

BRIGHT Intervention

(Building Resilience through Intervention: Growing Healthier Together)

An Innovation Station Emerging Practice

Purpose: This document is intended to support MCH professionals to implement a practice found in Innovation Station. This resource provides the information needed to replicate the practice and is divided into two sections: the first section provides a high-level overview of the practice while the second section describes how to implement the practice. For additional information on any of the content provided below, please reach out to the practice contact located at the bottom of this document.

Section I: Practice Overview

Location:	Massachusetts	Title V/MCH Block Grant Measures Addressed
Category:	Emerging	NPM #7.1: Injury Prevention
Date Submitted:	2/2020	

Practice Description

BRIGHT is an attachment-based trauma-responsive therapeutic intervention for mothers with substance use disorder/opioid use disorder (SUD/OD) and their infants/young children birth through age five that aims to improve the parent-child relationship and maternal mental health, and decrease child maltreatment by increasing maternal sensitivity and parenting capacities, thereby promoting healthy child development.

Over the past 10 years, BRIGHT has been offered within substance use treatment, a prenatal clinic, and in the home. BRIGHT includes weekly sessions to encourage parental attunement and reflective functioning, play and relationship activities between parent and child, emotion regulation, and recovery maintenance.

Purpose

The global epidemic of SUDs and OUDs (WHO, 2014) is significant for infant mental health professionals as mothers 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 (**B**uilding **R**esilience through **I**ntervention: **G**rowing **H**ealthier **T**ogether) was developed to address the needs of children from birth to age five and their mothers with a SUD/OD. 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 includes mother-child dyadic techniques to improve maternal reflective functioning, mother-child attachment, and child social-emotional development and reduce child maltreatment.

With Substance Abuse and Mental Health Services Administration (SAMHSA) funding from 2009 through today, the Institute for Health and Recovery (IHR), Jewish Family and Children's Service (JFCS) (2009-2016) and Boston University School of Social Work (BUSSW) have offered BRIGHT as an enhancement to addiction treatment. Evaluation findings demonstrated that the intervention is promising in improving parenting capacities and maternal mental health (Paris, et al., 2015). Given these findings, BRIGHT is currently being rigorously tested in a randomized controlled trial (RCT; the Growing Together Study) with funding from the Health Resources and Services Administration (HRSA, 2018-2021) as a home-based intervention. This current study includes women with OUD or poly substance misuse, begins during the second trimester of pregnancy in a prenatal clinic for women with SUD/OUD, and continues through 6 months postpartum.

BRIGHT is a strength-based, attachment-focused intervention concentrating on the parent-infant relationship. The dyadic therapeutic model is trauma-responsive, using play and relationship activities to improve parent-child interactions, overall mental health and child development and decrease child maltreatment.

By addressing the dangers of opioid and substance misuse, maternal 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 women with SUD/OUD and their infants or young children is urgently needed.

BRIGHT addresses the underserved target population of women with SUD/OUD and their young children. More specifically, women who are pregnant and parenting and in SUD/OUD 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 women 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 the target population by supporting women's SUD/OUD treatment, screening for and focusing on perinatal mental health and encouraging best parenting practices.

Practice Foundation

The BRIGHT intervention uses attachment theory to address the goals of improving parent-child relationships and reducing child maltreatment in pregnant and parenting women with a history of SUD/OUD and their young children. Attachment exists to provide a sense of security and protection for a child and provide a secure base from which a child can explore. An infant who develops healthy attachment with a caregiver during the early years of life is more likely to have numerous positive outcomes, such as, positive relationships in the future, greater resiliency, and

more self-confidence. These characteristics and skills demonstrate the importance of children developing healthy attachment through a strong emotional bond with caregivers.

Built from the understanding that the experience of being understood is essential to feeling secure, the ability of a caregiver to make sense of their child's feelings, behavior and experiences is called reflective function (Slade, et al., 2005; Seligman, 2014). Reflective functioning also plays a significant role in the intergenerational transmission of attachment, where without this safety and security, a child's capacity for developing relationships with trust and confidence is affected (Ordway, Webb, Sadler, & Slade, 2015).

Based on the research of how trauma impacts the brain, we can understand how child development can be disrupted by traumatic events. Regulation skills, exploration, and relational patterns are some of the essential components of development that can be affected by trauma. Enhancing the physical and emotional safety of attachment relationships is the most effective vehicle for promoting the child's healthy development as the child's sense of self exists in the context of relationships (Lieberman, Ghosh Ippen & Van Horn, 2015). Due to the impact that substance misuse can have on a caregiver's ability to provide optimal caregiving we must consider the long-term impact on a child who is potentially exposed to patterns of decreased emotional responsiveness and inconsistent care. Attachment is significantly impacted by substance misuse; however, it can also be a key component of recovery. Humans are relational beings and supporting attachment between a caregiver and child while in substance use treatment has been shown to lead to significant improvement in recovery adherence (Suchman, Pajulo, & Mayes, 2013).

BRIGHT builds from these theoretical understandings and uses the fundamentals of attachment in a dyadic trauma-responsive mother-child intervention, with the knowledge that working to support a caregiver-child relationship is the key to supporting long-term healthy development. The intervention fosters healthy parent-child relationships, while also supporting maternal recovery, reflective functioning, and mental health, setting the foundation for addressing the unmet needs and long-term implications for women with SUD/OD and their young children.

Core Components

There are 3 main goals of the BRIGHT intervention:

- 1) Improve parent-child relationships and reduce child maltreatment in pregnant/parenting women with SUD/OD.
- 2) Improve overall maternal mental health for pregnant/parenting women with SUD/OD.
- 3) Improve infant/young child social-emotional development.

In order to accomplish the above goals, the core components of BRIGHT include weekly sessions with a master's level infant mental health clinician who is also knowledgeable about substance use recovery. The intervention can begin either in pregnancy in a prenatal clinic or when a child is 5 years old or younger in the home or a 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.

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, 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.

Evidence of Effectiveness (e.g. Evaluation Data)

In an early evaluation of the BRIGHT intervention utilizing a one-group pre-posttest design involving women in residential substance use treatment and their young children, mothers with highest levels of baseline psychological distress showed significant improvements in psychological functioning post-treatment. Those who were most distressed at baseline showed increased levels of parental reflective functioning post-treatment while mothers with moderate and lower levels of baseline psychological distress showed improvements on clinician-rated assessments of parent-child relationships. Mothers who endorsed the highest levels of distress at baseline reported that their children's risk status regarding social-emotional development decreased post-treatment (Paris, et al, 2015). Preliminary evaluation findings from a current version of the BRIGHT intervention embedded in outpatient and residential SUD treatment demonstrated positive changes in child custody status, parent's assessment of child's social-emotional development, and parent's PTSD symptoms (Paris, Maru & Desai, 2019).

Appropriateness, feasibility and acceptability have been established in that BRIGHT has successfully been offered for 10 years as an enhancement to residential and outpatient SUD treatment. More specifically, implementation of the intervention is supported by findings from qualitative interviews with mothers who participated in the BRIGHT intervention which 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) perceived benefits such as improved understanding of themselves as parents, changes in their parenting approach and enhanced relationships with children (Paris & Quinn, 2020). Staff at various SUD treatment programs were also supportive of BRIGHT, with family focused sites being somewhat better suited to hosting the intervention (Paris & Mittal, 2019).

Currently, HRSA is funding an RCT for 100 pregnant women receiving treatment for SUD/OD (2018-2021). The study is testing the effectiveness of BRIGHT compared to an enhanced Treatment as Usual. BRIGHT is being offered from the 24th week of pregnancy until the infant is 6 months old. By conducting a pragmatic RCT of a home-based version of BRIGHT, the study aims to rigorously test the intervention and its effectiveness in improving parent-child relationships and parenting capacities, reducing child maltreatment, enhancing maternal mental health and maintenance in SUD/OD treatment, and improving infant social-emotional development.

Replication

The BRIGHT intervention was initially developed to address the needs of children birth to age five and their mothers with a SUD/OD in residential substance use treatment (SAMHSA, 2009- 2012). With continued SAMHSA funding from 2012 through today, IHR, JFCS, (2009-2016) and BUSSW have replicated the initial BRIGHT intervention as an enhancement to addiction treatment (e.g. outpatient and opioid treatment programs). In order to further develop the evidence base of BRIGHT, it is currently being tested in the Growing Together Study as a home-based program in an RCT (HRSA, 2018-2021). The study includes women with OUD or poly substance misuse, begins after the 24th week of pregnancy in a prenatal clinic and continues through 6 months postpartum.

Guiding principles and core elements of BRIGHT have remained the same across the various

sites, although the experience from over ten 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. 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/OD and their young children birth through 5 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 mother is receiving services.

Section II: Practice Implementation

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. Staff for the Growing Together Study which recruits participants from a prenatal clinic for women with SUD, includes a BRIGHT clinician, clinical supervisor, research coordinator, and study principal investigator. Another version of BRIGHT embedded within a large SUD treatment organization involves 2 clinicians working $\frac{3}{4}$ time, and a clinical/administrative supervisor working $\frac{3}{4}$ time. 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.

The three organizations that began the BRIGHT intervention brought together skill sets that enabled successful development, evaluation and implementation. Ten years ago, IHR had a 30 year history of providing services and treatment to women 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 vulnerable families with very young children for more than 10 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. These treatment 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.

The RCT of BRIGHT, the Growing Together Study, is enabled by the fact that the intervention was successfully launched in community treatment programs and found to have promising evaluation findings. Additionally, the co-Principal Investigator of the Growing Together Study had previously conducted a study at the prenatal clinic/study recruitment site for women with SUD at a local hospital. This prenatal clinic (RESPECT) is interested in innovative parenting-focused interventions for their patients and recognizes the great needs of women with SUD when pregnant and afterward as mothers of newborns.

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 now HRSA since 2018. We are grateful for their support and continue to consider avenues for sustainability of the intervention other than federal grants.

Collaboration/Partners

First, the collaboration among the three primary organizations 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 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 is allowing us to further adapt and test the intervention through a rigorous study that will hopefully garner further evidence to support our approach to mitigating the negative impact of SUDs and trauma on mothers and their young children.

BRIGHT has 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, work-force development, child welfare policies, submitting BRIGHT to the AMCHP Innovation Station, and training opportunities. When the study is completed, advisory board members for the Growing Together Study will offer 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 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

Practice Timeline

Practice Timeline				
Phase	Description of Activity	Date/Timeframe	# of hours needed to complete/oversee activity	Person(s) Responsible
Planning/ Pre-implementation	Training and familiarity with BRIGHT clinical framework, including dyadic infant mental health interventions (e.g., supporting reflective functioning and emotion regulation, trauma-responsive approach, substance use recovery)	Infant mental health and/or substance misuse training and ongoing consultation	24 hours of training, weekly reflective supervision or consultation	Trainer, clinician and supervisor

	Arrange collaboration with community partners to refer clients	3 months prior and ongoing		Program coordinator
	Purchasing necessary items to facilitate dyadic play- books, ball, rattle etc.	1 month prior and ongoing	2 hrs	BRIGHT Clinician
Implementation	Initial intake and assessment with parent including standardized measures; dyadic assessment	First few client meetings	3-5 hrs total	BRIGHT clinician
	Engagement phase- building clinical relationship, setting goals	1-2 months	1hr/week	BRIGHT clinician
	Middle of treatment- consistent sessions intervening with mother and dyad	2-6 months	1hr/week	BRIGHT clinician
	Termination and discharge of clinical work. Additional community referrals as needed	1 month	1hr/week	BRIGHT clinician
Sustainability	Build capacity within hospital, community clinic, methadone clinic, or residential setting to provide direct dyadic intervention to mothers and newborns.	Ongoing		Program coordinator/BRIGHT clinician
	Advocacy at the state level (e.g., child welfare agency) to promote BRIGHT intervention	Ongoing (Advisory Board)		Program coordinator, advisory board members

Resources Provided

Paris, R., Herriott, A., Holt, M., & Gould, K. (2015). Differential responsiveness to a parenting intervention for mothers in substance abuse treatment. *Child Abuse & Neglect*, 50, 206-217.

<https://www.sciencedirect.com/science/article/abs/pii/S0145213415003221>

Paris, R., Sommer, A., & Marron, B. (2018). Project BRIGHT: An attachment-based intervention for mothers with substance use disorders and their young children. In *Motherhood in the Face of Trauma* (pp. 181-196). Springer, Cham.
https://link.springer.com/chapter/10.1007/978-3-319-65724-0_12

Bosk, E. A., Paris, R., Hanson, K. E., Ruisard, D., & Suchman, N. E. (2019). Innovations in child welfare interventions for caregivers with substance use disorders and their children. *Children and Youth Services Review*, 101, 99-112.
<https://www.sciencedirect.com/science/article/pii/S0190740918310624>

<https://www.bu.edu/articles/2019/project-bright/>

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 and reduce 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/OD are involved with child welfare, as children of parents with SUD/OD 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 mothers who do not maintain physical custody of their child typically have supervised visits. In those situations where allowed, the BRIGHT clinician can accompany the mother to the child welfare office and conduct a session with the parent and child in this setting. When this is not possible or only possible infrequently, the BRIGHT clinician can conduct sessions with the mother 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, she 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. When BRIGHT is offered in a prenatal clinic during pregnancy or in the home and a woman/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 women 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 program within a health setting (e.g. prenatal clinic, pediatric setting), educate providers about the principles of BRIGHT including attachment, trauma, parenting and SUDs.
- 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

BRIGHT is currently being tested in a RCT. Once we have results from this study, they will be provided to AMCHP and other practice clearinghouses. The long-term goal is to establish BRIGHT as an evidence-based therapeutic intervention for women/mothers with SUD and their young children.

Simultaneously, 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. An application has been submitted to develop a training and technical assistance center to address workforce development around the country in the arena of parenting, substance use and early childhood.

Practice Contact Information

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