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ORIGINAL PAPER

Moral Experiences of Crisis Management in a Child Mental Health Setting: A Participatory Hermeneutic Ethnographic Study

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Abstract Restraints and seclusion are routinely used in child mental health settings for conflict and crisis management, but raise significant ethical concerns. Using a participatory hermeneutic ethnographic framework, we studied conflict and crisis management in a child mental health setting offering care to children aged 6–12 years old in Quebec, Canada. The use of this framework allowed for an in-depth examination of the local imaginaries, of what is morally meaningful to the people in the setting, in addition to institutional norms, structures and practices. Data collection involved participant observation, interviews, and documentation review, with an interpretive framework for data analysis. We argue that the prevalent view of children shared by staff members as “incomplete human becomings” led to the adoption and legitimization of authoritative norms, structures and practices guided largely by a behavioral approach, which sometimes led to an increased use of control measures for reasons other than imminent harm. Children experienced these controlling practices as abusive and hindering the development of trusting relationships, which impeded the implementation of more collaborative approaches staff members sought to put in place to prevent the use of control measures. Study results are discussed in light of conceptions of children as moral agents.

Keywords Child mental health · Crisis management · Hermeneutic ethnography · Participatory research · Moral agency

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Background

There is a growing interest within anthropology and interdisciplinary research for the study of children and childhoods (Bluebond-Langner and Korbin 2007; Spyrou et al. 2018). This resurgence coincides with the launch of the United Nations Convention on the Rights of the child, which highlights key primary principles of (a) protection from harm, (b) provision of required resources and (c) participation, referring to children's right to take part in decisions and matters that affect them. We here focus on children in a particular context present in Western countries, a mental health institution. As seen in Hetjmanek's book Friendship, Love & Hip Hop: An Ethnography of African American Men in Psychiatric Custody (2015), there are specific challenges that arise within this particular setting, most notably in relation to what is referred to as "crisis" situation. These situations can lead to the use of control measures—referring to the different types of practices that are used to limit a person's freedom of movement—which deeply affect both patients and staff members.

Control measures include human or mechanical restraints (i.e. using human force or a mechanical means to limit or prevent a person from moving freely), seclusion (i.e. to confine a person in a setting from which he/she cannot go out freely), and chemical restraints (i.e. to limit a person's capacity to act by administering a medication to him/her) (MSSS 2015). According to practice standards, control measures are supposed to be used in exceptional cases, to prevent the physical safety of the person or others, when "less restrictive measures have proven ineffective" (APNP 2014:4).

From a chart review, in most cases, restraints and seclusion were reported to be used with children in response to non-compliance with a request, and not because of safety issues (Nunno et al. 2006). This situation can result in wrongful treatment for children that can cause serious harms; measures such as restraints, including physical holds, can result in trauma and physical harms—cases of children's death have also been reported (Nunno et al. 2006). The rates of restraints and seclusion episodes on child mental health inpatient units are of particular concern, as they have been reported to be 5 to 6 times higher than on adult units (Lebel et al. 2004), with 25% of child inpatients having at least one seclusion episode during the hospitalization period and 29% at least one restraint episode (Hert et al. 2011). These numbers highlight the vulnerability of children who are more likely to be physically controlled than adults in mental health settings. An increasing body of literature is highlighting the harms resulting from using these practices, including physical and psychological trauma (Hert et al. 2011; Nunno et al. 2006; Lebel et al. 2004). This situation—which raises significant ethical and moral concerns—calls for an in-depth examination of the use of control measures with children in mental health settings and how crises are managed.

Yet, knowledge related to alternatives to control measures for crisis management with children is limited (Valenkamp et al. 2014). Certain alternatives have been studied, such as the use of collaborative problem-solving (Bonnell et al. 2014; Pollastri et al. 2016) or trauma-informed and strength-based approaches (Azeem

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et al. 2011, 2015), but it is unclear how these models are applied in practice, as well as what is the experiences of children, parents and staff members related to crisis management. This limited literature available contrasts with the literature related to alternatives to control measures with adults, an area in which extensive research has been conducted, as shown in various reviews conducted on the topic (Goulet et al. 2017; Hallett et al. 2014; Johnson 2010; Muskett 2014; Scanlan 2010).

In this context, this study sought to examine the institutional norms, structures, practices, and corresponding moral experiences around the use of control measures in order to develop care approaches that promote an optimal reconciliation of ethical concerns in child mental health. This was done in partnership with children receiving care in a mental health setting, as well as parents and staff members.

Conceptual Framework

A hermeneutic moral framework was used in this study, in line with the philosophical work of Charles Taylor. According to Taylor, a person's identity is rooted in one's own understandings of oneself and cannot be known outside of interpretation. This understanding is embedded in a horizon of significance, which represents the broader socio-historical-cultural background in which meaning is rooted (Taylor 1991). Meaning refers here to the "experiential significance of a thing for a subject or group of subjects" (Carnevale 2013, p. 87) and is at the root of our own self-understandings, as well as shared understandings. These understandings are informed by the broader socio-historical-cultural context. The moral order in a group or society is defined by Taylor (2004) as a shared understanding of what is moral, of what is good or right. This shared understanding emanates from a social imaginary:

> By social imaginary, I mean something much broader and deeper than the intellectual schemes people may entertain when they think about social reality in a disengaged mode. I am thinking, rather, of the ways people imagine their social existence, how they fit together with others, how things go on between them and their fellows, the expectations that are normally met, and the deeper normative notions and images that underlie these expectations (p. 23)

A social imaginary reflects common understandings at the root of collective practices; conversely, practices convey the understandings that are shared (Taylor 2004). Since this study was performed in a specific setting where there were locally shared imaginaries, the term "local imaginaries" will be used to refer to the shared imaginaries in this specific social space, which are informed by horizons of significance and social imaginaries (Montreuil and Carnevale 2018). Institutional structures are defined in this article as social constructions that reflect the practices that occur in the setting and are based on shared meanings, rooted in the shared horizon of significance and social imaginaries. The institutional structures exist through the practices and shared meanings of material resources and social roles. The concept of moral experience as defined in this work shares some similarities with traditions within anthropology, for example with Kleinman's notion of moral

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experience as what is most at stake for a certain group within a social space (1999). The specific definition of moral experience adopted is the following: "Moral experience encompasses a person's sense that values that he or she deems important are being realised or thwarted in everyday life. This includes a person's interpretations of a lived encounter, or a set of lived encounters, that fall on spectrums of right-wrong, good-bad or just-unjust" (Hunt and Carnevale 2011:659). This conceptualisation of moral experience draws on hermeneutic notions of experience that is contextualized.

Methodology

The specific methodological approach used was focused ethnography, adapted to Taylor's hermeneutic framework (Montreuil and Carnevale 2018; Taylor 1971). The use of Taylor's hermeneutics as a methodological framework allowed for the examination of horizons of significance and local imaginaries that contribute to understandings of norms, structures, and practices as well as the experiences in a specific group (Carnevale 2013), in the present case as it relates to child mental health within an institutional setting in Canada. In addition, the hermeneutic focused ethnography was conducted as part of a participatory research framework. According to Taylor (2004), what is moral (i.e. what is good, right, or just) is rooted in *shared* meaningful understandings and practices. The use of a participatory research approach led to a stronger articulation of moral life and deeper understanding of the institutional norms, structures, and practices, through a collaborative and equitable knowledge production process. Participatory ethnography has also been recognized as an effective methodology to address health-related issues and foster public and policy engagement (Hansen et al. 2013).

Data Collection, Analysis, and Interpretation[1]

The main data collection strategies were (1) participant observation, (2) interviews with key informants and (3) documentation review, three strategies frequently used when conducting a focused ethnography (Knoblauch 2005; Muecke 1994). This multi-method approach offered rich data and allowed for an in-depth examination of the moral experiences as well as the institutional norms, structures, and practices related to crisis management in the study setting. Data collection began following approval of the Institute's Review Ethics Board.

Access to the field—a mental health day-hospital offering services to children aged 6–12 years old and their family—was granted by the administration and also supported by staff members. Data collection strategies were operationalized in collaboration with an advisory committee, which included 4 children, 2 parents, and 4 staff members. The iterative nature of ethnographic research entailed concurrent data collection, analysis, and interpretation. I began consultations with partners 5 months before the start of data collection, and continued the consultations

[1] The use of "I" refers to the first author who conducted field work. "We" refers to the research team.

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throughout the remainder of the study.[2] I performed fieldwork over a 5-month period, from February to June 2016, going in the setting 3 to 5 days every week. Participant observation was the main research strategy, as is often the case in ethnographic studies (Denzin and Lincoln 2005) and recognized as a key strategy in researching children's experiences (Greene and Hogan 2005). I was engaged with the participants and collected data through informal conversations in combination with observations, which allowed for the collection of rich verbal as well as non-verbal data in-context and contributed to contextualize and make-meaning of the data.

I sought written informed consent from staff member participants, as well as from parents for their child's participation along verbal assent from children. Twelve children (from 7 to 12 years old) participated on a total of 24 children enrolled in the program. This high participation rate allowed for an in-depth examination of children's moral experiences and social interactions. I wrote field notes at the end of each day of fieldwork, recording data from observations and informal interviews, along with reflections relating to the data collected (Muecke 1994). Data from informal interviews were central to deepen the understanding of personal experiences and the local meaningful moral context. Data were analyzed in an on-going manner and were compared and contrasted with new data continuously. To improve the use of self in collecting, analyzing, and interpreting data, I kept a journal in which personal experiences were recorded (e.g. personal assumptions, feelings, and reactions) to promote self-awareness, maximize attunement to what was observed and foster reflection (Lipson 1991; Mulhall 2003). Sampling was done along three major dimensions: time, people, and context (Hammersley and Atkinson 2007). It was a process in which decisions about when, who, what, and where to observe were recorded to make more explicit the decisions that were taken in collaboration with the advisory committee.

Using purposive sampling in collaboration with the advisory committee, key informants were identified to provide insight into the phenomenon of inquiry (7 children; 4 parents; 7 staff members). The language used in the interviews was adapted to each child; for example, if children said they did not know what fair or unfair meant, other words were used such as just/unjust or good/bad. Key informants were chosen based on their experience and knowledge of the program (Muecke 1994). I conducted between one and four individual semi-structured interviews with each informant (lasting between 15 min and 1.5 h each); the number varied depending on the depth and richness of data from each interview. The interviews were conducted in a private room. With children, a specific room with different types of mattresses, cushions, fidgets, and a small tent was used, which was conducive to a more informal type of interview. Children could move freely around the room, and it was emphasized that what they would share would remain confidential, which was important considering the power differentials between staff members and children on the unit. Drawing and play were also used to maximize children's opportunities to share their experiences, to contribute to the

[2] The first person is used to refer to the first author, who conducted this study as part of her doctoral thesis.

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understanding of the "children's worlds" (Kirk 2007:1251). The semi-structured interviews started 2 months after the beginning of fieldwork, in order for children to familiarize themselves with my presence before meeting with them individually.

For documentation review, I consulted the clinical charts of children participants as well as normative and clinical documents related to the program chosen in collaboration with the advisory committee. This review informed on how crisis situations were documented and contributed to the understanding of institutional norms, structures, and practices in the setting.

The interpretive frameworks of Benner (1994) and Crist and Tanner (2003) were used to guide data analysis and interpretation; these frameworks were combined with the analysis/interpretation of the broader socio-historical-cultural context as described by Carnevale (2013). Benner's framework, which is situated within the Nursing discipline, is rooted in interpretive traditions that align with Taylor's hermeneutics, but focuses more explicitly on experiences and not on the context. Crist and Tanner later built on Benner's work to develop more specific guidance for data analysis, which we combined with an analysis of the socio-historical-cultural context in line with our hermeneutics framework (Montreuil and Carnevale 2018). More specifically, the following analytic/interpretive steps were followed, in an iterative, non-linear manner during and following data collection: (1) I (referring to the first author) developed detailed interpretive comments while recording field notes and transcribing interviews; (2) I prepared narrative syntheses for each participant and for the environment, based on field notes data, key informants' interview transcripts, data from the documentation review, and interpretive comments, including excerpts from the raw data; (3) I presented a summary of the syntheses to the advisory committee and researchers involved in the study to identify important themes, contextualize the data, and make-meaning of the data; (4) I wrote additional syntheses to clarify the initial interpretations. Throughout this process, exemplars were identified to enhance understanding (Benner 1994).

Results

This ethnographic study sought to answer the following questions: (1) What are the institutional norms, structures, and practices related to conflict/crisis management? (2) What are the moral experiences related to conflict/crisis management—both favorable and unfavorable—from the perspectives of children, parents, and staff members? (3) What are care approaches that optimally reconcile ethical concerns in child mental health in relation to conflict/crisis management? Questions 1 and 2 are addressed here concurrently, starting with a broader presentation of the program, followed by an examination more specific to conflict and crisis situations. The children and staff's perspectives are compared and contrasted throughout the text. Parents' perspectives are limited, as parents were not present on the unit; they have the legal authority to consent for their child's care, but were not part of the everyday experiences in the setting. The analysis of the wider background context, the horizon of significance, shed light on what leads to the adoption of different practices, and also, through the analysis of the local imaginaries, what is the moral

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order (the values, standards, norms) that are shared by children, staff members, and parents. Question 3 is addressed in the Discussion, examining the "ought" implications related to the optimal reconciliation of ethical concerns in child mental health, taking this context into account.

Study Setting: The Day Program

The study took place in a mental health day-hospital program for children with behavior challenges located in an urban centre in Quebec, Canada. Examples of diagnoses present in children's charts included attention-deficit/hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), disruptive mood dysregulation disorder (DMDD) and conduct disorder. Children were usually referred to this third-line of care program through their school, when it was considered the child and family needed additional support that schools and services through 1st and 2nd lines of care could not offer, and that the child needed specialized and ongoing care throughout the day.

The program offered care to 24 children at a time: 12 children aged 6–9 and 12 children aged 9–12, divided in groups of 6 children.[3] Each group shared a room and was assigned a primary worker, who was either a specialized educator or a psychoeducator.[4] The targeted length of stay in the program was 6 months, but many children remained in the program for most of the school year (i.e. from September to June). The children attending the program were going to the day hospital instead of going to their school, following the school calendar and hours (from around 8h30–15h15). When a crisis situation occurred, nurses were often called to help manage the situation and use control measures if deemed necessary. The only control measures used with children were seclusion and human restraint, in accordance with local legislation. Human restraint, also called a physical hold, refers to holding the child as to prevent him from moving. It could be done with one staff member holding the child's crossed arms by the wrists, from behind the child, or with two staff members each holding one of the child's crossed arms by the wrist, sitting on a bench on each side of the child. Other staff members sometimes also held the child's legs, either crossed or, less often, in an open position. For the seclusion room, it was about 2 by 1 meters with concrete walls and a window covered with a protective screen facing outside, and a small window with a two-way mirror on the door facing the hallway. It was totally empty, except for a twin mattress that was occasionally lying against the wall. I was told by the staff that the mattress was used to push the child in the corner when too aggressive since it is the

[3] Considering the limited number of children on the unit, specific information related to the characteristics of the child participants are not included to enhance confidentiality. Also, some of the participants' identifying information has been modified to enhance confidentiality (e.g. the masculine form is used to refer to the children, as only 1 girl participated in the study and she could be more easily identifiable as there were only 3 girls out of 24 children in the program). French quotes have been translated to English.

[4] In Quebec, Canada, where the study was conducted, specialized educators are workers who have earned a professional degree in this field, while psychoeducators must hold a Master's degree in psychoeducation and be registered with a professional Order. They are both trained in the field of psychosocial adaptation difficulties.

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same width as the room. The room had no lock as per an institutional decision not to seclude children (decision taken by upper management), but staff members were holding the door shut when children were secluded, which could last for hours, with staff members taking turns holding the door shut. There was a clipboard on the wall next to the seclusion room with sheets on which the staff could enter the information related to the use of control measures (i.e. date and time, name of the child, type of control measure used and reason). There was also a calm room, about 3 times bigger than the seclusion room, in which there were different types of mattresses and cushions, a small tent, soft chairs, fidgets and stuffed animals. Human restraint was usually performed in the hallway. If a child was restrained in a room, he was carried in a physical hold in the hallway. Here is an example in which a child was physically carried to the hallway because he refused to comply with a staff's request:

> I was in the hallway and heard a staff member calling for help on his walkie-talkie. A staff member went to see what was happening, I followed him. Two staff members physically restrained and carried a child on a bench outside the classroom. One of the staff members told the child: "I've told you to do something, you didn't do it. You stay here until you're ready to come back in". The child, who was sitting on the bench and looking at the floor, didn't say anything and lifted his legs on the bench, holding his knees in his arms. Once in a while he was crying silently. A child was in the seclusion room while this happened, and a staff member was holding the door of the room. He noticed the child was crying and asked another staff member if he could try to discuss with him. He went to sit beside him, but said he was closing up even more when he tried to talk to him. The child started hitting his head on the wall. The staff member holding the door asked someone else to go talk to the child. He went and sat beside the child, but came back saying he didn't talk to him. Then, the staff member who had told the child he had not listened to him arrived at the request of the person holding the door, and told the child he has to listen when he asks something, and asked if he was ready to eat his lunch. The child said yes and went quickly to the classroom to eat.

Staff members carried walkie-talkies with them almost at all times to ask for help when needed (e.g. if they had to leave the classroom to discuss one-on-one with a child or if a child was agitated and they needed assistance). Some staff members kept the volume level really low, so others could not hear what was being said, and others kept the volume louder, and everyone around could hear the conversations.

The use of control measures was included in children's interdisciplinary intervention plan; however, the seclusion room was referred to as the "therapeutic room" in the plan. Here is an example of an intervention plan:

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Problem description	Objective	Interventions
ADHD symptoms	Reduce symptoms	Monitor medication
ODD symptoms	Reduce events [in reference to a crisis]	Social skills program
		Anger management program
		Use of therapeutic room

When children were admitted to the program, the plan was shared with parents, who had to sign it, as well as the consent form for the use of control measures. This was mandatory for children to be registered in the program. Here is an excerpt of the consent form:

Title: 'Consent for registration and care'

'I therefore consent that he be treated within the scope of the Program in the manner judged necessary by the treating team. This includes:

- The possible use of the therapeutic withdrawal room if my child becomes disruptive and that the planned interventions have given no results.
- The possible use of human restraint if my child presents behaviours that are dangerous to himself or to others.

Parents shared they were confident that these measures would be used as a last resort.

Daily Schedule

Children arrived on the unit at around 8h30 via school transport. Half of the children went to school for 2 h in the morning, and the other half in the afternoon. The rest of the day, children had different activities and workshops with their group (e.g. pool, gym, music therapy, animal-assisted therapy, social skills workshop, conflict management workshop, anger management workshop, logic games, social games, reading, free play). The schedule was sometimes individualized: for example, the educators decided what a child was allowed to do according to their grade in their behavior book. If a child had a lower grade, he could for instance not participate in an activity he typically said he enjoyed. The activities in the different settings were highly structured: e.g. at the pool children had to do a certain number of swimming laps before having a free play as a reward. The amount of time in free play depended on children's behavior. Children occasionally "lost" their free time if one child did something that was not considered appropriate by staff members, like doing something that was against the rules or perceived by the staff as dangerous, disruptive or oppositional. For example, at the gym, one child did not want to do the warm up and was told by the staff to go sit on a bench and not come back with the group. The staff member told the child that children have to do everything that is expected of them, otherwise they are out. In addition, another staff member told the child he would have time taken off "park time" because he refused to participate in

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the activity, which is expected of him since it is part of his therapy. The child remained seated, his face red and his body tense, looking intensely at the staff member. These situations could occur during any of the program's activities and settings.

There was a token system in place with different levels, each having specific behavioral goals and objectives (e.g. I follow the rules; I do my activities, transitions and activities calmly). Each child had a booklet with a table listing the expected behaviors for the level they were at. Every day, the children received tokens based on the points from the table. They could also receive tokens spontaneously during the day when doing certain behaviors that fit the behavioral objectives outlined in the token system, or had consequences for not respecting them such as sitting in time-out at an empty desk or on a bench outside the room. With the tokens, children could buy rewards (e.g. bring a toy home for the weekend or take a candy from a candy box). When discussing with the children, they generally described the token system in positive terms and referred to it as being similar to programs in their previous schools (e.g. "it's like in all the schools"). The punitive consequences were sometimes considered by children as being "deserved" (i.e. having something bad happen to you for doing something considered bad by the staff) and sometimes unjust, especially when not knowing the reason for having a consequence. For instance, a child shared that when he was warned not to do a certain behavior, he found it helpful as he then knew what to do or not, but that staff members did not always do it and then he had a consequence without knowing the reason, which he found unfair. Children also mentioned not knowing what the score would be in their behavior booklet. As one child described: "Well, we say the number; they [the staff] fix it. They fix it right… Like, they give different numbers". When asked what the scores meant, most of the children emphasized the scores meant they were "good" or "bad", and being good meant "listening to adults", which was one of the stated expected behaviors. Children had to raise their hand and ask a staff member for permission before doing anything different than what they were previously doing (e.g. if they were drawing and wanted to get another sheet of paper; to go to the bathroom; or to get a different game during a play session).

The staff said they tried to recreate the school environment and expectations since children will go back to their schools when leaving the program. The staff expected the children to comply with their requests and with the rules in place, and children were rewarded or had consequences/punishments if not conforming or acquiescing, both individually and as a group. Staff members also offered positive reinforcements in the form of praise to children. They mentioned it is a way to show children what they are doing is right. Some children mentioned they often liked being praised and it made them feel good, but it depended on how it was done. For example, one child said in relation to positive reinforcement: "Some teachers are really authentic, they mean it. It's obvious it's authentic. Others they do it too much. Some children, like […], like when they get praised. It depends on the child". Certain staff members mentioned offering positive reinforcement brought them a good feeling: "It's fun also to have the feeling to be reinforcing the child! You know, I mean, to have this effect, positive. For the staff, that's cool". However, other staff members considered the interventions should be done in an emotionally

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neutral way, and enforced "like the police. Ok, you will have a consequence, you have been impolite". The rules were the same for all the children, with rare individual accommodations. Here is an example I observed of the staff's consistency in applying the rules:

> A child asked a staff member if he could go see the nurse because his foot hurt. The nurse heard what he said and mentioned she could help him; they went to the nursing office. When the child came back, he started to eat his lunch, but there was not much time left for lunchtime. When he was about half way done, the staff member told him he only had 3 min left. The child asked if he could have more time since he was at the nursing office. He added, looking directly at the staff member:

– If I don't eat everything I have to bring it home and then my mom forces me to eat it all before supper. I don't want that. Can I take more time to finish it?
– You decided to go see the nurse, now you have less time to eat.

> The child continued eating in silence in a hurry and did his after-lunch routine when told to. (field notes)

All staff members shared they were acting in the child's best interests, as a way for children to reintegrate the school system more easily. They emphasized there were different normative implications expected of children because they are children, notably to respect adult authority and to attend school, including all the different activities it involves. All the children mentioned listening to adults is "good", and certain children mentioned disliking school, but having to attend. As one child said, shrugging his shoulders: "everywhere we go, there's school".

Conflict and Crisis Situations

The Role of Institutional Norms, Structures and Practices in Conflict and Crisis Situations

The environment and organization of the unit were described by staff members as contributing to prevent crisis situations by making children feel safe. They mentioned that in a more "loose" setting, children do not know the limits, which makes them feel insecure. As a staff member mentioned: "A staff who does not provide structure contributes to the insecurity of the child who becomes anxious and acts out". Children considered having rules in place on the unit as generally positive. One child stated the rules on the unit help to learn "to be better", and another one stated that when a setting is "more loose"—with fewer limits—certain children have a hard time and escalate, having more frequent crises. Even though children emphasized the importance of rules, all of them said they would change certain rules, especially the use of group consequences that were described by many children as unfair (e.g. one child stated: "You shouldn't be consequenced [sic] for the behavior of others. That's not how life works") and the use of time-out. For example, one child mentioned he hates being in time-out, and would like to have a limit on the amount of time someone has to be in silence at the "think desk", which

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he said makes him depressed and would be even worse for people who are already depressed, as is the case of certain children on the unit. Some of the children considered they should share their opinion in relation to rules and then adults would decide what they are. One child compared the rules to country laws: “if everyone agrees that something is not right, the laws would change”. He suggested it should be the same on the unit. Also, most children emphasized it was important for them to understand why a certain rule was in place, and considered some rules would never change since, as one child stated, “that’s what humans have been doing for centuries”, giving the example of removing your hat inside. They considered sharing their perspective with the staff would not lead to changes on the unit.

If a child did not conform with the rules or requests, it could lead to a conflict with the staff, who then imposed consequences that were referred to by some children as “new rules” that sometimes they reported made them more angry and led to crisis situations (i.e. when the child continued to refuse to comply with a request or acquiesce, or became aggressive). In this sense, the structure contributed to both prevent and lead to conflicts, as it was setting the limits of what was considered right or not from the staff’s perspective. I observed different situations in which not following a rule resulted in a crisis and the use of control measures, for example with a child who was asked to remain in silence by the primary worker while playing a game. She explained to a co-worker that the child did not like the directive, threw his chair, and hit the bench in the hallway when asked to sit. I then observed the nurse and another staff member ask the child to sit closer to the seclusion room. The child yelled, and they carried him in a physical hold to the seclusion room, where the nurse was holding the door shut. The child was yelling from inside the room:

> The staff shared they know when he is not well he yells, so they put him right away in the seclusion room, so as not to disturb the other children on the unit. They said as soon as they’ve asked him to sit closer to the seclusion room, he started yelling, so they carried him to the seclusion room. The timer rang after he had been in the room for 5 min, and the nurse opened the door. The child was sitting cross-legged on the floor; his eyes were puffy and red. He looked at the staff members and expressed feeling depressed, frustrated and stressed in relation to his behavior. They closed the door saying it was the same discourse as always, adding 5 min to the timer. When the time was up, the nurse opened the door and asked if he was calm enough to come out and eat his lunch. He nodded and came out calmly to sit on the bench after being told to.
> The child later told me in relation to the staff on the unit: “I have a good relationship with them, but I get frustrated at them. I asked for clarifications and he explained that they are nice to him, which he said has not always been the case elsewhere, but ‘they get me in silence for things I didn’t do’ ” (field notes).

Some of the staff members described the use of control measures as an effective way to decrease the frequency and duration of disruptive disorders, as in this child’s case.

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One staff member described how a few years before, “it was really the staff who was taking all the power over the child”, and now they mentioned changing their practice to leave some power to the child, but take it all if the child does not behave as expected from them. Examples of power they now let the child have included “to let him make the right decisions” (i.e. by not interfering with the child’s behavior), and “to let him decide the amount of time he will be in the seclusion room”, which they said helps the child feel “safer”. I have observed children ask for 5 min to calm down, and one child asking angrily for 50 min, which they respected, telling the child they would check in every 5 min to make sure he did not change his decision. The staff explained to me this was a way to give more power to the child. On some occasions, control measures were also used as a threat, which the staff explained was to show children what the consequence of their behavior would be, and help them use the power they have to make the “right” choice. For example, a staff member once told a child who was lying prone on the bench outside the room, banging the bench with his feet: “Stop banging or I will put you in the time-out room, that’s for sure”.

Specific environmental conditions could also lead to more crisis situations, as I have observed during lunchtime. The level of noise and activity was much higher during this time as opposed to other activities (e.g. school or therapy sessions). Both the children and staff (as in my observations) reported there are more crisis situations during this time.

Moral Experiences Related to Crisis and Conflict Management

Some staff members mentioned the seclusion room and physical hold provided security to the child, as they contributed to identify the limits in the setting and the child would know he would be stopped if he was having a crisis. Some of the children shared this view to a certain extent, mentioning for instance that the use of control measures contributed to making the unit safe for them, as it prevented other children from being aggressive toward them or from injuring themselves. For example, one child said he felt good when another child who was aggressive was in the seclusion room, because he could continue to play with his friends. Another child emphasized: “if you’re running in a wall and bleeding, thank God they stop you”. The staff agreed they don’t want to take chances that children might hurt themselves or others, and said they stop them beforehand, as they consider they know when the child will escalate.

On the other hand, when children referred to their experiences of having been secluded or restrained, it was usually presented in a negative way, for example reporting it was making them “angry” or it was “painful”. All children agreed that the seclusion room was a punishment for “bad” behavior, for example hitting others and saying “bad words”. Some children mentioned it was so bad to be in the seclusion room they stopped being aggressive to get out. Others said they feared they would hurt themselves while in the room or that they would be physically restrained. A few children described physical holds as “painful”; they reported changing their behavior in fear of being restrained again. I have observed different situations in which children were being restrained, for example:

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> The child wanted to go to an activity the next day, but the primary worker had put as a condition that he had to participate in a certain activity he disliked. The child was lying prone on the bench in the hallway, banging the bench with his feet and repeating he wanted to go to the activity the next day. The nurse and another staff member asked him to take a tool (e.g. a fidget) to calm down. He refused, saying "I hate adults!" Then, the two staff members put on disposable gloves and came back in front of him. The child asked them if they were putting gloves on to hit him. They explained he was sick (he had a cold), and they could get sick too if they had to touch him. He then asked for 5 min on the timer to calm down. The nurse agreed and set the timer for 5 min. The child was sniffling and lying down on the bench calmly, remaining silent. After two minutes had passed, one of the staff members pushed the timer so it would ring without the child's notice. The nurse asked him if he was ready to go to the activity. He said no and started banging the bench with his feet. The two staff members sat on each side of him on the bench and did a physical hold (i.e. each person was holding one of his arms that were crossed on his chest). He said he could not breathe; his nose was running, the mucous going to the floor. He started to scream that he could not breathe. Another nurse brought a facecloth to blow his nose. After a few minutes, the staff members released the hold. The child did not say anything (he was frowning, teeth clenched, looking at the floor, catching his breath). One of the staff members asked him if they could trust him to participate in the activity. He nodded, looking at the floor. When told to, he went with the group to participate in the activity. The staff members who restrained him later told me they disagreed with the condition the primary worker had set, but had to respect it since it had been shared with the child and they could not go back on the decision made, as it would make the child feel insecure and lead to more crises (field notes).

The staff emphasized control measures were used in a benevolent manner, so as to prevent the child from hurting himself or others or, as mentioned by certain staff members, a punishment so the child can learn what is right or wrong. In the example presented above, the staff said he was too agitated, so they decided to restrain him. One of the staff members once explained that using physical restraints can decrease the number of disruptive situations during the day, which is then positive for both the child and staff. Children considered some of the staff members "abused their power" by resorting to coercive measures when the child and others were not in danger. In the example above, the child expressed to the staff what could be interpreted as a fear of being hit, of being hurt. Certain children also described having been in the seclusion room or restrained without knowing the reason, which they found was not right.

Certain staff members mentioned emotions were sometimes involved in decisions to use control measures or not, in that they could become angry that a child repeated a behavior that was prohibited and for which they had already intervened in the past. The use of control measures was also largely described as emotionally demanding: "It's just that it's the process, it's not fun… you don't want to use force with them, but sometimes we don't have the choice". Restraint was also

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described as more emotionally charged than the use of the seclusion room, as staff members are restraining with their own body and have to emotionally disengage from the situation. As a nurse mentioned: “Whether you want it or not, even if you know the child is wrong, well, it gets to me. I think emotionally, it’s somewhat normal. But here again, I put myself in my little nurse’s shoes when it happens, and try to detach a little emotionally from the situation”. Some children considered staff members had emotions when physically restraining a child (e.g. one child said: “For sure some people it disturbs them. You see it in their eyes, the adults too”), while others considered staff members were neutral, acting in a manner detached from the situation. The use of time-out was also described by the staff as a way for them to manage their own emotions during a crisis situation, not solely for the child to calm down.

Parents were glad they would not be called in case of a crisis and the team would handle the situation. For example, a mother said: “calling the parent is used as a last resort after many attempts to resolve the situation, and I’m fine with it”. Parents described the use of control measures as necessary when other interventions failed, and mentioned consenting to their use, being confident the staff would use them as a last resort. Parents were very rarely present on the unit, and shared feeling relieved the team would be in charge of their child’s care during the day, as most of them were working full time jobs and previously had to miss work when their child had a crisis at school.

The Role of the Staff

Staff members described their role on the unit primarily as authority figures who set limits to children as a group and teach them how to behave socially, through the use of the behavioral approach and the social skills workshops. They mentioned focusing on group interventions. Individual care was offered almost exclusively by therapists, who typically met with children individually in their office once a week, as well as weekly with the family. The staff mentioned being in transition to using a more collaborative approach with children, listening more to them before “stopping the behavior” (i.e. using the de-escalation approach, ranging from verbal request to restraint) and “set the limits”. For example, a staff member once told me he previously would have asked a child to go sit at his place while reading, but did not and let the child read in the reading corner to accommodate for his preference. I have sometimes observed abrupt changes in the staff’s approach, highlighting the tension between the behavioral and collaborative approaches, especially in the case of a conflict. The staff was alternating between “listening” and “stopping the behavior”, sometimes shutting the door of the seclusion room as the child was speaking to them if not saying what was expected of him. One staff member mentioned needing “a balance between structure-control-security and listening openly, knowing when it’s the right timing, when it’s not”. She said that if using exclusively an authoritative approach, it could impede the caregiving relationship with the child and prevent the attainment of the therapeutic goals.

However, other staff members mentioned the fear of losing control of the group if individualizing care and not using a uniform authoritative approach. They

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contrasted the interests of the group with the interests of the individual child, and mentioned they had to find a balance between these competing interests. In practice, this justified for example putting a child in time-out if considered as disturbing the group. Most staff members considered using a uniform authoritative approach helped in the development of a trusting relationship with the child, as the child could trust they would be firm and consistent, and they would be stopped if not behaving according to the rules or requests. They said children then collaborated more because they trusted the staff would put a limit. During participant observation, one child who was new to the program had been secluded for extensive periods of time during his first week in the program, with 4 episodes lasting up to 3 h. The staff explained they were setting limits, as they reported he had been verbally aggressive with a staff and had kicked a bench, and they "could not let him do everything". The staff said they were using control measures because they didn't have a trusting relationship with him, so they had to help him feel secure first by setting a firm structure in place, and then he would trust them and participate in the program.

From children's perspectives, staff members played a variety of roles on the unit. For example, consistent with the staff's view, children described them as authority figures who decided what the rules were and ensured they were respected. They were also often implicitly referred to as omniscient, especially by younger children who considered the staff would know if they did something bad and they would be "punished". Children also referred to the staff as educators and caregivers, who helped them learn anger management and social skills—which they found helpful—the nurse being present to offer physical care if needed. Some children also described them as playmates; children sometimes played board games with the staff and playing with an adult was a reward that could be bought with the token system. Children generally considered the staff was "nice", but it changed when there was a crisis situation. One child described this change: "When people [i.e. children] get mad, he [the staff member] starts to act like the kids doing that. When the kids get bad, he starts being mean and puts them in places and that." This view reflects in a way the tension described above between the authoritative and collaborative approaches from the staff.

What Children Consider Helpful

During the interviews with children, I asked them what helped the most when experiencing a crisis. Children mentioned the calm corner or calm room helped them become "calmer", as there were soft cushions and fidgets, as opposed to going in time-out or in the seclusion room where it was "boring" and "empty". Children also considered it was more the relationship with staff members, the skills they learned, as well as their own decision to change that helped to change their behavior, in contrast to rewards, consequences and the use of control measures. Children also emphasized that having the opportunity to talk with someone was helpful and more desirable than other behavioral or coercive strategies. Here is an example of a child describing how he said he decided to change:

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> The child said the program helped him, as before he was throwing chairs and biting teachers, and doesn't do that now. I asked what he thinks led to this change, he replied that he knows it is not safe what he was doing, and it is illegal. He added: "I just decided that if I want a good chance in life, I have to change". (interview, child)

Another child mentioned he didn't like how he was feeling when angry and decided he wanted to feel good and not be angry all the time, so he changed his behavior. He said at first he found the adults on the unit were "mean", but that he likes the program now as the adults helped him to learn ways to control his anger and he made friends on the unit.

Children emphasized the benefits of having free time to play with other children, and how it contributed to make them feel good. Many mentioned finding it easier making friends on the unit compared to school, as "we're all the same, we're here for a reason". The importance of these social relationships was also emphasized by the parents, who mentioned their child often had difficulties making friends at school.

Discussion

In the previous section, I presented the role of institutional norms, structures and practices in conflict and crisis situations, as well as the moral experiences of children and staff members (and to a lesser extent parents) related to these crisis situations. These results are discussed here in terms of local imaginaries of children and staff in the setting, and put in context within broader horizons of significance and social imaginaries.

In short, I argue that the prevalent view of the child shared by staff members on the unit as "incomplete human becomings" led to the adoption and legitimization of authoritative norms, structures and practices guided largely by a behavioral approach, which sometimes led to an increased use of control measures for reasons other than imminent harm to self or others. Children experienced these controlling practices as abusive and hindering the development of trusting relationships with the staff, which impeded the implementation of more collaborative approaches that staff members sought to put in place to prevent the use of control measures. I then discuss the study results in light of conceptions of children as moral agents, addressing the "ought" implications for clinical practice.

Children as Incomplete Human Becomings: Staff's Perspectives

On the unit, children were described by the staff as needing to develop specific socialization and rational thinking skills following a staged process, in their best interests, in light of their future participation in society. The different stages were embedded within the token system and various strategies were used so children would progress through these stages. This view of children in light of what they will become and their future contribution to society is consistent with what Lee refers to

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as a dominant framework within child psychology in which children are perceived as incomplete human becomings, in contrast to full human beings, seeing children in terms of what they will become as adults (Lee 2001). Lee (2001), in his book Childhood and Society, examines largely accepted conceptions of children as "incomplete beings", who are perceived as needing to be socialized to become adult "complete human beings" and challenges these established perspectives. He uses predominantly the term "human becomings" to refer to children as developing, incomplete beings. The term *incomplete human becomings* is used here to emphasize that within this dominant Western perspective of childhood, there is a perceived complete state, which is adulthood (Bluebond-Langner and Korbin 2007). In line with this dominant framework, children are described in terms of "investments for the future"; children's worth is assessed by their potential contribution to society as future adults and citizens (Hendrick 1997:34).[5] The staff shared that there were certain practices they would not use with adults, as well as activities they would not force adults to participate in, in contrast to children who were described as needing to follow this staged process. For example, the strong belief in children needing to attend school served to justify imposing activities and practices that were considered as normal within schools for children (e.g. washing their hands, not running down the stairs) and it was expected children would conform with what was described as a school norm. When looking at one of the children's example presented above, going to the gym was a request considered by some of the staff as legitimate since it is an activity required at school, and led to the use of a physical hold so he would comply. Staff members were using practices they considered necessary to bring the child to the last stage of the token system, which meant he could go back to his neighborhood school. Some of the staff referred to these practices as investing in the child, referring to teaching and modeling them how they should behave. They emphasized this could only happen once children were conforming with the program and ready to listen to adults. Once the child conformed and the staff invested in a child, the child was described as being on the right path to becoming a future "good" member of society, i.e. a complete responsible adult being.

In line with this view of children as incomplete human becomings, there was an expectation of children's compliance, conformity, and acquiescence with established norms and structures, as well as adults' requests. These expectations could be interpreted as representing the "hypergood" for most of the staff, i.e. a standard, the most important good from which to judge other goods or ends (Taylor 1989). As staff members mentioned, their practices were guided by a benevolent aim; they sought to help children so they could have better chances of "success" later in life, which was described as being closely related to success at school. When asked what was "good", children often mentioned "listening to adults" (i.e. acquiescence), following the rules (i.e. comply), and following group norms (i.e. conform), which mirrors the staff's expectations in the setting. Consistent with this view, staff

[5] This book chapter is part of James and Prout (2015, 3rd ed.) seminal book in the interdisciplinary field of childhood studies. Hendrick examines the historical western constructions of childhood and explains how the view of children as sites of investments became dominant.

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members defined their role predominantly as authority figures, and children were expected to respect adults' authority in all circumstances. When a child expressed disagreement with a request or rule—either through verbal or non-verbal means—the staff intervened so as to stop the discussion or behavior and express their authority over children. From this view, the child was perceived as not knowing what is true or right, and his perspective was rarely sought or recognized.

Within this perspective, children were not seen by the staff as moral agents (Taylor 1985) in reference to children's "capacity to act in the light of considerations of right and wrong" (Montreuil and Carnevale 2016:519). The staff's view could be interpreted as being consistent with a dominant perspective within developmental psychology on moral development in childhood, notably theories building on the works of Piaget and Kohlberg, in which children gradually develop a capacity for moral judgment through the development of cognitive and reasoning capacities, as well as teachings from adults (Montreuil et al. 2018). Larcher (2015), in a philosophical analysis of conceptions of children within medicine, states this view is still widely prevalent within western thinking and seemed to be part of the local imaginaries of the staff in relation to their view of children as described above. The staff considered children, especially younger ones, did not have the capacity to reflect on what is right or wrong due to their incomplete state, and needed adult teaching and modeling to know how to act. However, staff members did not consider they were providing moral education to children, but teaching them emotional and social skills to help them live in society, to become good citizens. Various values were nonetheless shared with children on the unit, even if they were implicit. Kohlberg considers there is a moral component to teaching that is often covert, for example "obedience to authority" that was largely "espoused" by both staff members and children (Kohlberg and Hersh 1977:54). Kohlberg and Hersh (1977) consider this type of institutional structure as being consistent with punishment and reward-based morality, as well as law and order within their moral development framework; this type of structure is described as not conducive to children's sharing of what they experience as morally significant. Kohlberg's framework has been largely critiqued for claiming there is a single universal staged process of moral development in children, but still predominates the field of moral development within psychology. I consider this framework reflects the practices in the setting and the view shared by the staff. For example, consistent with Kohlberg's framework, they mentioned younger children needed more consistency and guidance because of their less developed cognitive capacities. Within this firm environment, staff members were authority figures controlling both the group and individuals, using mainly a behavioral approach to guide their practices.

Staff members referred to the behavioral approach as evidence-based and necessary to achieve their aim in the best interests of the child. Some of the staff members referred to operant theories of behavior modification, in which children are externally rewarded or given consequences with aiming to increase their motivation to comply with expected behaviors. From this perspective, the child's behavior can be shaped through external interventions provided by adults; adults identify what behaviors need to change, and use a set of rewards and consequences

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to lead to these changes. There is some empirical support for these practices, but it is more limited than previously thought. As described in three reviews of the effects of behaviorist systems in institutional child settings, the "evidence" supporting the use of these approaches is highly limited, especially the lack of long-term effects and the numerous issues related to using uniform approaches (Eyberg et al. 2008; Frensch and Cameron 2002; Mohr and Pumariega 2004). From this view, children are perceived as the *objects* of the interventions and not as *agents* who have the capacity to act, reflect and take part meaningfully in the social world around them. In his early writings, Taylor (1966) critiques behavioral approaches for reducing actions to responses to external stimuli, with no consideration for the purposes of actions, for the interpretations from the person who is acting. By employing such approaches, the staff focused on finding strategies to get the child to act the way they considered was appropriate and would lead them to develop into complete adults, largely discounting children's experiences and moral lives.

Limited Parental Support

Children had highly limited parental support while on the unit. Both children and parents described this as normal, as this is how it would be in their neighborhood schools. Some parents also shared not wanting to intervene with what was happening on the unit, not to send the message to their child that they might disagree with some of the norms or practices in place, which they said could lead to their child being opposed to the program. This view led to children being prevented from receiving parental support while in the setting. For example, a child once asked the staff to call his mom because he was not feeling well, which was refused. These practices sharply contrast with other hospital settings in which parents can be present 24 h a day. It is now widely recognized that parental support is beneficial to children in hospital settings. Power and Franck (2008) conducted a systematic review of parent participation in the care of their hospitalized child and highlighted that parents are now largely expected to actively participate, which is beneficial for all the parties involved. Similarly, Foster et al. (2016) and Harrison (2010) examined the concept of family-centered care and emphasized the numerous benefits resulting from using such an approach to care, but difficulties nurses experience in implementing this approach. If we look at international law, the European Association for Children in Hospital (EACH) charter was adopted in 1988 (revised in 2001 and 2016). It is mentioned in article 2 of the EACH charter: "Children in hospital shall have the right to have their parents or parent substitute with them at all times", which highlights the broad recognition of the benefits of parental support. Within the mental health day hospital, I believe it was more the conception of the staff's role in this specific setting, as well as parents' expectations that the staff would be in charge during the child's usual school hours, that prevented parents from being more involved. Within the mental health day hospital, the view of the setting as a replacement for school led to a different way to imagine the parental role, which raises questions related to how decisions were made on behalf of children by the staff.

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In daily practices, the staff had to make multiple micro decisions related to children's care, which bore a moral component. For example, decisions related to the interventions to use, disclosing information regarding one child with the group, or access to food, among others. Children could not give consent for themselves while in the setting, leaving the staff members in charge of these decisions that would be taken by parents in other types of hospital settings. There was a distancing of parents from everyday care, choices and actions, who are the ones legally supposed to make decisions and provide ongoing consent for their child's care. This situation, which parallels the school context, transfers decision-making capacities to the adults in charge in the institution. This leads to certain ambiguities related to the ethical standards that apply in the day hospital setting, and how care and control are practiced. Children did not share any concerns related to their parents not being present on the unit; as with the imposition of rules decided by adults, children described the unit as a school setting where parents are not present and the adults within the institution make the decisions for children. Decisions were in fact often referred to by children as being rules, which could be related to the decisions being taken unilaterally and the children having to comply with them, as with a rule. Children mentioned finding some of these rules unfair, but having to respect them or otherwise have a consequence.

The Use of Control Measures

Within this authoritative setting oriented by a behavioral approach, control measures were seen by the staff as necessary interventional strategies to be used as a last resort when compliance, conforming and acquiescence (i.e. the hypergood) were challenged. This is a common view within de-escalation approaches for crisis management, which was normalized on the unit, as was demonstrated for example in the setting's documentation. This de-escalation approach reinforced the view of staff members as authority figures; children expressed for instance their fear of being restrained again and described the de-escalation approach as impersonal, making them angry and sometimes being unfair.

In addition to the use of control measures as part of the de-escalation approach, staff members used control measures to contribute to set limits for new children so they would feel safer and would trust that the staff would stop them. Within the literature, this perspective is controversial as there are very few studies on the experiences of children being secluded or restrained, and the emphasis from children is on the coercive nature of the interventions in contrast to a feeling of safety (Lundy and McGuffin 2005; Mercer 2013; Mohr et al. 1998). The view that control measures lead to a feeling of safety and trust could be interpreted as a form of rationalization, drawing on an apparently consequentialist ethics whereby the behavioral outcomes justify the controlling means. On the unit, to reach the ends of children's compliance, conformity, and acquiescence, the staff legitimized the use of control measures with children, sometimes for extensive periods of time (e.g. hours), including when the child was calm and did not pose an imminent risk of harm to self or others (e.g. I observed children asking to go to the bathroom while in seclusion, who walked calmly to the bathroom and back to the seclusion room).

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Control measures were thus not only used in case of imminent risk of harm to self or others, which is locally legally required for adults, but also as an authoritative intervention so the child would comply with the institutional structure in place. The dominant perspective of children as incomplete, developing beings—in contrast to active moral agents—justified the use of these controlling practices in the best interests of the child. This view of children led to what could be interpreted as the adoption of different ethical standards with children as compared to adults, in which it is justified to enforce what are considered established social norms through behavioral, controlling and sometimes punitive approaches.

Children shared examples of what they considered legitimate uses of control measures; all of them were related to imminent risks to self or others. Adopting a view in which it is recognized that children have moral experiences would likely lead to similar conclusions as the ones from the literature on alternatives to the use of control measures with adults, in which they are viewed as harmful, but permissible as an *exceptional* measure that is time-limited, in case of *imminent* harm to self or others (MSSS 2015; Van Der Merwe et al. 2013). By this statement, I do not mean children are "mini-adults" and have all the rights and responsibilities adults would have, but that children are agents with moral experiences and are entitled to receive care that is ethically-sound as adults would receive. In a study reporting on the implementation of a restraint and seclusion reduction program on a youth psychiatry unit, Azeem et al. (2015) stated a culture change was needed to reduce the use of control measures based on primary prevention. I would add that a change in conceptions of children is needed in the staff's local imaginary in order to allow for more collaborative practices to be implemented.

Conceptions of Children and Collaborative Frameworks

While I was performing fieldwork, staff members sought to use a more collaborative approach with children and decrease the use of control measures, referring in particular to the Collaborative-Problem-Solving approach developed by Greene et al. (2006). Staff members on the unit had participated to a workshop on this approach the year before I conducted the study. However, the prevalent view of children as incomplete human becomings created many tensions and challenges in using a more collaborative approach; the staff believed they knew what was right for children in light of what they would become, without recognizing children's moral agency and authentically including them in discussions and decisions affecting them. In fact, the exchanges between children and staff were almost exclusively oriented by the behavioral system in place. For instance, the staff gave tokens or offered praise when children respected the rules, reminding children of the program's expectations, warning them of the potential consequences of their behavior, and telling directives to which they were expected to comply without discussion. There were few exchanges between children and staff outside of this structure, except during certain individual meetings, occasional informal conversations or the social skills workshops. The staff considered a more collaborative approach was challenging to implement because care had to be individualized, which they said was not always possible in the current context with the staff

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resources they had on the unit. They thus mentioned they privileged a group approach in which the interests of the group were described as superseding the interests of children as individuals. They said they tried to be more collaborative within this group approach, for example by letting children decide the amount of time they would be in the seclusion room or asking them to identify crisis management strategies after a situation occurred. The staff presented this approach as leaving some power to the child, in contrast to imposing authoritative interventions unilaterally. However, privileging a group approach does not preclude the adoption of a view of children in which they would be recognized as agents. On the unit, behavioral practices, which are well-suited to group contexts through its uniform responses to children's behaviors and limited recognition of agency, were favored. These practices led to a vision of collaboration in which children did not fully take part in their care, but were allowed a limited participation within strict limitations.

The staff emphasized the importance of having a trusting relationship with children, which is often a key aspect of collaborative approaches (Berg and Danielson 2007). Most of the staff's perspectives of a trusting relationship referred to the child's trust that the adult would enforce limits through the behavioral system and be firm and consistent, which was described by the staff as contributing to making the child feel safer. It also entailed trusting the child would comply with the norms and acquiesce with staff. For example, I observed a staff member asking a child who was secluded to tell the truth, referring to corroborating what an adult had said, in order to be able to trust him and let him out to help him. As mentioned above, the effectiveness of these approaches has been challenged, and they are also considered as negatively impacting the relationship between staff and patients by emphasizing power differentials (Ryan et al. 2004). In the study by Ryan et al. (2004), the authors examined staff's assaults by patients on child and adolescent mental health inpatient units and noticed that most assaults followed a comment from the staff related to enforcing a rule in relation to a behavioral token system. Some of the children in the study also highlighted that the use of praise was inauthentic and not helpful when applied systematically or out-of-context. Within collaborative frameworks, the trusting relationship refers to a different concept than what was described by the staff in the study. For example, trust has been defined in a concept analysis as a process in which patients expect that the person providing care is competent, has good intentions, and is attentive to their needs, and in which the provider recognizes patients' vulnerabilities and acts so as to minimize their "fears of harm" (Dinç and Gastmans 2013:235). This different ontology was shared by one of the staff members who referred to the trusting relationship as a relationship in which children can share their opinion and what is important for them, knowing the adult is there to discuss with them. This perspective is also consistent with more collaborative approaches (e.g. Pollastri et al. 2016), but was not part of the local imaginary on the unit.

The staff's adoption of the collaborative approach was expected to ultimately decrease the use of control measures. However, when a crisis occurred, the staff's expectations of compliance, conforming and acquiescence increased and were enforced using control measures if necessary. This dynamic, combined with the

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behavioral approach orienting most exchanges and the staff's predominant conception of a trusting relationship as the child's trust in the adult being firm and consistent, is interpreted here as preventing the establishment of an authentic collaboration between children and staff. Children emphasized their submissive role in the setting as well as the extent of adults' authority on them. For example, one child mentioned that if children did not comply, there were always other things the staff could do to children to force them to comply, in addition to being put at the desk to remain silent and being secluded or physically restrained. He added in a fearful tone that he did not want to think about these things, emphasizing children's vulnerability in the setting and limited implementation by the staff of collaborative approaches.

Further Thoughts on Children's Local Imaginaries

There was a certain fatalism in how children disclosed that they had to comply, conform and acquiesce with the norms and structures in place. During the interviews, when I asked children about the program, the rules were often the first thing they mentioned, adding it was the same as in other schools, in that adults decide and children are expected to do as they are told by adults. Children did not consider they could bring about changes to the program, saying for example that sharing concerns with the staff would not change anything, so it was useless. The staff sometimes told the children they had the "power" to decide if they would remain with the group or be in time-out, and they lost this power if not conforming with a directive. The children thus had limited opportunities to discuss or share ideas with the staff, which many of them considered the norm within school settings.

The hypergood for the staff was an expectation of children's compliance, conformity, and acquiescence, which the children mentioned were "good" to do. However, children also shared and expressed what they considered as meaningful, which could be interpreted as the hypergood for them, which was having friends and having fun. They all enthusiastically shared enjoying free playtime and time outside, some suggesting to "put more fun time like recess", explaining that it's good to be able to go outside and play "especially when many people have ADHD". Children said these activities were "fun" and made them "feel good". Children expressed what was of utmost value to them through means other than speech, which I was particularly attentive to. For instance, a child once started making dance moves when the educator was not looking to make other children laugh, while he had just been told by the educator to stop acting this way. Also, most children were running down the stairs when the staff was not looking (which was against the rules), discreetly smiling at each other. Since I was not perceived by children as an authority figure (as some children directly shared with me and how they referred to me by my first name with no title, contrasting with how they were addressing staff members), I frequently observed these forms of expression. Some of the children mentioned in the interviews that they liked running down the stairs as "it is fun" and "good for your health" and enjoyed doing it. One child explained children needed to learn when do to certain things or not, so as not to have a consequence, in

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order to be able to do things they found fun (e.g. going high on the swing or making jokes during lunchtime). Most children referred to the social skills workshops as helpful to learn to get along with others, which can help to have friends. The use of Taylor's hermeneutic framework helped me to be more attuned to what children valued and reflect on how this was meaningful to children themselves as well as how it contributed to shape the interactions in the setting.

Children showed they navigated the system in place: they agreed with some of the norms, structures and practices, but did not perceive them all as meaningful to them. Seeking a *rapprochement* with children, by getting to know what is meaningful to them and try to bridge these horizons could help build more authentic trusting relationships that might be more conducive to the implementation of collaborative approaches. The term *rapprochement* is used by Taylor to refer to a process of reciprocal understanding between divergent moral horizons, e.g. in reference to different cultural outlooks (Taylor and Gutmann 1992). It is based on Gadamer's concept of *fusion of horizons* (1960/1975). It is used here in reference to bridging horizons and social imaginaries between the different views present in the mental health setting, seeking reciprocal understandings of what is significant and meaningful to the different people involved, including children. Throughout the conduct of the study, this concept guided my interactions with the people in the setting and relational engagement with them.

Strengths and Limitations

We want to first highlight that the research results presented here are an interpretation of the data; conducting the study and analyzing the data using a different framework would have resulted in a different account. This study does not seek to provide the only possible interpretation, but is one possible interpretation among many. Other frameworks such as critical theories would have yielded a different analysis, exploring for example in more depth power differentials and the subordinate role of children in the setting. Foucault, for example, has been highly critical of psychiatric institutions with adults and this type of framework could have been applied in this context with children, using for instance a discourse analysis (Hook 2007). In a similar way, using institutional ethnography would have changed the focus to the empirical mapping of social relations based mainly on an analysis of texts, in contrast to examining meanings through participant observation and interviews, as in hermeneutic ethnography (DeVault 2006). Each framework has its strengths and limitations. One of the advantages of using a moral experiences framework informed by Taylor's hermeneutics is the in-depth examination of the local imaginaries, of what is morally meaningful to the people in the setting, in addition to institutional norms, structures and practices. It allowed for the collection of rich data through my presence in the setting and ongoing dialogue with children and staff, on both experiences and context. Through this active participation (the *participant* aspect of participant observation), data could be contextualized and the interpretive process was highly iterative, which was also enhanced through the use of the participatory research framework.

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As with any research conducted in one particular setting, the data is not expected to represent all child mental health settings. However, it offers an in-depth analysis of this particular setting, which can inform practices in other settings with similar programs. Due to the richness of the contextual data provided, potential knowledge users can judge how the results of this study can apply to their specific settings.

Conclusion

This examination of the institutional norms, structures and practices in a child mental health setting, combined with an analysis of the moral experiences of children and staff members, sheds light on important ethical issues related to childhood and mental health. Children are largely viewed as incomplete human becomings, which legitimizes certain institutional norms, structures and practices that situate adults as having a highly authoritative role oriented by a behavioral approach. Within this behavioral approach, children are perceived by the staff as the objects of care and not as agents. Children view themselves as having to comply, conform and acquiesce with the norms, structures and practices in place—as is expected by the staff—which they sometimes agree with and sometimes not, but stated are obliged to do. The use of a behavioral approach, combined with a de-escalation approach for crisis management, led to an increased use of control measures with children for punitive reasons, which can be abusive and harmful to children. By adopting a view of children as moral agents and getting to know what is meaningful to them could contribute to the development of care practices that are more ethically-sound and respectful of children's own experiences. Future research could build on this work to foster the development of care approaches that are attentive to some of the key ethical concerns present in child mental health, by getting to know what is meaningful to children and seeking a *rapprochement* with them.

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Compliance with Ethical Standards

Conflict of interest On behalf of all authors, the corresponding author states that there is no conflict of interest.

Ethical Approval All procedures performed in the study involving human participants were in accordance with the ethical standards of the institutional research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained for all individual participants included in the study.

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