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MCH Innovations Database Practice Summary & Implementation Guidance

BRIGHT Intervention (Building Resilience through Intervention: Growing Healthier Together)

BRIGHT is a dyadic attachment-focused therapeutic parenting intervention for caregivers with substance use disorders and their young children birth to age six.



Location

Massachusetts



Topic Area

Safe and Connected Communities; Mental Health & Substance Use, Injury Prevention & Hospitalization



Setting

Clinical, Home



Population Focus

Children, Infant, Women & Maternal



Date Added

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Contact Information

Ruth Paris, PhD, LICSW, Boston University; (617) 353-7717; rparis@bu.edu
Susan O'Donnell, LMHC, Institute for Health and Recovery; (617)-661-3991;
Susanodonnell@healthrecovery.org

Section 1: Practice Summary

PRACTICE DESCRIPTION

The global epidemic of substance use disorders and opioid use disorders (SUDs/ODDs) (WHO, 2014) is significant for infant mental health professionals as mothers and caregivers with substance use and often co-occurring mental health disorders can exhibit problematic parenting, putting their young children at-risk for maltreatment and poor developmental outcomes (SAMHSA, 2018). Few interventions address the complexities of parenting while in recovery, particularly with an attachment focus. The BRIGHT intervention (Building Resilience through Intervention: Growing Healthier Together) was developed to address the needs of children from birth to age six and their mothers with SUD/ODD. BRIGHT includes weekly sessions to encourage parental attunement and reflective functioning, play and relationship activities between parent and child, emotion regulation, and recovery maintenance. BRIGHT is rooted in the principles of Child-Parent Psychotherapy (Lieberman, Ghosh Ippen & Van Horn, 2015) and attachment-informed parenting interventions for mothers with SUDs (Suchman, et al., 2013). It utilizes mother-child dyadic techniques to improve maternal reflective functioning, mother-child attachment, and child social-emotional development, and to reduce child maltreatment. BRIGHT has now been successfully implemented in five different settings. Adhering to best implementation strategies, we have maintained our core components and theories but incorporated techniques from other practices where appropriate (e.g., the evidence-based practice *Mothering from the Inside Out* and the newly developed curriculum for caregivers, *ARC-GROW*). The vast majority of parent participants have been women, though any caregiver is eligible to participate. For this reason, the terms mother, parent, and caregiver are used interchangeably in this practice summary.

The Institute for Health and Recovery (IHR), Jewish Family and Children's Service (JF&CS, collaborator from 2009-2016) and Boston University School of Social Work (BUSSW) have offered BRIGHT as an enhancement to addiction treatment and medical care for over 15 years with funding support from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA). (BRIGHT content is solely the responsibility of the authors and does not necessarily represent the official views of SAMHSA or HRSA). By addressing the dangers of opioid and substance misuse, maternal and child trauma/mental health symptoms and focusing on the parent-child relationship, this intervention addresses the MCHB National Performance Domain of injury prevention – specifically aiming to prevent injury from child maltreatment by improving parenting. Rarely do parenting programs address the specific challenges of these parent-infant dyads by offering interventions that recognize the dual impact of opioid or substance misuse and maternal trauma/mental health symptoms on parenting practices and child health and development (Mirick & Steenrod, 2016). For these reasons, identifying effective pragmatic therapeutic parenting interventions for mothers with SUD/ODD and their infants or young children is urgently needed.

BRIGHT addresses the target population of mothers with SUD/ODD and their young children. More specifically, women who are pregnant and parenting and in SUD/ODD treatment often did not have their own nurturance needs addressed when they were children potentially affecting their own nurturing parenting abilities. Additionally, many of these parents have experienced extensive trauma as children and adults. The infants born to them are frequently at high-risk for maltreatment, a long-term health risk that can lead to compromised social, emotional and cognitive development. BRIGHT benefits these families by supporting the parent's SUD/ODD treatment, screening for and focusing on caregiver trauma and mental health and encouraging best parenting practices.



CORE COMPONENTS & PRACTICE ACTIVITIES

There are 3 main goals of the BRIGHT intervention:

- 1) Improve parent-child relationships and parenting capacities, and reduce the potential for child maltreatment in pregnant/parenting people with SUD/ODU.
- 2) Address the impact of parental SUD/ODU on infants and young children and improve their social-emotional development.
- 3) Improve overall parental mental health for pregnant women/parentis with SUD/ODU.

In order to accomplish the above goals, the core components of BRIGHT include weekly sessions with a master’s level infant/early childhood mental health clinician who is also knowledgeable in substance use recovery. The intervention can begin either in pregnancy in a prenatal clinic or when a child is 6 years old or younger in the home, medical clinic, or substance use treatment program. The clinician begins by engaging the parent and conducting a psychosocial assessment. Standardized measures (e.g. trauma history, substance misuse, mental health symptoms, child development) are used for both clinical and evaluation purposes. Goals of treatment are discussed with the parent and identified. During pregnancy, the clinician provides emotional support, helps anticipate the birth of the infant and encourages reflective capacities. Postpartum and onward, the clinician fosters positive connection in the dyad through play and other activities, wonders with the parent about the infant’s or child’s feelings and actions, offers developmental guidance, and supports parental reflective functioning and emotion regulation. Trauma and substance use recovery are kept in mind and supported through all sessions. Resource assistance and community involvement is an essential part of the intervention (Paris, Sommer & Marron, 2018). The optimal length of treatment is 28 sessions (over 6-8 months), although positive changes have been noted in treatment that lasted 12 sessions. Weekly reflective supervision for the BRIGHT clinician with a trained supervisor is an essential part of the intervention.

Core Components & Practice Activities

Core Component	Activities	Operational Details
Engagement and Assessment	Assessment of parental mental health and resilience, substance use, trauma history, parent-child relationship, social supports	Clinician engages with parent by focusing on her identified needs. Assess baseline status of parent and young child (if postpartum) through open-ended questions and standardized instruments in order to identify strengths and challenges.
Goals and Treatment Plan	Discuss and identify parental goals and establish treatment plan	Clinician involves the parent in a discussion of her hopes for herself and her child in relation to the intervention and works to identify goals and a plan for future sessions based on the discussion and assessment.



Therapeutic Activities	Encouragement of play, physical contact, language; developmental guidance; attuning to child's feelings and behaviors; supporting parental reflective functioning and emotion regulation; focus on parental trauma and recovery	Clinician fosters a positive connection between parent and child, wonders about and translates the meaning of child's feelings and behaviors, provides emotional support and empathic communication, encourages parental trauma and substance use recovery.
Resource Assistance	Concrete resource assistance	Clinician provides referrals or actively supports parent and child with problems of daily living (e.g. food, housing, transportation, child custody).
Termination, Closing, Measures, and Referrals	Ending of treatment, closing assessment, and referral to continued resources	Clinician reviews treatment and accomplishments of parent and child, conducts closing assessment utilizing standardized instruments, and offers referrals for continued services where indicated.
Reflective Supervision	Weekly supervision for the BRIGHT clinician with a trained supervisor	Reflective supervision, an essential element to any infant mental health intervention, offers the clinician a safe place within which to reflect on the BRIGHT practice and the challenges that inevitably arise.

COMMUNITY WELLNESS

BRIGHT is focused on addressing the unmet needs of pregnant women/parents with SUD/ODU and their infants or young children. This population faces myriad stressors (e.g. financial instability, housing insecurity, stigma) that impact parenting behaviors and recovery while acting as challenges to service engagement. Unlike many other traditional parenting programs, BRIGHT clinicians intentionally acknowledge and respond to these challenges within the treatment process. Caregiver substance use history, recovery, trauma, and mental health, and child trauma experiences, emotions and behavior, along with current daily living challenges are all incorporated into the BRIGHT intervention. BRIGHT is designed flexibly so it can be offered within SUD treatment programs, outpatient settings, medical clinics or as a home visiting intervention. This ensures that all participants can be met wherever is most convenient: residential or outpatient program, home, community location, hospital, tele-visit, etc. We know of no other available evidence-based intervention that flexibly addresses the unique needs of these parents and children.



EVIDENCE OF EFFECTIVENESS

Pre/Post Evaluations (Single Group):

BRIGHT has been evaluated in three SAMHSA-funded projects (BRIGHT I, 2009-2012; BRIGHT II, 2012-2016; BRIGHT III, 2016-2021) using a quasi-experimental single-group pre-posttest mixed methods design. In each of these evaluations, participants were recipients of the BRIGHT intervention delivered at family residential treatment programs (BRIGHT I and BRIGHT III), methadone treatment programs (BRIGHT II), or outpatient treatment programs (BRIGHT III). Evaluation data assessed the impact of the BRIGHT treatment program on children and caregivers, with changes measured from baseline to discharge, a period of 6-12 months.

BRIGHT I:

In our first implementation of BRIGHT, quantitative data was analyzed from a sample of 66 postpartum mothers in residential substance use treatment (mean caregiver age: 29.2 years; 79% non-Hispanic white; 38% did not complete high school; 98% unemployed; 80% never married) and their young children under the age of 5 (mean child age: 21.1 months). Within the sample, mothers with the highest levels of baseline psychological distress showed significant improvements in psychological functioning post-treatment. Those who were most distressed at baseline also showed increased levels of parental reflective functioning and reported that their children's risk status regarding social-emotional development decreased post-treatment. Among mothers with moderate and lower levels of baseline psychological distress, there were demonstrated improvements on clinician-rated assessments of parent-child relationships. (Paris et al., 2015).

BRIGHT II:

In BRIGHT II, a baseline quantitative analysis of participants was conducted to investigate factors impacting parenting stress and parenting confidence within the population served. The sample included 54 women receiving outpatient substance use treatment services (mean caregiver age: 31.4 years; 98.1% non-Hispanic white; 31.5% high school diploma; 72% unemployed; 64.8% never married). The average child age was 34.4 months. We found that mother's reported trauma symptoms were significantly associated with increased parental stress, decreased parenting sense of competence, and lower levels of parental reflective functioning while mother's substance use history (measured as years of heroin use) was only associated with decreased parenting sense of competence. These findings demonstrate the importance of incorporating trauma-responsive strategies into parenting interventions for caregivers with SUD/OD, as is done in BRIGHT (Paris et al., 2023).

BRIGHT III:

The BRIGHT III pre/post analysis sample consisted of 82 caregivers (96% female, mean caregiver age: 30.8 years, 88% non-Hispanic white; 43.2% high school diploma; 83% unemployed; 82% never married). On average, their children were 18.9 months old. Quantitative evaluation findings from BRIGHT III demonstrated positive changes in child custody status, parent's assessment of child's social-emotional development, parent's PTSD symptoms, caregiver social connection, and parenting stress (Paris, Maru & Desai, 2021).

BRIGHT Qualitative Findings:

Findings from qualitative interviews with mothers who participated in BRIGHT I and II interventions (n=60) showed that overall they: (1) viewed the intervention as supportive and positive, particularly with regard to the nonjudgmental clinician and its difference from substance use treatment and (2) reported



perceived benefits such as improved understanding of themselves as parents, changes in their parenting approach, and enhanced relationships with children (Paris & Quinn, 2020). A qualitative analysis of BRIGHT III participant interviews (n=24) was conducted to assess participant's post-treatment perceptions of the BRIGHT III intervention and its impacts on parenting experiences and child relationships. A central finding was that a majority of caregivers viewed self-reflection as a central and beneficial element of the BRIGHT intervention for both recovery and parenting. Specifically, caregivers described (1) the development of new insights on how personal emotional states affected interpretation of child behaviors or cues, (2) increased awareness of how past traumatic experiences affected present-day parenting, (3) increased reflection on the emotional states of their children.

Randomized Control Trial Study:

More recently, we conducted a 12 month, two-armed pragmatic randomized control trial (RCT) of BRIGHT funded by HRSA from 2018-2022. This study is called Growing Together and involved the adaptation of BRIGHT for a perinatal clinic setting. BRIGHT was offered from the 24th week of pregnancy until the infant was 6 months old. By conducting a pragmatic RCT of a home-based version of BRIGHT, the study aimed to rigorously test the intervention and its effectiveness in improving parent-child relationships and parenting capacities, reducing child maltreatment, enhancing maternal mental health, and improving infant social-emotional development. Growing Together was designed for 100 women with OUD and polysubstance use. The two arms of the study are: 1) treatment, the BRIGHT attachment-based and trauma-informed therapeutic parenting intervention; and 2) control- enhanced treatment as usual (TAU+) involving the standard of care social service and mental health referrals and child development handouts. Main findings derived from coded videos of parent-infant interactions showed that compared to the TAU+ group, mothers in BRIGHT demonstrated less withdrawal from their infants. They also maintained the same level of intrusiveness while the TAU+ group increased in this behavior. The infants in the BRIGHT group demonstrated fewer negative emotions when interacting with their mothers. Overall, the mothers and infants in BRIGHT improved in dyadic reciprocity.

Section 2: Implementation Guidance

COLLABORATORS AND PARTNERS

First, the collaboration among the three primary organizations (IHR, JF&CS, & BUSSW) that initially developed and evaluated BRIGHT was essential to the success of the intervention. Second, the collaboration with SUD treatment settings anxious to offer a therapeutic parenting intervention to their pregnant and parenting women and young children enabled implementation, further evaluation and subsequent adaptation of BRIGHT. Third, the interest from and willingness of the prenatal clinic for women with SUD to host our research study allowed us to further adapt and test the intervention through a rigorous study that garnered further evidence to support our approach to mitigating the negative impact of SUDs and trauma on mothers and their young children. We have since expanded our collaboration in the hospital where the Growing Together Study was sited and are currently partnering with a pediatric medical home to deliver BRIGHT.

BRIGHT has typically been implemented within projects that include advisory boards made up of members of state agencies (e.g. public health, addictions, mental health, and child welfare), community non-profit agencies, developmental specialists, university faculty, health care, mental health, social service and SUD treatment providers and consumers. All of these groups and individuals have supported the development and



implementation of BRIGHT. Some of the feedback offered by advisory board members that has been helpful to implementation include ideas about: the focus of the two-generation work, further development of the intervention, where and how to offer the intervention, sustainability, replicability, workforce development, child welfare policies, submitting BRIGHT to the AMCHP MCH Innovations Database, and training opportunities. Advisory board members have also offered guidance in planning wide-ranging dissemination of the BRIGHT intervention into practice and policy at local, regional and national levels. Collaborators remain engaged due to a strong commitment to women with SUDs and their young children and subsequently to BRIGHT as an important vehicle of assistance. State and community partners remain engaged given the great need for intervention with our population. Collaborating agencies that host the BRIGHT intervention or research study also remain committed to offering optimal services to pregnant and parenting women with SUD and their children and to offering evidence-based/evidence-informed practice. Ongoing consultation and training within the communities we serve help sustain collaborators' involvement.

Practice Collaborators and Partners

Partner/ Collaborator	How are they involved in decision-making throughout practice processes?	How are you partnering with this group?	Does this stakeholder come from a community impacted by the practice?
Institute for Health and Recovery (IHR), Jewish Family and Children's Services (JF&CS), and Boston University School of Social Work (BUSSW)	IHR, JF&CS, and BUSSW are the co-developers of BRIGHT. BUSSW serves as the evaluation and research lead for the intervention. IHR and JF&CS (from 2009-2016) are the BRIGHT clinical facilitators and supervisors and manage intervention delivery.	BUSSW and the BRIGHT clinical facilitators typically meet on a monthly basis to monitor program performance indicators and research/evaluation activities.	Each of the co-developers of BRIGHT contributes extensive experience serving families in the fields of infant mental health, parenting support, and substance use recovery. People with experience with SUD have served on advisory boards and staff members of the organizations.
Site Partners (Residential Treatment Centers, Outpatient SUD Clinics, Healthcare Providers)	BRIGHT is delivered in partnership with local programs serving caregivers with OUD/SUD and their children. Partner programs aid in the development of participant recruitment and engagement processes, case consultations, as well as setting-specific intervention adaptations.	BRIGHT staff meet with partner program staff on a weekly basis. Partner staff are invited to participate in interviews assessing their perceptions of the BRIGHT intervention, delivery processes, and	Our partner organizations work directly with the population served by BRIGHT and some staff bring personal experience as parents in recovery.



		recommendations for improvement	
BRIGHT Program Participants	Client feedback is used to inform changes to individual treatment plans and the broader BRIGHT intervention model.	Throughout participation in BRIGHT, clinicians are responsive to the concerns, priorities, and needs expressed by clients. Clients are also invited to participate in discharge interviews assessing their experiences and perceptions of BRIGHT, as well as recommendations for improvement.	Yes, BRIGHT participants are the direct recipients served by the intervention.
Advisory Board	Advisory Board members provide field expertise, offer feedback on intervention design and implementation, and advise on dissemination.	BRIGHT leadership met with the advisory board twice a year in the Growing Together Study.	Each of the members represents different constituencies, including clinical providers, public health, infant mental health, substance use treatment, as well as people with SUD.

REPLICATION

With continued SAMHSA funding from 2009 through today, IHR, JF&CS (collaborators 2009-2016), and BUSSW have replicated the initial BRIGHT intervention in two sites as an enhancement to addiction treatment in outpatient and opioid treatment programs (BRIGHT II, 2012-2016; BRIGHT III, 2016-2021) and we are presently delivering BRIGHT in a pediatric medical home for children with exposure to caregiver substance use (BRIGHT-SOFAR, 2023-2028). In order to further develop the evidence-base of BRIGHT, it was tested in the Growing Together Study (2018-2022) as a home-based program in a randomized control trial funded by HRSA. The study included women with opioid or substance use disorders and their infants, beginning after the 24th week of pregnancy in a prenatal clinic and continuing through 6 months postpartum.

Guiding principles and core elements of BRIGHT have remained the same across the various sites, although the experience from over fifteen years of working with different high-risk groups of mothers with SUD and their young children and the resulting evaluation data has enabled further development and adaptation of the intervention (See evaluation section for findings). BRIGHT is flexible and informed by the needs of each particular parent and child dyad. The clinician is able to choose from various techniques and approaches depending on the status of the dyad and the site of the intervention. For example, a mother in early recovery may need more individual sessions interspersed with dyadic ones to address her recovery process, emotion



regulation, potential triggers for substance use and how best to keep her baby/child in mind. Another mother may be able to continuously participate in dyadic sessions focused on attunement to her child and parental reflective capacities.

Replication of the BRIGHT intervention in BRIGHT II, BRIGHT III, and the Growing Together Study has been successful given the similar needs of the focal population, primarily mothers with SUD/ODU and their young children birth through 6 years of age. The overarching principles and evidence-base that informs the intervention remain consistent. However, the flexible nature of the intervention encourages responsiveness to the needs of a particular dyad and to the specific setting where a caregiver is receiving services.

INTERNAL CAPACITY

The BRIGHT intervention is conducted by a master's level clinician with a background in infant mental health and trauma practice and aware of issues relevant for substance use recovery. One clinician can maintain a caseload of approximately 10-12 mother-child dyads at any one time. If the intervention is offered for 6-8 months, it is feasible for one clinician to offer services to approximately 24 families per year. Additional staff is dependent on the location of the intervention and the number of mother-child dyads to be served. Liaising with staff at SUD treatment agencies, health care settings, and other collateral organizations is an essential part of the intervention and is conducted by clinicians and supervisors. Successful implementation of the BRIGHT intervention involves coordination and consultation with host agencies on a regular basis.

The three organizations that began the BRIGHT intervention brought together skill sets that enabled successful development, evaluation and implementation. Sixteen years ago, IHR had a 30-year history of providing services and treatment to caregivers with SUDs and their families; JF&CS had been providing infant mental health services within the greater Boston community for more than 20 years; and Ruth Paris, PhD at BUSSW had been developing and evaluating interventions for at-risk families with very young children for more than 20 years. Our combined skills and professional relationships with public and private non-profit agencies concerned with parents with SUDs and their young children helped to support BRIGHT practice and deliver the intervention within SUD treatment programs and more recently, in perinatal and pediatric clinics. These programs were excited to offer a therapeutic parenting intervention to their clients and recognized that it could meet the needs of the mothers and their young children.

It is also important to note that the growing opioid epidemic in the U.S., the concomitant increase in infants born exposed to substances in utero, and the vast numbers of children removed from their parents with SUDs and placed in the foster care system has vastly increased the urgency to develop and disseminate interventions to support and improve parenting among caregivers with SUD. The opioid epidemic remains a significant problem in the U.S. and misuse of other substances (e.g. methamphetamines) is on the rise. There remains a great need for interventions such as BRIGHT and an intense interest by agencies serving this population. None of our work could have been accomplished without the financial support of SAMHSA since 2009 and HRSA from 2018 to 2022. We are grateful for their support and continue to consider avenues for sustainability of the intervention other than federal grants.

PRACTICE TIMELINE

The BRIGHT intervention is conducted by a master's level clinician with a background in infant mental health and trauma practice and aware of issues relevant for substance use recovery. One clinician can maintain a caseload of approximately 10-12 mother-child dyads at any one time. If the intervention is offered for 6-8 months, it is feasible for one clinician to offer services to approximately 24 families per year. Additional staff is dependent on



the location of the intervention and the number of mother-child dyads to be served. Liaising with staff at SUD treatment agencies, health care settings, and other collateral organizations is an essential part of the intervention and is conducted by clinicians and administrative supervisors. Successful implementation of the BRIGHT intervention involves coordination and consultation with host agencies on a regular basis.

Phase: Planning/Pre-Implementation

Activity Description	Time Needed	Responsible Party
Training and familiarity with BRIGHT clinical framework, including dyadic infant mental health interventions (e.g., enhancing reflective functioning and emotion regulation, trauma-responsive approach, substance use recovery)	24 hours of training, weekly reflective supervision or consultation	Trainer, Clinician and Supervisor
Present BRIGHT to community partners to arrange referrals and increase engagement		BRIGHT Clinician
Purchase necessary items to facilitate dyadic play- therapeutic books, blocks, duplos, puppets, balls, rattle etc.	3 hrs	BRIGHT Clinician

Phase: Implementation

Activity Description	Time Needed	Responsible Party
Initial intake and assessment with parent including standardized measures; dyadic assessment	4-5 hrs total	BRIGHT Clinician
Engagement phase- building clinical relationship, setting goals	1 hr/week	BRIGHT Clinician



Middle of treatment- consistent sessions intervening with mother and dyad	1 hr/week	BRIGHT Clinician
Termination and discharge of clinical work. Additional community referrals as needed	1 hr/week	BRIGHT Clinician

Phase: Sustainability

Activity Description	Time Needed	Responsible Party
Build capacity within hospital, community clinic, methadone clinic, or residential setting to provide direct dyadic intervention to mothers and newborns.	Ongoing	Program Director/BRIGHT Clinician
Advocacy at the state level (e.g., child welfare agency) to promote BRIGHT intervention	Ongoing	Program Director, BRIGHT Clinician, Research/Evaluation staff, Advisory Board Members

PRACTICE COST

**The following budget reflects the cost of the home-based version of the BRIGHT intervention for one year serving approximately 18-20 mother-child dyads through a community-based non- profit agency.

Budget



Activity/Item	Brief Description	Quantity	Total
Personnel	Masters level clinician	1	\$70,000
Staff travel and work phone	Travel to home visits and sites; Phone included for client contact	-	\$2,500
Meeting Expenses	Office and programmatic supplies	-	\$1,000
Occupancy and Administrative Needs	Office space, administrative such as payroll, audits, etc.	-	\$10,000
Total Amount:			\$83,500

LESSONS LEARNED

Assets:

The primary asset of BRIGHT is the ability to offer a flexible attachment-focused and trauma-responsive parenting intervention to mothers with SUD and their young children to promote optimal parent-child relationships, parenting capacities, parental mental health, child social-emotional development, and reduce potential for child maltreatment. Having implemented BRIGHT within varied substance use treatment programs, in a prenatal clinic and in the home, we have identified the common operational principles and techniques. Given the flexibility, BRIGHT can be offered in and adapted for a variety of different settings. Therapeutic services to a mother and child can be combined with advocacy, collaboration with other health, mental health, substance use, and social service providers, and concrete assistance.

Challenges and responses:

- 1) Many mothers with SUD/ODU are involved with child welfare, as children of parents with SUD/ODU are often removed from biological parents and placed in foster care/kinship care or parents who have custody of their children are closely monitored. Those parents who do not maintain physical custody of their child typically have supervised visits. In those situations, the clinician will observe the session, take notes, and later reflect with the parent on the experience. When this is not possible or only possible infrequently, the BRIGHT clinician can conduct sessions with the parent and focus on parenting capacities, reflective functioning, emotion regulation and keeping the baby/child in mind.
- 2) Many of the parents who have participated in BRIGHT over the years have been in early recovery. Therefore, relapse is a frequent occurrence. When BRIGHT is embedded in SUD treatment and the



parent relapses, they may drop out of the SUD treatment program and out of BRIGHT as well. As a policy, a parent who relapses is not terminated from the BRIGHT intervention. In order to address the reality of relapse, the BRIGHT clinician can integrate a focus on relapse prevention and maintaining sobriety, particularly as it relates to parenting and custody of the child. In terms of child custody, clinicians also support parents by attending foster care review meetings and probate court for custody hearings. When BRIGHT is offered in a prenatal clinic during pregnancy or in the home and a mother relapses, the clinician can actively work with her to re-engage in SUD treatment and maintain her connection with the BRIGHT clinician. With the mother's approval, the BRIGHT clinician is also available to consult with the child welfare worker to discuss the child's safety and the parent's current status.

- 3) Many SUD treatment programs where BRIGHT has been embedded have high staff turnover. As a result, BRIGHT clients may have breaks in their treatment for substance use and co-occurring disorders. This can complicate the therapeutic parenting work of BRIGHT. Given that BRIGHT is a flexible intervention and incorporates advocacy as part of its techniques, the BRIGHT clinician can work with the client to actively advocate for a new addictions counselor or make a referral to another agency. In the interim, the clinician can address the client's substance use or mental health issues as part of the BRIGHT treatment or schedule additional sessions. When new addictions staff are hired, the BRIGHT clinician orients them to the type of dyadic treatment offered to parents with young children and serves as an ongoing consultant around parenting and child-focused issues.

Given the challenges of offering a therapeutic parenting intervention to caregivers with SUD and their young children, there are steps that are useful to follow before beginning the BRIGHT intervention:

- Include well-trained infant mental health clinicians with clear knowledge of substance use and recovery at the outset.
- Incorporate reflective supervision as part of the BRIGHT program for the well-being of clients and providers and for the success of the intervention.
- When embedding the intervention within an already existing substance use treatment program, prepare all addictions staff, plan the logistics and offer foundational training in attachment, parenting, and trauma.
- When offering the intervention within a health setting (e.g. prenatal clinic, pediatric setting), educate providers about the principles of BRIGHT including attachment, trauma, parenting and SUDs.
- When offering the intervention within a partner organization, arrange for BRIGHT clinicians to spend regularly scheduled time at partner sites to embed themselves within the program and develop relationships with staff, which helps to increase referrals and facilitate engagement.
- When BRIGHT is offered in the home, educate and consult with community providers who will be referring to the program. Ongoing consultation with referring staff and providers, whatever the setting, is important for sustainability of the intervention.
- Collaborate with others who are providing services to the parent and/or child on a regular basis.
- Share family progress (with permission) with other service providers in order to maximize advocacy ability.
- Communicate with local child welfare services, as most families with SUD/OD are engaged with the child welfare system. Additionally, if foster or kinship care families are involved with the child, communicate with them to aid the success of the intervention.

NEXT STEPS

The long-term goal is to establish BRIGHT as an evidence-based therapeutic intervention for caregivers with SUD/OD and their young children and to disseminate as widely as possible. Simultaneously, more than 100



trainings have been offered at conferences nationally in the addictions, child welfare and infant mental health fields on the principles of BRIGHT, including the implications of SUD and trauma for parenting and attachment, the basics of the intervention, and evidence derived from our studies.

RESOURCES PROVIDED

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