

Companion Supplement

Assessing caregiving and matching families to support

This supplement contains worked examples, a household exercise, an evidence extraction record, and an editorial quality self-assessment. It accompanies the main article and does not replace local clinical or safeguarding procedures.

S1 Worked examples

These composite scenarios illustrate reasoning. They are not reports of actual families or evidence of intervention efficacy.

S1.1 A cultural disagreement calls for negotiation when safety is intact

A fourteen-year-old wants to attend an evening activity. Her grandparents describe respect as accepting adult decisions without debate; she interprets their refusal as distrust. There is no report of threats, violence, or significant functional impairment. Assessment identifies a practical concern about the return journey and a disagreement over how objections can be expressed.

The practitioner explores family obligations and the adolescent's perspective, then helps negotiate transport, an arrival check-in, and a review after an initial outing. The grandparents retain a proportionate safety boundary while allowing questions. Review examines whether the plan is safe, workable, and experienced as fair, rather than whether the adolescent became more obedient. New disclosures of intimidation would change the pathway.

S1.2 Material hardship calls for assistance before more instruction

A parent working rotating shifts reports morning shouting, missed school transport, and exhaustion. An eight-year-old struggles with multi-step instructions. Food and supervision are currently adequate, but the parent's schedule makes the proposed routine unreliable. There are no current indicators of abuse. The pattern is disrupting attendance and warrants focused support.

The plan combines school transport assistance, a realistic caregiver handover, a short visual routine, and assessment of the child's learning and communication needs. The parent is offered assessment for persistent low mood. A brief coached practice targets one feasible instruction. Review tracks attendance, shouting, child distress, and caregiver burden. If essential food or supervision becomes unavailable, urgent practical action and renewed safety assessment occur immediately. Resource support is part of the intervention, rather than a reward for completing parenting lessons.

S1.3 A disclosure of harm requires protection without a coaching trial

A nine-year-old tells a school practitioner that a caregiver struck him with an object and says he is afraid to return home. Visible bruising adds concern. The practitioner responds calmly, records the child's words and observations, and activates the local safeguarding pathway promptly. Injury assessment and immediate safety planning are arranged through the appropriate services. The practitioner does not send the child into a joint confrontation or offer a two-week behavior plan as the first response.

The subsequent assessment determines what happened and what protection and support are required. Caregiver treatment, nonviolent parenting work, and material assistance may later contribute to a safe plan.

They do not replace the initial referral. The case demonstrates a priority rule: an indicator of possible serious harm changes the response even when a caregiver also shows warmth or faces substantial adversity.

S1.4 Infant distress calls for health checks and responsive coaching

A parent of a seven-month-old reports prolonged crying and says, “I cannot do this.” First clarify the infant's feeding, growth, illness, safe care, and the parent's immediate ability to cope. Ask directly whether the parent fears harming themselves or the baby. Current inability to keep the infant safe changes the response to urgent assessment and safe alternative care.

If overwhelmed, place the baby on their back in an empty safety-approved crib or bassinet with a firm, flat, level mattress and fitted sheet, take a brief break nearby while checking on the baby, and ask a safe adult for help. Never shake, throw, or hit a baby. Seek medical advice for suspected illness, and emergency assessment after shaking or a concerning injury (CDC, 2024; NICHD, n.d.). This coping step must not delay arranging safe alternative care when the parent fears losing control.

When immediate safety is established, arrange appropriate infant health and caregiver mental-health assessment. Observation shows the parent missing early fatigue cues while trying repeated stimulation. A trained practitioner offers cue-focused coaching and, with consent, video feedback, while arranging practical respite. Review checks infant health and settling, observed responsiveness, caregiver symptoms, and whether relief was actually available. Crying alone is not a measure of parenting quality; coached sensitivity work does not replace treatment for depression or infant illness.

S2 Household practice exercise

This exercise draws on behavioral parent-training principles, including clear targets, attention to context, positive interaction, rehearsal, and specific feedback (Patterson et al., 1989; Kaminski et al., 2008; Furlong et al., 2012). Evidence supports the broader intervention family; the particular two-week schedule below has not been independently tested. Use it for a manageable difficulty while maintaining access to professional help.

Step 1 Choose one achievable action

Replace “be respectful” with something observable: “Put the shoes by the door after the evening reminder.” Check that the child understands and can perform the task. Choose an adult behavior to change too, such as using one clear prompt instead of repeated warnings.

Step 2 Notice the pattern over a few occurrences

Briefly record what happened beforehand, the behavior, and the adult response. Include fatigue, task difficulty, sensory discomfort, timing, and practical barriers. A few observations suggest what to try; they do not establish a diagnosis or a single cause.

Step 3 Remove a barrier and practice when calm

Prepare materials, shorten the task, use a visual cue, or offer suitable help. Demonstrate and rehearse the action outside the difficult moment. If pain, marked anxiety, communication difficulty, or other persistent concerns are present, seek assessment rather than intensifying consequences.

Step 4 Notice useful behavior and keep limits clear

Give specific feedback: “You brought the shoes over when I asked.” Maintain a reasonable nonviolent boundary. Protect people immediately if anyone is being hurt, and discuss the alternative after distress has eased. Avoid removing food, essential care, or affection as a consequence.

Step 5 Agree a review date and review sooner if needed

Around two weeks is a practical starting point for arranging this brief exercise, not an evidence-based deadline. Agree timing with the family and practitioner according to need. Ask whether the routine is easier, adults are shouting less, and the child feels supported. If the plan was too difficult to use, change the support or demand. If significant impairment persists, seek focused help. Any concern about abuse, serious injury, or immediate danger requires prompt protective action rather than waiting for the review date.

A simple record

Date and situation	What happened beforehand	Child action	Adult response	What helped or needs assessment

S3 Evidence extraction and source access

The records below describe what could be checked. An accessible author manuscript or full-paper transcription is distinguished from a publisher version and from an abstract. No missing confidence interval was reconstructed. Values retain the source's sign convention. The main article's tables summarize the evidence rather than rank programs.

Source	Report accessed	Extraction location	Interpretation or limit
Furlong 2012	Cochrane author abstract and PubMed PMID 22336837.	Main results and selection criteria: counts, comparators, caregiver and independent SMDs and CIs.	Full report not obtained; short-term and comparator descriptions limited to what primary summary explicitly reports.
Thomas 2017	Full-paper transcription of Pediatrics article, hosted on Scribd; author abstract cross-check.	Results, child externalizing and active-versus-inactive subgroup analysis, journal pp. 5–6; Discussion p. 9.	Distinguish active-control CI -0.86 to -0.17 from nonmastery CI -0.85 to -0.17 . Subgroups are not randomized comparator tests.
Menting 2013	Full publisher PDF hosted by Incredible Years.	Section 3.3.1, p. 907; comparator definitions and study descriptions pp. 904–906.	$d = .27$ [.21, .34] across 50 studies; .31 [.24, .38] after excluding 7 alternative-treatment studies.
Kaminski 2008	Publisher abstract and CDC full companion report, especially pp. 8–12.	77 evaluations; component associations with parent and child outcomes.	No new coefficient extraction. Component findings are observational comparisons among programs, not effects of separately randomized ingredients.
O'Hara 2019	Full Cochrane review PDF in Queen's University Belfast repository.	Summary of findings 1 and Analysis 1.1.	22 trials overall; 20 studies and 1,757 dyads in sensitivity analysis.
Jeong 2021	Full PLOS Medicine publisher article.	Methods Data analysis; Results Child development.	Cognition subset 58 studies; closest assessment to program end.
Bradshaw 2025	Accepted author manuscript on Self-Determination Theory website; final citation record.	Tables 1 and 2 for univariate results; Multivariate meta-analysis and Figure 2 for adjusted paths.	Not the publisher version of record. The simultaneous model uses all 238 studies, not the univariate subset counts.
Pinquart 2017	Full-paper transcription of Developmental Psychology article on Scribd, cross-checked against accessible PDF text.	Results, p. 879: baseline-adjusted longitudinal partial correlations.	Warmth $-.07$ and harsh control $.08$; not the larger concurrent associations.
Blume 2025	Full-paper transcription of Journal of Family Psychology article on Scribd.	Results p. 891, Differences in self-regulation by parenting style.	Supportive $r = .146$; suppressive $r = -.147$. CIs not added because the main text directs to supplementary forest plots.
Gershoff and Grogan-Kaylor 2016	Author-manuscript Table 2 in PMC, DOI 10.1037/fam0000191.	Externalizing row: 14 effect sizes, $d = .41$ [.32, .50], I^2 88.4%.	Do not call 14 effect sizes 14 independent studies or interpret this observational difference as a treatment effect.

S3.1 Sources used through abstracts or primary summaries

Furlong et al. (2012): numerical estimates, sample, eligible comparator types, and short-term conclusion checked in the Cochrane author abstract and PubMed record; full report access was unsuccessful. The current Cochrane page displays a 2022 publication date for the same pub2 DOI; the citation retains the original 2012 record and does not describe a newly searched 2022 synthesis.

Kaminski et al. (2008): component findings and the 77-evaluation scope checked in the publisher abstract and the CDC's full companion report Parent Training Programs Insight for Practitioners. The journal full text was not obtained. No pooled or component coefficient is presented as newly extracted from that paper.

Cuijpers et al. (2026): qualitative findings, update status, and 47-trial record checked against the PubMed abstract, PMID 41707889, DOI 10.1016/j.jaac.2026.02.005. This is a distinct 2026 advance-online article updating the earlier synthesis, despite the repeated title. No quantitative row was added without inspecting the full methods.

Narrative claims retained from primary abstracts or institutional summaries rather than complete reports also include Han et al. (2025), Gardner et al. (2019), Burt et al. (2021), Heilmann et al. (2021), Lansford et al. (2005), Larzelere and Kuhn (2005), van Eldik et al. (2020), Teubert and Piquart (2010), Piquart and Kauser (2018), and Wang et al. (2020). These are contextual citations; no new detailed numerical extraction is claimed for them. Full-report access for the other numerical entries is specified in the table. Foundational conceptual citations support definitions rather than an efficacy estimate.

S3.2 Interpreting adjusted associations

Bradshaw's one-stage model uses all 238 studies with available correlation information, accounting for interrelations among the parenting dimensions and wellness outcomes. The univariate subset counts in Table 2 apply only to those univariate estimates, not to the adjusted paths. The source denotes both types of estimates using *r*; adjusted values are model paths, not ordinary unadjusted Pearson correlations or causal effects. Only 36 studies measured both parenting dimensions, and 13 measured all four modeled variables.

S4 SANRA editorial self assessment

SANRA is a six-item quality-assessment scale for narrative reviews, not a reporting guideline, risk-of-bias instrument, or clinical validation. This provisional editorial self-assessment applies the published 0–2 item structure. It has not been independently rated; the total is not a submission credential or a claim of high-certainty evidence.

SANRA item	Score out of 2	Reason
Importance	2	Opening states the service problem and why a caregiving label alone does not select support.
Concrete aim	2	Audience and assessment-to-action purpose stated in the abstract and Section 1.
Source identification	1	Purposive source selection and access limits disclosed; no reproducible search or independent selection.
Referencing	1	Central estimates linked to primary reports; some contextual claims still use primary abstracts or summaries.
Scientific reasoning	2	Trials, component associations, observational models, rights, and proposed workflow distinguished.
Endpoint data	2	Key intervention and association estimates presented with outcomes and comparators; principal limits stated.

Provisional editorial total 10 out of 12. Independent assessment may differ.

S5 Materials for external review

Before service implementation, recruit independent safeguarding and clinical experts and diverse parents and young people, with accessible information and appropriate consent and ethics review where required. Ask reviewers to apply the checklist to the same cases, identify missed concurrent needs, explain referral choices, and rate clarity, burden, and acceptability. Predefine a consensus process and how dissent changes the text. Keep professional and family feedback distinguishable. No expert panel, Delphi, or parent review has been conducted for this manuscript; the proposed review materials do not substitute for participants.

Key supplementary sources

Centers for Disease Control and Prevention. (2024). About abusive head trauma. <https://www.cdc.gov/child-abuse-neglect/about/about-abusive-head-trauma.html>

National Institute of Child Health and Human Development. (n.d.). Safe sleep environment for baby. <https://safetosleep.nichd.nih.gov/reduce-risk/safe-sleep-environment>

Centers for Disease Control and Prevention. (2009). Parent training programs: Insight for practitioners. https://stacks.cdc.gov/view/cdc/5286/cdc_5286_DS1.pdf

Baethge, C., Goldbeck-Wood, S., & Mertens, S. (2019). SANRA—a scale for the quality assessment of narrative review articles. *Research Integrity and Peer Review*, 4, 5. <https://doi.org/10.1186/s41073-019-0064-8>

All author-year citations not listed here have complete references in the main article.