



A Study to Examine the Effectiveness of a Home-Based Program for Families affected by Maternal Substance Use

October 2026

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Abstract

Home visiting programs are interventions countering the stress of high need infant care on families that may already have large external stressors, such as poverty or mental health challenges, by providing home-based family support. The Team for Infants Exposed to Substance use (TIES) provides home visiting services to families with a history of maternal substance use. While previous research supports developing agency and hope through specific goal setting to encourage home visiting completion, and the effectiveness of home visiting in improving parenting skills, little is proven about the effect that those parenting skills have. Here we show that improving parenting skills is a key mechanism linking home visiting to improved child health. With two sets of linear mixed models, one using propensity score matching, we examine 273 treatment participants and 70 comparison participants. Models adjusted for parenting skill show the most impactful treatment effect, and identifiable baseline differences between demographic groups supports using propensity score matching as a method addressing selection bias. Our results demonstrate that building parenting skills is one mechanism that leads home visiting to improve child health outcomes. We anticipate this result to be informative in the focus of evaluation of future home visiting implementation.

Introduction

The combination of a compromised caregiver and a high needs infant can lead to insecure attachment, decreased maternal-infant mutuality, higher parenting stress, and possibly decreased infant cognitive development (Suchman et al., 2006). Children with healthy primary caregiving relationships are more likely to develop a foundation for positive social interactions with others and stronger cognitive skills. Mothers affected by substance use disorder often require support in learning to bond and respond effectively to their babies as they may have had limited positive role models for parenting and personal social support while also coping with trauma, substance use disorder, and recovery while caring for a newborn. The Team for Infants Exposed to Substance use (TIES) is a home-based family support program that provides a community-based model to address the complex needs of families with young children affected by maternal substance use. This study examines the impact of the TIES intervention on parenting practices and child health outcomes, while accounting for relevant demographic characteristics.

Description of TIES Program

The TIES model targets intervention to reduce parental substance use, build parenting skills and capacity to support child development, enhance the parental response to both child health/behavioral health care needs, and self-health/behavioral health needs, and improve access to stable income and housing by developing goals with families and tracking progress over time (Chaing et al., 2022). Participation in the TIES program is voluntary and free of charge, but it is contingent on a mother's willingness to address and acknowledge the issues that substance use is creating for herself and her family. The TIES program provides individualized, culturally appropriate services delivered by master's prepared social workers and endorsed infant family specialists to the whole family, including all other children and adult partners. Families enrolled in TIES receive a needs assessment, engagement of families in problem-solving relationships, and development of a home-based intervention plan (Chaing et al., 2022). Parent Resource Specialists foster strong, positive parent-child relationships by providing coaching and reflective observation that help parents recognize their value in their infant's life and build on their existing strengths, while incorporating activities and tasks designed for parent completion into the TIES parenting model (Chaing et al., 2022).

Literature Review

Previous research on the impact of home visiting on families finds evidence for these interventions as a method of improving parenting skills. Perhaps most robustly, Winston LeCroy et al. recruits 461 Parents as Teachers families and 166 control families to complete 19 surveys ranging from child development to family health and safety before and after six months of intervention (2024). They find that program participants have several significant differences from the control group including a sense of parenting efficacy, and parenting practices such as frequency of reading to the child. Winston LeCroy et al. credits the hopeful

outlook for improvement as the mechanism of this difference, comprising a sense of agency through the development and meeting of goals (2024). Similarly, following 95 primary caregivers and their children from the last year of Head Start to second grade with 16 home visits, Nix et al. find that distressed parents are less likely to use the program learning materials and learn new parenting strategies (2018). Meanwhile, children with parents that engage with both home visitors and program activity boxes have improved child outcomes in second grade (Nix et al., 2018).

Beyond the direct improvement of parenting skills, research also supports the secondary impact of home visiting as a facilitator of social support for families. Wasser et al. examine the effectiveness of Mothers & Others home visiting, where participants receive eight home visits and educational materials encompassing one of two interventions—either obesity or injury prevention (2020). Participants also identify a peer study partner, a non-medical person that will support their learning. While Wasser et al. fail to find support for a statistically significant effect of the intended intervention, they do find that formalizing peer support using the study partner reduced social isolation and provides validation of parenting practices (2020). Also highlighting the influence of personal networks, Fauth et al. matched 611 families enrolled in a home visiting program which, like TIES, is geared to mothers with mental health or substance use concerns, with demographically similar families (2026). They find that home visiting participants were 51% more likely to receive postpartum care at 21 to 60 days, and 38% more likely at 61 to 90 days than the comparison group (Fauth et al., 2026). Social connection is a continuing theme here, as Fauth et al. suspect that the increase in postpartum care is due to the home visitors' ability to identify health concerns that might otherwise go unnoticed and help participants navigate a complicated and intimidating healthcare system (2026). Moreover, relationship building with primary caregivers could act as a prerequisite to feeling hopeful that home visiting will succeed. Interviewing 19 home visitors from Oklahoma, Milojevich et al. emphasize the confidence in ability to achieve outcomes and readiness for change as key factors for sustained participation in home visiting (2025). While community experience of trauma and exploitation within healthcare may cause distrust, financial and tangible support for families such as providing diapers, food, and books counteract that distrust, building connections and hope for change (Milojevich et al., 2025).

Finally, hope for a change in parenting patterns is fundamental to the motivation to follow through on a home visiting program. Surveying 148 mothers and 52 visitors in 21 home visiting programs on initiation and six months into intervention, Burrell et al. find that 96% of mothers enroll in home visiting to promote child development and parenting (2018). Visitor responsiveness to this through goals was most effective in promoting engagement (Burrell et al., 2018). While the literature provides considerable insight into how successful home visiting programs foster hope and support positive change, as well as how the social supports associated with home visiting contribute to that hope, it gives less attention to the ways in which improving parenting practices themselves can lead to home visiting success as a tangible internal mechanism to child health outcomes.

Methods

Study Design

This study used a two-group comparative design to evaluate the effectiveness of an intervention on parenting skills and child health outcomes. Participants were assigned to either the treatment group (TRT) or control group (CON). Baseline demographic characteristics included race, ethnicity, education (highest grade completed [HGC]), employment, housing status, and state of residence. These variables were selected based on observed baseline imbalances between groups, and conceptual relevance to both intervention exposure and outcomes and potential confounding effects. Parenting skills were assessed using a continuous composite score (`par_skill_score`), with higher values indicating better parenting practices. Child health was measured using a continuous composite index (`chld_health_score`), where higher scores reflect better child health outcomes.

Research Questions

1. Do families in TIES have higher parenting scores than similar families in the comparison group?
2. Do children in TIES have better child health scores than children in the comparison group?
3. Does stronger parenting skills help explain the link between TIES participation and child health?

Hypotheses

1. Parenting Outcome – Participants in the treatment group will demonstrate significantly higher parenting skill scores (`par_skill_score`) compared to those in the control group following the intervention after adjusting for key demographic variables (e.g., race, ethnicity, and education/HGC).
2. Child Health Outcome – Children of participants in the treatment group will exhibit significantly improved child health scores (`chld_health_score`) compared to those in the control group after adjusting for key demographic variables (e.g., race, ethnicity, and education/HGC).
3. Adjusted Parenting Effect – Parenting skills serve as a mediator in the association between the intervention and child health scores after adjusting for key demographic variables (e.g., race, ethnicity, and education/HGC).

Participants

The sample used in this analysis includes 273 participants from the treatment group (TIES program participants), and 70 participants (excluding 4 contaminated with the treatment group, and 2 early discharged without data) from the comparison group. The treatment group excludes TIES participants who exited the program before March 16, 2016, and excludes observations obtained before March 16, 2016, or after September 29, 2023, in order to be consistent with the grant cycle. The comparison group includes all

available participants who enrolled starting in April 2016. Table 1 provides descriptive statistics of the comparison group and TIES treatment group.

Table 1: Baseline Characteristics by Study Group

Characteristic	Treatment (TRT)	Control (CON)	ES (Cramer's V / Phi) or Cohen'd	p-value
Marital status (N, %)			0.074	0.184
Not single	51 (19.8%)	18 (27.3%)		
Single	207 (80.2%)	48 (72.7%)		
Race (N, %)			0.155	0.020
Black	82 (31.7%)	33 (50.0%)		
Other	19 (7.3%)	4 (6.1%)		
White	158 (61.0%)	29 (43.9%)		
Ethnicity (N, %)			0.138	0.013
Hispanic	30 (11.6%)	1 (1.5%)		
Non-Hispanic	229 (88.4%)	65 (98.5%)		
Education (HGC) (N, %)			0.039	0.484
HS and above	148 (57.4%)	41 (62.1%)		
Less than HS	110 (42.6%)	25 (37.9%)		
Employment (N, %)			0.269	<0.0001
Employed	37 (14.3%)	27 (40.9%)		
Unemployed	222 (85.7%)	39 (59.1%)		
Housing type (N, %)			0.179	0.0015
Stable	195 (78.3%)	62 (95.4%)		
Unstable	54 (21.7%)	3 (4.6%)		
State (N, %)			0.214	<0.0001
Kansas	124 (45.4%)	13 (19.1%)		
Missouri	149 (54.6%)	55 (80.9%)		
Age (mean, SD)	28.76, 5.01	27.64, 5.17	0.22	0.11
Number of Children (mean, SD)	1.79, 1.53	1.92, 1.60	0.09	0.53

Note. Values are n (%) within group. ES = effect size (Cramer's V or Phi). p-values from chi-square or Fisher's exact tests.

Measures

The Individualized Family Service Plan (IFSP) Goal Attainment Scale. The TIES IFSP goal attainment scale (Chiang, et al., 2022) consists of a 5-point Likert scale that assesses and tracks participants' goal attainment over time in the following areas: maternal substance use, parenting skills, child physical and mental health, maternal physical and mental health, income stability, and housing stability. Plans are individualized, and families and specialists mutually agree on goals based on specific needs. The tool details the plan for service delivery, and supportive activities provided during home visits enhance participants' abilities to work towards the established goals. The home visitors and families develop these goals together and jointly score goals and track progress using the IFSP goal attainment scale. TIES specialists score the family's status in goal areas at intake (Time 1) and discharge (Time 5), and, together with the family, track progress over time at the child's age of 3–7 months (Time 2), 9–13 months (Time 3), and 18–22 months (Time 4). On the five-point Likert scale, 1 represents very low (crisis); 2, low (vulnerable); 3, adequate (stable); 4, high (advanced); and 5, very high (thriving). Goal areas are scored by calculating a mean score from subscale items.

Analysis

Baseline characteristics were summarized using frequencies and percentages for categorical variables and using means and standard deviations for continuous variables. Between group differences were assessed using Chi-square tests for categorical variables. Independent sample t-tests for continuous variables. Effects sizes were calculated as Cramer's V (or Phi) for categorical variables and Cohen's D for continuous variables.

Baseline characteristics indicate some imbalances between the treatment (TRT) and control (CON) groups. While most variables demonstrate small effect size (e.g. marital status, education), several characteristics show moderate imbalances, including race (Cramer's V =0.16), ethnicity (0.14), housing (0.18), employment (0.27), and state (0.21). Statistically significant differences are observed for race ($p=0.020$), ethnicity ($p=0.013$), employment ($p<0.001$), housing ($p=0.002$), and state ($p<0.001$). These findings suggest that the two groups were not fully comparable at baseline, raising potential concerns about confounding in subsequent outcome analyses.

We applied propensity score techniques to address these baseline discrepancies, specifically including race, ethnicity, and highest grade completed (HGC) as covariates. These variables demonstrate meaningful between-group imbalances, are conceptually linked to both treatment assignment and key outcomes, and represent underlying sociodemographic factors that may influence access, exposure, or response to the intervention. By incorporating these variables in the PS model, we aim to reduce confounding and improve comparability of the TRT and CON groups, thereby strengthening the validity of the estimated treatment effects.

We evaluate the primary research outcomes—parenting skills and child health—using Linear Mixed Models (LMMs) fitted to the matched sample. These models include fixed effects for time, treatment group and time and treatment interactions (or covariates, if residual imbalances remained), and random effects were specified as appropriate to account for repeated measures. The main parameter of interest is the estimated effect of the intervention (TRT vs. CON) on each outcome. All statistical tests are two-sided with a significance level of $\alpha = 0.05$. Analyses are conducted using SAS.

Results

Across the three mixed-effect models, the results indicate that treatment effects on child health are modest in the unadjusted models but become clearer when parenting skills are considered. In Model 1, there was not a statistically significant overall treatment effect on child health; however, a significant negative interaction between treatment and Time 1 suggests that children in the treatment group initially exhibited lower health scores compared to the control group. Additionally, race was an important predictor, with Black participants showing significantly lower child health scores than White participants.

In Model 2, which examined parenting skills, the treatment group again did not show a significant overall main effect, but the significant negative interaction at Time 1 indicates initial lower parenting skills among those receiving the intervention. Race remained a significant factor, with Black participants reporting lower parenting skill scores. These findings suggest that treatment effects may operate differently over time rather than through immediate improvements.

In Model 3, when parenting skills were included as a covariate, the treatment effect on child health became statistically significant and positive, indicating improved outcomes for the treatment group after accounting for parenting behavior. Parenting skills emerged as a strong and highly significant predictor of child health, and previously observed racial disparities were no longer significant. This pattern suggests that parenting skills may serve as a key mechanism linking intervention exposure to improvements in child health outcomes. Overall, these findings imply that the intervention's effectiveness is not directly observable in baseline models but becomes evident when accounting for parenting processes, highlighting the importance of parenting skills as a mediating pathway (Table 2).

The difference between Table 2 (propensity score matched sample) and Table 3 (complete data sample) primarily reflects how sample construction and selection bias influences estimated treatment effects. In the propensity score-matched models, treatment effects are generally weaker and often not as statistically significant in the unadjusted specifications (e.g. Model 1), whereas in the complete data models, treatment effects are larger and statistically significant (e.g. Model 4). This pattern suggests that the original, unmatched sample likely contains systematic differences between the treatment and control groups, which inflate the apparent effectiveness of the intervention when not controlled.

Propensity score matching reduces these pre-existing differences by creating a more balanced composition group, leading to more conservative and potentially less biased estimates of treatment effects. As a result, the weaker or non-significant findings in Table 2 likely provide a more accurate estimate of the intervention's direct effect. In contrast, the stronger effect observed in Table 2 may reflect residual confounding, where untreated differences (e.g. demographic or baseline characteristics) remain in the data and bias the treatment effect upwards.

Across both tables, a consistent pattern emerges when parenting skills are included in the models (Model 3 vs. Model 6). In both datasets, the treatment effect becomes statistically significant and positive, and the parenting skills measure is a strong predictor of child health. This convergence suggests that, regardless of sample type, parenting skills function as a key mechanism linking treatment to improved child health outcomes. Further supporting this interpretation, racial disparities observed in early models diminish or disappear after adjusting for parenting skills in both datasets.

Overall, the discrepancy between the two tables highlights the importance of addressing selection bias through methods such as propensity score matching. While the complete data model suggests stronger direct treatment effects, the matched model indicates that these effects are more modest unless mediated through parenting behaviors. Together, the findings suggest that the intervention's impact operates primarily through improvements in parenting skills rather than direct effects on child health, and that failing to control for baseline differences may overestimate treatment effectiveness.

Table 2: Summary of Matched Data from Mixed-Effects Models

Outcome	Model 1: Child Health	Model 2: Parenting Skill	Model 3: Child Health (Adj.)
Intercept	3.573 (0.214)	3.779 (0.183)	0.237 (0.238)
Treatment (TRT)	0.484 (0.267)	-0.123 (0.225)	0.559 (0.170) *
Time 1	0.300 (0.149)*	0.097 (0.117)	0.205 (0.113)
Time 2	0.102 (0.125)	-0.026 (0.096)	0.119 (0.103)
TRT × Time 1	-0.604 (0.271) *	-0.553 (0.211)*	-0.090 (0.203)
TRT × Time 2	-0.299 (0.218)	-0.260 (0.166)	-0.043 (0.178)
Race: Black	-0.592 (0.217) *	-0.661 (0.190)*	-0.022 (0.127)
Race: Other	0.184 (0.328)	0.085 (0.283)	0.101 (0.188)
HS and Above	-0.032 (0.190)	0.124 (0.166)	-0.128 (0.108)
Parenting Skill	—	—	0.884 (0.053) *

Note. Values are unstandardized estimates with standard errors in parentheses. Significance levels: * $p < .05$,

Reference groups: control (CON), Time 3, White, and less than high school education.

Table 3: Summary of Mixed-Effects Models Using Complete Ties Dataset

Outcome	Model 4: Child Health	Model 5: Parenting Skill	Model 6: Child Health (Adj.)
Intercept	3.402 (0.156) *	3.601 (0.142) *	0.981(0.192) *
Treatment (TRT)	0.809(0.156)*	0.121 (0.139)	0.725 (0.122)*
Time 1	0.313 (0.141)*	0.113 (0.116)	0.230 (0.119)
Time 2	0.117 (0.118)	-0.012 (0.095)	0.122 (0.105)
TRT × Time 1	-0.752(0.177)*	-0.517(0.146)*	-0.422 (0.151)*
TRT × Time 2	-0.201 (0.147)	-0.102 (0.118)	-0.149 (0.131)
Race: Black	-0.322(0.117)*	-0.477(0.110)*	0.007 (0.088)
Race: Other	-0.146 (0.225)	-0.172 (0.210)	-0.010 (0.166)
HS and Above	0.044 (0.111)	0.264 (0.104) *	-0.140 (0.082)
Parenting Skill	—	—	0.673 (0.042) *

Note. Values are unstandardized estimates with standard errors in parentheses. Significance levels: * $p < .05$. Reference groups: control (CON), Time 3, White, and less than high school education.

Discussion

The diversity of intervention strategies and measured outcomes of home visiting interventions sometimes creates the impression of home visiting as a “black box” (Nix et al., 2018). There is a consensus that home visiting interventions work to improve child outcomes. However, the nuts and bolts of how home visiting leads to meaningful change for families is more obscure. Previous literature circles around this question, supporting emotional factors that lead to retention in services, such as caregivers having hope for change and social support, or alternatively examining how home visiting impacts parenting practice (Winston LeCroy et al., 2024; Milojevich et al., 2025; Burrell et al., 2018; Wasser et al., 2020; Fauth et al., 2026; Nix et al., 2018). Few studies examine the second half of this equation, how improved skills link to improved child health. In this study, we find that parenting skills appear to be an important link between TIES participation and child health. In doing so, we shed light on one of the bolts that create home visiting success, providing practical recommendations for home visiting implementation.

TIES participants started with lower baseline parenting and child health scores than the control. Time one estimates in Model 1 and Model 2 for the treatment group are negative (Table 2). This indicates that TIES is successful in reaching higher risk families. Recent statistics indicate that while over 8 million families could have benefited from home visiting in 2022, only 33% (270,000) received services (Milojevich et al., 2025). Effective recruitment and sustained engagement are the largest barriers to accessing services (Milojevich et al., 2025). Thus, TIES’s ability to identify higher risk families speaks to their success in closing this resource

gap. The need to secure sustained engagement is aligned with understanding what the most successful internal mechanisms of home visiting are.

Parenting skills appear to be an important mechanism for TIES participation to lead to child health outcomes. The TIES program often improves child health indirectly by first improving parenting. Individually, in Model 2 examining parenting skills, the treatment group did not show overall main effect, but the negative score at time one indicates this may have been caused by a lower initial parenting skill score among those who received the intervention (Table 2). Model 3, with parenting as a covariate, illustrates the importance of parenting skills as the treatment effect on child health is statistically significant and positive (Table 2). The clearest evidence, however, is in the comparison between the propensity matched models and the complete data models, where across Table 2 and Table 3, including parenting skills into the model (Model 3 and Model 6), results in the treatment effect remaining statistically significant and positive, flagging parenting skills as a strong predictor of child health outcomes. This result may enlighten the Nix et al. finding that even though the number of home visits parents received was not significantly related to child health outcomes, the parents use of program parenting materials and engagement with home visitors uniquely predicts children's sustained growth (2018). It is not just home visiting that causes change, but the daily practice of new parenting skills that home visiting encourages. More importantly, parenting skills go hand in hand with the overwhelming evidence for the underlying desire behind family's enrollment in home visiting: 96% of families list parenting as a reason they enrolled, and interviewed visitors site focus on growing and changing parenting patterns as a major way parents acknowledge their need for change (Burrell et al., 2018; Milojevich et al., 2025). Listening to what families are asking for from their home visiting programs, support with parenting skills, likely validates the meaning of their home visiting relationship, translating to positive child health outcomes.

Parenting practices may influence child health outcomes positively in a couple of ways. First, parenting shapes daily health behaviors: when parenting improves, health habits improve too. Research on Parents as Teachers has found a positive improvement in children's talking, listening, and understanding skills when their parents read to them more often (Winston LeCroy et al., 2024). Home visiting may also encourage parents to take care of their own health. Allowing families to practice putting their own oxygen mask on before their child's, mothers enrolled in home visiting are 51% more likely to receive postpartum care (Fauth et al., 2026). Secondly, parenting affects children's stress and emotional regulation. Parenting builds self-regulation skills. Supportive parenting helps children feel safe and reduces stress, which protects their health. Positive parenting practices are linked to lower behavioral and emotional problems in children and are particularly important in building resilience in the face of adversity, buffering children from the negative effects of poverty and trauma (Winston LeCroy et al., 2024).

Parenting skills remain a consistent link to child health outcomes between different racial demographics. Speaking to the importance of addressing selection bias through methods like propensity score matching, racial disparities were initially observed in both child health and parenting skills, with Black families

having lower initial scores reflected in negative estimates in Table 2 and Table 3. However, these differences disappear after accounting for parenting in Model 6, indicating that parenting skills remain an important mediator for child health, and that the unmatched sample in Models 1-3 still contain systemic differences between treatment and control groups. By creating greater balance in demographic characteristics between the treatment and control group, the propensity score matched models, while generally weaker and often not statistically significant, are likely a truer image of relationships between variables than the full data set. Previous home visiting evaluations also hold the echoes of structural racism as a confounder. Nix et al. find that race/ethnicity is the only demographic characteristic that predicts intervention attendance (2018). Burrnell et al report. Hispanic mothers endorsed more reasons for enrolling in services and stayed enrolled in the program for longer than non-Hispanic mothers (2018). Fauth et al. indicate that generally Black and Hispanic mothers are less likely than White mothers to receive postpartum visit (2026). Together, we can conclude that it is a disservice to assume that the baseline for all demographic groups is the same. The systematically unequal distribution of resources and power in society requires, at minimum, a statistical adjustment. Propensity score matching proves to be a good method for this.

To implement these findings, that parenting skills are linked to home visiting improving child health outcomes, programs should prioritize and invest in components that directly support and improve parenting skills. Research supports that these components include coaching, modeling, and relationship building. When families feel that their home visitor is responsive to their needs, and that the goals they have with their home visitor are accomplishable, this establishes a sense of agency and hope (Burrell et al., 2018; Milojevich et al., 2025; Winston LeCroy et al., 2024). That perspective on parenting, that change in patterns is possible, allows for growth. This study supports growth in parenting skills as a key mechanism for improving child health. Whether it be through nurturing an emotionally safe household for their children, or through creating habits for early learning like reading, parenting skills could be the foundation of child health (Winston LeCroy et al., 2024). To that extent, TIES and similar home visiting programs should develop methods of tracking parenting skills as a key intermediate outcome. Understanding the importance of parenting skills for the outcomes of home visiting guides where the focus of evaluating these programs should be.

Conclusion

This study provides evidence that parenting skills are a central pathway through which TIES home visiting may improve child health among families affected by maternal substance use. Although direct treatment effects were modest after accounting for baseline differences, parenting skills consistently predicted child health, and the positive treatment effect became evident when parenting was included in the models. These findings support prioritizing coaching, modeling, relationship building, and family-centered goal setting within home visiting programs, while routinely measuring parenting skills as an intermediate outcome.

Future research should test this pathway prospectively with larger, well-balanced samples and direct mediation analyses. Overall, the findings suggest that strengthening everyday parenting practices may be one of the most meaningful ways home visiting programs translate family engagement into better child health.

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