Ombudsman
Fairness for all

Inappropriate placement of individuals with complex mental health needs and intellectual disability

Insight Briefing: 11 June 2026

Purpose

1. This insight briefing outlines observations and insights on the impact on people with complex mental health disorders or an intellectual disability who are held in prison because suitable specialist services are not available, or who are in specialist services that cannot meet their needs because of capacity pressures.

2. Our observations arise from our role in monitoring places of detention and oversight of serious incidents in prisons, as well as from own motion investigations. We see the real-life consequences of the impact on individuals in detention, including deaths and significant risks to the safety of those on remand.

Context and considerations

3. This is not a formal Ombudsman report. As the focus is at a system-level, the report does not contain any new adverse findings concerning individual agencies.

4. The briefing provides an overview of what we currently know about the issue from our inquiries with agencies and observations from various oversight functions, and signals where we are considering further inquiries and investigation.

5. The briefing includes two anonymised case studies used to illustrate the common patterns that we see and to highlight key risks and the impact on individuals. These draw on cases arising from our work.

Role of the Ombudsman

6. The Ombudsman provides New Zealanders with assurance that individuals are being treated lawfully and reasonably by the state, that people in detention are being treated humanely and that there is transparency over government activities and access to public information.

7. Where we think something has gone wrong, our role is to identify remedies for individuals and ways to address systemic causes.

Executive summary

- Individuals with complex mental health needs and intellectual disabilities in detention are not always able to be placed in appropriate forensic mental health and intellectual disability services (specialist services).
- They are increasingly being remanded into prisons. Judges are having to order detention in prison because of the lack of available beds in secure specialist services.
- Roles and responsibilities are distributed across multiple agencies in the health and justice systems. This diffusion of responsibility poses risks in terms of clear stewardship and accountability.
- Individual with complex needs face an increasing risk of self-harm, distress or harm to others (and deterioration) when access to specialist services is delayed or unavailable. They may be placed in environments that cannot meet their needs, and experience disruptions to continuity of care.
- The risks are increasing across the system due to the capacity constraints in health system, the pressures from the increasing prison population and other factors. We are concerned that there will be more serious incidents and deaths.
- This is a long standing and known issue. While there are work programmes and shared governance arrangements in place across agencies, our long-term monitoring of recommendations in the previous Chief Ombudsman's report[1] suggests that there has not been any real improved access to services or better outcomes for individuals.
- These issues raise questions about the adequacy of current funding, planning and health system stewardship. This includes whether there is sufficient visibility of demand and system pressures, and whether monitoring and accountability mechanisms are in place to support improved access and outcomes over time.
- We have engaged with key agencies to understand the issues and contributing factors. We have also engaged with the Minister of Mental Health and the Minister of Corrections to discuss our observations.
- Examining these system pressures is a priority area for our Office over the coming year.

Issue Overview

Context

Some individuals have needs that are not suited to placement in prison.

8. This briefing focuses on two groups for whom placement in prison may be inappropriate due to their level of need.

Individuals with complex mental health needs

9. This group refers to individuals (offenders) who require specialist forensic mental health services while in detention. It can include:

   a. Those on the forensic waitlist.

   b. Those subject to compulsory treatment and care under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (CTO).

   c. Those being assessed as unfit to stand trial or not criminally responsible under the Criminal Procedure (Mentally Impaired Persons) Act 2003 (CP(MIP)) Pathway.

10. There are no statutory criteria for accessing forensic mental health services. However, Corrections and Health agencies worked together to develop national criteria for this service.

Individuals with an intellectual disability

11. This group refers to individuals with a diagnosed or suspected intellectual disability, who requires specialist assessment, care, rehabilitation or support services. It includes individuals who may be eligible for assessment and care under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, as well as those whose needs have been identified but who have not yet completed that process.

12. Between 200-250 people with intellectual disabilities are supported under the High and Complex Needs Framework at any one time.[1]

Placement considerations

13. For both groups, legislation provides detention pathways for care and treatment outside prison. There are distinct processes for each.

14. When the pathways cannot be accessed, individuals may be placed in prison while awaiting assessment. If a person is found unfit to stand trial under CP(MIP) they cannot lawfully be held in prison.[2]

Figure 1: Placement pathways for management of individuals during assessment

[1] Disability Support Services, "High and Complex Framework Operational Strategy", accessed 10 June 2026, High and Complex Framework Operational Strategy.

[2] This is covered under section 23 of the Act.

Roles and responsibilities are fragmented across the system.

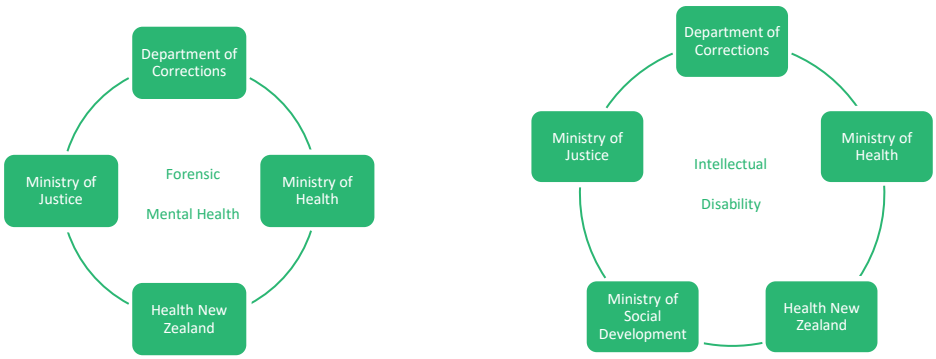

Figure 2: Key agencies involved in forensic mental health system and intellectual disability system

15. Across the systems, illustrated in Figure 2 above, responsibilities are distributed across multiple agencies. This requires effective system stewardship, coordination, clear accountability, and shared visibility of demand and capacity to ensure timely access to care.

16. There are delays in referral, assessment and access to services. Planning across the system does not appear coherent.

Forensic mental health and intellectual disability systems are under considerable strain and there are implications for access to appropriate placements.

17. The issues in the intellectual disability and forensic mental health systems are not isolated. There are common challenges.

18. Both are designed on the underlying principle that individuals entering the criminal justice system are assessed, their needs are identified, and they are then placed in the most appropriate setting. If not released on bail, they may be placed in prison, mental health or intellectual disability services.

19. In practice the pathways are often blocked due to a lack of beds. This results in individuals being placed in prison for extended periods of time while waiting to access specialist services. Prison becomes a holding environment for access to these services.

20. There are also known gaps in provision. Some cohorts have no pathways available despite significant needs, for example people with neurodiverse conditions.

21. Capacity pressures are being exacerbated by the increasing number of people being assessed and being found unfit to stand trial (a 103% increase over ten years)[3] and recent changes in case law[4]. This means the gap between need and provision is widening over time.

[3] Information is from Ministry of Justice data set Outcomes for mentally impaired persons.

[4] T v Te Whatu Ora HNZ Ltd [2025] NZSC 119

22. There are some potential unintended consequences of this, including:

    a. Placement decisions are constrained by the availability of suitable beds and available pathways.

    b. The demand is hidden which impacts long term planning and management. Where a court order is made, health and disability services are required to comply with the order. Where no order is made (but should have been made based on need), unmet need is not recorded. Data only shows people admitted, not people who should have been admitted. True demand is unknown.

Intellectual Disability Services Issue Overview

Capacity and access issues are a longstanding concern in the intellectual disability system.

23. In 2021, my predecessor released the Oversight report[5] (the report) which found that there were not enough beds available for people with intellectual disabilities who needed specialist care in detention.

24. The report identified gaps in system stewardship, including limited visibility of demand, gaps between funded and operational capacity, and a lack of effective planning to ensure services were available where needed.

25. From our monitoring of system improvements as recommended in the report, there is limited evidence that the acute situation has improved in the 8 years since this issue was raised with my Office.

Capacity and access issues are reaching critical levels at present.

26. During our engagement with agencies, we've heard that Disability Support Services (DSS) cannot always access the beds they need.

27. As a result, people are waiting in prison to be placed in the right service (or to be assessed on remand).

28. Prisons appear to be increasingly used as a temporary option to manage capacity issues in the health system.

[5] Office of the Ombudsman, Oversight: An investigation into the Ministry of Health's stewardship of hospital-level secure services for people with an intellectual disability July 2021. https://www.ombudsman.parliament.nz/resources/oversight-investigation-ministry-healths-stewardship-hospital-level-secure-services

It appears that individuals with intellectual disability are increasingly being placed in prison.

29. In the past, the Ombudsman was occasionally notified of cases in which individuals with intellectual disabilities were placed in prison due to a lack of appropriate placement. Since the beginning of 2026, we have been notified of several more such cases.

30. We are concerned that the shift from isolated cases to a more frequent pattern indicates increasing pressure on the system and a reduced ability to meet legal obligations in practice. It also raises concerns about the appropriateness and safety of placements for individuals whose needs are not suited to custodial environments, and whether current capacity and planning are sufficient to meet demand.

31. Case Study A below illustrates the risks that arise where access to appropriate care is constrained by capacity. This results in individuals being placed in prison as a last resort. It also highlights a system that responds to escalation, but where access may depend on crisis or intervention rather than timely, planned pathways.

Case Study A: Delayed Access to Intellectual Disability Services

This case involved a young person with significant intellectual disability (and the cognitive functioning of a primary school student) who was remanded in prison custody due to a lack of beds in intellectual disability services.

The presiding judge noted their concerns about the appropriateness of the placement. Both the judge and Corrections raised the case with the Ombudsman due to the level of risk to the individual.

The person was awaiting assessment, with an estimated timeframe of 6-8 weeks before this could be completed.

The Ombudsman contacted the relevant Chief Executives to express his concern about the case and to request ongoing updates.

The person remained in custody despite clear indications that the environment was not suitable for their level of need. This caused high levels of distress and resulted in multiple incidents.

Corrections assessed the person's needs and implemented enhanced monitoring, including one-to-one supervision to mitigate the risk of harm, and provided other supports needed.

The Ombudsman engaged with health agencies and Corrections weekly to inquire about the person's wellbeing and to monitor progress on securing an appropriate placement.

A placement was ultimately identified with a community provider and, after several weeks in prison, the person was transferred out of custody.

A lack of step-down beds means some people are staying too long in these services which also blocks access to entry.

32. My inspectors completed inspections at three intellectual disability units over the past two years.[6]

33. In two of the three units, staff reported challenges with accessing appropriate step-down services. Inspectors noted that at least four individuals across these units were staying for extended periods of time as a result. This meant that new people could not be admitted for assessment or care. Some individuals were being placed in forensic mental health units instead, which may not be appropriate.

34. My inspectors also noted potential underutilised capacity in the system, for example at one site that a cottage has been vacant since the COVID-19 pandemic due to ongoing staffing challenges.

There appear to be ongoing challenges in stewardship, accountability and delivery.

35. These observations are consistent with findings from the earlier Oversight report. While there is a strategy, an operational plan, work programmes and a shared governance model in place, this suggests that issues identified have not yet been addressed.

36. There is a need for further monitoring or investigation of the gaps in system stewardship, accountability and planning for demand.

Forensic Mental Health Services Issue Overview

Capacity and access pressures also exist within the forensic mental health system.

37. The evidence strongly suggests that issues in the forensic mental health are widely reported and well known by government agencies.

38. There are a range of reports that have documented the delays, waitlists and adverse experiences of individuals. These include reports from my Office, the Coroner, the Office of the Inspectorate, the Department of Corrections, Health and Disability Commissioner and Health agencies.

39. There also appears to be expert consensus on the matter. In March 2020, every clinical director of Area Mental Health Services in the country co-signed an editorial declaring the situation ‘a’ human rights violation’.[7]

[6] Inspections were completed at Whaikaha Unit at Hillmorton Hospital, Haumietiketike Unit at Rātonga-Rua-O-Porirua and Ward 10a at Wakari Hospital.

[7] Monasterio, E., Every-Palmer, S., Norris, J., Short, J., Pillai, K., Dean, P., & Foulds, J. (2020). Mentally ill people in our prisons are suffering human rights violations. The New Zealand medical journal, 133(1511), 9–13.

40. The current scale of the problem is outlined below.

The prison population is increasing, so is the demand for mental health services.

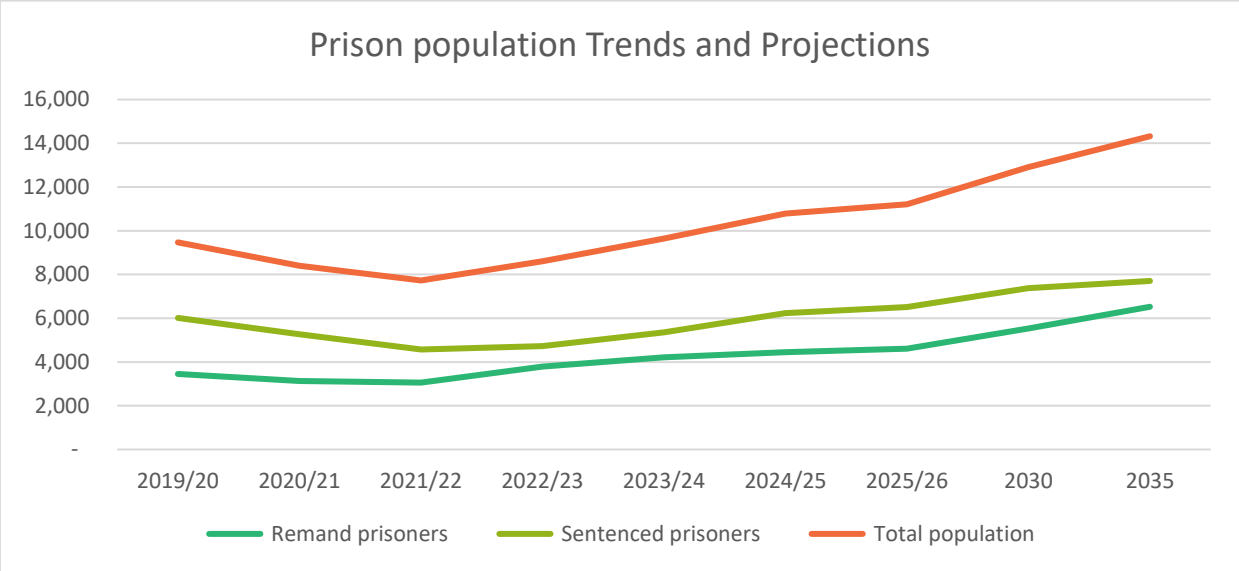

Figure 3: Historical prison population trends and projected future demand[8]

41. The prison population increased from 9,469 in 2019/20 to 11,210 in May 2025/26 (an 18% overall increase). It is projected to increase further to 14,230 by June 2035 (a further 28% increase).[9]

42. The remand population across the same period increased by 33%, from 3,458 to 4,452. It is projected to increase further to 6,525 by June 2035 (a further 42% increase).[10]

43. There is a high level of mental health needs in prison. People in prison are three times more likely than the general population to have a 12-month diagnosis of a mental health disorder (62% compared to 21%).[11] This increases to 90% of the population when looking at lifetime diagnosis.[12]

44. Mental health needs are particularly acute among people on remand, who experience higher rates of mental illness, and greater vulnerability, including elevated risks of suicide and self-harm.[13]

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8 Data is taken from reports provided to OOTO on prison population. Data for 2025/26 was as at 14 May 2026. Projections are taken from Ministry of Justice. Justice Sector Projections 2025-2035.

9 Ministry of Justice. Justice Sector Projections 2025-2035.

10 Ministry of Justice. Justice Sector Projections 2025-2035.

11 The delivery of Mental Health Services within the Department of Corrections – Te Ara Tika Report. December 2024. See page 22

12 Indig, Devon, Craig Gear, and Kay Wilhelm. (2016). Comorbid substance use disorders and mental health disorders among New Zealand prisoners. Wellington: New Zealand Department of Corrections.

13 Office of the Inspectorate. (2023) Suspected Suicide and Self-harm Threat to Life Incidents in New Zealand Prisons 2016-2021 Thematic Report.

45. A growing prison population means more people need support which leads to greater pressure on services.

Corrections is not equipped to provide mental health services for those with severe or complex needs.

46. A small number of people are very unwell or have more complex needs They should be in hospital but often stay in prison and are placed on a waitlist for forensic mental health services (30-50 people are waitlisted). They may require psychiatric care or compulsory treatment.

47. Under the Mental Health (Compulsory Assessment and Treatment) Act 1992, *compulsory treatment* cannot be provided in prison. It must be delivered by the health system.

48. This means Corrections cannot treat someone who declines care even if they require compulsory treatment. If no bed is available in forensic services, the person remains in prison, untreated while on the waitlist. This compromises the quality and continuity of care.

49. People in prison should have access to the same level of health services as those in the community[14].

Forensic mental health services are provided by Health NZ but provision has not kept up with the demand over time and waitlists are growing.

50. Specialist forensic mental health services are delivered by Health New Zealand through five regional forensic services. There are approximately 315 forensic mental health hospital level beds nationally.[15]

51. Five to ten percent of prisoners need treatment from forensic mental health services.[16]

52. It appears that no additional forensic beds were added to the system over the past five years despite the growing prison population.

53. All Health NZ forensic mental health services are currently operating at or above capacity. There are 30 to 50 people waiting for transfer from prison at any time.[17]

[14] This is a requirement under the Corrections Act section 75(2).

[15] Health New Zealand. Briefing for information: Forensic mental health services capacity pressures and planning15 August 2025. Reference H2025071021. See page 4.

[16] Health New Zealand. Briefing for information: Forensic mental health services capacity pressures and planning15 August 2025. Reference H2025071021

[17] Health New Zealand and Ministry of Health. Briefing for decision: Opportunities to better respond to forensic mental health capacity pressures. 11 December 2025. H2025075508B5009 See page 5.

The impact on individuals and the devastating consequences that can result from inappropriate placement is evident from serious incident reporting.

54. We reviewed 60 deaths in custody over a three-year period. Over a third (22 cases) were suspected suicides. Of these, 16 involved individuals on remand, and a high proportion were Māori (67%).

55. A significant portion had interacted with forensic mental health services, with 14 individuals referred at some point during their time in custody. Eight engaged with forensic services, however five were assessed as not meeting criteria and were declined. In one case it is unclear whether engagement occurred. Two others should have been referred but were not.

Case Study B: Compulsory Treatment Order & Delayed Access to Forensic Mental Health Services

This case involved a man with a history of complex mental health challenges who had been receiving compulsory treatment in the community.

Following an incident, the man was remanded into custody, at which point the compulsory treatment order ceased.

On arrival in prison, he was assessed as at risk and placed in the Intervention and Support Unit.

Over time, his mental health deteriorated. He frequently declined medication, began to self-harm and grew more aggressive towards staff and other people in prison.

During this time, custodial staff were required to manage complex and escalating behaviour within an environment not designed for therapeutic care, and without access to the full range of clinical tools and supports available in clinical settings.

Corrections applied for him to be assessed for hospital level care; access was delayed as no beds were available.

The man remained in custody and his mental health deteriorated further. While waiting, he died by suicide.

56. Four cases involved individuals with compulsory treatment orders (CTO). There was a further death related to CTO in July 2025.

57. There are heightened risks among the remand population, where vulnerability to self-harm and suicide is already well established.

58. Case Study B illustrates the risks that arise where continuity of care is disrupted at the point of entry to custody (remand), and where delays in accessing specialist mental health services result in individuals deteriorating in environments that are not therapeutic.

There are increasing systems pressures due to rising prison population, which appear to be compromising the safety of prisoners on remand and increasing the risk to vulnerable individuals.

59. Observations from recent prison inspections[18], serious incidents and deaths in custody suggest the increasing remand population is intensifying pressure across prisons.

    a. *Prison infrastructure does not appear to meet current needs.*

       More people arrive at prison each day. There are a limited number of cells available, which means more prisoners are sharing cells. Staff appear to have less flexibility in placements as options are limited, impacting safe, considered placement decisions.

       Some sites are not designed to manage high numbers of remand prisoners alongside a sentenced population. This often results in high numbers of separate unlock regimes in remand units, which limits time out of cell and can increase levels of frustration and risk.

    b. *High demand for mental health support and insufficient capacity*.

       The demand for Intervention and Support Unit (ISU) beds was greater than the beds available at multiple sites.

       As a result, people who had been assessed as at-risk of self-harm were being accommodated in other units, in non-designated at-risk cells. These cells are not fit for purpose (no anti-ligature features and no monitoring by CCTV). As a result, staff were pulled from their usual duties to provide 1:1 monitoring. There were flow on effects for the prison.

    c. *High levels of volatility and violence at some sites.*

       Concerns about safety and exposure to violence, assaults and bullying were frequently raised. Observations include:

       i. Ten incidents were recorded over four days in the high security units at Rimutaka Prison involving violence, abuse and/or threats to prisoners. Three incidents involved serious assaults to prisoners, injuries, and hospitalisation. Two of these involved improvised weapons.

       ii. Three deaths occurred in shared cells over a six-month period at one site.

60. These pressures reduce the system's capacity to safely manage vulnerability, mental distress, and violence. If these pressures continue to grow, there is a risk that some settings could find it increasingly difficult to respond safely and effectively. At the individual level there could be more serious incidents and deaths.

[18] These observations are based on preliminary findings.

61. Mount Eden Corrections Facility provides an example of the growing strain on remand sites.

Mount Eden Correctional Facility

The site held 1,276 prisoners at the most recent inspection, however site leadership advised that it operates most effectively and safely at a population closer to 900. Around 90% of prisoners are on remand.

The high number of daily arrivals, lack of spare capacity onsite and increasing prevalence of shared cell arrangements are creating safety risks.

Demand for mental health services and support is high. The number of people identified as 'at risk' is over three times the current ISU capacity.

The impact of the pressure is being observed through reporting on serious incidents such as assaults and self-harm. We were notified of ten deaths over the past two years, with most relating to mental health.

Individuals are also being inappropriately accommodated in forensic mental health services to meet capacity pressures.

62. In the past two years, my inspectors completed four forensic mental health unit inspections.[19] Three of the four units were using seclusion or de-escalation rooms as bedrooms due to capacity pressures.

63. Two of the four units were operating over capacity consistently. Data showed the units were operating at up to 130% capacity for the last six months. One unit was funded for 15 beds. On the day of inspection 20 people were in the unit.

64. Following these two inspections, I recommended that Health New Zealand work with other relevant agencies to ensure that the Forensic Adult Inpatient Mental Health Services can meet the demand for their services, including providing suitable bedrooms for all those admitted.

[19] Inspections were completed at Rangipapa Forensic Acute Mental Health Unit in Rātonga-Rua-O-Porirua, Tāwhirimātea Inpatient Unit at Rātonga-Rua-O-Porirua, Te Whare Hohou Roko at Hillmorton Hospital, and Pūrehurehu Forensic Acute Inpatient Unit in Rātonga-Rua-O-Porirua.

The risk is growing as demand for forensic mental health beds is likely to exceed future capacity.

65. Ministry of Health forecasting in 2024 showed that an estimated shortfall of 40 forensic inpatient beds is expected by 2027, and 460 total beds will be needed by 2035 to meet demand. This means an additional 151 beds are needed to meet future demands.[20]

66. At present only ten new in-patient beds and eight step-down beds are expected to be added. $51 million was provided over four years through Budget 2025 to increase hospital level capacity in the forensic system and provide additional step-down beds.[21]

67. Some additional funding was also provided through Budget 2026. It is unclear how many additional beds will be added as a result of this funding or when they will be available.[22]

A joint work programme has been developed and shared governance arrangements are in place.

68. The Ministry of Health, Health New Zealand and Corrections are working together to identify improvements and efficiencies within the current forensic mental health system, to relieve current capacity pressures and to plan for future demand.

69. Some initial areas of focus include capacity and policy planning, system improvements clinical and operational safety and short-term capacity.[23] Further work is being considered.

There are concerns about stewardship and accountability that warrant further consideration.

70. Historically agencies have known about these issues, but this has not translated into improved access or outcomes for vulnerable individuals.

71. Greater system level oversight and monitoring may be needed to help reduce the likelihood that individuals experience harm.

72. Examining these system pressures is a priority area for the Ombudsman's oversight functions for the coming year.

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[20] Health New Zealand and Ministry of Health. Briefing for decision: Opportunities to better respond to forensic mental health capacity pressures. 11 December 2025. H2025075508B5009 See page 5.

[21] New Zealand Government. Investment to grown number of forensic beds. 04 June 2025. Investment to grow number of forensic beds | Beehive.govt.nz

[22] Treasury. Budget 2026 Summary of Initiatives See page 33

[23] Health New Zealand and Ministry of Health. Briefing for information: Update on forensic mental health work programme. 28 August 2025. H2025071627.