

The purpose of this essay is to critically reflect upon the concept of person-centred practice (PCP) within health and social care, with a specific focus on the centrality of children and the implications that practising with a child-centred approach can have on children and their circumstances. In order to critically reflect on the concept of PCP this essay will primarily define PCP briefly and consider theory in relation to child-centred support models. Secondly it will consider the natural 'child to adult power imbalance' in society and the impact this may have if not considered in advocacy services. Thirdly it will challenge the assumption that a child is powerless to define his or her own needs. Finally, it will consider the underpinning of co-production principles within child-centred practices, and how when combined with a centralised orientation promotes children's rights, a child's voice, and the intention of autonomous and agentic human beings. It will conclude with confirmation and justification on how best advocacy practice cannot be achieved without person/child-centred practice, both of which rely on decisions made WITH and not FOR a user of services (World Health Organisation, 2017). Within this essay, the terms child, children, and young people define anyone who has not yet reached their 18th birthday. The term 'practitioners' is used throughout the essay to refer to individuals who work with children and their families in a health and social care context.

Significant legislation in Wales to inform health and social care practice is the Social Services and Well-being (Wales) Act 2014, and it is generally recognised that advocacy plays a substantial part within the bill, demonstrating that Welsh Government and its local authorities are legally bound to arrange the provision of an independent professional advocate to individuals who are at risk of becoming or are already socially excluded (Age Cymru, 2015). However, despite defining advocacy within the act as a 'one to one partnership' (*chapter 8*) and that it is for an advocate 'to decide the best way of supporting and representing the person they are advocating for' (*annexe a*) there is little guidance or clarification on appropriate approaches or frameworks to follow when developing this relationship. In contrast to other advocacy concepts such as citizen advocacy which Henderson and Pochin (2001), regard as being delivered by an uncontaminated layman, or peer advocacy which Donnison (2009), refers to as groups of people providing support to each other with knowledge and understanding having experienced similar circumstances, Bateman (2000), encourages us to realise that although it is easy to ignore, advocacy in the professional form must have structure. He insists that neglecting to create a framework will not only cause you to lack efficiency but can lead to inappropriate situations within practice. This suggestion of structure is supported by the

Advocacy Code of Practice (2014), in both its Clarity of purpose chapter and its accountability section, underpinning the requirement of robust systems to hold advocates and advocacy providers responsible for their practice. In deciding structure, it is important to consider the appropriate approaches from which an advocate can choose, with policy offer many frameworks in terms of practice being decided. A solution-focused approach, for example, concentrates heavily on people being the expert of themselves, NSPCC (2015), a rights-based approach uses a more legislation focused framework Wilkes (2012), the person-centred practice aims to create.....what Welsh Government (2015), describes as a co-produced relationship within which 'practitioners and individuals share the power to plan support together'.

It is argued that nothing is more important than the welfare of children, and despite it being the duty of parents or carers to respond to the basic needs of their children, local authorities and health boards have specific duties to safeguard young people and promote their welfare within their specified geographical area. Defined by Berwick (2009), Person-centred care is an encounter of individualisation, an experience of respect, dignity, and recognition, and above all else, a choice in all areas of an individual's health and social care without exception or complication, to the degree of which they desire it. Sharma, Bamford and Dodman (2015) enhance this definition by adding that it is the provision of a personalised model of health care, where providers delivering care and support collaboratively. An extension of Person-Centred care within health and social care services is Child-centred care and it is this approach that is fundamental to keeping a child in focus when working with children and their families. Where previously advocacy may have focused on what Frankel (2018), defines as qualified adults speaking out for unqualified children, the child-centred approach utilises speaking to or engaging the child themselves recognising that as Race and O'Keefe (2017), point out, practitioners cannot promote positive outcomes for children without actual meaningful engagement with them. This is imperative to establishing a sense of person, what they may need, how their circumstances make them feel and how they view their future.

Theoretically, it is Bronfenbrenner (1979), who places a child at the centre of his ecological approach, emphasising the importance of five systems encompassing a child and his or her development. Ashiabi and O'Neal (2015), explain the inner microsystem is a child's immediate environment, carers, siblings and learning atmospheres. The mesosystem then informs the connections between microsystems and Ashiabi and O'Neil (2015), use the example of the influence a parental relationship with a school and its staff may have on a child. A child is less

concerned with the fourth level known as the exosystem, however no less impacted by its indirect influences such as governmental policy on housing and healthcare as exemplified by Sanders, Fitzgerald and Bratteli (2008), with the macrosystem relating to socio-cultural values and attitudes. Bronfenbrenner's (1979), final and most outward principle in the circular model, is the Chrono system. This acknowledges the inevitable changes in a child's life concerning growth, relationships, circumstances, and environment. It is with this theory of Bronfenbrenner (1979), it can be seen how positioning a child at the centre of a model, health and social care can be created around them and how this can be introduced into practice. Stressing that as well as understanding the systems surrounding child development, it is also imperative to understand the characteristics, capacities, and interactions of them. This is clarified by Quality Standards (2017), who state that anyone who works with children has a responsibility to see and hear that child, offering that ideas and views should be seriously considered, wishes and feelings accommodated, and their rights are respected.

If ageing definitions of advocacy such as 'advocacy seeks to represent the powerless clients to powerful individuals and structures' Payne (1997), and 'advocacy is an inevitable consequence of work with people who are disadvantaged' Bateman (2000), are to be believed, and if they reflect the nature of contemporary advocacy, it could be assumed that advocacy is one-sided. Advocates arriving at an instruction with a *power over* approach to catapult a defenceless and incapacitated individual in need of elevation to a perfect utopia is neither achievable nor desirable. However, despite well-evidenced barriers to person-centred practice such as those quantified by the Health Foundation (2016), who question if the process takes too long, if it is more expensive, and as explored by Santana *et al* (2019), proves too difficult to measure outcomes due to a lack of one single definition, It is argued by Naldemirci (2018), that person-centred advocacy practice is a replacement for the biomedical, dehumanising medical model, with a holistic libertarian approach by recognising that patients, clients, service users are above all else, people, and accepting that the approach depends on the collaboration of individuals in need of support and healthcare professionals. This suggests that PCP is a stark contrast to the medical model of a system centred service defined by budgets, criteria, and dependence Heagele and Hodge (2016), but as Open Future Learning (2013) state, an opportunity for individuals, advocates, communities', and services to share the power that a client's mandate holds, tailoring a response that is individual to their needs, has respect for their agency, and an occasion to seek out strengths and goals rather than define and fix limitations.

Harvard (2006) argue that person-centred practice pressurises and inhibits those individuals who lack capacity, have reality distorting mental illnesses or simply those who struggle to discuss themselves and therefore it can be seen across many client groups that placing a support requiring individual at the heart of planning services without an independent mental capacity advocate (IMCA) could be intimidating, uncomfortable and oppressive. However, according to Byrne *et al*, (2020), person-centred practice within health and social care services continues to grow and evolve, specifically crediting the wealth of information available in contemporary society. This, they argue, creates an atmosphere of those in need of care as valid members of their own support plan rather than a medicalised model of a non-resistant recipient of treatment.

Examples of people of any age who may lack capacity and therefore ‘power of autonomous choice’ Buchanan (2004) are those with a complex learning disability, someone unconscious or in a coma or someone with dementia or Alzheimer’s NHS (2019), however, according to the Mental Capacity Act (2005) capacity is to be assumed unless proven otherwise. Therefore, unless someone is unable to retain, understand or weigh up information Mental Health Foundation (2020), then he or she has the capacity and the power to choose. This theory is enhanced by Pecotic (2018), who believes capacity is not a binary strategy but a spectrum, giving way to the belief that there are different levels of capacity and that attending to people with this in mind affords people as much autonomy as is possible. Baratta (2019), continues the debate, demanding that an individual requiring the assistance of an advocate is assumed to have power even before an advocacy instruction takes place and the partnership agreed, urging the consideration that power is not unequal on the basis of its difference and that positions of power, though relative to each other do not account for more or less power to be perceived. Herring (2008) argues that coming across adults and children with uncertain levels of competence is normal, which makes it complicated to decipher whether or not someone has capacity, this, therefore, encourages professionals to recognise many different degrees of capacity exist both within one individual and also at different times in their lives.

With this in mind it can be seen that not all who mandate an advocate to support them, are voiceless and powerless, Pecotic (2018), further argues that an individual requiring services arrives at the advocacy relationship already empowered and equal to if not more powerful than an advocate. This is agreed by Tadros (2010), who maintains that power is relative, offering that those who are marginalised, or disadvantaged may often feel completely powerless yet manage to retain a sense of self. This confirms the need for practitioners to address the

perceptions of power and recognise the power that an individual mandating an advocate already holds.

A primary source of advocacy in a child's life is a family doctor and the Royal College of General Practitioners (RCGP) (a) (2020), commit to teaching person-centred approaches within their training of doctors. GP's, described as the 'bedrock' of health and social care services within the *Fit for the Future visionary statement* (2020), declare a commitment towards teaching the importance of engaging patients in their own care and state that person-centred approaches will continue to evolve to provide relationship-based care, claiming the patient expertise of one's self will increase in value within GP appointments with the practitioner inviting a patient to discuss their current circumstances and together deciding a plan of action and the best way forward (RCGP (b) 2020). However, research published by Ospina *et al* (2018), in the journal of internal medicine, argues that on average a G.P. interrupts a person's voice within eleven seconds of the appointment beginning, suggesting that this is not the best interpretation of person-centred, although as Leece and Leece (2011), agree there appears to be a certain shift in establishing provisions that are personally tailored to individuals rather than accommodating people into existing services which may not holistically suit them. Gondek *et al* (2016) further complicate the ideology of person-centred care by introducing that the concept is more difficult to establish with children. They explain that conversations with vulnerable young people who are potentially confused by feelings and emotions are complicated and difficult. Gondek *et al* (2016), further stress that an advocate accepting a mandate from a child to seek support and prevent social exclusion will need to navigate the adult/child balance of power before any sense of professional relationship can be formed. MCLOED (2008), supports this by suggesting that there are many factors which could inhibit a child, offering that since adults are habitually in a position of authority over children, it is hard for children to understand that the purpose of communication has any other function than to control. Mcloed (2008), continues by suggesting children may be scared to voice thoughts and opinions, they may say what they believe adults want to hear or feel trapped between opposing parental views, Race and O'keefe (2017), also offer, that given the policies and procedures at an organisational level are driven by adults, who are lacking in child engagement skills, creating barriers unknowingly, resulting in a reduction of participation and meaningful connection. Significantly raising the argument further, Traseira & Singh (2020), question how parental anxiety over an unwell child may impact the approach used in the setting. As well as a lack of time during appointments and it potentially being faster for a parent to advocate on a

child's behalf, the personalities of both the child and the GP need to be considered, questioning if the approachability of the doctor, their level of familiarity and a child's confidence has an impact on practicing with a child-centred focus (Traseira & Singh, 2020).

Research shows that there are strategies available that can both reduce the imbalance of power and enhance communication with children. Where direct observation may be the only option with babies and infants Barnes (2018), offers a range of options from which to choose or combine. She primarily suggests an acknowledgement that engaging a child, will not always be easy, however, that an appreciation for the pace at which language develops is paramount, as well as a recognition of formal communication aids such as sign language or electronic software and a healthy supply of toys, papers and pens which can aid role play, writing and drawing. Tammivaara and Enright (1986), also believe that children can be empowered creatively. They suggest that children in general, particularly the younger generation, find it easier and more relaxing to do something while they are talking rather than mindlessly chatting or being aimlessly questioned. They continue their ideas for child engagement by encouraging practitioners to 'play dumb' taking on the persona of a confused and fatuous participant who is completely reliant on the child to get 'things right' this can leave a child feeling more superior and in control, thus creating a more equal balance of power.

In contrast to the positive aspects of child-centred practice, there are evidenced reasons why professionals fail to listen to children and struggle to adopt a child-centred approach. Race and O'Keefe (2017) maintain that while the important principles of advocacy, person-centred practice, and collective effort are credited with beneficial implications to practice, there is evidence to support the suggestion of little more than tokenistic lip service being paid to their application. A complication of the approach is offered by Coyne *et al* (2018), who state that the balancing of child-centred care within family involvement is complex, and that managing the triadic element of the situation in terms of encouraging the child's voice, risks offending the adult carer. In order to quiet an adult voice, a practitioner places themselves at risk of complaint and becoming unpopular, thus, respect and flexibility need to remain in focus within the collaboration. However, according to (Porter *et al* 2020). It was the United Nations on the Rights of the Child (1989), that propelled the study and practice of child-centred models of care onto the health and social care arena asserting within it, a child's right to both give and receive knowledge, a right to associate freely, and the right to contribute to life, increasing the potential for children and young people to participate in and control their own lives more. Continuing, Porter *et al* (2020), that children and young people's problems and issues, that

would have previously been viewed and assessed by a paternalistic adult lens are now addressed collaboratively. This approach recognises the importance of children as societal actors with the concepts of children's rights and empowerment underpinning their efforts.

A common theory which can be incorporated within person-centred and child-centred practice is co-production. Defined by Chan (2000), as a concept in which outcomes are created by both professional and non-professionals working together, is underpinned by the principle that those requiring support are better positioned to design it. Used to manage and avert violations to a perceived social injustice, assistance is created and tailored mutually, constructing an equal partnership between practitioners and the public. Chan (2000), offers that the co-production model, not only socially transforms the relationship between advocate and client, but this model also allows for advocacy organisations and practitioners to have the opportunity to improve and evolve, based on the needs and aspirations of clients. Cox *et al* (2015) write that globally, people traditionally have less ability to obtain the assets and advantages, societal status, power, and wealth than others, suggesting that often those at the pinnacle of the social ladder use these advantages to arrange society to meet their own needs. This is perpetually to the detriment of those lower on the social scale necessitating the need for a greater equilibrium and a model which recognises the relevance of clients co-defining and developing outcomes to advance their own agency and autonomy, (Cox *et al*, 2015). In response to this Flinders *et al* (2016), offers that the concept of sharing expertise disguises power and encourages a way to practice more ethically. This suggests that co-production acknowledges opportunities for mutual learning and ownership of self, allowing for the promotion of choice for all involved stakeholders. When viewed through a coproduction lens, the perception of a power imbalance within the framework of PCP and between service user and practitioner is reduced. This is supported by Mead and Bower (2002), which leads us to believe that PCP has the potential to improve the quality of care received exponentially. This not only benefits the client, but the professionals involved arguing that practitioners often feel more confident within their own practice for the equal involvement of the clients. However, in comparison, Oliver *et al* (2019), heavily criticise the concept of co-production, citing its psychological and financial costs as its greatest barriers to implementation. Oliver *et al* (2019), state that the maintenance of transactional relationships takes both time and effort, indicating an increased likelihood of burnout and stress. Practical costs such as travelling, room-hire and administrative burdens reduce motivation to engage in this way and finally they argue that there are significant risks to a practitioner's credibility by relinquishing the paternalistic attitude of expertise in allowing

for equal participation and producing ‘nothing of substance’ in terms of professionalism. However, in the spirit of co-production, Dickie and Muirie (2017), maintain that comprehending how power functions in our lives is key to understanding improved outcomes, stating that power is an integral element of health and therefore of inequalities in healthcare. They advocate that power acts as an asset and a capacity which needs to be shared within healthy relationships. This facilitates a move toward working which fosters a power to and power with approach giving people of any age, a stronger voice, an acceptance of their knowledge and recognition of their lived experiences to influence planning and care. Currently, in Wales, the new Health and Social Care (Quality and Engagement) (Wales) Act 2020 promises to reform health and social care. If this is to be believed then the voices of Welsh citizens are to be strengthened and heard, offering more candour and transparency in its provisions. This is disputed, however, by the Welsh Council for Voluntary Action (2019), who in a joint response with the Coproduction Network for Wales (2019), suggest that the legislation is heavily focused on health care, neglecting social care and refusing to clarify how citizens will be engaged or involved risking a diluted and tokenistic picture of both person-centred practice and co-production within services.

In conclusion, this essay has critically reflected on the concept of person-centred practice within health and social care, and its implications for service users, looking specifically at the centrality of children. It has briefly defined PCP, regarded contemporary legislation in which PCP is considered, reflected on the theoretical view of Bronfenbrenner in terms of centralising children, and evaluated examples of best practice working within a co-produced model of PCP. Person-centred practice with both adults and children, if used effectively and not used in a tokenistic manner, is the very core of a personalised service and at the very heart of advocacy. To be mandated by anyone who requests the support of a professional should be seen as an opportunity to develop a mutually respectful relationship and an acknowledgement of a person being their own expert will serve to mitigate any power imbalance. The evidence presented supports the ideology that within a reciprocal partnership of co-produced effort and a mutual balance of power, person-centred practice underpins best practice. This recognises that though it is assumed that when an individual is offered the support of an advocate they are at a social disadvantage of some sort or on the cusp of social exclusion, they are identified as already holding their own power and are capable to some extent of being at the centre of their support.

The research for this essay highlighted the many multifaceted definitions of advocacy, person-centred approaches and of co-production. Despite Sharma, Bamford, and Dodman (2015),

suggesting that a common definition of person-centred is complicated to establish due to the concept's individualism and personalised nature, if the debate around best practice is to continue, it is worth suggesting that further work will need to be done to clarify meanings with more contextual awareness. This will establish a greater degree of accuracy in the field and have significant beneficial implications in practice.

It is clear that PCP is an approach that needs longevity and consistency, a long-term model allowing for growth and evolution, a living theoretical methodology. The implication for both adults and children being that it is a model which will grow and evolve alongside ever-changing societal attitudes, personal values and the support needs of an individual now as well as in their future.

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