided (Murray & Cooper, 1997). Depression and problems with alcohol or other drugs can affect women, victims of violence, making it difficult to develop bonds with their children and provide care to them (Romito et al., 2009). It is also possible that violent men with untreated mental disorders have a compromised capacity to promote the healthy development of their children and care for them. Violence against children is also relatively common, varying from verbal abuse to maltreatment and extreme punishments, which are not reported to health professionals due to fears of separation, police involvement, or retaliation by the other parent (Pan American Health Organization, 2011).

These are issues with difficult solutions. These challenges constitute significant barriers to the inclusion of affected children and high-risk families in home visitation programs. At the same time, these are precisely the families which would most benefit from these programs. Therefore, it is urgent to do research and build the capacity of home visitation workers and others responsible for these programs. To build healthy and safe communities, it is fundamental that these issues be dealt with under the lens of social and human rights. This way, these problems can be minimized in the most efficient way so that families feel safe and comfortable to talk, confidentially, about the risks they are facing, receive information on how to reduce them, seek care and treatment for mental health issues, and obtain support to change their life conditions (MacArthur Foundation Network, 2010).

These challenges point to the association between social determinants of health and the efficacy and sustainability of home visitation programs. Social and gender equity—through the development of sustainable programs and policies to promote the healthy and safe development of individuals and communities, and at the same time to protect and promote human rights—can be the way to expand the utilization and impact of home visitation programs in other parts of the world (Room et al., 2006; Schmidt et al., 2010; WHO/Commission on Social Determinants of Health, 2008).

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