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Preventing Detention: Ethical and Legal Disputes Between Professionals in the Detention of Young People Who Present a Risk to Others

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ABSTRACT

The detention of young people who pose a risk of harm to others can present major ethical and legal challenges to professionals. In this paper, we discuss those challenges with a particular focus on the causes of interprofessional disagreements that can seem intractable, and even lead to costly court proceedings. We use a clinically accurate composite case vignette to explore the commonest ethical dilemmas, which include (i) the costs of secure provision for young people and limits of resource provision (ii) the impact of professional anxiety about harmful outcomes, and (iii) the lack of attention to the voice of young people concerned. We discuss potential ways of improving ethical discussion between professionals in ways that are ethically coherent and respectful of different views.

Introduction

The decision to detain a young person in mental distress who poses a risk to others presents professionals with a range of ethical and legal dilemmas. These typically involve a balance between the benefits of detention (in terms of harm and risk reduction) and the harms caused by detention to a young person who is vulnerable. In England and Wales, when professionals have not been able to agree about the 'right' course of action, they can take their dispute to court for judicial resolution; although formal data is not available, informally, this is a situation that many consultants have encountered at least once in their lifetime. The UK Ministry of Justice is also unable to provide details of the costs of such proceedings, but given the numbers of legal professionals involved (typically five or more), it is clearly a costly process in terms of both legal time and medical time in terms of report writing and court appearances[1].

The aim and scope of this paper is to discuss the ethical dilemmas encountered when clinicians are asked to consider whether to detain a young person with risk behaviours, within the day-to-day reality of the resources available in the UK. To do this, we use a fictitious but clinically valid case vignette to illustrate the legal and ethical complexity of making a decision to detain (or not), and how it is that such profound disagreements arise. Given the cost of going to court, we suggest that there may be better ways of resolving these differences, which involve attention to the ethical as well as legal arguments about (a) how to determine the best interests of a young person with emerging autonomy and capacity to make choices and (b) how to resolve disputes about resource allocation for complex conditions, such as the needs of young people in complex situations.

Background context

In England and Wales, three types of legislation (mental health, criminal justice and welfare) exist to enable young people with capacity to be detained involuntarily in a variety of services. Young people may be detained under the Mental Health Act in open or secure psychiatric beds; or detained using criminal justice measures in a range of secure facilities for young offenders; while others who have been placed in the care of social services (generally because of parental abuse or neglect[2]) may be placed in secure children's homes (SCHs)[3]. In addition, the Family Court (which deals with child protection issues) may place a small number of young people in community placements, using a legal measure that restricts their liberty[4].

Detention is justified on the basis of risk to others, risk to self, risk to both self and others, plus a professional perception that this young person's risk cannot be managed in the community. The ratios of children detained in secure clinical, welfare and justice-based placements can vary across time (as noted below) and different jurisdictions[5]. The explicit purposes of each type of establishment also varies and is often ill-defined and overlapping. Furthermore, young people detained across these settings have similar kinds of psychosocial needs[6,7], and a number are moved between the different types of secure establishments, under different legal frameworks[6,8]. Within this complex secure system, it is common for professionals to dispute which kind of service is most appropriate for the young person, because of conflicting views about the level of risk the young person poses, the consequences of failure to detain, the purposes of detention and its benefits, and anxieties about the costs of long-term placements.

As noted above, the process of deciding to detain young people in England and Wales, who pose a risk to themselves, or others or both, involves multiple legal frameworks (commonly the Children's Act, the Mental Health Act and the criminal law) which draw on the views and recommendations of professionals from different disciplines and agencies. Some ethical principles are assumed; for example, the Mental Health Act Code of Practice specifically advises that the 'least restrictive' option is both a legal and ethical priority for all those detained under that legislation[9]. There is also specific professional guidance about the detention of young people which aims at ensuring transparency about the basis upon which the decisions to detain are made. The guidance also reflects ethical principles that underpin medical practice (although the technocratic language in which such frameworks are expressed may obscure the ethical nature of the decisions)[10,11].

Over time, busy professionals who, on a daily basis, deal with decisions to detain may find that the legal frameworks, policies and guidelines become processes of procedure and habit, rather than opportunities to take time to debate the ethical dimensions of any child's detention, and especially what is 'right' for this particular child. Professionals and parents of young people involved often consider the process to be about availability rather than appropriateness, which suggests a focus on short term solutions that reduce professional anxiety rather than the long-term implications of detention and a balance of risks and benefits[3].

Detention of young people: Numbers and costs

The scale of the issues discussed here can be judged from the number of young people locked up. This has varied considerably across time depending upon National Policies and priorities. In 2008/9 2881 young people were detained in England in justice facilities[12]. In the following years, UK national policies focussed on setting up community services and successfully reduced this number[13].

National census data for English young people detained in secure care in 2016 indicated that overall 1322 young people in England were detained in secure care, 312 (24%) in secure beds in psychiatric hospitals, 218 (16%) in SCHs and 792 (60%) in Secure Training Centres (STC) or Young Offender Institutions (YOI)[6]. By 2018, 505 young people were detained under mental health legislation in Tier 4 open or secure CAMHS hospital beds, 186 in SCHs and 774 in STCs or YOIs[4]. Recent data suggests there are now only 430 young people in custody (SCHs (justice), STC, YOIs)[14]. There is however increasing

concern about the rising number who are placed on DOL orders in community placements which are not always regulated or care monitored[15]. The nature of these placements is not yet nationally recorded[4].

The costs for these different modes of detention of young people are hard to clarify but figures derived from data published by the UK Office of the Children's Commissioner suggest that the annual costs of mental health detention (secure and open beds) is c.£192 million, secure children home c.£39 million and STCs and YOIs c.£81million[4]. From this report, hospital beds are the most expensive with medium secure beds costing over £500,000 a year per young person, seven times the cost of the cheapest placement in a YOI; furthermore, secure hospital placements can be of long duration[16].

Case Vignette

This case is based on a composite of similar cases known to the authors.

Case vignette

Professionals working with children, from both children's mental health services and Local Authority Social Services, are asked to meet due to concerns about Deanna, a 14-year-old girl who is currently in the local Emergency Department. On bringing her to the Emergency Department, her care home gave notice and said she could not return there due to the violence risk to their staff and peers in the home. Therefore, there is now a question about where Deanna should be placed: whether in a different open children's home, a secure children's home or a mental health facility.

Many professionals who have met Deanna are worried about her risk to herself and to others. She regularly cuts herself on her arms, and when staff try to stop her, she hits them, causing injuries sufficient for staff to be sent home or attend the Emergency Department. The worst injury caused to a staff member has been a broken nose when she head butted someone trying to stop her running away. The most recent incident that led to her admission to the Emergency Department was after a major conflict with staff in the care home, when they tried to take her phone from her, she hit out at staff and tried to run away, requiring them to restrain her and others to keep her safe. Deanna is angry that she has been brought to the Emergency Department and denies that she has posed a risk to anyone in the care home.

Deanna has been 'diagnosed' with Autism and ADHD, but has no other mental disorder. She has not been in contact with youth criminal justice as yet; although it has been suggested that the care home staff press charges against her.

Deanna is considered to be at risk of child sexual exploitation. She has been groomed online on several occasions. Most recently, her phone was removed from her because she was preparing to send a naked video of herself to an older man who had offered her money to send one. Deanna does not agree that she is at risk of exploitation and argues that she could make money selling naked images of herself.

Deanna has been in care for over a year. Her mother had originally agreed to her going into the care of the Local Authority because she felt unable to cope with Deanna's behaviour, and there was violence between them. However, Deanna and her mother, who remain in close contact, now minimise their past history of violence to each other and current risk and say she should return home.

On discussion, all staff agree with the general principles in child care and mental health legislation that requires professionals to use the least restrictive care possible and to respect the wishes of the young person if possible but there is disagreement about what this means in practice. But there is significant disagreement about the consequences of detention; and whether the good outweigh the bad. Some staff (especially those who have been assaulted by Deanna) feel that she should be placed in a secure adolescent home; partly because such a setting could contain her violence and anger but also because they feel she needs to 'learn that her actions have consequences'. Other staff feel that detaining her in a secure unit is stigmatising for Deanna and identifies her as an 'offender'. Some staff think she needs therapy in a mental health unit before she will be sufficiently settled for a social care placement. Mental health professionals note that such therapy could be part of a longer-term care plan but doubt that Deanna is detainable under local mental health legislation as it is not clear that she has a mental disorder. There is also concern that her admission would put her at risk of contagion (learning other types of self-harm from peers on the ward) and an escalation of behaviours such that she may get 'stuck' in a secure hospital. Professionals agree that there is no solution which does not have some kind of negative outcome for Deanna; and wonder privately if the costs of different placements are influencing their decisions.

Conceptualising ethical dilemmas about the detention of young people: young people are not adults

We suggest that Deanna's story is typical of the kind of case that leads to professional disputes about detention. It involves conflicting perspectives on the ethics of detention as well as different approaches to legal frameworks and cultural constraints. It is also the kind of case that goes to court because professionals are under pressure not to spend scarce resources but also under pressure not to make a mistake about a child's needs for care and containment that might end badly and cause public condemnation.

One of the first ethical challenges is the comparative absence of publications discussing ethical dilemmas in the treatment of young people who are not yet adults, but also not children, and whose capacity to make complex decisions is emerging. Traditional accounts of mental health ethics have been heavily influenced by the work of Beauchamp & Childress, who set out a principles-based approach to medical ethics[17]. This approach invites practitioners to consider their duties to respect the autonomy of the individual patient while also attending to the consequences of any medical decisions, such as maximising benefit and minimising harm. Beauchamp & Childress also propose that doctors have duties to justice, where 'justice' refers to just and fair allocation of medical resources, although this is less discussed than the other principles which articulate duties to respect autonomy, maximise benefit and do minimal harm.

This model has been highly influential and remains so, especially in psychiatry[18]. The emphasis on respect for autonomy above other ethical duties is especially challenging in psychiatric practice because mental disorders and distress can compromise autonomy and the capacity to make decisions. This ethical stance is explicitly reflected in the English Law, which states that a person's capacity to exercise their autonomy must be presumed, even if their choices seem unwise to professionals[19]. But it is not clear how to apply these principles in child psychiatry, and especially how best to respect a child's 'voice' and wishes[20], when fulfilment of their wishes seems incompatible with risk reduction. If respect for autonomy has 'first among equals' status in terms of ethics, then this presents a challenge in relation to children and young people whose capacity to exercise autonomy is emerging, fluctuating, and contingent on their relationships with adults on whom they are dependent[21]. In particular, young people's capacity to make high risk, high-cost decisions (such as deciding to refuse medical treatment) is not related to age or stage; but is rather a process that may be situation specific[22]. Their views and choices may be embedded in the relational network of the young person and highly influenced by adults to whom they are attached[23,24,25]. This impact of others on young people's decision-making and behaviour (which can be positive but often harmful in those who are in vulnerable and complex situations) provides further challenge to conventional accounts of autonomy, which are individualistic rather than relational.

These dilemmas are commonplace for those professionals who work with adolescents; especially that minority of young people who become 'looked after children', and who have both strengths and difficulties[26,27]. Such adolescents are neither 'children' nor 'adults', but may occupy different places on a spectrum between these two poles at different times. Like adults, stress and mental disorder may compromise their autonomy and the capacity to make good quality decisions, but only for a while, and with support they may be able to make a good quality decision[28]. But like children, some adolescents may not yet have developed either the neuroarchitecture or the psychological capacity to make decisions that require metacognition and perspective taking. Some adolescents may well be able to make choices about what subjects they want to study at GCSE, yet be unable to make emotionally mature choices about who to have sex with (or why).

The importance of this question about the nature and quality of adolescent capacity is at its most stark in relation to the capacity to be held criminally responsible. At present in England and Wales, this level of capacity is set by chronological age (10 years) regardless of evidence that suggests that many teenagers lack that capacity, let alone younger children. In a capital case in the USA, the American Psychological Association drew the court's attention to the evidence that adolescent brains continue to mature during and after puberty and so young people's capacity to make serious decisions may fluctuate and change[29].

Best Interests - Detention of a Young Person on the grounds of risk reduction and protection from harm

From an ethical and legal perspective, there is a duty on professionals (and families) to act in the best interests of those who lack capacity to make complex choices for themselves. In relation to the detention of children in local authority or mental health care, there is an ethical and legal presumption that the intended detention is in the child's best interests. The concept of 'best interests' is based on the duty of beneficence (what is good for the child) but also acknowledges that there may be a tension with respect for autonomy in terms of what the child wants. For example, child protection legislation enables children to be removed from their parents because of proven risk of abuse or neglect, even if the child does not wish to be removed, because it is in their best interests to be protected from harm.

However, the assessment of best interests is complex as young people get older, and as they acquire more capacity to have a voice and make decisions. Furthermore, whilst detention may both protect a young person from one or several forms of harm, it may also cause a different type of harm to that young person; for example, there is evidence that children in care are repeatedly moved between placement, often far away from home, and this is disruptive to their psychosocial development[30].

In Deanna's case, it seems that detention might keep her (if not) safe, at least *safer* from some harms e.g. cutting, vulnerability to sexual exploitation and violence from her mother. It is striking to note that legal frameworks regarding child detention seem to make it easier to protect a vulnerable child using detention than to intervene to contain exploitative or violent adults, which involves lengthy criminal processes. However, Deanna's case illustrates how detention may be, in full or in part, justified in terms of keeping others safe *from her*; including the professionals who are currently caring for her who are at risk of being assaulted. That risk might understandably affect their assessment of what is in Deanna's best interests. They might argue that Deanna should be dealt with by the youth justice system; and that the wrong and harm done to them is overlooked if

Deanna is seen only as a vulnerable child with mental health needs.

Detention to address a Young Person's Mental Health needs and risk: professional anxiety

Most young people with mental health needs will not require detention of any sort, so Deanna represents a minority of young people with complex needs. However, framing her problems only in terms of a psychiatric diagnoses which can only be treated if she is detained, overlooks her other needs for care, including social, attachment, and educational/developmental needs. Formulating her needs is a nuanced process which includes helping her to develop the agency to make 'good enough' choices and relationships with people who can support her.

When faced with a young person placing themselves or others at risk, medical (and other professionals) may be tempted to focus exclusively on the young person's state of mind (psychiatrics needs), and a limited range of diagnostic categories. Psychiatrists may be under particular pressure to offer interventions to reduce risk and/or distress, which will then justify detention under mental health legislation. This perspective is problematic given the lack of an evidence base about the efficacy of therapies to address risk in young people, especially those who have experienced high levels of childhood adversity; and may explain why young people in secure mental health care may spend longer there than in other settings.

More often, young people like Deanna need security and care in a settled placement, which can manage their capacity to be assaultive to others when distressed. But as described above, there are a small group of young people who are repeatedly moved between placements, often far away from home, which causes disruption in their care and exacerbates their sense of insecurity and rejection[30].

Professionals may favour a young person's placement in an open mental health setting rather than in a secure psychiatric unit, because then their actions are not 'criminalised'; even though they could in theory be charged with assault. It is true that anyone who is seen as having committed a criminal offence is stigmatised, and there is evidence that having a criminal record can have a long term impact on young people, especially those detained in the youth offender system[31]. There are complex ethical questions about whether it is fair to excuse young people for harmful actions, just because they are young, traumatised or distressed; and it is not clear that professionals in this case are qualified to make such a decision about fairness. Although excusing Deanna may feel compassionate in the short-term, (although probably not to the staff she hurt), in the long term, that such compassion may mean that Deanna fails to learn that violence is a high-risk strategy with serious consequences that in adulthood will not be similarly excused.

These questions evoke strong feelings in professionals who are making decisions about the placement of a risky adolescent. It is noteworthy that the medical ethical literature is largely silent on what professionals 'should' do when principles of criminal justice and patient welfare conflict. Professionals may be anxious about being criticised if they make an assessment of risk that later turns out to be 'wrong'; especially in cases that involve child protection[32]. In the UK there was a public outcry and criticism about how professionals had handled cases like that of 17 year old 'David', who gravely injured another child by hurling them from the roof of a public building; or 18 month old baby P, whose risk of being harmed by his mother and her partner was not fully appreciated, leading to his death[33,34]. In the case of baby P, the Head of Social Services was publicly denigrated by politicians and she lost her job[34].

Personal proximity to that risk can impact unconsciously or consciously on professional decision making. Therefore 'safety first' might seem to be a 'good' principle (reducing risk of harm and increasing protection), but may be less true if the 'good' principle leads to the outcome that Deanna is detained in a secure setting which may exacerbate her problems and from which it may be hard to release her. A Danish study outlines narratives that justify secure placements, including protecting the child, caregivers, and the perceived lack of viable alternatives[35]. These narratives may obscure the need for developing less restrictive options tailored to the child's long-term wellbeing[35].

Anxiety about detention can manifest in inter-agency and professional conflicts; each professional best knowing their own practice framework. Evidence examining the actual process of decision making, as opposed to the outcome of it, points to power imbalances, role ambiguity and group norms tilting decision making authority to the dominant professional group[36]. While this may be intrinsic to the operation of relevant law, it may be that opportunities for reflective, multidisciplinary processes that might reduce anxiety are not used to the full.

Impact of constrained resources on decision making

The Beauchamp & Childress model of medical ethics places a duty of justice on health care professionals, where justice means fairness, especially in the use of resources[17]. But the allocation of resources for health care raises ethical questions, especially in relation to managed care, where clinicians may not be responsible for how resources are allocated[37]. In England & Wales, resources are allocated by Government departments who commission services, especially services that are specialist and may only affect a few people. Distribution of resources depends not only on the 'values' of those selecting them, but also on their understanding of what the need is, and how perspectives on costs may change with time. For example, failure to provide resources to treat a common condition in the short term may end up costing much more if the condition develops into a severe state with an unusually bad outcome.

Local decision making about resource allocation adds in another layer of human perspectives; including people's personal experiences and knowledge of patients, and professional perspectives. Social workers' perspectives on how resources should be allocated are likely to differ from the views of mental health nurses, which may differ from local law enforcement[38]. All these professionals may have valid views about where money is 'best' spent, where assessment of 'best' is, again, 'values' laden[39,40].

Professionals in England & Wales have had to deal with the reality of austerity policies imposed by national governments which have seen massive cuts to public services, and an associated message to professionals that the cheapest option is the best option[41]. Although funding for health has been relatively protected, the impact on local authorities and social services has had a knock-on effect on mental health services and all professionals are under pressure to reduce service usage as much as possible[42]. If placements have to be available in emergencies, hospital admission may be seen as a more easily available (immediate capacity to admit) and accessible (quicker to admit and closer to home) placement. However, these may be more expensive, as an inpatient bed in an open General Adolescent mental health unit will cost £260,000 pa whereas a bed in an SCH will cost £210,000 pa[4]. Furthermore, if seeking the cheapest option, if Deanna were to be criminally charged with assault, a remand into custody would cost much less, which may encourage the view that she should be charged. Notably, in the complex network of public services with responsibility to care for a young person, the actual cost may be less important in decision making than whose budget will be depleted. This unholy combination of expensive and scarce resources and contested case detail can generate protracted debate amongst professionals which cannot be resolved.

In Deanna's case, it might be argued that her 'best interests' require that she is placed in a specialist placement. It may even be the case that everyone agrees with this, but such specialist placements, whether in health and social care settings are often full because of low number of such services and, as described above, are very expensive. When such services are not readily available, children who need a secure children home may be placed in "alternative accommodation" of debatable quality and suitability, and young people in prison with a serious mental health condition who also need such a bed wait so long that their mental health problems are exacerbated[6,13].

The professional time it takes to make these decisions is a health care resource that is not often considered in ethical textbooks on resource allocation. Taking time to work out Deanna's 'best interests' and arguing over who has the most resources takes professional time away from actually caring for and treating Deanna and young people with similar needs. Some decisions may actually be urgent, but in other cases, a false perception of urgency may be driven by professionals' past bad experiences and high levels of emotional arousal, which leads to poor (and high cost) decision making[43]. The decision not to allocate time to decisions is in itself an ethical decision, if only because this prevents reflection and exploration of options, some of which have the power to alter the life trajectory of a young person.

In a recently reported case, the social care and healthcare teams brought a legal case to try and get a family law judge to decide what was the best thing to do[44]. Ironically, the cost of bringing such a case could pay for not just a placement for a Deanna, but also some therapy to help her manage her anger better, and explore the psychological pain and fear behind the anger.

Voice of the Young Person

Part of the difficulty is that there are few professionals who feel trained and competent to manage situations like this and engage in the necessary complex conversations with all the professionals involved; and, of course, there is a need to include Deanna herself. In cases like this, it is argued that children's voices are often marginalized and they are not enabled to participate meaningfully in discussion or helped to exercise their autonomy because the systems are adult-centred[35,45]. The same authors suggest that children need greater representation through advocates and that their rights to be heard must be taken into account[45].

Respect for people's rights relies entirely on other people fulfilling their duties and we have seen that the professionals may disagree not only on what their duties are, but whether they can be afforded[46]. If Deanna's situation can be resolved with a relatively cheap placement that no-one has heard anything bad about, then that will probably happen, no matter what Deanna says or her claim to have 'rights'. The fact that a court has already separated Deanna from her mother means that her views are outweighed by adult views about her best interests; a view further validated by the professional consensus that Deanna's preference cannot be justified in terms of risk. As we have seen, separating a child from their parents, even on the grounds of risk, does not guarantee positive consequences for that child in future; for example, children who are taken into care are over-represented among young people in prison.

Neither respecting Deanna's wishes or acting paternalistically in response to understandable professional anxiety look like uncomplicated options. Even if she has capacity to make some kind of decisions, her wish to return to live with her mother is unlikely to be seen as definitive, especially since she is in state-care and cannot be released from it without a judicial hearing. Her voice will be heard but her wishes cannot be agreed to, even if her 'voice' should be more influential than the voices of professionals.

In terms of respect for people's views, it is hard to know what to make of the interesting discrepancy between the way Deanna and her mother 'see' and 'weigh up' the risk, and the way professionals do. Strong feelings of anger and fear in staff assaulted by Deanna have presumably influenced their view that she should be detained in a secure children's home, to teach her the consequences of her behaviour; psychologically we might note the

repetition of a pattern whereby Deanna is rejected by caregivers when she gets angry. We might also notice that there may be an unconscious tendency to perceive a young women's anger as more 'out of control' and riskier than young men's anger, so that Deanna is perceived as needing 'extra' security to manage her risk.

Learning from Deanna's experiences

Deanna's case highlights the ethical and legal challenges faced by professionals when there are no obviously 'good' options, and the importance of naming those challenges. We note the tendency for people to polarise around perceptions of Deanna and her needs; she is or is not mentally ill, she does or not have capacity, she does or does not need a secure bed in a local authority secure children' unit or hospital. What is needed is a 'both-and' approach, that looks at the process of making decisions as much as the outcome. The reality is that there is some validity to everyone's perspective. Deanna is both vulnerable *and* risky; she needs containment *and* care.

We argue that there is a need for professionals, of all relevant disciplines, to approach these contested decisions using arguments guided by ethical principles and values. This is because health, social care and legal professionals may breach their duty to use resources justly and fairly; forced to do this by national policies that (a) distinguish health, justice and social care in ways that are empirically incoherent (in terms of what is known about adolescent development) and (b) reduce funding for services while providing funding for legal disputes; an approach which is ethically incoherent and unjustifiable. We identify a need for the implicit values built into these disputes to be brought out into the open in decision making; an explicit ethical framework of decision making would encourage this.

What might help is a practice friendly framework where routine and "unacceptable" issues can be articulated as part of the decision-making process. Fulford has argued for a multi-disciplinary approach to decision making when there are strong feelings about what seems 'right' and 'wrong' between different groups[39,40]. Acceptance of difference and disagreement about issues like risk, vulnerability, and diagnosis is crucial to his model, including consideration of options that no-one likes. In this way, professionals with different views can come together to cooperate over their duty to make the best decision they can, using the best process they can. Such meetings can help professionals looks at the short *and* long term consequences of their decisions for Deanna, and also give her a chance to speak.

Conclusion

While there may be no algorithmic process to follow, clarity about common ethical issues could provide a practical and more rigorous approach to decisions to detain, particularly if professionals disagree. In surgical care, for example, a checklist has been developed to make sure that no important issues that affect care are overlooked[47]. In this kind of case, an ethical checklist might ensure that no perspective has been ignored or rejected without debate and a written record of justifications for different courses of action. In a similar way, the AMBIT disintegration grid (available on the Anna Freud AMBIT website) asks the professional network to consider, for each professional: (a) how they would define the 'problem'; (b) what their recommendation for intervention / placement would be; and, (c) who is responsible for providing that[48].

Such a reflective and multi-disciplinary approach offers a way to make different ethical perspectives overt, rather than disguised as legal argument or a singular clinical assessment. It also helps people articulate their views safely, be based on either principles or consequences or both, and recognise the realities of making a decision when all the options have their downsides. Discussing, understanding, and acknowledging one's colleagues' different but valid perspectives under an ethical umbrella may reduce conflict and enable collaborative decision making with all professionals, the young person and their parents / carers.

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