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Police Officer Perspectives of Section 136 Detention Processes for Children in the North of England

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ABSTRACT

Section 136 of the Mental Health Act 1983 (also 2025) enables police officers in England and Wales to detain individuals in public places who appear to be experiencing mental distress and require mental health assessment. Whilst detained adults have received research attention, little is known about how Section 136 is used with children. This study addresses that gap by exploring police officers' perspectives on their role in these detentions and examines the extent to which current practices align with children's rights under the United Nations Convention on the Rights of the Child. Ten police officers from one constabulary in the North of England, with experience of detaining children, were identified and interviewed. A phenomenological lens was used to analyse officers' accounts of the detention process and their experiences of managing children experiencing mental distress. Three interconnected themes were identified: policing mental distress, gaps in provision for vulnerable children and places of safety. Interviewed police officers described concerns that children detained under Section 136 are frequently viewed as offenders rather than patients, particularly within Accident and Emergency (A&E) departments. Officers highlighted a lack of specialist mental health provision, especially out of hours, often resulting in children remaining under police control for extended periods, and the significant emotional impact on officers associated with the prolonged supervision and restraint of distressed children. The findings highlight a significant gap between the intentions of mental health legislation and the realities of practice, raising concerns about children's rights, the suitability of current places of safety and the continued reliance on police officers to provide care during periods of acute mental distress.

1 | Introduction

Mental distress, used here to describe an acute state of being where the person's cognition, decision-making and behaviour are impaired, can be experienced by children and adults alike, and exists as a distressing experience which can pose a serious risk of harm to the person themselves but rarely to others (Morgan 2024). In England and Wales, Section 136 of the Mental Health Act, 1983 (as amended in 2017) permits the forcible removal of a person, thought by the attending police officer to be experiencing mental distress which poses a risk to themselves or others, from a public space to a place of safety for the purpose of a mental health assessment. No agency other than the police holds this authority to detain, although on reaching the place of safety the person's ongoing detention and care can be passed onto other professionals. The assessment team for children should include professions from Child and Adolescent Mental Health Service (CAMHS), and is formed of an Approved Mental Health Practitioner (AMHP), a specialist role usually within social work, and two doctors, one of whom must be recognised by Section 12(2) of the Mental Health Act as having the prerequisite expertise to diagnose mental health disorders.

2 | Structure

First I outline the United Nations Convention on the Rights of the Child 1989 (UNCRC; UNICEF 1989) which establishes fundamental rights to which all children are entitled, before moving to UK legislation which must encompass the UNCRC. I then examine the use of Section 136 detentions for children in England and Wales and discuss legislative reforms that have been introduced in response to concerns about the absence of child-appropriate provisions—concerns that historically involved children being held in police cells while awaiting psychiatric assessment, which contravened the UNCRC.

I then explore existing literature before introducing this research and its methodology. After presentation of the data and exploration of the findings, the discussion explores the extent to which the findings align with children's rights as articulated in the UNCRC, before considering subsequent legislative and policy developments. Despite reforms, there is little evidence to suggest that Section 136 processes for children have substantively improved. Indeed, emerging indications point to a continued gap between policy intention and operational practice, particularly in relation to the provision of child-appropriate care following detention.

3 | Legislation

3.1 | United Nations Convention on the Rights of the Child

Fundamental to any discussion about the detention of children is how the process aligns with the rights of the child as set out by the UNCRC (UNICEF 1989). Ratified by the UK government in 1991, this international treaty lists specific and interlinking rights which apply to every child. Central is that 'the best interests of the child shall be a primary consideration' (Article 3; UNICEF 1989, 4), and that any detention is used as a 'last resort and for the shortest appropriate period of time' during which time the child should not be exposed to inhumane or degrading treatment and should be treated with dignity (Article 37; UNICEF 1989, 10).

Article 12 of the UNCRC demands that the views of the child, offered through an advocacy service where appropriate, should be considered (UNICEF 1989). Children, like adults, who are detained under the Mental Health Act are entitled to an advocate, a right which should be shared with them. However, due to the urgency and supposedly short duration of a Section 136 detention, advocacy services are not offered (GOV.UK 2011). With no appointed advocate, it is the responsibility of individual professionals to abide by the principles of their professional body and place the needs of the child at the forefront of their practice and decision-making to ensure that legislation is followed and UNCRC principles are upheld. In the absence of research in this area, the experiences of children are unknown.

A report by the Office for Children's Commissioner (OCC), an official within government responsible for upholding the rights of the child, found that statutory requirements and professional processes often take precedence over UNCRC principles in the provision of child advocacy services across England (OCC 2019). More broadly, the OCC noted that there are further challenges to upholding the UNCRC when there are multiple professionals involved, as occurs in Section 136 detentions.

3.2 | Mental Health Act 1983, as Amended 2017

A decade ago, there was concern in England and Wales at the rise in the Section 136 detention of children who, usually owing to inadequate health-based facilities to take them to, were detained within police stations (Home Affairs Committee 2015). This led to legislative changes to Section 136 in 2017 which reduced detention duration from 72- to 24-h (with a possible 12-h extension if the detained person's health prevented a mental health assessment within 24-h) and forbade the use of police cells for children aged 17 and under. Since this time, little is known about children's Section 136 detentions and data were absent in the OCC report *Who are they, Where are they?* (OCC 2020) which explored forced detentions of children.

The discussion section considers recent legislative amendments, which do not change Section 136 detention practices.

4 | Existing Research

Whilst Section 136 detentions of adults have garnered much research attention, whether this is because of an increasing number of detentions (Loughran 2018) or repeated detentions of the same persons (Warrington 2019), perhaps because of the ethical complexities of hearing the voices of children (UKRI 2024), very little is known or understood about the detention of children by police officers under the 2017 amended mental health legislation. Indeed, in the annually published *Police Powers and Procedures* report (GOV.UK 2024b), as with previous years, there is no elucidation of the experiences of the 2428 children (7% of annual Section 136 detentions in year ending 31st March 2023), aged 17 years or under, in the way that the report explores data pertaining to detained adults. Internationally, although mental health legislation across much of the developed west also applies to children, a recent scoping review (Schölin et al. 2024), which reviewed 42 research articles on detentions of children under mental health legislation across 15 jurisdictions, included only one article (Eswaravel and O'Brien 2018) which explored detentions by police officers rather than health-based assessment and/or treatment orders.

Most existing academic research which mentions Section 136 detentions of children offers neither comment nor analysis beyond the lowest age of detainees in their studies: Laidlaw et al. (2010) analysed a dataset in which the youngest person was aged 14 years, and persons aged 15–20 years accounted for 11.8% of the detentions under analysis in research by Burgess et al. (2017).

Exceptions to this are research by Patil et al. (2013) and Eswaravel and O'Brien (2018) both of which offered some quantitative insight into children's detentions; notably, the over-representation of looked-after children (meaning those children who are under

local-authority care rather than living with parents/guardian) and that more females than males are detained. Whilst useful, both studies were within single paediatric mental health units rather than offering insight into alternative places of safety. The studies used pre-2017 data when the maximum duration of detentions was 72-h when, owing to a lack of paediatric health-based facilities such as where the studies were conducted, children were overrepresented in the Section 136 detainees who were taken to police cells (Home Affairs Committee 2015).

Following the 2017 amendments which forbade the use of police cells as a place of safety for under 18-year-olds, thereby aligning practice with the UNCRC, the Care Quality Commission (CQC) predicted an increase in the use of Accident and Emergency (A&E) departments as a place of safety whilst the detainee awaited a mental health assessment (CQC 2017). A&E departments as a place of safety were mentioned in a brief commentary by Evans (2021), where it was claimed that the number of presentations to A&E departments had fallen during the COVID-19 pandemic. No existing qualitative research could be found on the experiences of children under Section 136 detentions, although there is qualitative understanding of adults' experiences (e.g., Bendelow et al. 2019).

More recently, Erlam (2022) explored a dataset of Section 136 detentions from one police constabulary in the North of England. Of the 4978 Section 136 detentions over the 40-month period (December 2017–end of April 2021), 300 (7.12%) were of children aged between and including 9 and 18 years of age. As with the existing studies (Patil et al. 2013; Eswaravel and O'Brien 2018), more females than males were detained and looked-after children were over-represented. Notably, though, when compared to detentions of adults, detained children experienced more time under the control and supervision of police officers, and local clinical funding together with staffing problems meant that very few detained children gained access to children's Section 136 suites where they would be cared for by medical staff, thereby highlighting a disparity in provisions.

A considerable amount of police time is spent managing mental distress (NPCC 2022). The *Right Care, Right Person* policy paper (GOV.UK 2024a) attempts to return matters pertaining to mental health into the hands of the most suitable profession, although the effects of this, especially for children, are as yet unknown. The experience of police officers at managing adults detained under Section 136 has been illuminated by previous research (e.g., Wondemaghen 2021), providing an evidence base with which stakeholders can lobby for change. However, since the 2017 legislative change dealt with the use of police cells as a place of safety, these narratives have excluded the experience of detained children.

Despite the growing understanding that contact with police connects children with mental health services, internationally there is an absence of research which addresses police engagement with children under mental health legislation (Hoffman et al. 2024). There is broad agreement in research on adult Section 136 detentions that the experience is harrowing and frightening (e.g., Laidlaw et al. 2010; Bendelow et al. 2019; Warrington 2019), but the legislation pertaining to children is under-researched, meaning that the experiences of children, when they are at their most vulnerable, are insufficiently understood and absent from public awareness (Schölin et al. 2024). This exploratory research hears police perspectives on their role in the detention of children experiencing mental distress.

5 | Data and Methods

The qualitative data analysed and presented here were collected during a mixed-methods doctoral research project. The research was approved by Lancaster University (ref 18021, 19082, 19140) and IRAS (ref 283249) and was supported by the constabulary.

5.1 | Sampling

Police officers were recruited from a single constabulary in the North of England which exists within the catchment area of one National Health Service (NHS) Trust (hereafter 'the Trust'). Convenience sampling occurred over a 2-month period when a call for participants was placed weekly on the constabulary's intranet. Fourteen police officers expressed an interest to participate: two failed to respond to follow-up communication. Following email exchange of information sheets and consent forms, 12 police officers were interviewed for the original research, 10 of whom had experience of Section 136 detentions of children; it is interviews with these officers which are analysed and presented here.

5.2 | Data Collection

Data collection via telephone interviews was forced by COVID-19 social restrictions; telephone interviews are known to add a further level of anonymity for participants, thereby enabling comparable data to that collected via face-to-face interviewing (Sturges and Hanrahan 2004; Musselwhite et al. 2007). With consent, interviews were audio recorded. An interview guide was developed around the key stages of a Section 136 detention and these broad topic areas were used to provide structure and ensure consistency across interviews while allowing participants flexibility in how they described their experiences.

A Narrative Inquiry (NI) approach informed the interviews. NI is recognised as an effective method for enabling participants to tell their stories and for allowing researchers to understand which aspects of an experience participants consider most significant (Clandinin and Connelly 2000). Participants were invited to describe their experience as a narrative, with prompts and follow-up questions used only to encourage elaboration, clarification or reflection. They were not required to discuss events in a predetermined order and could focus on aspects of detention they perceived as most meaningful. Unlike semi-structured interviews, where the researcher determines topics and questioning, NI privileges participants' accounts and interpretations, recognising storytellers as the primary interpreters of their experiences (Nolan et al. 2018). This approach may also reduce researcher confirmation bias by giving participants greater control over interview content and direction (Nickerson 1998; Reissman 2008).

5.3 | Data Analysis

Data were analysed though a phenomenological lens, with particular attention paid to Husserl's emphasis on understanding participants' lived experiences whilst seeking to bracket pre-existing assumptions regarding Section 136 detentions and associated legal processes (Husserl 1931; Groenewald 2004). The process was overseen by doctoral supervisors.

Audio recordings were transcribed within 2 days of each interview to facilitate early immersion in the data and the identification of recurring issues, experiences and points of significance within participants' narratives. Preliminary analytical observations were documented during transcription and informed subsequent analysis.

Transcripts were imported into NVivo within 3 days of interview completion. Analysis was inductive, with coding guided by the data rather than a pre-existing analytical framework. Initial coding identified recurring experiences and concerns, including accounts of different places of safety, policing and detention processes and perceived gaps in service provision. These observations were treated as provisional themes and reviewed through repeated engagement with the dataset.

Each transcript was entered in NVivo and was awarded a unique identifying number after 'PO' (police officer). Data extracts were coded into nodes representing concepts, experiences or issues identified within participants' accounts. A total of 13 nodes were generated. Connections between nodes were explored and related nodes grouped into higher-order themes as shown in Table 1.

Transcripts were revisited throughout the analytical process to ensure themes remained grounded in participants' accounts and accurately reflected the meanings attributed to their experiences. Quotations were selected to illustrate findings and preserve participants' voices within the presentation of results.

6 | Findings

Of the 10 police officer participants, six were males and four females; eight were constables and two were sergeants with between 3 and 13 years' experience (mean 5.5 years). Ethnicity was not obtained. The participants were geographically dispersed, offering insight across the area served by the constabulary and of the various hospitals within the Trust.

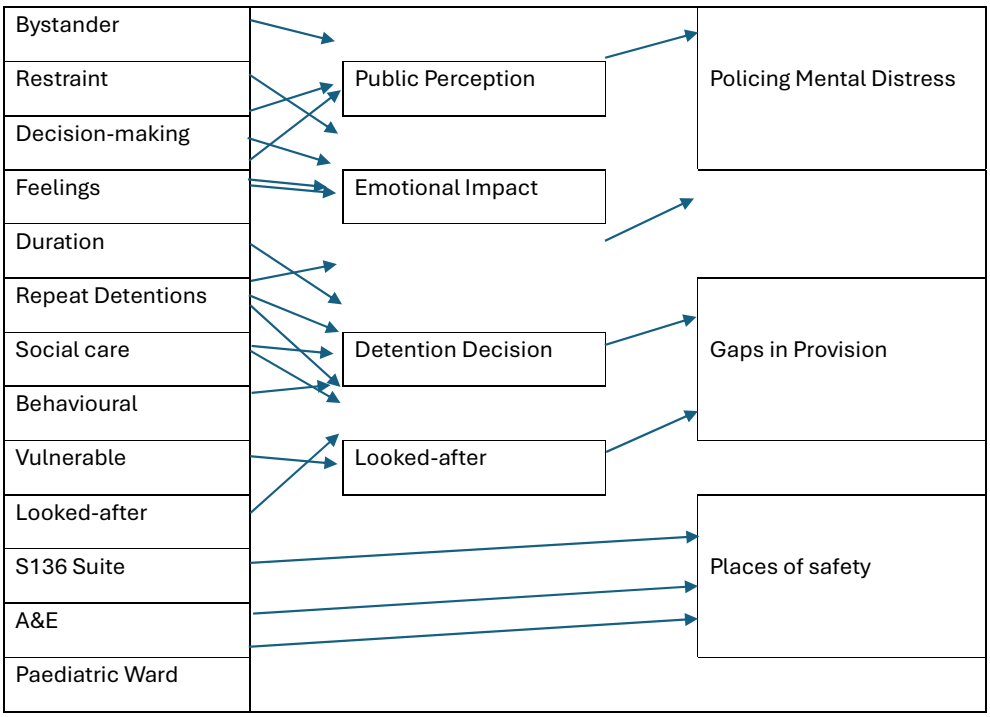
Three major themes were identified in the experiences of police officers, with a total of seven subthemes (Table 1); these are presented below within headings and subheadings. The findings are illustrated with verbatim quotes which are ascribed to the participant with the unique participant number awarded during the analysis process.

6.1 | Theme 1: Policing Mental Distress

6.1.1 | Public Perception: Being Seen as Criminal

Participants all raised concern that they are not the right service to be managing mental distress beyond the point of delivering a child into the hands of trained NHS staff at a place of safety.

TABLE 1 | Coding process.



Participants were aware of their status as law enforcement officers who have limited skills in spending extended periods of time with mentally distressed children. Participants expressed concern at children being seen in their company. Several police officers share experiences of being in A&E, aware that the child under their supervision could be viewed by members of the public as having committed a crime:

> [We were in] a busy A&E department with members of the public there who will be looking at them held under the control of police officers [...] Everyone looks around to see who is with the police, and everyone starts making assumptions about what they may or may not have done.
>
> (PO1)

> You're stood there with them, and they might see someone who they know in a busy A&E corridor, and you look like a criminal when you are stood with two police officers with you. And if they are in handcuffs if they are quite agitated etc., we might have to carry on using restraint. And it can be quite distressing for people.
>
> (PO3)

Whilst it was appreciated by participants that police cells were also not the right place for a child to await assessment, PO6 thought that protecting children in mental distress from the public gaze was important:

> We obviously can't take them into police custody, which would be more suitable because they are secluded from the general public.
>
> (PO6)

6.1.2 | Emotional Impact on Police Officers

There is evidence of the emotional toil that the detention of children and having to manage extreme levels of mental distress over many hours has on police officers. Participants spoke of their own distress at having to physically restrain mentally distressed children for extended periods of time:

> We were like, something's not right here. We are not giving [them] the best care that we can.
>
> (PO6)

> It pulled at your heart strings, but you have to deal with [the child] at the time.
>
> (PO3)

In the absence of appropriate health care staff provision to take over the care of detained children, and secure rooms in which detained children can be securely held, police officers use the skills that they possess to keep children safe and prevent them from absconding from the detention. Physical and mechanical restraints, although used, were recognised as being highly inappropriate in a health care setting and causes psychological discomfort for detaining police officers as well as for the children being restrained.

6.2 | Theme 2: Gaps in Provision for Vulnerable Children

6.2.1 | Decision to Detain

Participants spoke of their frustration that, owing to insufficient social support from other agencies for vulnerable children, it falls on the police service to intervene when children are in crisis. The lack of effective provision for children with known behavioural problems was noted by PO8, who spoke of a child whose frequent episodes of mental distress meant that police were frequently called:

> A couple of times a week ... [we] would end up wrestling this teenager, in the buff (naked), out in the street. It was such a drain on police resources as once you have detained [them] it would need at least 2 of you because [they were] one that you would have [to restrain] for the entire shift before [they] got assessed. And then [the assessment team] would turn around and say, 'sorry there is nothing wrong, it's behavioural.'
>
> (PO8)

Participants, knowing the lengthy police involvement if they do detain a child under Section 136, seek alternatives to detention. PO7 spoke of how they try to return children in mental distress back into the care of their parents or carers rather than detain them.

> I will always do my utmost to avoid sectioning a child now because I know it is not in my best interest to detain them. I will say 'now, mum and dad, you are going to have to sit with them all night and if it means you have to hold them down to stop them from jumping out of the window, then that is what you have to do. And get in touch with your doctor in the morning and get them some help that way.' Because otherwise I am fighting with them in hospital for 12 hours.
>
> (PO7)

6.2.2 | Looked-After Children

As with previous research (Eswaravel and O'Brien 2018; Patil et al. 2013), Erlam (2022) found that looked-after children were overrepresented in Section 136 detention figures. This fact is recognised by PO7: 'probably the majority of children in mental health crisis is children in care'. Returning children in mental distress back into the care of the care home staff is not as easy as returning them into the care of parents:

> [Care homes] have 2 to 1 staff ratio so I will always put the onus back on to the care staff: 'Look you are being paid to care for this child. If that means that you have to sit up all night and watch them then that is what happens. And then you need to access the doctor, the social worker, CAMHS, whoever that child is engaging with'. But to me detaining them on a 136 isn't the right course of action.
>
> (PO7)

Looked-after children are disadvantaged in this situation as, should damage to property or injury to staff occur because of the mental distress, the child risks arrest in a way that is unlikely within their own home:

> If it gets to that stage then we can arrest them for assault and look at it from that route. It's perhaps not the right way to go about it, but the [Section 136 detention] isn't either – so it's the lesser of two evils. They have still got the mental health support in custody ... they get support that way.
>
> (PO7)

A participant shared that looked-after children are placed within the region so that they are geographically distanced from dangers within their home location. A government report suggested that 44% ($n = 4080$) of looked-after children are placed more than 20-miles from their home (Foster, 2021). If these children attempt to return home, they become vulnerable missing persons who, when found, are sometimes detained under a Section 136 owing to threats to harm themselves:

> Children in care who are involved in drugs or grooming - anything where they are being exploited - are moved [away from their home area] and then the more involved [in child exploitation they are] the further away [social services] move them. That just means they go missing a lot more because they are trying to get home ... a lot them say [I will kill myself] but no one wants to risk the child's life so it's all hands-on deck. But a lot of the time children in care seem to say it because it's a threat if they can't go home.
>
> (PO5)

Part of the 2017 amendments to Section 136 stated that, where possible, police officers should attempt to seek medical advice for the person in mental distress so that alternatives to detention could be explored based on previous presentations. PO5 notes that knowledge of the medical history of looked-after children is not always available, which complicates police decision making:

> Children in care are moved around the country and come under different NHS Trusts ... [the Trusts] don't talk to each other so obviously, [if] we've got someone from London in a care home [locally] and they go missing, then you find them, and they threaten to kill themselves ... we have nothing on our records.
>
> (PO5)

Aligning with the quantitative findings of existing research by Eswaravel and O'Brien (2018) and Patil et al. (2013), children known to have existing additional vulnerabilities were overrepresented in qualitative data offered by police officer participants. Where there is a breakdown in social care and support provisions for looked-after or other vulnerable children, it is police officers who are called on to intervene. Where there is uncontrollable distress and threats to harm themselves, police officers, despite a preference not to, resort to Section 136 detentions to enable a formal assessment of mental health needs.

6.3 | Theme 3: Places of Safety

Important to note is that the place of safety to which detained children are taken is determined centrally by the Trust, during a telephone discussion between detaining police officers and the 'Bed Hub', according to which place of safety is available. Physical health concerns take priority over a mental health assessment (Royal College of Emergency Medicine 2023) and so under these circumstances a child would always be taken to an A&E department as a first place of safety before, ideally, being transferred to a paediatric Section 136 suite.

6.3.1 | Section 136 Suite

The region has one paediatric Section 136 suite which is a private room where detained children can be cared for by paediatric nurses. Participants report that 136 suite processes are easy and the best option for the detained child. PO7 acknowledged that there were 'specialist intervention teams' in the paediatric Section 136 suite and taking a child there 'fast tracked the process a bit'. PO6 spoke of how officers were 'able to withdraw [if] the risk was deemed low'.

PO7 described his experience of having been able to take a detained child to the paediatric Section 136 suite against the alternative ways of managing a child in enduring distress whilst awaiting an assessment:

> [It was a] much smoother process; there was a specialist nurse who came down from the paediatric team and it was the right way to do it ... otherwise I am fighting with them in hospital for 12 hours. It just baffles me why we don't have some specialist suite intervention where these children can go.
>
> (PO7)

As PO7 alluded to, the paediatric Section 136 suite is not always available. Reasons for this were three-fold. Firstly, several participants commented that there were three geographical locations where the Integrated Care Board (ICB), who manage the local health care budget, do not fund overnight or weekend use of the Trust's paediatric 136 suite. Secondly, there might already be a detained person occupying

the suite. Finally, there may be staffing problems: when required, paediatric trained staff are called from other wards to care for the detained child. Participants informed that if there are no staff available, then the paediatric 136 suite cannot be opened. Several participants spoke of how they tried to advocate for a detained child. PO1 asked if they could use the 136 suite, despite there being no NHS staff present, in order that they could take advantage of the peace that it offered, but this request was turned down:

> You just get told there's no staff for there, which seems crazy when you are [on] the other side of the hospital with a juvenile.
>
> (PO3)

> I have made suggestions in the past around opening the suite so that we can get in there ... so we are not holding the person in the A&E department. If that could happen then at least the young person is not distressed in an A&E department. We'd [still] be with them, but at least we could get them in the suite and in a different environment.
>
> (PO7)

In the absence of a paediatric 136 suite, as they are viewed as adults by the NHS, children beyond their 16th birthday could access an adult Section 136 suite. However, doctoral research Erlam (2022) found that an absence of provision meant that these suites were often occupied with detained people awaiting a bed, thereby making the suite inaccessible to new adult detainees. Since the 2017 amendments prohibited the use of police cells as a place of safety, although two participants suggested these as preferrable to current alternatives, in the geographical area of study the main alternative place of safety to a Section 136 suite is an A&E department.

6.3.2 | A&E Departments

All officers who spoke about keeping detained children in A&E departments consistently agreed that it was far from ideal with PO2 commenting 'it is wholly, wholly inappropriate'. Speaking of one of the busiest A&E departments in the Trust, PO2 stated: 'that place is like a zoo, it's the most chaotic environment you can imagine'. Another participant spoke of the stressful environment not being conducive to calming a mentally distressed child:

> It's not nice because it's noisy. You've got machines going off 'beep, beep, beep', and noisy staff, and other patients who are not mental health – people in pain wincing and making noises, things going up and down corridors.
>
> (PO3)

Further showing advocacy for detained children, PO3 found a quiet resuscitation area of A&E for a child who struggled with the over-stimulating A&E environment: 'I got a bed in resus where it wasn't busy, and I turned the lights off. There was only one other patient, it was pretty quiet, and [the child] stayed calm.' (PO3).

Further regarding the busy A&E department environment, participants spoke of the lack of private spaces in which mental health assessment can occur, meaning that these often occur behind curtains owing to an absence or lack of doored cubicles: "They can't even find room to do the assessment [...] so the patient can talk privately. They are sometimes just in a bay with a curtain. This person may be disclosing [...] sex abuse. They are not going to do that when the only sound barrier is a curtain." (PO2).

It was noted by participants that many of these detentions occur outside of office hours when staff with the necessary training to perform paediatric mental health assessments are not available, thereby causing an overnight wait:

> There is always an argument about who's going to come and assess that child: are we going to wait for CAMHS in the morning or are we going to do it overnight with the normal process with social workers and doctors? It's always about waiting for CAMHS, so it is always a long-term detention. Usually, it is that [the Trust] need to bed the child down for the night and CAMHS will come out in the morning.
>
> (PO7)

> Invariably [CAMHS staff] are not available during the evening or night, so you may end up with someone who has been detained at 6pm in the evening. If that assessment hasn't been able to take place because of the lack of a consultant, then it then gets passed to the day team and it would be dinner time at the earliest. So, you could have that young person there, under the detention and watch of police officers for way in excess of 12-hours because of the lack of out-of-hours provision.
>
> (PO1)

Under these circumstances, concern was raised by two participants regarding the lack of sleeping facilities:

> [We were] stuck in an A&E corridor ... there was nowhere to take [them], so [they] had to stay in A&E, and it took nearly 13-hours for someone to come out and they did the assessment there ... I tried to get [them] somewhere to rest, such as a 136 suite but there wasn't one. It's frustrating.
>
> (PO3)

> I had a 17-year-old on a 136 and [they were] asleep on the floor in the corner, and I thought 'this is absolutely ridiculous; this is awful', but there is nothing I could do about it.
>
> (PO5)

As predicted by the CQC (2017), the legislative changes forbidding the use of police cells as a place of safety whilst children await a mental health assessment has increased the use of A&E departments. The Royal College of Emergency Medicine (2022) reported that 70% of paediatric emergency departments lacked dedicated spaces in which to monitor or assess children experiencing mental distress. In its guidance for emergency departments, the same organisation further advised that responsibility for the ongoing care of individuals detained under Section 136 can only be transferred from police to medical staff where facilities and staffing levels are sufficient to ensure safe management and prevent absconding, as failure to do so may expose medical staff to allegations of negligent care if the detainee absconds (Royal College of Emergency Medicine 2025). Together, this guidance implicitly indicates that such transfers of care are often not feasible within A&E settings, thereby reinforcing the continued reliance on police supervision in these clinical environments.

Officers spoke of the assessment team collectively as 'CAMHS' rather than mention the availability of an AMHP who, in giving a social perspective, might be expected to take the lead on safeguarding the detained child; there is no suggestion here that AMHPs attended before the assessment team could arrive simultaneously. A survey by the Royal College of Emergency Medicine (2022) highlighted the limited availability of out-of-hours mental health assessment provision in A&E departments, with 64% of respondents (representing 23% of 240 departments) reporting no CAMHS availability after 17:00.

Combined, the consequences of this lack of provision are significant. Distressed children are placed in situations where they are visibly under the control of police officers, creating the potential for members of the public to misinterpret their circumstances as criminal rather than clinical. Moreover, the absence of out-of-hours mental health assessment teams means that children experiencing acute mental distress remain under police detention for extended periods. In many cases, there is no overnight clinical provision or access to a private, calming space away from the noise and disruption of the busy A&E environment. Such conditions risk compounding children's distress and raise serious concerns regarding the appropriateness and rights-compliance of current Section 136 arrangements.

6.3.3 | General Paediatric Ward

In some cases, a child under the age of 16 may be transferred from A&E to a general paediatric ward overnight; however, they must remain under police supervision due to the risk of absconding. Participants said that the management of these children is left to the detaining police officers, although health care staff did perform periodic observations of temperature and heart and respiration rates:

> We are left to deal with it while they concentrate on the other children on the ward while we are a hindrance to them. Which I get it, I understand why, but we are left as police officers to manage that situation.
>
> (PO7)

PO7 shared details of ongoing distress in a 13-year-old who had been detained from a bridge over a motorway:

> We detained [them], and we then did a 9-hour night shift with [them], literally fighting with [them] on the children's ward. We'd go through the points of handcuffs, limb restraints, headguard. [They] would then calm down and we would deescalate and remove, one by one, all of those different restraints [...] They would be calm for 5 or 10 minutes and then everything back on again, and that was a process for 9 hours [overnight] on a children's ward with other very poorly children ... for the other children, and the child you have detained, that is horrific.
>
> (PO7)

Although paediatric wards offer a bed and privacy away from other members of the public within A&E departments, distressed children remain under the control of police officers rather than paediatric health care staff. For other children on the paediatric ward, seeing and hearing the distress of a child under the control of police officers is an avoidable trauma, and the trauma caused to the detained child is highly problematic.

7 | Discussion

This research reveals highly concerning findings regarding the detention processes of children subject to Section 136 detentions. Firstly, Article 3 of the United Nations Convention on the Rights of the Child states that 'the best interests of the child shall be the primary consideration' (Article 3.1; UNICEF 1989, 4). In principle, once a person detained under Section 136 arrives at a designated place of safety, and where a risk assessment permits, responsibility for their ongoing detention can be formally transferred to a healthcare professional. This arrangement enables children experiencing mental distress to be cared for by appropriately trained nursing staff. However, participants reported that, due to healthcare funding decisions and a lack of suitably qualified staff, this transfer frequently does not occur, resulting in detained children remaining under police supervision. This situation is not only contrary to the best interests of the child but also falls short of the obligations set out in Article 24, which requires States Parties 'to ensure the provision of necessary medical assistance and health care' (Article 24.2(b); UNICEF 1989, 7).

The absence of a secure Section 136 suite where children can be safely contained and monitored while awaiting assessment results in police officers using physical or mechanical restraint to maintain ongoing detention. While preventing absconding is both a legislative requirement and, for safety reasons, aligned with the child's best interests, as PO6 highlighted, children detained in this manner are not receiving optimal care. I argue that leaving police officers to manage prolonged episodes of extreme distress exposes those children to avoidable 'cruel, inhuman or degrading treatment' and thereby contravenes Article 37.

Since this research was conducted there have been legislative amendments. Firstly, the Mental Health Bill received Royal Assent in December 2025, enabling amendments to the

existing Mental Health Act to be incorporated into legislation. One proposed change sought to extend the power to detain under Section 136 to include health and social care professionals, rather than limiting this authority solely to police officers. This proposal reflected a governmental aim to reduce police involvement at the initial point of detention, with Ministers arguing that 'police presence at mental health incidents can escalate safety issues' (Gajjar et al. 2025, 46). However, the amendment was subsequently withdrawn (Gajjar et al. 2025) following safety concerns raised in a joint statement from healthcare professional bodies led by the Royal College of Psychiatrists (RCPSYCH 2025). Considering this reversal, it appears that the revised Mental Health Act will retain the current Section 136 framework, as set out in 2017, without substantive change.

The legislative context aligns with wider policy developments concerning the role of the police in mental distress. The *Right Care, Right Person* policy paper (GOV.UK 2024a), which sought to ensure that people are cared for by the most appropriate profession, acknowledged the growing demand placed on police services across England and Wales in responding to mental distress. While the policy accepts that police involvement remains necessary in situations involving an immediate or active risk, it stipulates that, once this threshold is no longer met, responsibility should be transferred 'in a timely manner' to mental health or other appropriate services. The policy further proposes that this handover should occur within 1 h, thereby aiming to ensure that individuals in crisis receive care from the most suitable professionals.

Taken together, these developments illustrate a broader policy trajectory aimed at reducing the routine involvement of police in mental health crises. However, how this is applied at a local level requires further investigation. Anecdotal evidence provided by the constabulary's Mental Health Lead prior to publication suggests that, although the number of Section 136 detentions has decreased since this research was conducted, the operational processes governing the ongoing care of children following their arrival at the place of safety have remained unchanged. This continuity appears to persist despite the expectations set out in the *Right Care, Right Person* policy, raising questions about the practical implementation of national directives and the capacity of local systems to adapt to evolving policy frameworks.

Maybe too much reassurance was felt after the 2017 changes forbade the use of police cells as a place of safety. The *Are we listening?* report (CQC 2018) appeared to take comfort in the fact that hospital-based places of safety were increasingly being used in the years leading up to the 2017 legislative changes, but there has been no consideration for what this looks like.

8 | Conclusion and Recommendations

Here, police officer perspectives have illuminated the processes involved in Section 136 detentions of children, for which there exists a paucity of knowledge. Data shows that, owing to a lack of provision, especially out-of-hours, detained children remain under police, rather than health-led, care, raising concerns about compliance with the rights set out in the UNCRC.

There are alternative places of safety available under the terms of Section 136 which are not practiced within the constabulary or the Trust in the geographical area of study. For instance, a detained child could, with the permission of the property owner, be detained within a home whilst they await a mental health assessment. However, this would not remove the fact that police officers would be the professionals in attendance.

Furthermore, there are alternatives to Section 136 detentions to manage children who are in a situation which poses a threat to their safety. Section 44 of the Children Act (GOV.UK 1989) enables police officers to remove a child from a place where they are deemed to be unsafe. Again, this would mean that the child would be under the care of police officers, but where there are repeated police calls to the same individuals whom officers believe are not receiving effective social support, such as in the situation described where there were twice weekly calls to the same child, this alternative intervention would enable a more holistic assessment of needs.

Ideally mental distress would not reach the point which attracts police attention and so work must continue to address the causes of childhood mental distress. Alternatives to manage situations of acute mental distress should be considered, with a priority being to avoid using A&E departments for children experiencing mental distress, to ensure that privacy is protected and wellbeing is prioritised. Although children may need to be initially detained by police for mental health assessment, adequately funded out-of-hours services are required to enable ongoing detention and care to be transferred promptly to social care or paediatric healthcare professionals.

A limitation to this research is that it explores one constabulary and one NHS Trust, and it is acknowledged that other geographical areas might have different policies regarding Section 136 detentions of children. Future studies which compare practices in different geographical areas would highlight best practice. Future research might also further consider the personal impact on police officers who are managing children's mental distress for prolonged periods of time.

Author Contributions

Jayne Erlam: writing – original draft, funding acquisition, investigation, conceptualization, methodology, writing – review and editing, data curation, formal analysis.

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Conflicts of Interest

The author declares no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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