

BRIDGING THE EVIDENCE-TO-IMPLEMENTATION GAP IN EARLY MENTAL HEALTH

A pragmatic review of psychodynamic and attachment-based parenting interventions for under-fives and their common elements

SUMMARY REPORT



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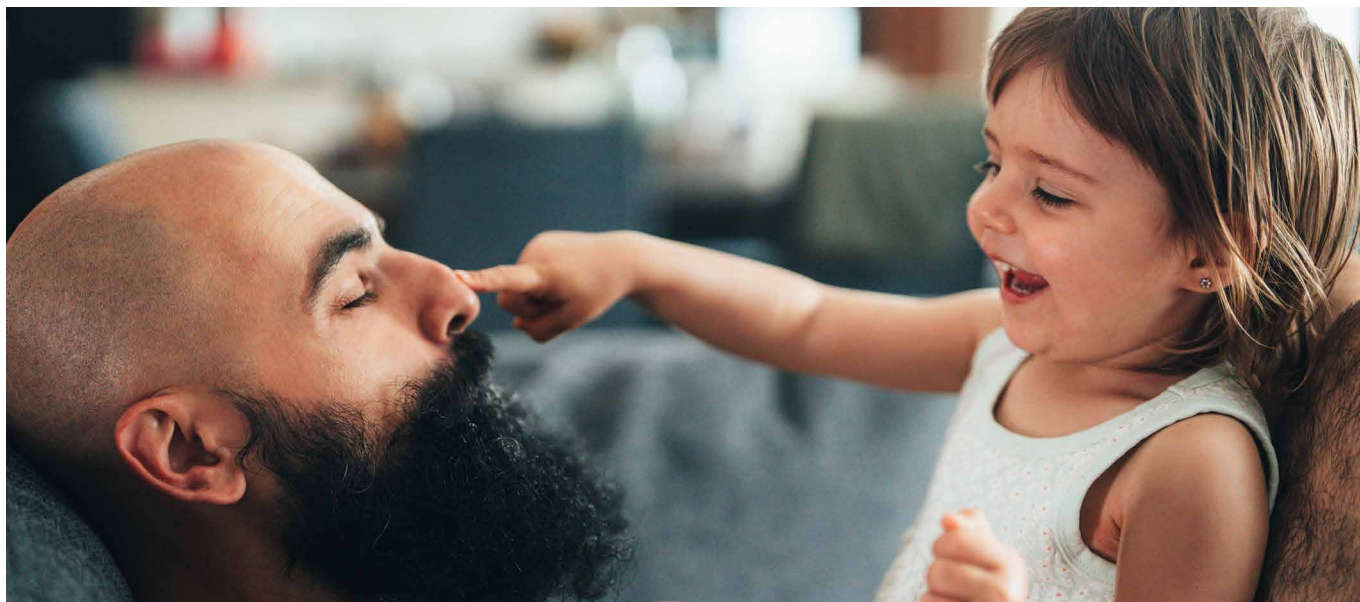
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SUMMARY REPORT¹



Bridging the gap between evidence and implementation in early mental health

Good mental health in the earliest years provides a foundation for children and families to thrive, both now and in the future. It is shaped in large part by the quality of relationships between babies and young children and their caregivers. Consistent, responsive, and nurturing caregiving strengthens family relationships and supports children's social and emotional development.

There is a strong and growing evidence base showing that early relational interventions can improve caregiving, parent-child relationships, and children's mental health and development. However, this evidence is not consistently translated into practice. In the UK, mental health service development has historically overlooked the youngest children, leaving a relative gap in provision for babies, young children, and their families.

Recent investment in perinatal services, parent-infant teams, and 0-5 Child and Adolescent Mental Health Services (CAMHS) creates an important opportunity to strengthen support for this age group. It also creates practical questions for commissioners, service leads, and practitioners about which interventions to commission, how to deliver them, how to prioritise limited resources, and how to build a coherent offer across universal, targeted, and specialist provision.

This report aims to support evidence-informed planning for 0-5 provision by clarifying what the current evidence shows, where it is strongest, where it is more limited, and what effective interventions tend to have in common.

What this report does

This report provides a structured synthesis of attachment-based and psychodynamic interventions for babies and young children aged 0 to 5 and their caregivers. These interventions place the caregiver-child relationship at the centre of change, although they vary in theoretical emphasis, target population, intensity, and delivery model.

The report has two aims:

1. To identify attachment-based and psychodynamic interventions with the strongest available evidence for improving outcomes for babies/young children and their caregivers.
2. To identify the common elements that recur across these interventions, including caregiving practices, delivery strategies, and the guidance practitioners are given and the skills they need to deliver the interventions.

This report complements PEDAL's wider Golden Threads work, which will consider other brief caregiving interventions, including those grounded in social learning theory and those more closely aligned with universal provision.

1. This is a summary of the full report, available at www.pedalhub.net. References to sections, tables and appendices refer to that document.

How to interpret the findings

The review focuses on interventions that are sufficiently specified and documented to enable systematic comparison. It does not capture the full range of individualised, non-manualised therapeutic work delivered in practice and provides only a partial view of the wider 0-5 offer because it does not include other evidence-based parenting interventions.

The interventions identified in the review should not be read as equally effective, equally relevant to UK services, or suitable for the same families, and the review does not rank them. Interventions met the threshold on the strength of their overall evidence base, so an intervention may be included here without having been tested in the UK, or having been tested in the UK without showing effectiveness in that context. Trial level results, including banded effect sizes where available are set out in the full report in Table A4 and Appendix B summarises the evidence base for each intervention.

To our knowledge, this is the first granular common elements analysis of attachment-based and psychodynamic interventions for babies and young children. It identifies recurring caregiving practices,

delivery strategies, and the guidance practitioners are given and the skills they need to draw on to deliver these interventions. These common elements may inform service planning, workforce development, and adaptation, but they are patterns across interventions rather than causal mechanisms. The findings are best understood as clarifying what effective interventions tend to share, and what may need to be preserved when interventions are adapted or implemented in new contexts.

What we found: intervention evidence

The review found an uneven evidence base for this age group. Most interventions have been evaluated in a small number of trials, some in a single country, and few have been tested at scale in UK services.

The review identified 12 attachment-based and psychodynamic interventions that met the threshold for sufficient evidence. This required two or more controlled trials of 50 families or above showing benefit on at least one relevant outcome. One further intervention, Video Interaction Guidance (VIG) met the threshold for preliminary evidence.



Table 1: Interventions included in the review

Intervention	Main population or context	UK evidence status
Attachment and Biobehavioral Catch-up (ABC)	Caregivers of young children facing early adversity	No UK trial identified
Child-Parent Psychotherapy / Toddler-Parent Psychotherapy (CPP/TPP)	Young children and caregivers affected by trauma, adversity or relationship difficulties	No UK trial identified
Circle of Security Parenting (COS-P)	Caregivers of infants and young children, including perinatal and clinical contexts	UK RCT in routine NHS community perinatal mental health services found no added benefit over treatment as usual
Minding The Baby (MTB)	Young first-time mothers facing psychosocial risk and their infants	UK RCT evidence identified
Mother-Infant Transaction Program (MITP)	Caregivers of preterm or low-birth-weight infants	No UK trial identified
Mothering from the Inside Out (MIO)	Caregivers of young children in treatment for substance use disorders	No UK trial identified
Parent-Child Interaction Therapy (PCIT)	Young children with disruptive behaviour or conduct problems and their caregivers	No UK trial identified
New Beginnings (Parent/Mother Infant Psychotherapy; PIP/MIP)	Mothers and infants in prison-based mother and baby units – in New Beginnings trial	UK RCT evidence identified
Child adult relationship enhancement in PRImary CARE (PriCARE)	Caregivers of young children in paediatric primary care settings	No UK trial identified
Promoting First Relationships (PFR)	Caregivers of young children needing support with sensitive and responsive caregiving	No UK trial identified
Tuning in to Kids (TIK)	Caregivers of young children, focused on emotion coaching and emotional communication	No UK trial identified
Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline (VIPP-SD)	Caregivers of infants and young children where there are relational or child behaviour risks. Adaptations for perinatal and other contexts.	UK RCT in routine NHS health visiting services
Video Interaction Guidance (VIG)*	Babies, young children and caregivers across early years, health, social care and parent-infant contexts	UK pilot RCT identified

Note. 'UK evidence' refers to trials or evaluations conducted in the UK that met this review's criteria; it does not necessarily indicate UK availability or readiness for implementation. *VIG was classified as having preliminary evidence and did not yet meet the full evidence threshold for the review.

Several findings are particularly relevant for UK service development. Video-feedback Intervention to promote Positive Parenting and Sensitive Discipline (VIPP-SD) currently has the clearest UK implementation-relevant evidence in this review, alongside additional international evidence. A pragmatic trial delivered largely through NHS health visiting services found modest effects on child behavioural outcomes, with follow-up suggesting that these effects were sustained six years after families received the intervention. VIPP also has a developing evidence base in UK perinatal mental health contexts.

Minding The Baby (MTB) and New Beginnings (parent-infant psychotherapy) also provide promising UK evidence in more specialist or context-specific settings. For New Beginnings, this should be read alongside wider reviews of parent-infant psychotherapy, which suggest potential benefits, particularly for attachment-related outcomes, but also highlight the limited size and variable quality of the evidence base. By contrast, COS-P has been tested at scale in NHS community perinatal mental health services but showed no added benefit over usual care in that context.

Other interventions, including Attachment BioBehavioral Catch-up (ABC), Promoting First Relationships (PFR), and Tuning in to Kids (TIK), also have supportive international evidence and may be relevant to UK service development, although transferability and implementation infrastructure would need careful consideration. ABC and PFR had the strongest US-based research evidence in our review for delivery in targeted settings, although they have not yet been implemented and evaluated in the UK. More relevant for services supporting children aged three and over, TIK had the strongest international research evidence in our review and is available in one region of the UK, although not yet formally evaluated in the UK.

VIG occupies a different position. It is already widely used in UK services and aligns closely with the relational and video-feedback mechanisms identified in this review, but its evidence base remains preliminary when judged against the RCT/QET threshold used here.

Overall, the review suggests that interventions should not be treated as interchangeable. Services need to consider what each intervention has been shown to improve, for whom, in which contexts, and what implementing it would require. Worth noting is that UK availability of practitioner training and supervision is uneven across interventions, and more information can be found in Section II of the full report.



What improves for caregivers, babies and children

There is no common outcome set for parenting interventions, and different trials measured different outcomes. Across the trials included here, effects were most consistent for what caregivers do with their children and for their experience of parenting: five interventions showed consistent reductions in parenting stress, and several showed gains in positive parenting behaviours and warmth. Half of the interventions showed consistently favourable effects on at least one child outcome. Parental mental wellbeing and emotion regulation were an exception, with no intervention showing consistent improvement, including in trials with parents experiencing mental health problems. The picture is less clear for attachment and parent mentalising. Attachment showed no effect where tested in attachment-based interventions, though two psychodynamic interventions showed mixed evidence; mentalising improved consistently in three interventions, but showed only mixed evidence in the mentalisation-based ones. Beyond this review, meta-analyses pooling across a wider set of trials show different patterns for some interventions and outcomes, including gains in attachment security.

What effective interventions have in common

This section highlights the main findings from the common elements analysis. A more complete account of the most common practice elements, delivery strategies and practitioner skills is provided in the full report.

Despite differences in theory, target population and delivery model, many of the most prevalent practice elements were linked by a shared focus on strengthening the caregiver-baby/child relationship.

Caregiving practices

Nurturing the relationship through sensitivity, play and positive regard. Caregiver sensitivity was central to the common elements identified. Across interventions, caregivers were commonly supported to notice and attend to their child's cues, respond in an attuned, timely and individualised way, and be engaged and responsive play partners. Play emerged as a key relational space in which babies and young children can experience sensitivity, shared attention, warmth and co-regulation. The prominence of affirming the child's importance and individuality suggests that attuned responding, play and positive regard are likely to be closely intertwined, helping babies and young children feel seen, understood and valued as individuals.

Supporting co-regulation and accepting feelings.

Co-regulation and emotional support were common across interventions, alongside support for caregivers to accept and share in the child's feelings. Caregivers were supported to stay emotionally available when babies and young children were distressed, to accept intense or uncomfortable feelings, and to respond with calm, comfort and developmentally appropriate support. In this way, caregivers lend their own regulation to babies and young children as a way of supporting their emerging regulatory abilities.



Supporting caregiver reflection and emotional availability. Many interventions supported caregivers to infer their child's emotions and needs, and to consider possible reasons behind behaviour perceived as challenging. These elements appeared alongside attuned and responsive caregiving, suggesting that caregivers may need support to understand the child's experience and translate that understanding into sensitive responses the child can experience. Other common elements focused on caregivers' own emotional and relational capacities, including noticing their own feelings, recognising how these may affect the child, and reflecting on expectations and past experiences. These capacities may help caregivers remain emotionally available and responsive through both rewarding and difficult moments in caregiving.

Relationally informed behaviour support. Many interventions included practical support for routines, transitions, limits, positive attention and non-harsh responses to challenging behaviour. This is interesting because relational and behavioural approaches are often discussed as separate intervention traditions. In these interventions, practical behavioural strategies were typically delivered in relationally informed and developmentally appropriate ways.

Delivery and practitioner skill

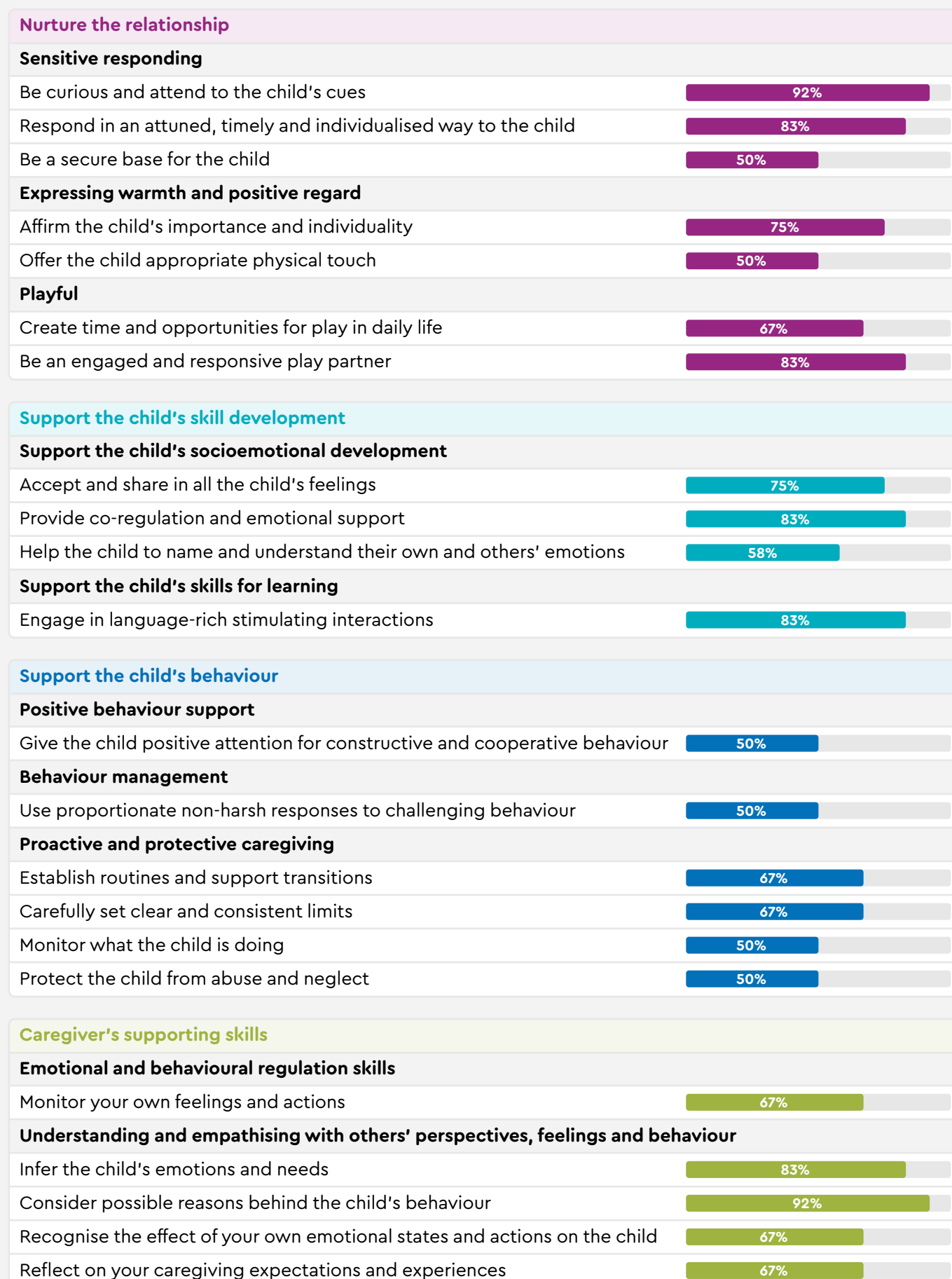
The common elements analysis also showed that effective interventions are not defined by content alone. Delivery strategies and the guidance practitioners are given and the skills they need to draw on were central.

All interventions used didactic teaching alongside other approaches, and most also used reflective or open discussion and structured conversation. Many interventions supported caregivers to see or practise content in action, including through modelling, video feedback, at-home practice and rehearsal.

Alongside practical guidance (e.g., fidelity checklists, scripts), practitioner skill was also highly visible in intervention materials. Across interventions, practitioners were expected to empathise and take perspectives, provide reassurance, normalise caregivers' emotions and experiences, tailor content to each family, model intervention content, and use reflective practice. These skills are part of how intervention content lands with caregivers, so that it becomes meaningful and usable in everyday caregiving.

Figure 1: Common practice elements of the interventions reviewed

Note. Percentages show the proportion of the 12 interventions including each element, indicating recurrence rather than contribution to outcomes.





Implications for policy, practice and research

The findings point to several implications for developing a coherent 0 to 5 years mental health offer:

1. **Prioritise interventions with the strongest and most relevant evidence.** A coherent mental health offer for 0 to 5 years should include a range of supports, but interventions should not be treated as equivalent. Investment should be guided by evidence strength, UK applicability, fit with local need, and implementation feasibility, alongside what matters to babies, young children, families and practitioners.
2. **Use evidence in planning a differentiated system of support.** Different interventions serve different functions across universal, targeted, and specialist provision. Services should use evidence strategically to match support to developmental stage, presenting need, wider family circumstances and the intensity of support required.
3. **Create a clear, developmentally informed pathway for identifying need and matching families to support.** Services need a shared, evidence-informed approach to identifying family need and assessing the right level and type of support, taking into account the caregiver-baby/child relationship, baby/child mental health need and development, caregiver mental health, wider adversity, cultural background, and safeguarding context.
4. **Invest in workforce capability, supervision, and implementation support.** Effective delivery requires practitioners who can build trust, observe interactions, tailor support, model and coach caregiving practices, and work reflectively. Training alone is unlikely to be sufficient without supervision, fidelity support, caseload capacity, and time for reflective practice.
5. **Use common elements to strengthen universal provision.** Sensitivity, play, reflective functioning, co-regulation, and relationally framed behavioural support can help build shared language across the 0-5 pathway. The companion Golden Threads work will help translate these principles into brief, scalable support for universal settings, without replacing targeted and specialist interventions where these are needed.
6. **Set a whole-system research strategy for the 0-5 offer.** Within this, interventions with stronger evidence need implementation research on scale-up, workforce requirements, supervision, fidelity, costs, and sustainability. Widely used or promising interventions with more limited trial evidence, such as VIG, need investment to support more rigorous evaluation, targeted to priority gaps in the current 0-5 offer.

Conclusion

This report shows that attachment-based and psychodynamic interventions with a sufficient evidence base are available for babies, young children, and their caregivers, including some with UK evidence. However, the evidence base remains uneven. These interventions vary in their target populations, outcomes, and implementation requirements, but share a focus on helping caregivers notice, understand, and respond to babies' and young children's cues, emotions, and behaviour. Building a coherent 0 to 5 mental health offer will take more than selecting interventions one at a time. It requires a whole-system approach to evidence, implementation and workforce development that shows where provision is strongest, where gaps remain, and what is needed to close them, so that families have the best chance to thrive now and in the future.



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