CHCDEV004

Confirm developmental status

Aspire
Learning Resources

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Release 1

Learner Guide

Aspire Version 1.1

Aspire
Learning Resources

CHCDEV004 Confirm developmental status, Release 1

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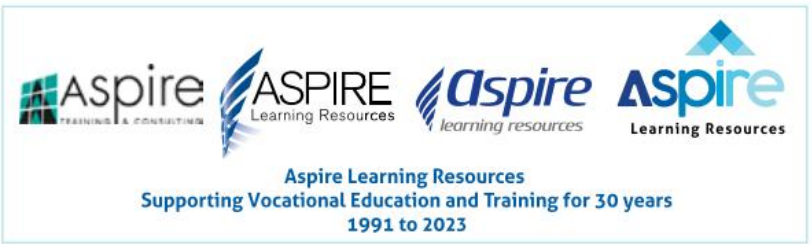


Contents

Aspire acknowledges the homelands of all Aboriginal and Torres Strait Islander peoples and pays our respect to Country

Before you begin

This Learner Guide is based on the unit of competency *CHCDEV004 Confirm developmental status*, Release 1.

Your trainer or training organisation must give you information about this unit of competency as part of your training program.

How to work through this Learner Guide

This Learner Guide contains a number of features that will assist you in your learning. Your trainer will advise which parts of the Learner Guide you need to read, and which Practice Tasks and Learning Checkpoints you need to complete.

Feature of the Learner Guide	How you can use each feature
Learning content	Read each topic in this Learner Guide. If you come across content that is confusing, make a note and discuss it with your trainer. Your trainer is in the best position to offer assistance. It is very important that you take on some of the responsibility for the learning you will undertake.
Examples	These highlight learning points and provide realistic examples of workplace situations.
Practice Tasks	Practice Tasks give you the opportunity to put your skills and knowledge into action. Your trainer will tell you which Practice Tasks to complete.
Callouts	Callouts reiterate key learning points to help students revise for their assessments.
Weblinks	Weblinks provide learners with additional content to contextualise their learning and develop their understanding.
Videos	Videos provide a visual reference of key concepts to aid comprehension and guide learner exploration. Each video is accessed by a QR code in the Learner Guide (or a button in the eBook version) for ease of access. 
Glossary/margin definitions	Key terms are defined where they first appear to help consolidate understanding. A glossary of terms is provided at the end of the Learner Guide to assist learner revision of key concepts.
Summaries	Key learning points are provided at the end of each topic.
Learning Checkpoints	There are Learning Checkpoints at the end of each topic. Your trainer will tell you which activities to complete. These activities give you an opportunity to check your progress and apply the skills and knowledge you have learnt.
Case studies	Case studies are interspersed throughout the learning content to provide a workplace setting that contextualises key concepts.

Foundation skills

As you complete learning using this guide, you will be developing the foundation skills relevant for this unit. Foundation skills are the language, literacy and numeracy (LLN) skills and the employability skills required for participation in modern workplaces and contemporary life.

These skills are listed below:

Foundation skill area	Foundation skill description
Reading	• Understanding how documents are presented and being able to navigate through documents • Understanding industry- and job-specific terminology • Interpreting key information in relevant documents • Understanding routine workplace checklists and documentation
Writing	• Planning, drafting and writing reports and documents • Communicating through written letters, email and online • Recording progress; reporting incidents
Oral communication	• Clarifying instructions • Providing information • Supporting others through encouragement, negotiation and conflict resolution • Using body language to model desired behaviour and responding to others' body language
Numeracy	• Calculating costs, weights, measurements of height and distance • Interpreting measurements
Learning	• Understanding your job role, organisational procedures and legal responsibilities • Managing your work and seeing how well you are going • Making goals for yourself at work • Seeking professional development opportunities for continuous improvement
Problem-solving	• Identifying problems • Working out how to fix a problem using problem-solving processes • Reviewing the outcome
Initiative and enterprise	• Recognising opportunities to develop and apply new ideas • Generating ideas by thinking of new ways to do something • Making suggestions to improve work
Teamwork	• Working well with other people by cooperating, collaborating, encouraging and building rapport
Planning and organising	• Planning your workload and commitments • Implementing tasks • Completing work on time • Knowing how to deal with hazards and risks

Foundation skill area	Foundation skill description
Self-management	• Understanding and applying decision-making processes • Reviewing your behaviour and the impact of your decisions
Technology	• Efficiently using digitally based technologies and systems correctly and safely • Accessing, organising and presenting information • Using equipment correctly and safely

Note: Not every unit of competency will contain all foundation skills.

What do you already know?

Use the following table to identify what you may already know. This may assist you to work out what to focus on in your learning.

Topic	Key outcome	Rate your confidence in each section
Topic 1 Clarify child or young person developmental status	1A Obtain information about developmental status	❑ Confident ❑ Basic understanding ❑ Not confident
	1B Clarify developmental status	❑ Confident ❑ Basic understanding ❑ Not confident
	1C Apply lifespan development theories	❑ Confident ❑ Basic understanding ❑ Not confident
Topic 2 Identify child or young person developmental issues	2A Recognise developmental factors in a person's behaviour	❑ Confident ❑ Basic understanding ❑ Not confident
	2B Clarify that services fit the person's developmental status	❑ Confident ❑ Basic understanding ❑ Not confident
	2C Identify potential risk factors associated with developmental issues	❑ Confident ❑ Basic understanding ❑ Not confident
Topic 3 Check for and respond to child or young person specific issues	3A Follow legislative and mandatory reporting requirements	❑ Confident ❑ Basic understanding ❑ Not confident
	3B Refer and document issues that require more support	❑ Confident ❑ Basic understanding ❑ Not confident
	3C Report and document accurately	❑ Confident ❑ Basic understanding ❑ Not confident

Topic 1: Clarify child or young person developmental status

1A Obtain information about developmental status

1B Clarify developmental status

1C Apply lifespan development theories

1A Obtain information about developmental status

Human development refers to the cognitive, physical, linguistic, social and emotional changes that occur throughout the lifespan from birth to old age.

Although there can be significant variations in development, and changes in the way the brain and body function, babies and children develop in roughly the same expected timeframes and ages, and adults often reach new stages of life within predictable decades.

Child development is complex and multi-faceted. It includes growth, change and increased independence in a range of domains, including:

Physical	Physical development involves the growth and development of fine and gross motor skills, changes related to puberty, and changes in bone strength, muscle strength, weight and height.
Cognitive	Cognitive development relates to the intellect, and the ability to think, learn and reason.
Psychological	Psychological development is connected to emotional maturity and the ability to practice self-control.
Social	Social development relates to learning to interact with others, to develop speech and language, and to understand expected social cues and behaviours.
Affective	Affective development relates to the capacity to experience, recognise and express emotions.

Developmental milestones

Developmental milestones help professionals gauge whether a child might need support in an area of development so they do not fall behind other children the same age.

Developmental milestones
A set of physical, cognitive, social and psychological skills that most children and adolescents are able to do within a certain age range.

In children and adolescents, these expected timeframes are called **developmental milestones**. Checking and reporting problems in reaching expected developmental milestones can help with early detection and prevention of developmental delays.

It remains important to remember that children can and do develop at different paces and may reach developmental milestones at different times, while still being perfectly healthy. It is widely accepted that growth and development occur in phases that include spurts, plateaus and times of regression. The age at which a milestone is reached can be influenced by many factors, including culture, environment and parenting style, and later development may not be indicative of a problem or condition.

It is no longer appropriate to talk about people as 'normal' or 'abnormal', in the way that development was once discussed. However, we do know that when a baby or child falls behind these milestones, there can be ongoing effects, sometimes reaching far into the child's future. Delays in reaching developmental milestones can have a snowball effect on other areas of development.

For resources about development during the first 1,000 days of life, see: aspirelr.link/1000-days

In infancy, important milestones are often checked by maternal and child health services, and during childhood and adolescence, by teachers. However, some milestones can be missed, or not picked up as they should be.

Example

Missed developmental milestones

Jett is a 15-year-old boy who has been involved in the criminal justice system. During his early childhood, a case worker supported the family as his mother used drugs and alcohol until she successfully went through a rehabilitation program. When he was 10, Jett's mother re-partnered, and he began to experience sexual and emotional abuse from his stepfather.

Before this time, Jett had shown great interest in learning, and was top of his class in writing and spelling. However, this changed suddenly when he entered high school. His high school teachers, who did not know him before his change, reported that he was sullen and withdrawn from his peers. He was considered to be uninterested in school, was labelled as having low literacy levels, and he has been underachieving at school ever since.

If the case worker who managed this family, along with Jett's teachers, had been able to identify the unexpected developmental changes and delays that Jett was experiencing, the abuse might have been picked up. Instead it continued, and Jett's education, emotional wellbeing and future potential were significantly impacted.

Checklists and charts

Milestone charts can be a helpful way for parents and professionals to identify the early signs of a problem, either within the child, or an extrinsic factor that is hindering their development.

You can see a detailed example of a milestone chart here: aspirelr.link/acecqa-developmental-milestones-pdf

Human development throughout the lifespan

When we have a good understanding of the stage of human development that a person has reached, we can recognise signs of healthy development as well as signs that might point to concerns, such as mental illness, or cognitive conditions.

While our brain and physical development reach their peak in adolescence or early adulthood, humans continue to change through middle adulthood and senior years in ways that follow a predictable pattern. These changes include both positive changes in response to the environment and social interactions, and deterioration, particularly physical decline.

The following section outlines the development stages typical of different stages of the lifespan.

Birth

Reflex
An unconscious response to an environmental stimulus.

At birth, healthy babies are expected to have a series of **reflexes** present. These are considered as precursors to healthy brain and body development. They include:

Grasping reflex	Hold a finger or other object firmly
Rooting reflex	Turn head when touched on cheek
Gag reflex	Clear the throat
Startle reflex	Fling out the arms, fan the fingers, and arch the back in response to a sudden noise
Sucking reflex	Suck objects placed in mouth
Babinski reflex	Curl toes when outer edge of sole of foot is stroked

Within a few days of birth, babies are expected to be able to recognise their mother's voice, and discriminate between closely related sounds.

Birth to 12 months

Type of development	Typical milestones
Physical	• Babies are usually able to get onto their hands and knees in a crawling position between 6 and 9 months. • By 8 months, they are expected to be rolling around and crawling on their tummies, called 'commando crawling'. • By 11 months, they are expected to be able to stand well unassisted. • A baby often takes their first steps at around 12 months.

Type of development	Typical milestones
Psychological	• During the first weeks of life, a baby's main focus is on having biological needs met, including food and warmth. • The baby begins to understand that there is a link between crying and help arriving. The baby cries initially as a reflex but by the time the baby is a few weeks old, crying becomes a conscious way to get help. • The baby forms an attachment to their mother and other primary caregivers, and through these interactions, learns to love, trust, and depend on other human beings. • Attachment is fully developed by about 6 months.
Cognitive	• The infant brain is constantly stimulated by new sensations, sights, sounds, tastes and smells. • The intellect is developing through music, language and social interactions. • By 7 months, infants can discriminate all sounds relevant to language. • The baby begins to understand words and will recognise people and objects.
Social	• Babies begin to smile at other people beginning at about 2 months. • They start to coo and gurgle and are soothed by the sound of a familiar voice or by low rhythmic sounds. • They imitate adult tongue movements when being held and talked to and then begin to copy sounds. • By 7 months, the baby understands facial expressions, such as smiles or frowns. • By 12 months, they start to produce simple short words that begin with a consonant sound; but they understand more than they can speak.
Affective	• The baby cries when hungry or uncomfortable and is often comforted by being held or rocked. • Responds to gentle touching, cuddling, rocking. • Shows excitement as parent prepares to feed.

Adapted from the Early Years Learning Framework Practice Based Resources – Developmental Milestones, under CC 3.0 AU licence.

Video: Baby development

Watch this video to see more about the expected development of a baby: aspirelr.link/yt-baby-development

Early childhood

Type of development	Typical milestones
Physical	• Growth and weight gain continue, though at a slower rate than in infancy. • Gross and fine motor skills, movement and coordination continue to develop.
Psychological	• Children begin to develop greater self-awareness. • They are increasingly able to interpret the emotions of other people, the beginnings of **empathy**. • The child seeks love and approval from their parents.
Cognitive	• At 18 months, children begin to develop the idea of permanence. Before then, if someone or something leaves their field of vision, they are not able to understand that it still exists. • Two-year-olds continue to primarily understand the world in concrete ways, and can solve concrete problems, rather than abstract ones. • Between the ages of 2 and 7, children begin to use more abstract thought. • A pre-schooler can remember two to three chunks of information, while a 7-year-old can remember five chunks of information.
Social	• Infants on average speak their first words by 12–14 months, and by the 18th month they have a speaking vocabulary of about 50 words. • At 18 months, they can put together short phrases. • By 3 years, children are starting to develop larger vocabularies. This begins with two- and then three-word sentences and progress to more grammatically complex sequences. • By 4 years, most children can speak in full sentences and begin to master basic rules of grammar and meaning-making. • By the age of 2 years, children start to become a little more independent from parents. They are more likely to play next to other children, rather than *with* them.
Affective	• Toddlers become very frustrated and impatient, and often don't have the ability to control their emotions.

Empathy
The ability to understand, share and identify the feelings of others.

Video: Child development 1–2 years
Watch this video to see more about the expected development of a child between 12 and 24 months: aspirelr.link/child-development

Childhood

Type of development	Typical milestones
Physical	• Growth, muscle strength, and gross and fine motor skills continue to develop.
Psychological	• Attachment is strongest to parents and family, especially in the younger years. • The child can use moral reasoning (understand the difference between 'good' and 'bad' behaviour). • They can feel internal guilt and self-recrimination. • Their sense of self-esteem is developing and positive or negative experiences can affect their confidence. • The child may seek out fun and enjoyment, but they also thrive in routine and predictability. • They start to develop a sense of privacy and shame.
Cognitive	• The biggest area of growth at this age is language development. The child learns to use and understand thousands of words. • Between 7 and 12, the beginnings of logic appear in the form of classifications of ideas, and an understanding of time and numbers. • The child learns to read and write. • Creativity develops and imaginative play is important. • They might have a short attention span, but they are curious and ask lots of questions. • As they get older, they begin to develop more complex and abstract thinking skills. • They learn to think logically and to understand cause and effect.
Social	• By the school-age years, children play more elaborate games with each other, with less need for play and games to be structured by adults. • Play is a vital way for children to learn communication skills, social rules and different ways of interacting. • They mimic the behaviours that they see acted out by others. • They learn to be polite. • Children start to recognise that they can affect the way other people feel.
Affective	• In this stage, children learn to regulate their emotions. • They are also able to modify the behaviour of other children.

Adolescence

Type of development	Typical milestones
Physical	• Physically, adolescence begins with the onset of puberty and culminates in adulthood. The ages at which people enter and finish puberty vary. • Secondary sexual characteristics appear. • There begins to be a distinct difference in body shape and appearance between the sexes. • Menarche (onset of menstruation) begins in females. • The person achieves their adult form in terms of muscle strength and bodily form. • After puberty, the rate of physical growth slows down. Girls stop growing taller around age 16, while boys continue to grow taller until the age of 18 to 20.
Psychological	• Adolescence is typically a period of self-discovery, rebellion and questioning. • Young people often reject their childhood interests. • There is a strong interest and curiosity about sex and attraction. • There is a desire to express their gender and personal identity. • There is often the development of a more mature set of values and self-direction.
Cognitive	• The human brain develops rapidly during adolescence and reaches full maturity between 21 and 25 years of age. • There is a greater ability for complex abstract thinking and reasoning. • Adolescents can use deductive, rational, and systematic ideas of their own creation. • They can self-manage many parts of their lives and be independent in self-care.
Social	• They reduce their emotional and physical dependence on their parents. • They can be self-centred and self-absorbed. • The peer group often become the centre of their world, and they can feel a strong need to dress and behave in the way that their peers do. • Not being accepted by their peers at this age can have a strong emotional effect, which can continue through life. • They begin to establish romantic and sexual relationships. • They have a growing sense of their identity and feelings of self-confidence or insecurity can become firm.
Affective	• They may experience mood swings, and degrees of anxiety and depression. • Puberty brings hormonal changes that can affect mood and can lead to anger, frustration and sadness.

To see more about social and emotional changes that happen in pre-teens and teenagers, see: aspirelr.link/social-emotional-changes

Early to middle adulthood

Type of development	Typical milestones
Physical	• Physical form and muscle strength is at its peak. • These years represent the peak years for reproductive health and fertility, with fertility beginning to decline once women reach their 30s.
Psychological	• In early to middle adulthood, people often reassess life choices and make commitments and goals. • During the middle 30s it's typical for people to develop a sense of their mortality; previous behaviour patterns or beliefs may be given up in favour of new ones.
Cognitive	• Adulthood is a period of optimum mental functioning when the person's intellectual capabilities are at their peak.
Social	• The focus can be on career, singular romantic relationships, forming long term intimate partners and starting a family. • During this stage many people become parents. • There are challenges of balancing work and family life, especially when there are young children at home. • Social friendships tend to be fewer in number but more committed and long term.

Middle to late adulthood

Type of development	Typical milestones
Physical	• In women, dramatic shifts in hormone production lead to perimenopause and then menopause. • Sensory and perceptual skills, muscle strength, and memory tend to slowly diminish, though intelligence does not.
Psychological	• Middle adulthood is often a time of reassessment of life choices and making new commitments or goals. • People are often most satisfied in their work life at this stage, particularly when there is a good fit between their personality and chosen career. • Middle age is often a period of adjustment between the hopes of the past and the limitations of the future. People may either take satisfaction from their achievements, or become anxious over unachieved goals. • During late middle age, people become more aware of ill health and may consciously or unconsciously alter the patterns of their lives.

Type of development	Typical milestones
Cognitive	• Middle adulthood remains a period of optimum mental functioning when the person's intellectual capabilities are at their peak. • Older adults often have practical knowledge and emotional maturity regarding interpersonal problems and the big questions of life, often referred to as wisdom.
Social	• When adult children leave home, it can lead to feelings of freedom, or feeling unwanted or unneeded.

Late adulthood to old age

Type of development	Typical milestones
Physical	• Changes in skin, muscle, build, bone strength and joints correspond with gradual physical decline. • Changes in circadian rhythms lead to fewer hours of sleep, waking in the night and/or early rising. • Having fewer well-functioning nerve cells leads to decreased acuity in sight, smell/taste and hearing. • Eye/vision conditions such as age-related macular degeneration and cataracts may occur. • Loss of balance and flexibility can increase the risk of falling.
Psychological	• In many societies, older adults are highly valued, but in western nations, ageism can contribute to feelings of worthlessness in older adults. • Older people's beliefs about themselves can influence their memory and cognitive performance, and the degree of psychological stress they experience.
Cognitive	• Throughout adulthood, nerve response times increase, making people slower to react to danger, which can affect the ability to drive. • As people age, they become less adept at solving problems, and **episodic memory** reduces. However, many cognitive functions including **semantic memory** and **procedural memory** as well as verbal skills remain intact. • Cognitive changes are also linked to overall physical health. There are steeper declines in memory for people with diabetes, who do not exercise, and who do not participate in intellectually stimulating activities. • Older adults show **neuroplasticity**, the ability to improve brain/cognitive functioning with practice.

Episodic memory
The ability to recall personal experiences and specific events from the recent and longer-term past.

Semantic memory
Also referred to as 'general knowledge', this is the ability to remember facts about the world, such as scientific or historical information.

Procedural memory
A kind of implicit (unconscious) memory that aids in the performance of tasks involving both cognitive and motor skills, such as driving a manual car.

Neuroplasticity
The brain's ability to change and adapt based on experience, including learning through practice.

Type of development	Typical milestones
Social	• There is a growing cohort of 'skip generation' households in which grandparents take primary responsibility for the care of children. • Retirement from active employment can result in people taking up new pursuits and activities. • Older adults may become more emotionally and physically dependent on their children/other younger people.

Factors that affect developmental status

A person's development can be affected by environment, genetics, disability, cognitive conditions and a range of other factors.

The degree of influence of 'nature' (genetics) versus 'nurture' (experience) is a question that scientists have studied for generations. Nature refers to the effects of genes on the way we develop, including, or even especially, on brain development. In past eras, the belief that genetics influenced intelligence vastly more than environmental factors did, helped to shape the idea that people from wealthy or noble families 'deserved' more prominent places in society, because intelligence was linked to genetics and ancestry.

Conversely, we now know that the effect of the environment following conception (including exposure, experience and learning) can have a very significant impact on the way our brains develop. Children or adults who have many or significant negative experiences can have difficulty reaching their full potential.

Genetics

It is generally accepted that both genetics and the environment work together to influence the development of the person throughout life stages.

For example, the age of onset of puberty is considered to be influenced by both genetics and the environment. Human females inherit genes that trigger the onset of puberty from anywhere between eight to 14 years of age. The age of puberty for girls can also be influenced by body height to weight ratio, which is influenced by nutrition and physical activity, as well as exposure to certain chemicals.

In a complex interaction with the environment, our genes can strongly influence developmental characteristics, including:

- personality, such as whether we are introverted or extroverted
- brain development and cognitive ability
- physical development
- the potential to develop certain mental health disorders.

Physical growth follows one's genetic blueprint to a degree, but a person's height might not reach the potential given by the genes if they experience poor nutrition or chronic illness.

Genetic disorders can have a significant effect on the person's intelligence, learning and development, as well as on their physical and sexual development.

Here are some examples of how genetic conditions can 'switch off' certain parts of brain development:

- **Klinefelter syndrome** affects males who have an additional X chromosome, and leads to some developmental delay and less prominent male secondary sex characteristics.
- **Fragile X syndrome** affects both males and females and can lead to slow brain development and mild to severe intellectual disability.
- **Turner syndrome** affects females who have a missing or incomplete X chromosome and can result in learning disabilities and difficulty recognising facial expressions and emotions. It also affects physical and sexual development, causing short stature and a lack of female secondary sex characteristics.
- **Down syndrome** affects males and females who have an additional copy of chromosome 21. It nearly always leads to reduced intellectual development and certain physical characteristics.

Environment

During infancy and childhood, brain development also depends on factors in the child's environment, including:

- a good diet with adequate nutrition
- social interactions
- love and attention
- intellectual stimulation
- feeling safe and secure
- access to good hygiene and medical care.

The process of child development involves acquiring multiple skills at the same time. The environment plays a crucial role in the development of babies and children and continues to do so into adolescence and adulthood. For example, children who grow up with more socio-economic advantage are taller on average than children of the same age and sex growing up in lower socio-economic conditions. This is thought to be related to nutrition and access to health care. In many cases, the effects of neglect, lack of love or poor nutrition can significantly affect a child's future. As we age, certain environmental factors continue to shape our growth and development.

Environmental impacts	Examples
Nutrition	Malnutrition has a negative effect on growth and development. Iron deficiency can affect **psychomotor development**. Zinc deficiency can cause physical and developmental delays.
Obesity	Rapid weight gain in early childhood influences health in the later part of life, leading to a greater chance of obesity later in life.
Intellectual stimulation	Higher education levels within the family can have a positive impact on emotional and cognitive development.
Pollutants	This can include lead or mercury: Studies have consistently proven a relationship between environmental pollutants and sexual maturation, obesity and low birth weight.

Psychomotor development The development of physical skills such as movement, coordination, manipulation and dexterity, that require both cognitive and physical capacity.

Environmental factors that can contribute to physical, intellectual and psychological development at each life stage include:

Age	Potential effects of the environment
Before birth	• Ante-natal exposure to alcohol can lead to foetal alcohol spectrum disorder (FASD), which can have significant effects on brain development and IQ. • If there is a lack of nutrients received through the mother's diet, the foetal brain will attempt to take whatever nutrients are available, at the expense of physical growth. • Babies born premature can experience a range of delays and effects throughout their life, including learning delays, reduced sensory and social development and physical impairments.
In early childhood	• When a child is not cared for in a loving home environment, or when they are not exposed to good nutrition and positive social interactions, they are at risk of developmental delays in learning, social interaction, physical growth, and psychological wellbeing. Children particularly at risk are those who are exposed to poverty and trauma. • Access to early childhood care and education is known to be a significant factor in the educational outcomes of the child, with impacts on the rest of their lives. • There is also good evidence that children who are exposed to books and reading from a young age, and those who are taught a musical instrument or a second language, are more likely to develop to their full potential in brain growth and development.
In adolescence	• Adolescents need to feel liked and accepted by their peers in order to develop self-esteem. • Adolescents who are bullied, or who feel 'less than' their peers, can have problems with confidence throughout their lives.

Age	Potential effects of the environment
In adulthood	• As we grow older, our relationships with others are often the most influential factor for our growth and development. • Through positive social and intimate relationships we learn: - a positive or negative view of the world - anger or restraint when responding to others.

View the following link to find out more about foetal alcohol spectrum disorder: aspirelr.link/fasd-hub

Parenting styles

The way a child is parented is thought to have a significant bearing on the way they develop emotionally and psychologically. There are four main categories of parenting styles:

Authoritative	This style of parenting sets firm limits but allows the child to be flexible and negotiate limits; parents provide a lot of emotional support. This is considered to be the style of parenting which produces the most positive outcomes.
Authoritarian	These parents expect their children to obey them and often give less emotional support.
Permissive	These parents give their children little direction or authority but provide a lot of emotional support.
Uninvolved	These parents show little interest in regulating their child's behaviour or providing emotional support.

Disability

People with disabilities can show significant differences in their development. People with intellectual disability might reach developmental milestones later than other children or adults of the same age. They might not reach the same level of cognitive, psychological and social growth as their peers, and some milestones they might not meet at all.

Type of development	Potential effects of disability
Physical	• Some disabilities, such as cerebral palsy, can limit the achievement of physical milestones such as: - fine motor skills - gross motor skills and mobility - forming coherent speech. • Children with sensory disabilities, such as a hearing impairment, can experience delayed or reduced speech and language. • Some **congenital** disabilities can lead to delayed or absent puberty.
Psychological	• Our ability to reach psychological milestones can be affected by mental illnesses, such as depression.
Cognitive	• A person with an intellectual disability such as Down syndrome can struggle to reach expected milestones in learning skills, critical thinking and applying knowledge. • Communication depends on the capacity to learn connections between symbols and meanings. A cognitive disability can affect the person's ability to learn to use speech and language. They might use biological responses such as crying, smiling or moaning without intending to communicate a message to others.
Social	• Conditions like autism can affect the person's ability to understand social cues and interact with others. • Children or adults who have difficulty communicating because of a disability can experience delays in social development, because they are not able to experience the same quality and complexity of social interactions as often as others. • People with severe intellectual disabilities or dementia might not recognise their ability to communicate with others by using behaviour or non-verbal means. They might not see a connection between the way that other people around them behave in response to their own behaviours.

Congenital
A condition that is present at birth.

View this link to find out more about behaviour and development in children with autism: aspirelr.link/autism-behaviour

The impact of trauma on development

Trauma is common in children who are involved in the child protection system.

Although it has not been proven, there is thought to be a significant link between trauma and cognitive development in children. Children who are placed into care outside the home are frequently traumatised. This can be the result of violence, neglect, unstable attachment to a caregiver and instability in their home life.

Effects of trauma on the brain

While not all children experience delayed development when they have been exposed to deprivation or threat, trauma during childhood can often affect both short- and long-term development. Some of these outcomes can cause physical changes to the brain and can be identified in cognitive tests. For example, children who have been exposed to trauma and abuse are more likely to have a smaller area of the brain for processing emotional and social information than children who have not been abused.

Trauma is known to have different developmental impacts depending on other factors:

Reason for trauma	Impact on development
Threat	Children exposed to uncontrollable fear of danger, such as violence or humiliation, may feel an ongoing and ever-present threat. This can trigger overproduction of stress hormones, leading to ongoing sensitivity to stress and anxiety, affecting brain development.
Omission of care	Children who have been deprived of care, love, attention or basic needs can develop differently from those who are traumatised by ongoing threats. When a child is neglected, their brain needs to focus on survival, at the expense of learning intellectual, social, and emotional skills and regulation.

Serious effects of abuse and neglect can include:

- delays in learning and cognition, leading to a lower IQ
- reduced language and reading skills, including difficulty using language to interact socially
- low self-esteem
- difficulty with attention span and memory
- reduced ability to regulate emotions and behaviour
- poor planning and organisation skills

- poor mental and physical health in adulthood
- overreaction or underreaction to stimuli in the environment
- disruptions to sleep.

Example

Developmental effects of trauma

Tawie is 12 years of age. He lives in foster care and has been moved from several different placements because of his extreme behaviours, often labelled as disruptive and violent by teachers and foster carers. Tawie was diagnosed with foetal alcohol spectrum disorder shortly after birth, and was removed from his parents at age six, as he was the victim of sexual and physical abuse at the hands of a stepfather. He has been diagnosed with post-traumatic stress disorder (PTSD) and complex developmental trauma. His literacy skills have not developed past reading and writing levels expected at age seven. He has a short attention span, poor memory, and finds it difficult to regulate his emotions. He sometimes shows extreme reactions to small requests from teachers or care givers. He is also reactive to sensory stimulation, such as competing noises.

Tawie finds it difficult to communicate with adults and other children. He struggles to voice his needs without becoming angry and is seemingly unaware of social cues that other children his age have mastered.

Practice Task 1

Question 1

Name the five areas of human development and give an example of each.

Question 2

List three specific factors that might limit the development of a child's social development.

Question 3

Which of the following could be examples of the effects of trauma on a child? Tick the correct responses.

- ❑ A smaller area of the brain responsible for processing emotional and social information
- ❑ Underproduction of stress hormones
- ❑ Low self-esteem
- ❑ Problems with memory
- ❑ Reduced language and reading skills

Question 4

Explain why parents are usually the most appropriate source of information about a child's developmental status.

1B Clarify developmental status

When you recognise unusual developmental patterns, you can refer the child or person to the right supports in a timely way.

Formal assessments of developmental delays/problems are generally done by medical professionals or child development professionals. However, case managers and other community service workers can play an important role in recognising unexpected or unmet developmental milestones. You might recognise potential issues with a person's developmental status while making formal and informal observations, asking questions or referring to information documented by healthcare professionals.

Make observations about the person's developmental status

Observation is a powerful tool because it provides subtle and complex clues about the person's abilities, skills and cognitive awareness.

Here are some examples of what you might observe as clues to developmental status.

Speech and language	Listening to the child or person talk and the content of their speech can tell you about their cognitive, social and psychological development. • A child or baby who is not using speech at the expected level might have a hearing impairment, or developmental or cognitive delays, such as intellectual disability or autism. • A child who has reverted to 'baby talk' or who is not talking at all might be experiencing trauma such as abuse or neglect. • Confused or repetitive speech and forgetfulness might tell you that a person may be experiencing cognitive decline.
Social interaction	Observing the person interact with others, including friends, family members, care workers or strangers can give you information when they are not showing an expected level of social development: • Ongoing withdrawal from others can be a sign of depression or other mental health condition. • A four-year-old child who is uninterested in playing with other children might have developmental delays in social functioning, such as autism or another condition. It could also mean they have experienced trauma or abuse.

Level of independence	Observing the person's ability to perform self-care and self-management can tell you about their cognitive or psychological status: • A person who is overly compliant or dependent on others when they would be expected to be more independent might not be empowered to make their own decisions or choices. • A person with dementia who appears dirty or badly dressed might be having difficulty meeting safe levels of personal hygiene.
Motor skills	Observing a person's fine and gross motor skills can help you understand their physical development status and how it aligns with their cognitive abilities. This might tell you: • whether an infant has mastered expected gross motor skills, such as crawling or walking • whether a child has reached expected milestones in fine motor skills for their age, such as being able to use crayons, scissors or pens.
Behaviour	You might observe a range of behaviours that can tell you about the person's cognitive, social and psychological development. For example: • A child who appears frightened of their parents might be experiencing abuse. • A child who is acting up in the classroom might be experiencing the effects of poverty or trauma.
Appearance	A person's appearance, odour and dress can sometimes alert you to signs that they are not able to care for themselves adequately, or that they are experiencing the effects of poverty or neglect.

Ask questions to obtain information about the person's developmental status

Parents' concerns are considered to be generally accurate in identifying developmental, language and behavioural problems in children. To gather further information about developmental status, you might consult with and ask questions of:

- the person or child
- a child's parents or foster carers
- family members or others identified by the person
- support workers or service providers.

Consent from the child's parent or carer to seek information from others requires that the parents be provided with adequate information about what and why information is being collected and how it will be used. Informed consent means that

the parents or the child's carer has made their decision freely and without pressure from others. Your workplace may have a consent form that is used when information is shared with staff from another agency.

Your workplace will frequently use a tool or combination of tools, such as a questionnaire, checklist or form to help ask questions based on the child or person's age or reason for support.

Here are some examples of questions that might appear on a questionnaire designed to be asked of parents.

Question/prompt	What this can tell you
Can you tell me a little about your child?	A broad question like this can be a very useful starting point. Very few parents (as few as 2%) will provide strongly negative responses to this question. If you do encounter very negative responses, such as 'He is naughty/aggressive/difficult' with limited positive statements to offset them, this is reason to be concerned about the child's development, and about the parent's relationship with the child.
What can your child do independently?	Comparing responses against expected milestones can help you to assess the child's developmental skills, including their physical and cognitive development.
Have you noticed any problems in the way your child is growing and learning?	This question can help to highlight developmental problems such as: • speech • attention • fine and gross motor control • sight and hearing • health problems.
How does your child interact with other people or other children?	This question can help to draw out emotional and/or behavioural issues.
Do you have any questions or concerns about your child?	This can help to draw out issues that the parent might see as not serious or not worth raising, but that could affect the child's development, such as not reaching expected crawling or walking milestones, or lack of interest in playing with other children.
How are you doing as a parent?	This question can help you to pinpoint frustrations, problems or issues that might have an impact on the child, such as lack of interest in the child's development, or over-supporting an adolescent who needs to learn to be independent from their parents.

Review any documented information about the person's developmental status

Screening tools are not designed to diagnose a problem. They are designed to help you identify where there might be delays or issues, so the person can be referred, and results signposted for future comparison. They are most commonly and effectively completed by the child's parents or carers. When the results are available for you to review, they can be useful references for identifying possible areas of concern.

Here are some examples of commonly used Australian developmental screening tools:

Ages and Stages Questionnaire (ASQ)	This questionnaire is completed by the parent or carer. It helps to identify age-specific development for babies and children from four months to five years. The tool can help to identify delays in: • communication • gross motor skills • fine motor development • problem solving abilities • personal adaptive skills.
The Parents' Evaluation of Developmental Status (PEDS)	This tool has ten questions to be answered by the parent or carer. It can be used from between birth to eight years of age. The PEDS is an evidence-based questionnaire that parents can complete at ages: • 6 months • 12 months • 18 months • 2.5 to 3.5 years • 4 to 5 years. In some states and territories, the PEDS is included in the child's maternal health record.
Brigance Screens	This tool is used by allied or medical professionals. It can be used from birth to seven years and consists of nine different forms which help to screen: • articulation and speech • expressive and receptive language • gross motor skills • fine motor skills • general knowledge • personal social skills.

Adaptive Behaviour Assessment System – Third Edition (ABAS-III)	This tool can help to assess **adaptive behaviours** and functioning in children and adults and can be used from birth to 89 years.
The Griffith Mental Development Scales (GMDS)	This tool can help to assess cognitive development in children from birth to 8 years.
Paediatric Evaluation of Disability Inventory Computer Adaptive Test (PEDI-CAT)	The PEDI-CAT is used with children and youths up to 20 years of age who have physical and/or behavioural conditions. It can help to identify delays, and track improvements over time.
WHODAS 2.0	This tool can be used to measure milestones for children and adults with specific types of disabilities. It is linked to the International Classification of Functioning, Disability and Health (ICF), so that milestones can be checked against measures related to classified disabilities.
Contextual Fit Checklists for Families and Schools	This checklist is used by the family or school of a child who is receiving Positive Behaviour Support (PBS).

Adaptive behaviours
Age-appropriate abilities to perform self-care, go to work or school, develop relationships with others and participate in the community.

View this link to read more about the Parents' Evaluation of Developmental Status (PEDS): aspirelr.link/peds-test

View this link to see more examples of developmental screening tools used in Australia for children and adults of all ages and abilities: aspirelr.link/deai-assessments

Practice Task 2

Question 1

What might you observe in a baby that may indicate they are not meeting physical development milestones as expected?

Question 2

Name a tool that can be used by parents to help answer questions and identify developmental concerns about their child.

Question 3

Explain how a PEDS questionnaire is used.

Question 4

Provide two things that should be done when seeking consent from a child's parent or carer before gathering relevant information about the child.

1C Apply lifespan development theories

Human lifespan development theories have changed as we learn more about psychological and emotional development.

Human development theories help us to understand human behaviour, motivations, social interactions and growth. Some theories are considered outdated in their entirety, but can nevertheless contribute some understandings to the complexity of human development.

Attachment theory

British psychologist John Bowlby (1956) proposed that the bonds formed by children with their caregivers early in life have an impact on their development throughout life, and form the basis for their relationships in adulthood.

His theory proposed that:

- attachment serves a biological purpose: to keep a baby close to the mother
- children are born with an instinct to form attachments
- the need to be nurtured drove this attachment, more than the need for food
- when specific caregivers are available and responsive to the child's needs, the child develops a sense of security
- this creates a secure base for the child to then explore the world
- children with secure attachments tend to be more independent, do better in school, form effective social relationships, and be less prone to depression and anxiety
- adults who were securely attached in childhood tend to have good self-esteem, strong romantic relationships, and the ability to trust others
- children who do not have a nurturing carer may never develop the sense of trust needed to form an attachment
- lack of secure attachment in early life can lead to negative behaviours in childhood and later life.

There are thought to be four main types of attachment:

Secure attachment	This is the most common attachment style. These children show distress when separated and excitement when reunited with their parents. Although the child may be upset, they can be reassured that the caregiver will return.
Ambivalent attachment	These children can become very distressed when a parent leaves because they cannot depend on them to return when they need them. The child may be needy, clingy and anxious.
Avoidant attachment	These children tend to either avoid their caregiver, or show no preference between a caregiver and a complete stranger. They will stop seeking connection or love from the parent. This can be a result of abuse or neglect.
Disorganised attachment	These children may avoid or resist the parent and seem confused about whether the parent is a source of comfort or fear. This is usually linked to inconsistent (rather than dependable) behaviour from the caregiver.

Children who may experience attachment problems include children who:

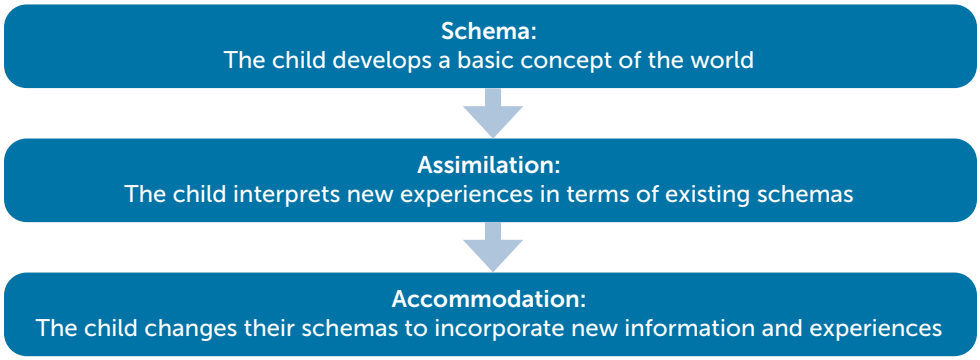
- are diagnosed with oppositional defiant disorder (ODD) or post-traumatic stress disorder (PTSD)
- have been abused or neglected
- were adopted after the age of 6 months
- were raised in foster care or group homes.

Piaget's theory of cognitive development

Swiss psychologist Jean Piaget believed that children try to explore and make sense of the world around them in a series of stages. Piaget defined each stage as an increasing ability to adapt to the environment. The child develops ideas about the world (**schema**), learns to assimilate new experiences into their existing schema, and is finally able to accommodate experiences that challenge their schema, by changing it.

Schema
A concept or idea about the world, such as the idea that all dogs bite.

This takes the child through the following outlook on the world:



At each stage, Piaget believed that there is a constant balance between assimilation and accommodation, through a process he called equilibration. The child maintains a balance between their previous schema, only changing their behaviour to account for new knowledge in a careful balance.

In Piaget's theory, each transition between assimilation and accommodation can be roughly assigned to an age group, and each transition results in an increasing ability to adapt to and understand the world.

Birth – age 2	The sensorimotor stage	During this stage, infants and toddlers understand and learn about the world through sensory experiences, people and objects around them, rather than words.
Age 2 to around age 7	The preoperational stage	The child cannot see from the perspective of others, and can only see problems from their own perspective, referred to as 'egocentrism.' The child is unable to use logic to solve problems and does not understand concepts such as reversibility.
Around age 7 to age 11	The concrete operational stage	The child begins to use simple concrete logic, but their thinking is still rigid. They tend to struggle with abstract ideas.
Adolescence to adulthood	The formal operational stage	In this stage, the capacity to use logic and reason increases, and the child begins to understand abstract symbols and logic.

Example

Applying Piaget's theory

If a two-year-old girl pulls the fur of a dog and then it snarls and bites her, the child develops a schema that all dogs bite. She is not able to understand that the biting dog was responding to its own fear. She is also not able to see that this might be an isolated incident, or to problem solve around how to avoid hurting a dog, because these are both abstract concepts. Instead, she cries and screams when a dog comes near her.

By the time the child reaches seven or eight, she has seen many dogs in a range of settings and has watched other people pat and play with dogs. She begins to assimilate these experiences into a vague understanding that not all dogs bite. She can problem solve ways to be near a dog without frightening the dog, including standing perfectly still when a dog comes near her. However, she is still frightened of all dogs, and is unable to see her own fearful behaviour from a dog's perspective.

Later, in her teens, the girl has changed her schema into an understanding that very few dogs bite, and that when they do, they are usually responding to their own fear. She accommodates her feelings about dogs into this new schema.

Freud's psychosexual theories

Many of Sigmund Freud's theories of development are no longer considered sound, but they did open doors to discussion about psychological development. Freud believed that personality develops through psychosexual energy, or early libido. His theory suggests that personality is mostly established by the age of five, and that early experiences play a large role in the behaviour of the adult later in life.

Erikson's psychosocial theories

Erik Erikson's theory considered the development of personality as happening throughout the entire lifespan, rather than being firmly fixed in childhood. Like Freud, Erikson believed that personality develops in a series of stages. However, Erikson's theory is more flexible, recognising the importance of building on successes in previous social experiences. There remains widespread support for Erikson's ideas.

Erikson's psychosocial stage theory put forward the idea of ego identity. Ego identity is the conscious sense of self that we develop through our social interactions. In this theory, our ego identity is constantly changing as we are exposed to new experiences and information gained in social interactions.

Erikson also believed that behaviour is motivated by the need to feel competent. If we become skilled in an area, we will feel a sense of competence, sometimes referred to as 'ego strength' or 'ego quality'. If we do not master the skill, we feel a sense of inadequacy. Each of these events are a turning point in our development: we either develop a new psychological quality, such as confidence, kindness or empathy, or we fail to develop that quality.

There are eight stages, with each stage building on skills learned in previous steps.

Stage	Age	Balance between success and failure
1. Trust vs mistrust	Birth to 12 months	• An infant's capacity to develop trust is based on the quality of care they receive, and how dependable the parents are to meet the baby's needs. If the baby can trust their caregivers, they will feel that the world is safe and secure. If their parents or caregivers are emotionally unavailable, unpredictable or neglectful, the child will believe that the world is frightening, inconsistent and unpredictable. • Erikson believed that most of us develop with a balance between these extremes: an openness to experience balanced with wariness of risk and danger.
2. Autonomy vs shame and doubt	Early childhood	• Children develop a sense of personal control at this age. Learning to make choices, such as the clothes they wear, and to control bodily functions, as occurs with toilet training, lead to a sense of control and independence. • Children who learn choice and control feel a sense of **autonomy**, security and confidence, while those who do not, feel shame, inadequacy and self-doubt. • A balance between these extremes leads to the child understanding their ability to act with their own will, within fair limits.
3. Initiative vs guilt	Preschool years	• Through play and social interaction, children learn to assert power and control over their world. • Children who succeed feel capable in leading others. • Those who do not succeed feel guilt and self-doubt, and lack initiative. A good balance leads to a sense of purpose and initiative together with a willingness to work with others. This ego quality is known as purpose.
4. Industry vs inferiority	Primary school years	• Children begin to develop a sense of pride in their accomplishments and abilities. When they are praised, they develop a feeling of competence. If there is little or no encouragement from others, they will feel inferior. • A balance of these qualities leads to a belief in our own abilities, while managing problems and working industriously.

Autonomy
A person's ability to make their own decisions.

Stage	Age	Balance between success and failure
5. Identity vs confusion	Adolescence	• At this age children develop a sense of self through independence. When they are encouraged by peers and others in their search for independence, they will develop a firm sense of identity. If they are not, they will feel insecure and confused about themselves and the future. • A balance allows them to live confidently in their own skin, in line with society's standards and expectations.
6. Intimacy vs isolation	Early adulthood	Close personal relationships define this stage. If young people are successful and have achieved balance in previous ego qualities, they can form committed and secure romantic relationships and friendships. People with a poor sense of self tend to have less committed relationships and are more likely to experience isolation, loneliness, and emotional distress. Success in this arena means lasting, meaningful relationships with other people.
7. Generativity vs stagnation	Adulthood	Career, family and relationships become a focus of this stage. If people are successful in this stage, they feel that they are contributing to their home and community. If they feel unsuccessful, they feel unproductive and socially disconnected.
8. Integrity vs despair	Senior years	At this phase, the person develops wisdom as they reflect on life. If they are proud of their accomplishments, they feel a sense of integrity. If they have felt failures at previous stages they are likely to feel regret, bitterness and despair.

Example

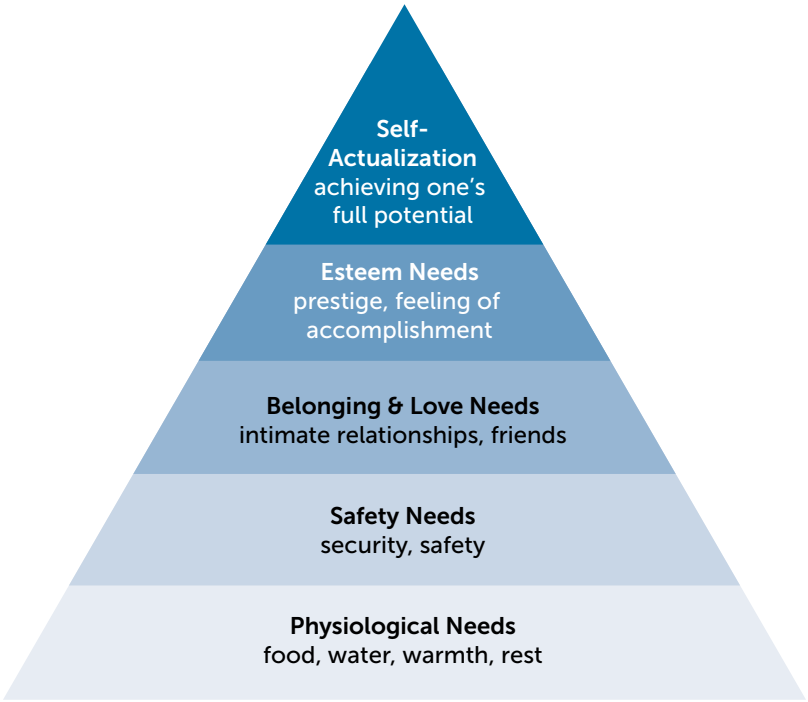
Applying Erikson's theory

Manish was supported during childhood by loving, supportive parents. As a teen, he built a strong sense of personal identity and was liked by his peers. Achieving this stage successfully meant that he was more capable of forming a loving and committed intimate relationship in adulthood.

Maslow's hierarchy of human needs

Abraham Maslow's theory of human motivation sees development and behaviour as a response to our ability to meet progressive stages of need.

In this model, we are biologically driven to seek first the lower, more basic levels of need before we are driven to seek out higher levels of need. The needs that we are biologically driven to seek out first are at the bottom of the triangle. Only when that level of need has been met is it possible to focus on the needs at the next level, and so on.



Example

Applying Maslow's theory

Greta is 15, and feels unsafe at both home and school. She is exposed to domestic violence at home, and her parents use her as an emotional pawn in their ongoing, alcohol-enflamed arguments. At school, she is shy and awkward, frequently bullied by other children for her outdated clothes and shabby appearance.

Once a friendly child who frequently sought out the company of other children, she has become withdrawn. Without realising it, she is entirely focused on trying to meet the needs at the safety and security level of Maslow's triangle. Until she is able to have these needs met, she will be unable to progress up the pyramid, and will not seek out love and belonging, self-esteem or **self-actualisation**. The longer she goes without striving for these higher-level needs, the less likely she will be to develop the skills required to meet them.

Self-actualisation
The highest need in Maslow's hierarchy, it is associated with reaching one's full potential and feeling successful and fulfilled by creative, intellectual or spiritual pursuits.

Practice Task 3

Question 1

Match each term about attachment theory to its definition/description.

Ambivalent attachment	This is the most common attachment style. These children show distress when separated and excitement when reunited with their parents. Although the child may be upset, they can be reassured that the caregiver will return.
Secure attachment	These children can become very distressed when a parent leaves, because they cannot depend on them to return when they need them. The child may be needy, clingy and anxious.
Disorganised attachment	These children tend to either avoid their caregiver, or show no preference between a caregiver and a complete stranger. They will stop seeking connection or love from the parent. This can be a result of abuse or neglect.
Avoidant attachment	These children may avoid or resist the parent and seem confused about whether the parent is a source of comfort or fear. This is usually linked to inconsistent, rather than dependable behaviour from the caregiver.

Question 2

Briefly outline Piaget's theory of cognitive development.

Question 3

In Stage 4 of Erikson's theory (Industry vs Inferiority) explain how praise helps the child to develop.

Summary

- Human development refers to the cognitive, physical, psychological, social and affective changes that occur throughout the lifespan.
- Developmental milestones are an important signal for when a child might need support so they do not fall behind other children the same age.
- Milestone charts can be a helpful way for parents and professionals to identify the early signs of an internal or external problem that might be hindering their development.
- Recognising unexpected or unusual developmental patterns can help you to refer the child or person to the right supports in a timely way.
- Observation is a powerful tool because it can help to provide subtle and complex clues about the person's abilities, skills and cognitive awareness.
- Asking questions of the person or significant others can help you to determine their developmental status.
- There are many screening tools used to capture social, cognitive, behavioural and other developmental milestones. They can be useful references to help to identify possible concerns.
- Human development theories help us to understand human behaviour, motivations social interactions and growth.

Learning Checkpoint 1

Clarify child or young person developmental status

Part A

1. Which of the following are ways you might use to clarify a person's stage of development? Tick all that apply.

- ❑ Making observations of their abilities
- ❑ Consulting other children
- ❑ Obtaining consent and asking questions of parents
- ❑ Reading peer reviewed journals
- ❑ Reviewing documentation, such as a PEDS

2. List one factor that might be likely to affect social development in a two-year-old.

3. Which of the following statements are correct? Select yes or no for each one.

a. The availability of food determines attachment style more than any other factor.	Yes / No
b. Piaget believed that there is a constant balance between assimilation and accommodation, a process he called schemas.	Yes / No
c. Erikson believed that personality develops in a series of stages and recognised the importance of building on successes in previous social experiences.	Yes / No
d. Maslow's theory proposes that we seek out a lower, more basic level of need first, before we are driven to seek out higher levels of need.	Yes / No

4. Number each of Piaget's stages of cognitive development from 1 to 4.

	The formal operational stage
	The sensorimotor stage
	The concrete operational stage
	The preoperational stage

Part B

Read the case study and answer the questions that follow.

Case study

A 13-year-old First Nations child called Belle has a developmental condition, resulting in delays in language and literacy skills. She has been seen by allied health professionals including speech therapists from an early age.

Over this time, Belle has developed a distrust of community and health services and non-First Nations workers, in part due to her experiences with white people, and in part because of the attitudes and experiences of her parents. Belle was the victim of child sexual abuse by a teacher at her school when she was six, and this contributed to her fear of people outside of her own community.

1. Using Erikson's theory, outline how Belle might have developed schemas to account for her distrust of community and health services at the concrete operational stage of development. Can her schema be changed at this point in her development?

2. Which cognitive milestones might Belle have been expected to reach by this age? Give three examples.

3. Sexual abuse during Belle's childhood has left her with a feeling of ever-present threat. What physiological effect could this have on Belle's brain development?

Topic 2: Identify child or young person developmental issues

2A Recognise developmental factors in a person's behaviour

2B Clarify that services fit the person's developmental status

2C Identify potential risk factors associated with developmental issues

2A Recognise developmental factors in a person's behaviour

When a person is behaving in ways that appear anti-social, unusual or disruptive, it can indicate that there are developmental issues or other factors at play.

In your role, it is important to be aware of expected developmental milestones, to know whether the child or person has reached them, and thus to observe whether there may be delays in development.

There are several reasons why your observations are important:

1. Reporting concerns that a child is not reaching expected milestones can trigger early intervention, reducing the likelihood that they experience compounding developmental losses.

2. Your reports can result in the earlier diagnosis of a condition or disability, such as dyslexia, autism, cerebral palsy, or intellectual disability, so that a child can receive the right support.

3. Being able to recognise delays or differences in developmental status can help you understand the needs of a person at any age, including how you communicate with them and what you should reasonably expect of them.

4. You must often take into account the person's developmental status, not just their age, when planning and referring specific supports and services.

5. Developmental delays or unexpected differences can indicate that there are other social, environmental or health issues in the person's life.

Recognise factors that influence behaviour

Behaviour is a natural expression of our emotional and psychological state. Behaviour can be deliberate or it can be a subconscious biological response to past experiences that have affected brain development. Here are some examples.

Cognitive or learning delays	Some early behaviours might be signs of cognitive impairment, such as an intellectual disability or learning disability. Behaviours that could indicate a learning disability or cognitive delay in a child could include: • poor progress or late development of physical milestones such as smiling or crawling • being slow to develop speech and having a smaller than expected vocabulary • disruptive or disengaged behaviour towards other people including other children • problems with focus or attention span • difficulty with cognitive flexibility (meaning that children may find it hard to adapt their behaviour to suit different settings, to transition from task to task, and to plan, initiate or complete schoolwork).
Neurodevelopmental disorders	Conditions such as **ADHD**, auditory processing disorder or dyslexia are often diagnosed in childhood. Occasionally the child may grow out of the condition as they enter adulthood. Behavioural signs can depend on the condition. For example, children with ADHD may exhibit behaviours that include: • daydreaming and lack of focus • forgetfulness • hyperactivity including fidgeting and restlessness • difficulty controlling impulses • difficulty making friends.
Autism	Early signs of autism usually appear in the first 1-2 years of life. Behaviours that might need referral to a professional in infancy and early childhood include: • unusual social behaviour, such as lack of interest in other children • repetitive movements and restricted interests • limited facial expressions • limited gesturing or pointing • no response to hearing their name • lack of eye contact.
Dementia	When supporting older people, it is important to observe and investigate behaviours that might indicate early signs of dementia that are not an expected part of the ageing process. These can include: • unexplained or significant memory loss • confusion • repetitive speech.

Attention deficit hyperactivity disorder (ADHD)
A neurodevelopmental disorder characterised by inattention, hyperactivity, and impulsive and disruptive behaviour.

Attachment disorders	Children who have attachment disorders resulting from childhood abuse or neglect can show behaviours such as: • little emotion during social interactions • difficulty calming down when stressed • unhappy, irritable, or scared when with their caregivers • extreme distress when the caregiver is out of sight • difficulty with behavioural regulation and impulse control. In adults, signs of attachment disorders can include: • difficulty establishing and maintaining relationships • difficulty controlling anger • difficulty reading emotions • resisting affection or difficulty showing affection • difficulty trusting people • an extremely negative self-image • excessive neediness • poor social boundaries, such as asking intrusive questions to people that they have just met.
Abuse and trauma	Children and adults who are victims of past or current trauma or abuse can display behaviours such as: • anti-social behaviour, for example criminal activities, truancy, running away from home • violent, argumentative or disruptive behaviour • problems maintaining relationships • risk-taking behaviour, such as heavy use of alcohol or other drugs • learning delays and difficulty in paying attention and remembering • reduced ability to feel physical pain • a drop in performance at school or work • fear of a particular person, or generalised signs of fear and anxiety • difficulty with emotional regulation • flashbacks, nightmares and intrusive ideas.

Read more about the early signs of autism at Raising Children: aspirelr.link/raising-children-autism-assessment

Being aware of your own values and attitudes

It is important to put aside your opinions and judgments when you witness behaviours that might be signs of developmental issues. Your attitude can have negative consequences on the family seeking help.

You may find yourself triggered when the behaviour of someone with developmental issues, traumatic histories or delayed emotional or psychological growth goes against your values and beliefs.

We are all products of our experience and upbringing, and have our own biases and blind spots. It can be an automatic response to make judgments about children or adults who use antisocial or socially unacceptable behaviours, however it is important to recognise these judgments and consciously put them to the side.

For example:

- You may have strong religious or ethical views about criminal or antisocial behaviour.
- Your values about parenting styles may differ from those of the person or family.
- You may feel irritation or annoyance about attention seeking behaviours.
- You may feel triggered by people who do not show empathy for others.
- You may think the person has brought their life problems on themselves.
- You may hold incorrect beliefs, for example, that significant memory loss and confusion are the usual signs of ageing.

The potential effects of your values and attitudes

When a service provider or health professional is judgmental towards someone needing support, it can have a number of negative effects. The following table offers some examples.

If the person or family feels judged, they may be less likely to seek help.	This can impact children in need of early intervention, or people experiencing or at risk of abuse or neglect.
Imposing your values or attitudes on the family or person can cause them to be less honest about their needs.	They may attempt to play down or hide behaviours that could be important clues to developmental issues, such as struggling at school.

Feeling judged can reinforce the child or person's negative self-image.	Some professionals might have expectations of acceptable behaviour in children and adults. For example, if you believe that children should be quiet and polite, you might see disruptive behaviour as a sign that the child is being wilfully disobedient. Negative responses can entrench the child's world view that adults are mean and cannot be trusted.
Holding assumptions or misconceptions can make you less likely to identify people at risk or cause you to downplay the importance of certain signs.	For example: • If you consider that self-harm in adolescents is merely attention seeking, you can miss important clues about trauma and attachment issues. • If you think that all older people eventually develop dementia, you might overlook the need to refer memory loss or confusion.
Unconscious bias might cause you to overlook signs of abuse or violence in families from higher socio-economic groups.	For example, behavioural signs of child abuse should be a cause for concern whether it is noticed in the child of a well-presented, educated parent or an unkempt family in a poor neighbourhood.

Unconscious bias
Subconsciously forming social stereotypes about certain people and expressing these.

Recognising lived experience

In the past, mental health and other professionals often took charge of people who had experienced trauma or neglect with an attitude of 'I know better, because I am the trained professional. Listen to me, and I will tell you how to cope and what to do.' These days, professionals recognise and acknowledge people's experience in the situation, or 'lived experience' as just as valuable, if not more valuable, than knowledge gained through study.

Using this approach can be difficult for workers who are anxious and eager to jump into problem solving. However, putting aside your own assumptions, and listening to and making use of the person's lived experience can help you to see the person's developmental issues as a sum of their experiences, and outside of their control.

The person can then also become a valuable contributor to the conversation about ways to move forward, such as seeking counselling or other supports. As well as leading to better solutions, this approach has the additional benefit of being a great way of developing rapport, and fostering empathy and mutual understanding.

Example

Unconscious bias

A case manager might be aware that the child of a First Nations family is using extreme and disruptive behaviours at school, while making poor progress in literacy. While the case manager might not consider themselves in any way racist, unconscious bias about First Nations communities could lead to the assumption that the child is reacting to abuse or poor parenting, rather than considering the potential of a disability or disorder that should be assessed by a medical professional.

Unconscious bias like this can lead to a family being unfairly accused time and time again of problems for which there is no evidence. Over time, this might lead to resistance in the family and/or the community to seek help from institutions such as police, hospitals and other services.

Practice Task 4

Question 1

What is the meaning of unconscious bias?

Question 2

Give three examples of negative outcomes that might result from a worker imposing their values or attitudes on a client.

Question 3

List two factors that might contribute to an adolescent being involved in risk-taking behaviours.

2B Clarify that services fit the person's developmental status

Humans are complex and there are many, many types of 'normal' and 'acceptable'.

Much of the information you learned in Topic 1 focused on developmental milestones and skills that people are expected to develop in a certain way, at a certain age. While the concept of developmental milestones is a useful tool to identify unexpected issues in development, they should never be used to imply that the child or adult is not 'normal', or that they are less valuable or worthy as a human being because they do not reach stages of development alongside their peers.

The importance of early intervention

Up to eight years of age, a child's brain changes rapidly, and even though the child has not finished learning or expanding their skills, the brain has reached its optimum potential for intellectual, social and physical development. After this age it becomes harder to change. When a child is experiencing a developmental delay of any kind, the earlier an intervention is put into place, the less likely the child will experience significant or ongoing effects. Early interventions can begin from when a person is an infant.

Example

The importance of early intervention

If a baby is not reaching expected social milestones such as smiling or babbling due to an undiagnosed hearing impairment, they may have significant delays in reaching other important milestones too, such as developing speech, and playing with other children. These delays can significantly affect the child's future, including their engagement at school, self-esteem and their future education and employment.

The earlier the child is referred to appropriate supports, the greater the chance that their hearing impairment can be diagnosed and supported, improving their long-term speech development and other important milestones.

Determine and clarify services

There are a range of mainstream and specialised services to suit the needs of a child or person with developmental issues.

Now that you better understand the development status of people and can identify factors that influence development, your role can include clarifying whether current services are appropriate for the person's needs, and/or determining new services for the individual.

Keep in mind that mainstream services are often the preferred option for children and adults with developmental disabilities. This aligns with the principles of community **inclusion**, and supports people's right to access mainstream services in their own community. Mainstream services may need to make adjustments so they meet the needs of people with a developmental disability. These are called reasonable adjustments. They might include installing ramps, providing a quiet space, installing hearing loops, or allowing flexibility for employees.

Inclusion
Providing equal access to opportunities and resources for people who might otherwise be excluded or left out.

However, some developmental disabilities or behavioural concerns can make a specialised disability service a better fit for those who are not able to participate in mainstream services.

Read more about the pros and cons of mainstream education compared to a special school for children with developmental disabilities, and the reasons why mainstream education should be the first option for some children: aspirelr.link/education-rights-school-types

Sector	Mainstream options	NDIS supports that might be available to supplement mainstream options	Specialist alternatives to mainstream
Education	• Early childhood education services • Primary and secondary private and government schools • TAFE and universities	• School readiness programs • Support for behaviour • Teacher aids • Modified computer hardware • Education software • Braille books • Transport options to take children on excursions • Case coordination for early childhood supports • Small classes in a mainstream school	Schools that specialise in providing education to children with: • autism • emotional or behavioural issues • hearing impairments • intellectual disabilities • learning delays • speech/language disorders • vision impairments.

Sector	Mainstream options	NDIS supports that might be available to supplement mainstream options	Specialist alternatives to mainstream
Youth justice	• Legal services • Youth detention centres • Rehabilitation services	• Assistive technology, such as communication aids • Training for staff in custody to provide disability support • Capacity-building supports, such as support coordination, a recovery coach, occupational therapy or behaviour supports • Justice support program and the disability advocacy and information service	• Disability-specific legal supports • Specialist court lists for people with a mental illness or a cognitive impairment • Disability justice centres (secure accommodation facilities for people with an intellectual or cognitive disability who have been charged with a serious offence)
Child protection	• Foster care placements • Mainstream facility-based care	• Development of daily living and life skills • Assistance to continue care at home • Disability-specific parenting training programs • Behaviour support • Assistance with daily personal activities, aids and equipment, community participation and home modifications supports	• Specialist facility-based care • Kinship carers programs

Behaviour of concern
An action that can cause harm, either to the person who presents with the behaviour or to others.

Example

Mainstream versus specialised schooling

Harriet has ADHD and is enrolled in a mainstream primary school. She has been experiencing problems at school because the teachers lack experience in supporting her when she is engaging in a **behaviour of concern**. Rather than use positive approaches, they tend to segregate her from the class and keep her isolated in another room whenever a behaviour begins. This has a cyclical effect: the more Harriet is segregated, the less she learns about self-control and managing her behaviour in class. Other parents have lobbied to have Harriet removed from the school because they feel the teacher's time with their children is being affected by Harriet's increasingly disruptive and occasionally aggressive behaviours.

Harriet's case worker helps Harriet's parents to access a behaviour support specialist through the NDIS. The specialist is able to work closely with Harriet's school, including the principal and teachers, to help them understand how their reaction to Harriet's behaviour contributes to a negative cycle, and provide positive, pro-active support strategies to use when Harriet is most likely to engage in a behaviour of concern. In addition, the case manager helps Harriet's family and the school to access funding for a specially trained aid who will provide one-on-one support to Harriet several hours a week while she is at school.

View this link for more information about supporting children and families who are involved in the child protection and family services, where the child has a developmental or other disability: aspirelr.link/dffh-vic-family-guidelines

Video: Working with parents with disabilities
Watch this video about helping families to navigate NDIS services, where the parent has a disability: aspirelr.link/vimeo-parents-with-disabilities

Strengths-based approaches

A **strengths-based approach** takes into account that every person, regardless of developmental issues, has their own unique set of skills, abilities and goals. Rather than focusing on the person's deficits, contemporary services focus on strengths and building capacities. Strengths-based approaches do not emphasise comparisons between an individual's development and that of their peers, nor what we think it 'should' be.

Strengths-based approach
Recognises that all individuals are resourceful and resilient experts in their lives, and can progress in a way that enhances their quality of life.

Strengths can include:

- the person's abilities, such as being able to point to pictures to communicate
- the person's positive personality traits, such as being generous, affectionate, smiling a lot, enjoying attention, or having fun
- the goals the person has, such as one day being able to go on holiday to Queensland
- having a family that loves them
- having inner resilience that they have drawn on in the past
- having healthy coping mechanisms that the person can use, such as meditation
- a talent, such as writing or painting that can help them to express their thoughts and make sense of their experience.

Strengths-based approaches are used and taught to staff in most contemporary community and education services including:

- early childhood education
- primary and secondary school environments
- social work services
- disability services
- alcohol and other drugs services
- child protection services.

Not all services apply strengths-based approaches well. Some services might not be able to support the person's unique strengths.

You might consult with a child, adult or others about concerns about strengths-based development approaches to make sure that the services and experiences they are involved in are suited to their particular strengths.

Consulting with the person and others about the suitability of services

Asking questions can help you determine whether the services received encourage the person's strengths rather than highlighting their deficits, and whether the services are the right fit for the person in terms of their developmental status. Here are some examples of questions that could be asked during consultations.

Asking a health service about their ability to meet the specific needs of the person	You might ask questions such as: • Are workers in the service trained to support behaviours such as aggression, or alcohol or drug use?
Asking a child in protective services about a foster care placement	You might listen to the child's stories and expressions of their positive and negative experiences in their placement and pay particular attention to expressions that might indicate that the child is not thriving as they might. You might ask the child questions such as: • Do you get to do things that you like to do? • What is your favourite thing about living there? • What is your least favourite thing?
Asking an adult with an intellectual disability about their goals and how they are being met	You might talk to a person with Down syndrome about what they would like to achieve, and how they are being supported to reach their goals. For example: • What would you like to do in your future? • How does your service help you to do this?
Asking a child's teacher about how well the educational program is able to focus on the child's strengths	You might ask questions to identify whether the child is reaching their potential, and how the teacher feels the child's strengths might be better supported. For example: • Which positive strategies work well to overcome the child's behavioural issues? • How are these strategies used? • What types of environments does the child learn best in? • How well is your school or program able to meet these learning needs? • Is there additional funding available that might help to support the child, e.g., learning support in school?

Example

Suitability of foster placement for a child with autism

Children with autism can often react in negative ways to a sudden change in routine. Being able to predict what will happen in their day can help them to manage better without the need to engage in a behaviour of concern. A suitable placement for this child might include a setting in which noise from other children and animals are not daily factors, and where a daily routine will be followed as much as possible.

Document developmental issues

Your organisation will have a set of organisational policies and procedures relating to documenting concerns or observations you have made about the child or adult.

Developmental issues that you might observe or become aware of should be documented, so that your concerns are communicated clearly and on time to relevant others, including professionals. A running record of developmental milestones and progress made can help to paint a more accurate picture of the person's needs and issues. Detailed information over time can help professionals with diagnosis and support for developmental conditions.

Your service might expect you to document concerns in the following ways:

- in the client's file notes
- in a standard assessment form used in the workplace, such as a child development assessment
- in a referral form to a relevant professional, such as a GP or allied health professional
- in a report to people who are relevant to the needs of the child or person, such as child protection officers, teachers or disability support services.

Example

Documenting concerns about development

Ginny works with people who receive supports in alcohol and other drugs services. Today she is seeing Thula, who has her six-month-old baby with her. Ginny knows that Thula does not reliably attend her maternal and child welfare centre appointments.

Ginny notices that the baby is listless and doesn't seem interested in her surroundings or the people around her. Thula tells Ginny that the infant rarely smiles or makes eye contact with her or other family members. Ginny asks Thula whether the baby is reaching other milestones, such as crawling. Thula says 'No' but does not seem concerned.

After the appointment, Ginny documents the conversation, along with her observations of the baby in Thula's file notes. The report triggers a referral to a paediatrician.

Refer or seek assistance

You may be involved in referring a person, child or family to a professional, authority or service to support issues relating to their developmental delay or disability.

Here are some examples:

Professional	Service provided
Medical professionals	Can diagnose and treat physical and mental health conditions.
Allied health professionals	Provide physiotherapy, speech pathology, occupational therapy.
Child protection services	Respond when a child is at risk of harm.
Social worker	Social workers can help to link people in crisis to the right support services. They can help clients who are at risk of: • family and domestic violence • homelessness • mental health concerns • being involved in the youth justice system • poverty.

Professional	Service provided
Crisis intervention and accommodation services	Can provide services such as: • urgent income support and food services • domestic and family violence intervention • child protection.

You can find more information about accessing a social worker at Services Australia: aspirelr.link/sa-social-work-services

Example

Seeking assistance for a child who has been traumatised

When services are providing support to a child who has been abused, the service must understand and use a trauma-informed approach for the intervention.

A child who has been traumatised may need referrals or support for interventions such as:

- a report to authorities to ensure the child is safe
- supporting families or placement families and teachers to understand the link between trauma and cognitive development
- helping the child to build positive relationships with their placement family.

Practice Task 5

Question 1

Explain why mainstream services might be preferable over a disability-specific service for a child with a developmental disorder.

Question 2

Give two examples of services that should use strengths-based approaches.

Question 3

Who might you consult with if you feel that a child is not receiving strengths-based supports in the classroom? Give two examples.

Question 4

A ten-year-old child, who is supported by child protection services, lives in out-of-home care, and is increasingly using behaviours of concern in the classroom at school. List two places you might document your concerns about the child.

2C Identify potential risk factors associated with developmental issues

It is important that you be able to identify people who may be vulnerable to abuse and other types of harm, and recognise signs of abuse and neglect.

Due to the interconnection of different factors, people with developmental delays or issues are vulnerable to harm. For instance:

- Children and adults with extreme behaviours can put pressure on parents or carers, putting them at risk of **abuse** or **neglect**.
- A person's ability to control their emotions might be affected by a developmental disability, putting them at risk of situations of domestic violence.
- The person might use alcohol to help them cope with these emotions. The alcohol can further impair the person's ability to make safe decisions and can put them at further risk of harm.

Abuse
Any intentional action that harms or injures another person.

Neglect
Failing to properly care for a person.

Risk factors for harm

Risk factors that make a person more vulnerable to abuse or neglect include living alone and being isolated from community, and depending on others for financial support or help with basic needs.

If a child is in a situation that makes them vulnerable to abuse, this does not mean they are being abused. There are many healthy, happy, well-cared-for children who live in families faced with challenges. Conversely, there are also many abused children at risk of further harm in families that seem to be healthy, happy and well adjusted.

There are further compounding factors that can complicate a person's vulnerability to risk of harm:

- social or cultural disadvantage
- violent family or social backgrounds
- discrimination and intergenerational trauma
- mental or physical illness
- homelessness
- drug and/or alcohol dependence
- disability
- chronic health conditions, including mental illness

- cognitive impairment such as dementia, intellectual disability or acquired brain injury
- poverty
- being a long-term carer for a person who has high level or complex needs
- unemployment
- stress
- gambling.

Self-harm

Self-harm
Causing deliberate physical harm to a person's own self, with or without the intention to end their life.

The number of people who die by suicide in Australia each year is relatively low compared with the number who **self-harm**. In many cases self-harm works as a coping mechanism to help the person to continue to live rather than ending their life. For many people, self-harm is a way to alleviate intense emotional pain or distress, or overwhelming negative feelings, thoughts or memories. Other reasons include self-punishment, to end experiences of dissociation or numbness, or as a way to show others how bad they feel.

The most common methods of self-harm are cutting parts of the body and deliberately overdosing on medication (self-poisoning). Other methods include burning the body, pinching or scratching oneself, hitting or banging body parts, and interfering with wound healing.

Some groups or people with certain experiences are more at risk of self-harm than others.

All kinds of people may have thoughts of self-harm or carry out actions to harm themselves, however, statistics show it to be more common for people who:

- live with mental illness such as depression and anxiety
- have experienced childhood trauma, such as a history of physical or sexual abuse or bullying
- have a family history of mental illness or other trauma
- have a certain personality type, such as a so-called 'addictive personality' or perfectionism
- misuse drugs and alcohol
- have low self-esteem.

Young women are more likely to self-harm than young men, but they are also less likely to carry out their suicidal thoughts than male youths or men.

Suicidal ideation

'Suicidal ideation' is a term used to describe having thoughts of suicide.

In Australian society, suicide is not often openly discussed, often because it carries a lot of stigma and is tied to feelings of embarrassment and shame.

Tragically, these feelings stop some people from getting the support they need. Sometimes there is no obvious trigger or life situation that leads a person to think about ending their own life. Other times, there can be clear reasons for the person's feelings of desperation, despair or hopelessness. They can be triggered or complicated by events and situations such as relationship breakdowns, unemployment, grief and loss, ill-health or loneliness.

While suicidal thoughts can affect anyone from any sector of society, there are some groups at greater risk than others. People who have made a previous attempt to end their life are one of the highest risk groups.

Other people at risk include:

- people who have a mental illness
- people who identify as lesbian, gay, bisexual, transgender, queer or intersex (LGBTQI+)
- men in rural communities
- older people
- Aboriginal and Torres Strait Islanders
- people with social problems, such as a gambling addiction.

Domestic and family violence

Domestic and family violence Threatening, violent or coercive behaviour towards a partner, spouse, child, parent, housemate, carer or care recipient.

Domestic and family violence can be inflicted on married and de facto partners of any gender, children, parents, flatmates, other relatives, carers or care recipients. Violence can be physical or emotional. It is illegal and sadly common at all levels of society.

Each state and territory in Australia has its own definition of and laws surrounding family violence. In many state jurisdictions, family violence legislation defines domestic and family violence as being threatening and coercive, or including behaviour such as 'causing or threatening injury to a person'. It can include physical violence, threats or intimidation, coercive control or isolating the person from others.

People exposed to family violence may feel that reporting it will make it worse. They may feel there is no escape, particularly if the violent person is living under the same roof. The nature of this kind of abuse is that its victims often blame themselves or feel they may deserve it in some way.

Here are some signs of domestic or family violence:

The behaviour of the potential victim	• They seem afraid of their partner or anxious to please them • They seem anxious or upset when you mention their partner or family situation • They don't seem comfortable making a decision about themselves or their health • They say they don't want to leave the children with their partner or ex-partner • You know that there is an existing intervention order and they are making contact with the partner and breaching that order (which is a criminal offence) • Children seem anxious, afraid or nervous when the potential perpetrator is nearby or discussed
The behaviour of the potential perpetrator	• They are jealous, angry, controlling or possessive • They criticise or embarrass the potential victim in front of other people • They pressure them into doing things they don't want to • They check in on the person a lot • They blame the person
Physical indicators	• A person with unexplained physical injuries and giving unlikely explanations for them

While you do not have a mandatory reporting obligation to report domestic violence that is perpetrated against an adult who is not in your care, you do have a duty of care to ask them or encourage them to report the abuse to police or other authority. There can be many reasons for a person not wanting to make a report, and it is important to gain their trust when they are reluctant to do so.

If you become aware that a child is the victim of violence, you must report your concerns to the relevant authority in your state or territory, such as child protection services or the police, and then take actions to protect the child from further abuse, such as insisting that the child does not return to the abuser.

If the person does not want to report the abuse, you must still attempt to support them to find safe emergency or other accommodation. This can be done through domestic violence safe hubs and services in your local area.

Male perpetrators of domestic violence can be referred to men's behaviour change programs in your state or territory.

In some locations, Aboriginal families experiencing family violence can be referred to Aboriginal services, such as those provided by Koori Family Violence protocols.

Example

Domestic and family violence

A woman who is being physically abused by a male partner is reluctant to seek help from the police. She talks to Yvonne, her case worker, about her concerns. The woman is distressed and crying. Yvonne encourages her to go to the police as soon as possible, but the woman is adamant that this will put her at more risk of harm.

Yvonne locates emergency accommodation. She encourages the woman to pack and leave with her children. At first, the woman refuses, but Yvonne focuses on the need to be safe. Once they are relocated, a domestic violence worker will talk further with the woman about the benefits of having the police involved, and information on how the police will respond to the crisis.

Child abuse

If you work with children or families, you may notice behaviours that are uncharacteristic for a particular child or unusual for children of a particular age or stage.

Like other types of abuse, **child abuse** can occur in all parts of society. However, certain groups are overrepresented in child protection services.

Child abuse
Any physical, emotional, sexual abuse or neglect of a child under the age of 18.

These groups include:

- families from low socio-economic backgrounds
- parents who themselves experienced child abuse
- Aboriginal and Torres Strait Islander communities
- people in rural and remote communities.

There are complex factors involved in these backgrounds, including isolation, lack of role models, social problems and intergenerational trauma leading to people repeating their own childhood abuse.

Type of abuse	Examples	Indicators
Physical abuse	Physical abuse is any deliberate use of force towards the child. It may include: • pushing or throwing • slapping, hitting or punching • burning, for example, with a cigarette • kicking or biting • choking • tying down • assaulting with a weapon • shaking the child violently.	• Physical signs - unexplained bruises, welts, bites, broken bones or burns - injuries that don't match the story of how they occurred - injuries in the shape of an object, for example, a belt buckle or cord - faded bruises or other noticeable marks after they have been absent from care - no medical help given for an injury needing care. • Behaviour - shrinking at the approach of adults - extremes in behaviour, for example, being aggressive, withdrawn or shy - fearful or upset about going home - afraid of a particular person - unusual or violent play. • Parent behaviour - parent is controlling and displays signs of violence and aggression in public - subjects the child to harsh discipline - unrealistic expectations of the child.

Type of abuse	Examples	Indicators
Neglect	Neglect happens when the person or people responsible for the child fail to provide the basic necessities to ensure physical and emotional wellbeing. These include: • food • love • warmth • clothing • shelter • medical attention • proper supervision.	Neglect may have occurred if a child shows one or more of these signs: • Physical signs - consistently dirty and/or has severe body odour - lacks appropriate clothing for the weather or situation - weight loss or dehydration • Behavioural signs - frequently absent from school - constant hunger or begs, steals or hides food • Parents' or carers' behaviours - treats the child indifferently or with resentment - uses excessive drugs or alcohol in front of the child or when caring for the child - doesn't provide the child with medical or dental care - leaves the child alone at home despite a young age.
Sexual abuse	Exposing a child to sexual activity. This includes: • **grooming** • fondling a child's genitals • masturbating in front of a child • performing oral sex or asking for it to be performed • vaginal or anal penetration • exposing a child to pornography.	There might be child sexual abuse if you become aware of: • Physical signs - sexually transmitted infections - pain, swelling or itching of the genital area - stained or bloody underwear • Behavioural signs - regressive, baby like or childlike behaviour that is not in line with their age - talks about sex or pornography - doesn't like being touched, hugged or kissed by an adult • Adults' behaviours - uses sexual language or suggestive behaviours towards the child - avoids leaving the child in the care of other adults - cuts the child off if they discuss their emotions.

Grooming
Common behaviour used by a child sex offender to prepare a child for sexual abuse.

Type of abuse	Examples	Indicators
Emotional abuse	Subjecting a child to ongoing verbal intimidation or humiliation. This can include: • name calling • threats of harm • put downs • isolating the child from social interactions.	Emotional abuse may have occurred if you see signs such as: • Physical signs - self-harm or suicidal ideation • Behavioural signs - extremes in behaviour, such as being overly compliant or demanding, extremely passive or aggressive - signs of depression or severe anxiety - signs of low self-esteem - learning delays • Parents' or carers' behaviours - blaming, belittling or humiliating the child - overtly rejecting the child.

Elder abuse

Elder abuse occurs when there is a power imbalance between the older person and another person, and they misuse that power.

Elder abuse
Harming an older person using financial, physical, sexual or emotional means, or through neglect.

Elder abuse can happen to older people who live in their own homes or in residential aged care. It can be perpetrated by partners, family members, friends, aged care workers, intruders, or other strangers in the community, such as tradespeople or service providers.

The Australian Aged Care Royal Commission uncovered widespread abuse and neglect in aged care services in its 2021 report. As a response, the government has made significant changes to legislation and clarified protocols for the reporting of potential signs of abuse. Abuse may be perpetrated by a family member, a stranger, another resident, a volunteer or a worker.

Older people are especially vulnerable to abuse, exploitation and neglect, especially those with cognitive impairments such as dementia.

There are several reasons for this:

- Older people are more likely to be targeted by scammers or abusers in the community because they may be easier to take advantage of.
- Dementia can make it difficult for the person to recognise or report the abuse.
- Other people are sometimes less likely to believe them if they do report or hint that they are being abused. For this reason, abusers in aged care services might particularly target people with dementia.

Type of elder abuse	Examples	Indicators
Physical abuse	Physical abuse can include: • hitting, slapping, punching, pinching a person, pulling their hair • using physical restraints, such as tying someone to a bed or chair • restricting the person's freedom, such as holding them down • using objects to hurt the person • using force or rough handling an older person • using a restrictive practice that has not been properly approved according to law.	• Bruises, cuts, scabs and scars • Abrasions, welts, rashes • Swelling, burn blisters • Agitation, cowering • Tenderness, pain, restricted movement • Broken or healing bones • Drowsiness • Weight loss • Hair loss
Financial abuse	Financial abuse can include: • forging the person's signature for gain • stealing from the person • forced changes to a will • withholding funds • failure to repay money loaned from the person.	• Missing items or documents (e.g., jewellery, coin collection, bank card) • Inability to pay for basic items • Unpaid bills • Large withdrawals from bank accounts • Changes in banking habits • Fear, stress, anxiety
Sexual abuse	Sexual abuse can include: • touching the older person's genitals for any other reason except to provide personal care • rape • showing the person sexual materials • talking or joking about sex • grooming the person for sexual contact.	• Withdrawal, disturbed sleep patterns, agitation, fear • Drowsiness, vagueness, confusion • Unexplained difficulty sitting or walking • Unexplained bruising • Sexually transmitted infections • Unexplained bleeding around the genitals, chest, rectum or mouth • Torn or stained clothing

Type of elder abuse	Examples	Indicators
Emotional abuse	Psychological or emotional abuse is ongoing behaviour that is designed to intimidate, frighten or disempower a person. Psychological and emotional abuse can be verbal or nonverbal and includes: • pressuring, intimidating or bullying • belittling, name-calling, degrading or humiliating a person • threatening harm • verbal abuse, insults, harsh commands • withdrawal of affection • silencing and emotional blackmail.	• Feeling helpless or ashamed • Depression, sadness, tearfulness • Confusion and disorientation • Loneliness and social isolation • Apathy • Nervousness and anxiety • Insomnia
Neglect	A person who has some responsibility for a vulnerable older person is considered to be neglecting them if the older person: • does not have enough to eat or drink • does not have adequate warmth, shelter or protection from harm • is not helped to access needed medical attention.	• Weight loss, dehydration, poor skin quality • Person appears unkempt – same clothing worn every day of the week, loose or baggy clothing, clothing in poor state, hair unwashed, untrimmed nails, poor hygiene • Person lacks their dentures, hearing aids, mobility aids or glasses • Skin burns from urine being in prolonged contact with skin • Severe sunburn

Practice Task 6

Question 1

List three signs that might indicate a child is being sexually abused.

Question 2

Give two examples of behaviours exhibited by a person who might be perpetrating domestic violence.

Question 3

Which of the following statements are correct? Select yes or no for each one.

a. You must be certain that a child has been abused before acting.	Yes / No
b. People with dementia are more vulnerable to physical, sexual, and emotional abuse than other older people without dementia.	Yes / No
c. Financial abuse can be committed by the person's family.	Yes / No
d. Abuse can be committed by people who are strangers to the person.	Yes / No

Question 4

Which of the following statements about risk factors for self-harm and suicide are correct? Tick all that apply.

- ❑ Only people from low socio-economic groups are at significant risk of acting on suicidal ideation.
- ❑ Self-harm is nearly always the first sign that a person is at risk of suicide.
- ❑ People who have made an attempt to end their life in the past are a high-risk group for suicide.
- ❑ Older people in aged care only express wishes to end their life if they have dementia.
- ❑ Men in rural communities are a high-risk group for suicide, especially when there are signs of mental illness.

Summary

- Behaviour that is anti-social or disruptive may indicate that there are developmental issues at play.
- It's important to understand possible reasons for particular behaviours, and what they might indicate about the person's past experiences.
- Recognise and consciously put aside your judgements and opinions when working with people or families. They can have negative consequences on the family seeking help.
- People's lived experience should be acknowledged and respected. It is just as valuable, if not more valuable, than knowledge gained through study.
- Early intervention can reduce the likelihood that a child will experience significant or ongoing effects of developmental delays.
- Clarify whether current services are appropriate for the person's needs.
- Mainstream services are often the preferred option for children and adults with developmental disabilities, though in some cases, a specialised disability service may be a better fit.
- Always use a strengths-based approach that identifies and builds on a person's strengths and capacities, rather than focusing on their deficits.
- People with developmental delays or issues can be particularly vulnerable to harm.
- Risk factors for abuse or neglect include: living alone, being isolated from the community, being dependent on others for finances and/or basic needs.
- Child abuse refers to any physical, emotional, sexual abuse or neglect of a child under the age of 18. It is often perpetrated by a person in a position of trust.
- Elder abuse can happen to older people living in their own home or in residential aged care. It can be perpetrated by anyone, known or unknown to the person.

Learning Checkpoint 2

Identify child or young person developmental issues

Part A

1. List two types of harm for which people with developmental disorders are at a higher risk.

2. Match each sign or indication to the possible form of abuse or neglect.

Lack of hygiene, weight loss and offensive odour	Physical
Injury to genitals	Financial
Unexplained scratches or bruises	Sexual
Not having enough money to buy essentials	Neglect

3. Explain the meaning of unconscious bias and give an example of how it might have a negative effect on the way you respond to indications of abuse or neglect.

Part B

Read the case study and answer the questions that follow.

Case study

Helena is 15 years old and lives in out-of-home care, after growing up in a home where she was neglected by her single mother (who has died recently of a drug overdose). Helena was diagnosed with auditory processing disorder when she was five, a developmental disorder that affects her ability to take in and make sense of verbal information.

Helena finds schoolwork difficult; her teacher usually only provides verbal instructions for classroom tasks and homework.

She has begun to frequently skip school, and when she does go to school she often distracts her classmates by acting up and making jokes. She is frequently in trouble, but shows no emotion when a teacher or principal disciplines her. She dislikes authority and becomes irritable when a teacher tries to talk to her. She has difficulty with impulse control, often wandering off into a different part of the classroom when something more interesting than the lesson catches her eye.

Helena becomes distressed when child protection workers or other family members talk about her mother, and they find it difficult to calm her.

1. List two factors that might be contributing to Helena's behaviours in class.

2. List two signs that Helena might also have an attachment disorder. What might have caused this?

3. What might a strengths-based approach in the classroom look like for Helena?

4. Explain who could support the schoolteachers and other professionals to find practical and strengths-based ways to support Helena, and how you might obtain these referrals.

5. Why is it important to regularly document your observations about Helena's progress and set-backs?

Topic 3: Check for and respond to child or young person specific issues

3A Follow legislative and mandatory reporting requirements

3B Refer and document issues that require more support

3C Report and document accurately

3A Follow legislative and mandatory reporting requirements

Workers in certain job roles must follow all legislative and mandatory reporting requirements when a crime such as abuse or domestic violence has been reported, suspected or witnessed.

If you become aware that a child is the victim of abuse or neglect, or suspect that they may be, you must report your concerns to the relevant authority in your state or territory, and then take actions to protect the child from further abuse.

Mandatory reporting of actual or suspected child abuse

Mandatory reporting
The legal requirement of people in certain job roles and industries to report suspected or actual abuse to the police.

Mandatory reporting of child abuse describes the legislative requirement imposed on selected people to report suspected cases of child abuse and neglect to government authorities. Professions that are subject to mandatory reporting include those who interact with children and young people in the course of their work. This includes doctors, dentists, nurses, midwives, teachers, police officers, counsellors and coordinators of home-based care for children, and public servants who deal directly with children. Requirements for mandatory reporting of child abuse varies between states and territories. Make sure you familiarise yourself with your obligations according to your jurisdiction.

In many states and territories, all adults in the community have the legal responsibility to report to police if they have reason to believe that a child is being (or has been) sexually abused. Your mandatory reporting requirements hold true even if the child is not your client, such as a grandchild visiting their grandparent in an aged care facility. Penalties can apply to all adults who had good reason to suspect abuse but did not alert authorities.

You can check the requirements for your state and territory at this link: aspirelr.link/mandatory-reporting-child-abuse-and-neglect

Reporting elder abuse

Mandatory reporting of abuse and neglect of older people is a legal requirement for managers in all aged care services. The Serious Incident Response Scheme requires that any of eight types of incident that put the person at risk be reported to the Aged Care Quality and Safety Commission (ACQSC), and in some instances, to the police. This includes any suspicion, observation or claim of these incidents, even if the person making the claim is an unreliable witness, for instance, if they have dementia.

Incidents that must be reported under this scheme include:

- unreasonable use of force
- unlawful sexual contact or inappropriate sexual conduct
- neglect of a consumer
- psychological or emotional abuse
- unexpected death
- stealing or financial coercion by a staff member
- inappropriate use of restrictive practices
- unexplained absence from care.

If you are concerned that an aged care service has not taken the correct steps of reporting to the police or the Aged Care Commissioner, you can take your concerns to a higher manager, or go to the police/make a complaint to the Aged Care Complaints Commissioner yourself.

For more information, visit the Aged Care Quality and Safety Commission's Serious Incident Response Scheme (SIRS) at: aspirelr.link/sirs

Example

Respond to signs of elder abuse

Rebecca has dementia and receives home care services from a local provider. Rebecca often makes up stories and says things that are not true.

Today Rebecca has told Jason, her case manager, that a staff member hit her. Jason knows that this might not be true, and he can't see any signs of bruising, but he knows that he must report what Rebecca told him, because abusers often target people who are less likely to be believed. As Rebecca's advocate, he does not need to have proof of abuse, and must act on Rebecca's statement.

Jason reassures Rebecca that he will keep her safe. Jason informs the service manager about what Rebecca has said. He then ascertains that the manager has reported the claim to the ACQSC, who direct the service to undertake an investigation. After talking to Rebecca and other staff, the managers are reassured that Rebecca was not abused. However, the ACQSC require the service to document every new claim that Rebecca makes in future, and to review any new evidence or concerns.

Responding to abuse

If a crime such as abuse has been committed within the service where you work, the following steps are a general guide to follow. Procedures might vary between organisations, but in any case, they must include adhering to mandatory reporting requirements.

1. If you suspect that a child or vulnerable adult is at risk of abuse or violence, your first step is to ensure that the person experiencing abuse is kept away from ongoing exposure to the perpetrator. You might need to insist that the child does not return to the abuser, for example, and provide alternative accommodation. Reassure the child that they are safe.

2. Report your concerns immediately to your supervisor, to the police, or to an appropriate authority, such as a relevant government department in your state or territory. For example, the first point of contact for child protection services in Victoria is Child First.

3. Make notes about what you were told and/or what you saw as soon as possible. This information may be required to help police investigate the possible crime.

Write down:
• What you saw (for example, the size, location and type of bruising)
• When you saw it (date, time, day)
• What you did (for example, removed the person from the situation)
• What you said (for example, explained to the person that you had to report the incident)
• The person's response (what they said or did)
• Follow-up action to be taken

Child Information Sharing Scheme
An initiative that requires workers in sectors such as police, child protection, youth justice and maternal and child health to share information that could affect a child's safety.

The Child Information Sharing Scheme

The **Child Information Sharing Scheme** is a reporting protocol applicable to workers in certain sectors. People who work in certain sectors such as the police, child protection, youth justice and maternal and child health must share information that could affect a child's safety. It works on the premise that even small pieces of information can alert authorities to potential harm when they are pieced together from multiple sources.

Abuse in disability services

People with disabilities are exposed to a number of risk factors which make them particularly vulnerable to harm, neglect and abuse. Disability services have many similar protections to aged care services, including legislation regulating the use of **restrictive practices** and a zero-tolerance abuse framework.

Restrictive practice
Any intervention or practice that restricts rights or freedoms of movement of a person.

All NDIS providers have obligations under the NDIS Code of Conduct, including that they:

- provide supports and services in a safe and competent manner, with care and skill
- promptly take steps to raise and act on concerns about matters that may impact the quality and safety of supports and services provided to people with disability
- take all reasonable steps to prevent and respond to all forms of violence against, and exploitation, neglect and abuse of, people with disability
- take all reasonable steps to prevent and respond to sexual misconduct.

You can find out more about reportable incidents for people with disabilities receiving NDIS supports at NDIS Quality and Safeguards Commission: aspirelr.link/ndis-incident-reporting

Practice Task 7

Question 1

What are two sources of information you could consult to find out about your mandatory reporting obligations?

Question 2

Which of the following statements are correct? Select yes or no for each one.

a. Under mandatory reporting, you should report any unexpected developmental delays to your senior manager.	Yes / No
b. You must be certain that abuse has been committed before undertaking mandatory reporting.	Yes / No
c. Requirements for mandatory reporting of child abuse is the same in all states and territories.	Yes / No
d. Family violence is included in mandatory reporting of child abuse, even if you don't have concerns about a child.	Yes / No

3B Refer and document issues that require more support

Situations needing a higher-level response often require the coordination of a wider range of services and more significant interventions.

There are many options for support services and professionals to meet the current and future needs of a child or adult person who has developmental delays.

When you are deciding how to act in a situation involving a child, you must always:

- prioritise the best interests of the child over the interests of all other parties
- work towards protecting the child from harm
- help to contribute to the child's learning and development
- allow children to express their views freely on all matters affecting them.

When you become aware that an out-of-home care placement is not working in the child's best interests, or if you are concerned about the welfare of a child living with their family, it is your duty of care to refer the child or family to the correct service or professional.

Check for issues that may require a referral

You have a responsibility to speak up for the interests of people who are not able to self-advocate.

Certain issues that negatively affect the child's development may require specialist help from community services organisations, health and mental health practitioners, or police and court services.

Issues that may require specialist intervention include:

- not reaching developmental milestones as expected
- struggling or falling behind at school
- being unhappy in or unsuited to a foster care arrangement
- family and domestic violence
- health issues
- crisis situations, such as when a client voices suicidal ideation
- children or adolescents who are homeless or at risk of homelessness.

Allied health professionals

Allied health professionals can help diagnose, treat and support a range of needs, and provide information and training about suitable aids and equipment to support development.

Professional	Role and function
Speech therapist	A speech therapist can help children who have difficulties communicating because of developmental delays, intellectual disabilities and cerebral palsy. They can help the person access and learn to use new aids, and to develop communication strategies. Speech therapists are often able to help families to identify and apply for funding to reduce the end cost of communication aids.
Physiotherapist	Physiotherapists help people affected by illness, injury or disability through manual therapy, and movement and exercise. They can help children with developmental delays to increase their mobility and gross/fine motor control.
Occupational therapist	Occupational therapists (OTs) can help provide and adapt aids to support participation in school, work or community, and to help a child with a disability to be more independent.

Developmental concerns

If a child or adolescent does not meet expected milestones, or when they may have an undiagnosed developmental delay or condition, you might share information with, or make a referral to one of the following:

- maternal and child health services
- GP
- adolescent health specialist
- specialists such as paediatricians or behavioural psychologists (these are usually referred via a GP).

Family issues

When children and/or their families are vulnerable, it is known that children benefit when supports are provided to their parents. You might consider providing referrals to parents, such as parenting classes, anger management or conflict resolution, and community groups that help to tie parents to their community more closely. These can be difficult topics to broach, so always make sure you hold any judgements, take a collaborative approach and speak with empathy and respect.

In some situations in Victoria, Aboriginal families experiencing family violence can be referred to First Nations-specific services as part of local Koori Family Violence Police Protocols.

Male perpetrators of domestic violence can be referred to men's behaviour change programs in your state or territory.

Social workers can help to link clients to appropriate support services.

They can help clients who are at risk of:

- family and domestic violence
- homelessness
- mental health conditions
- being involved in the youth justice system
- poverty.

The person can access help from a social worker at no cost by contacting or visiting Centrelink.

Find more information about accessing a social worker at Services Australia: aspirelr.link/sa-social-work-services

Culturally specific services

Aboriginal Controlled Community Organisations (ACCOs) can provide specialist support for Aboriginal and Torres Strait Islander people, in order to help overcome barriers to accessing community, health and mental health services, and gaps in service provision.

Other services can provide specialist support for children, adolescents and families, people from different cultural backgrounds, young people, people who identify as lesbian, gay, bisexual, transgender, queer or intersex (LGBTQI+) and other groups with specific needs.

Disability specific services

Services such as Autism Australia, Vision Australia, Hearing Australia, Yooralla and Scope can give tailored advice, training and support for people with a disability and their families.

Referrals can be made to support the client with assistive technologies such as electronic communication devices or mobility aids. These aids can sometimes be acquired with NDIS funding. Assistive technology advisors can support people receiving government- or NDIS-funded supports to identify and access aids that are funded or partially funded.

Example

Referral to a communication professional

Hayley works at an NDIS provider service and has been assigned a new client called Sachem. Sachem is 13, and was involved in a car accident which left him with low vision and an acquired brain injury.

Sachem would like to be able to use social media like his friends do, but the complexity of his brain injury and low vision mean that Hayley does not feel qualified to help Sachem to do this.

With the support of her supervisor, she arranges an appointment with Vision Australia. The staff at the centre help to assess Sachem's abilities and limitations. They trial a range of digital devices that are simple to use and accessible for people with low vision, and teach Sachem how to use them.

After three visits, Sachem is confident using his new iPad and special speech to text software. Hayley is then able to support him to communicate with his friends on social media.

Making a referral

Your role might involve helping the person to identify services and supports, or it might be to support the person in a practical way by making the referral for them.

You need to know the procedures for referrals both for your service and the service you are seeking to access, as referral protocols vary between services and work roles. The first point of contact is often (though not always) the person's GP. In most cases, you need to obtain the client's consent to make a referral.

Here are examples of how to determine the correct procedures.

Referral protocols from your own service	Read and follow your service's policy and procedures for making referrals. This will include information about: • which job roles are permitted to make referrals • the requirements for privacy and confidentiality of client information • how to seek client consent before making a referral.

Referrals to a professional or external service	Most professionals and services have a set process for referrals. These procedures can often be found on the website or by making enquiries by phone. Procedures for referrals might include: • whether a referral is needed to access all or parts of the service • how a referral is made, such as by phone or in writing • which professionals are permitted to make the referral, such as doctors or police officers • documentation that must accompany the referral • wait list times • privacy and confidentiality requirements and protocols • other services that information will be shared with.

Making referrals that involve children

Child Safe organisations are assessed as having met Child Safe principles and should be used as a priority when providing referrals for children.

See this link for more information about Child Safe organisations and Child Safe principles: aspirelr.link/child-safe-human-rights

Privacy and confidentiality when undertaking referrals

Before you share any information about a person with another agency, you must know the privacy and confidentiality requirements in your jurisdiction.

This means you must:

- obtain the person's or their guardian's consent before passing on personal information about them
- only send the information that the referral agency needs
- take steps to protect the information from unauthorised access, such as double checking that an email is sent to the correct person.

Practice Task 8

Question 1

Briefly explain why you must check your service policy before making a referral.

Question 2

Give one example of how you could determine the referral requirements for a professional or service.

Question 3

Give two examples of your responsibilities when passing on information about a client to other services.

3C Report and document accurately

Clear, accurate and objective reporting and documentation is in the best interests of your clients and yourself.

Proper documentation is an important way to demonstrate a child's developmental progress and milestones, and a written report can be used as evidence that you have fulfilled your duty of care.

Examples of documentation used for this purpose can vary between sectors and services, but they can include:

- file notes
- incident reports
- online industry reporting portals
- referral letters.

Industry-specific documentation

Some documentation requirements are legislated within particular sectors. For example, in disability services, concerns about abuse must be followed up within a certain timeframe with documentation on an online portal that follows a specific format.

In child protection services, specific procedures exist for documenting all stages of intake, risk assessment and supports. Online portals such as a Client Relationship Management System (CRM) are designed to record and store information about children involved in child protection, so that information can be shared safely between service professionals and other authorised people.

When writing any kind of report or documentation, adhere to the principles in the following table to the best of your ability.

Write with appropriate detail	When commenting on a child's developmental status, you might need to include: • the area of development you are referring to • the child's specific abilities in that area of development • milestones relating to age and stage of development and whether or not the child has reached them, including the extent to which a milestone has not been reached.

Be objective and factual in your writing	Documents should include facts and direct observations. For example, if you are recording that a child has not reached a particular milestone, write down the evidence for this statement that you have observed or been told, i.e.: • what behaviours or signs the child showed that indicate they have not reached the milestone • who assessed the child and made this observation • who reported evidence that the child has not developed as expected • what you have seen or heard while with the child that supports this evidence.
Record information in a timely manner	If you are writing down observations in a file note or CRM system, write down what you saw or heard as soon as possible, ideally directly after a meeting with the child and their family, while it is fresh in your mind.
Use appropriate language and avoid jargon and acronyms	Each industry often has its own language and jargon. Try, where possible, to use complete words, unless they are accepted and common abbreviations. Use plain English rather than big words and jargon and write in simple, clear, direct sentences.
Use correct spelling and grammar and read over your work	Spelling a person's name incorrectly is not a good look, and wrong spellings of medical terms can cause confusion. Good spelling and grammar gives your writing more authority, and makes it easier to read. Always read over what you've written. It can be all too easy to miss out words or punctuation when we're in a hurry!

Maintaining confidentiality

Personal and sensitive information
Information that is protected by law and must be carefully protected from unauthorised access.

The *Privacy Act 1988* (Cth) requires you to protect **personal and sensitive information.**

Personal information includes a person's name, address, contact details, date of birth and gender. Sensitive information is a special category of personal information and is subject to stricter legal requirements for its collection, storage and use. Health information is considered to be sensitive information. It details a person's physical and mental health, disability, health preferences, use of health services and genetics. Sensitive information also includes information or an opinion about a child or their family, such as their racial or ethnic origin, political opinions, religious or philosophical beliefs, sexual preferences or practices, or criminal record.

You must ensure that personal or sensitive information is used and stored in a way that they cannot be accessed by any unauthorised person.

Practice Task 9

Question 1

List one responsibility you have for protecting personal information.

Question 2

Which of the following are examples of objective and factual documentation? Tick all that apply.

- ❑ The child told me that he was unhappy in his foster placement.
- ❑ The child looks unhappy in his foster placement.
- ❑ The child has been sullen and resistant to help.
- ❑ The foster carer is not the right fit for the child.

Summary

- If you witness or suspect that a child is the victim of abuse, you must report your concerns to the relevant authorities and take actions to protect the child from further abuse.
- Mandatory reporting of child abuse is the legislative requirement imposed on selected people to report suspected cases of child abuse and neglect to government authorities.
- While you do not have a mandatory responsibility to report domestic violence perpetrated against an adult, you have a duty of care to encourage them to report it to police and seek help.
- Some issues that impact the child's development and the supports they receive may require specialist help from community services organisations, health and mental health practitioners, or police and court services.
- Know and follow procedures for referrals of your organisation and the service you're seeking to access, as referral protocols vary between services and work roles.
- Child Safe organisations are assessed as having met Child Safe principles and should be used as a priority when providing referrals for children.
- Before you share any information about a person with another agency, understand and follow legislation regarding privacy and confidentiality.
- Clear, accurate and objective documentation is an important way to help demonstrate a child's developmental progress and milestones and acts as evidence that you have done your job.
- The *Privacy Act 1988* (Cth) requires you to protect personal and sensitive information.

Learning Checkpoint 3

Check for and respond to child or young person specific issues

Part A

1. Outline the response you must take if you become aware that a child in foster placement is being sexually abused.

2. Give two examples of elder abuse in aged care services that must be reported.

3. Give three examples of issues (not including abuse or neglect) that should be referred or considered for referral.

Part B

Read the case study and answer the questions that follow.

Case study

Roberta is a case manager in a small town. She has been managing a case involving an Aboriginal family, and has become aware that the teenage son has been perpetrating violence towards the adult women in the family. Roberta follows her service policy, and refers to the Koori Family Violence Protocols, which instructs that this situation should be managed by an Aboriginal Controlled Community Organisation (ACCO).

1. Why must Roberta check her service's procedures before referring the situation directly to authorities or family violence services?

2. Give one example of how Roberta could determine the referral requirements for the ACCO in her local area.

3. Briefly explain how Roberta can ensure that the referral protects the family's confidentiality.

4. Explain why it is important for Roberta to use accurate and objective documentation in the referral.

Glossary

Abuse

Any intentional action that harms or injures another person.

Adaptive behaviours

Age-appropriate abilities to perform self-care, go to work or school, develop relationships with others and participate in the community.

Attention deficit hyperactivity disorder (ADHD)

A neurodevelopmental disorder characterised by inattention, hyperactivity, and impulsive and disruptive behaviour.

Autonomy

A person's ability to make their own decisions.

Behaviour of concern

An action that can cause harm, either to the person who presents with the behaviour or to others.

Child abuse

Any physical, emotional, sexual abuse or neglect of a child under the age of 18.

Child Information Sharing Scheme

An initiative that requires workers in sectors such as police, child protection, youth justice and maternal and child health to share information that could affect a child's safety.

Congenital

A condition that is present at birth.

Developmental milestones

A set of physical, cognitive, social and psychological skills that most children and adolescents are able to do within a certain age range.

Domestic and family violence

Threatening, violent or coercive behaviour towards a partner, spouse, child, parent, housemate, carer or care recipient.

Elder abuse

Harming an older person using financial, physical, sexual or emotional means, or through neglect.

Empathy

The ability to understand, share and identify the feelings of others.

Episodic memory

The ability to recall personal experiences and specific events from the recent and longer-term past.

Grooming

Common behaviour used by a child sex offender to prepare a child for sexual abuse.

Inclusion

Providing equal access to opportunities and resources for people who might otherwise be excluded or left out.

Mandatory reporting

The legal requirement of people in certain job roles and industries to report suspected or actual abuse to the police.

Neglect

Failing to properly care for a person.

Neuroplasticity

The brain's ability to change and adapt based on experience, including learning through practice.

Personal and sensitive information

Information that is protected by law and must be carefully protected from unauthorised access.

Procedural memory

A kind of implicit (unconscious) memory that aids in the performance of tasks involving both cognitive and motor skills, such as driving a manual car.

Psychomotor development

The development of physical skills such as movement, coordination, manipulation and dexterity, that require both cognitive and physical capacity.

Reflex

An unconscious response to an environmental stimulus.

Restrictive practice

Any intervention or practice that restricts rights or freedoms of movement of a person.

Schema

A concept or idea about the world, such as the idea that all dogs bite.

Self-actualisation

The highest need in Maslow's hierarchy, it is associated with reaching one's full potential and feeling successful and fulfilled by creative, intellectual or spiritual pursuits.

Self-harm

Causing deliberate physical harm to a person's own self, with or without the intention to end their life.

Semantic memory

Also referred to as 'general knowledge', this is the ability to remember facts about the world, such as scientific or historical information.

Strengths-based approach

Recognises that all individuals are resourceful and resilient experts in their lives, and can progress in a way that enhances their quality of life.

Unconscious bias

Subconsciously forming social stereotypes about certain people and expressing these.