research
in practice

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Assessing risk of further child maltreatment

How to use the Jones Model

- Complete the table below by summarising information from other assessments, chronologies, statements and court reports, rather than repeating detailed evidence (as in the case example). Complete the boxes that apply for this case and delete the others. The completed table can be cut and pasted into a report and provides a visual representation of the risks and protective factors within the family, to support a social work assessment of the likelihood of further maltreatment.

- Factors shown in italics are more strongly associated with increased risk: prior maltreatment, neglect, parental conflict and significant mental health problems in one or both parents. Domestic violence, mental health problems and substance misuse interact to escalate harm.

- If this model is used in court reports, it should be referenced and the rating criteria (below) made available on request.

- This tool is only suitable for use in cases in which there is evidence of previous child maltreatment to this child or other children by one or both parents/carers. It is not a substitute for investigation or fact finding.

- All men involved in the child's life should be included in the parent section – not just resident biological fathers.

- Review the assessment at least every six months as risk of significant harm increases with length of exposure (particularly in relation to domestic violence and neglect).

Factors	Future significant harm more likely	Future significant harm less likely
Abuse	**Severe physical abuse, including burns/scalds** Definition: severe injury caused to child to warrant hospital admission/medical treatment (eg broken bones, head injury). The term 'rough handling' may mask risks of injury or even death (Brandon et al 2009). Include children who are exposed to partner violence in utero.	**Less severe forms of abuse** Physical abuse that does not warrant hospital admission or treatment. Note: If abuse is severe, yet parent shows compliance with child protection plan, does not deny abuse occurred and accepts responsibility for their part in it, success is still possible.
	Neglect Include children who are left alone, have many changes of carers, are left with inappropriate or very young carers, are unkempt or unsafe, live in dirty or unsafe homes, are exposed to adult substance misuse or chaotic life styles, do not have their health needs met, are cold, hungry or have inadequate sleep, are left unattended for long periods, are not played with, spoken to or given freedom to explore (ie strapped in buggy or chair), lack comfort or affection. Include children allowed to play out in dangerous areas, given inadequate supervision, lacking rules and routines or allowed to become out of control. Also include exposure to drug or alcohol misuse in utero, failure to attend ante-natal appointments, unplanned or concealed home deliveries.	

	Severe growth failure Stunted growth and failure to thrive without evidence of medical reasons (eg. parents forget to feed infant).	
	Mixed abuse Child is experiencing more than one type of abuse (eg. neglect plus experiencing domestic violence). Emotional abuse includes threats of abandonment and experiencing domestic violence. Sexual abuse includes the presence in the home of an adult who presents a risk of sexual harm.	
	More than one affected child in household Either or both of the adults involved in caring for this child have previously had a child permanently removed from their care or made subject to a child protection plan.	
	Previous maltreatment Either or both of the adults involved in caring for this child have previously had a child permanently removed from their care or made subject to a child protection plan.	
	Sexual abuse with penetration, or repeated over long duration If adults caring for the child were either responsible for or compliant with the abuse.	
	Fabricated/induced illness Medical evidence of fabricated or induced illness perpetrated by one or both of adults caring for the child.	
	Sadistic abuse Cruel, inhumane or degrading treatment of the child.	
Child	**Development delay with special needs** Medical evidence of developmental delay, whether caused by illness/disability or poor parenting. Include special needs attributed to disability/illness and emotional or behavioural difficulties.	**Healthy child** Child who does not have illness/disability/developmental delay/special needs/emotional or behavioural difficulties.
	[Child's] mental health problem Diagnosed mental illness for which medical or therapeutic intervention is necessary. Do not include this category for babies or very young children.	**Child does not blame themselves for sexual abuse and recognises that it caused harm**
	Very young requiring rapid parental change	**Later age of onset of abuse** Not applicable for babies under one
		One good corrective relationship Not applicable for babies under one
Parent: Include mother and father if involved with child AND new partners if resident or having	**Personality disorder or problematic personality traits** Identified by psychiatrist or psychologist (anti-social, sadistic, aggressive).	**Non-abusive partner** Partner for whom there are no concerns of abuse to partner or child (regardless of gender or relationship to child) OR for whom past concerns have been entirely overcome.
	History of violence or sexual assault	
	Lack of compliance Hostility towards professionals, deliberate deception, sporadic access to children, numerous cancelled appointments with social workers without good reason.	**Willingness to engage with services** Carer(s) accepts that professional involvement is necessary to safeguard their child. Appointments are kept and not cancelled without good reason.

contact with child	Also include false compliance – telling workers what they think they want to hear rather than working with them.	Children's attendance at school/nursery is not a cause for concern. They are taken to all necessary health appointments, which are not cancelled without good reasons.
	Denial of problems Inability to acknowledge own destructive behaviour, accept responsibility for abuse to this child or previous children (eg. no understanding of impact of experiencing domestic violence on a child).	**Recognition of problem** Adults caring for the child acknowledge why their behaviour has/is affected ability to care for child and meet their needs.
	Mental illness **Learning disabilities plus *mental illness*** Learning disability combined with mental illness, plus mental illness alone (must be diagnosed by a medical professional). Learning disabilities alone do not count as a risk factor.	**Responsibility taken** Adults caring for the child do not blame others for their own destructive behaviours and are making some steps towards accepting responsibility for their actions.
	Substance abuse within the last two years Misuse of class A or B drugs or alcohol or any substance that impairs the capacity of those caring for the child to make sound judgements and meet the child's physical or emotional needs. Include parents on a methadone script. Also include those who do not misuse substances themselves but allow their home to be used for this purpose or routinely leave their child with others who are under the influence of drugs/drink.	**Mental disorder, responsive to treatment** Adults caring for the child are accessing and responding to the treatment given for their mental disorder.
	Paranoid psychosis This must be medically diagnosed – do not include adults who say they feel paranoid without formal diagnosis.	
	Abuse in childhood – not recognised as a problem, or which now preoccupies the parent This includes any experience of abuse. Evidence from case files, assessments and parents own accounts can be included. It can be difficult to ascertain whether a parent views their childhood abuse as a problem – include parents where there is evidence that they experienced childhood abuse, but it is unclear that they recognise it as a problem.	**Abuse in childhood – acknowledged as a problem and parent is not overwhelmed by distress, able to focus on children's needs.**
Parenting and parent/ child interaction	**Disorganised; and severe insecure patterns of attachment** Based on direct observation by a health or childcare professional. This factor cannot be ascertained from information held on social care files alone.	**Secure attachment; less severe insecure patterns.** Do not assume attachment is secure in the absence of observation or recordings.
	Lack of empathy for child One or both adults caring for the child does not show understanding of how child might feel in adverse situations (eg. if their parents are fighting or they are neglected). Include those who treat a child in a degrading or inhumane way.	**Empathy for child** Adults caring for the child understand how they might feel in adverse situations or if their needs were not met.
	Poor parenting competency Lack of competence in, for example, routines, feeding, bathing or clothing child, maintaining a household, paying bills, getting child to school on time. Include failure to show warmth and affection or provide a nurturing environment.	**Competence in some areas of parenting**

	Poor parent child relationship	
	Own needs before child's Adult caring for child puts own needs first (eg. remains in an abusive relationship or appears more attached to drugs or alcohol than to the child).	
Family	***Inter-parental conflict and violence*** Physical and emotional violence between the child's caregivers or any other adult taking place within the family home.	**Absence of domestic violence** Includes families where this has never been a concern and those where it is not a current concern.
	Family stress Eg. housing problems, homelessness, overcrowding, debt, extended family conflict, conflict in the neighbourhood, family crisis such as bereavement or relationship breakdown.	
	Power problems: poor negotiation, autonomy and affect expression Poor self-regulation, lack of congruence, unable to manage emotions pertinent to the situation.	**Capacity to change** Adults who care for child have demonstrated capacity to change and there is evidence of this (eg. abusive partner has left the house; parent provides clean drug screens for sustained period). Do not include parents who just say they want to change.
	Large family **Lone parent family** **High continuing access by abuser**	**Supportive extended family** Extended family provides practical and emotional support for adults and children. Those caring for the child view this as beneficial.
Professional	**Lack of resources** Resources unavailable, not offered or inaccessible. No professional or therapeutic relationships with child or family	**Resources available**, appropriate, accessible. Therapeutic relationship with child. Outreach to family.
	Breakdown in partnership working, exclusive focus on parents' needs, child not seen.	**Partnership with parents** Effective working relationships between parents and social worker based on honesty and trust.
	Professionals lacking appropriate skills/experience/supervision	
Social setting	**Social isolation** Caregivers have little or no contact with others on a social basis, may stay at home most days with no contact with their community.	**Social support** Adults caring for the child are able to access community resources and support on a voluntary basis.
	Lack of social support Caregivers with little positive contact within their community and no access to (or engagement with) community resources.	**More local child care facilities** Many local facilities such as children's centres and community groups. Only include this category if adults caring for the child are involved with these services.
	Violent, unsupportive neighbourhood Eg. drug taking and crime are rife.	**Volunteer networks** Positive community resources and environment.