ORANGA TAMARIKI
Ministry for Children

STRATEGY, INSIGHTS, AND PERFORMANCE

# Health Models of Care in Residences and Secure Facilities

## Evidence Scan

**September 2025**

## Introduction

This report provides an evidence scan of international research and Oranga Tamariki publications on health care models in residences and secure facilities. It informs a review of health service provision across Oranga Tamariki residences.

## Research questions

The review focused on the following questions:

1. What models of health care are used in secure facilities for children and young people?
2. What are the key differences between these approaches?
3. What are young people's experiences of receiving health services in secure facilities?
4. What disciplines are essential for service delivery?

## Methodology

The scan synthesised 10 international studies related to the research questions and four Oranga Tamariki reports that provide the broader context of the care and protection system in Aotearoa. Of the 10 international studies, there was one integrative review of international models, two from the United States, and one article each from Australia, United Kingdom, and Sweden.

The studies were synthesised and presented in a summary table, alongside responses to the research questions and key implications for practice and policy.

# Executive summary

### Only a small number of international studies have examined health care models within secure residences

This means that there is limited understanding of which health services best meet the needs of young people worldwide, and what approaches are most effective in an Aotearoa context.

### International health models of care in secure residences vary in structure, intensity, and cultural responsiveness

Secure care models emphasise trauma-informed, integrated approaches to health, such as medical homes and therapeutic care. These models are supported by multidisciplinary teams and culturally grounded practices, ensuring holistic and responsive support. Many also adopt preventive and developmental frameworks, alongside restorative justice and public health models, to promote healing, equity, and long-term wellbeing.

### Models of care differ in their focus and approach

Models of care differ across systems, with key contrasts including fragmented versus integrated care, crisis-driven versus preventive services, equitable versus unequal access, and custodial versus. therapeutic environments. Approaches that prioritise continuity, cultural safety, and youth voice consistently lead to better health outcomes for young people in secure settings.

### Youth experiences are mixed

Youth in secure facilities report mixed experiences with health services. On the positive side, they value supportive relationships, opportunities for skill-building, and feeling seen and heard. However, many also face negative health experiences, including lack of confidentiality, loss of services after leaving care, and systemic barriers such as transport, lack of documentation, and access to care.

### Effective health models rely on multi-disciplinary teams

Effective healthcare in secure facilities depends on multidisciplinary collaboration, involving nursing, mental health professionals, social workers, pediatricians, cultural advisors, educators, and policy makers. Working together across these disciplines ensures care is holistic, trauma-informed, and culturally safe, meeting the diverse and complex needs of young people.

### An integrated, multi-system approach is key

Key recommendations include adopting integrated, multi-system approaches that connect health, education, and housing; embedding culturally responsive and kaupapa Māori practices; and providing long-term support beyond age 18. Services should be trauma-informed and strengths-based, with a strong focus on community-led reform, whānau engagement, and equity monitoring to ensure better outcomes for tamariki, rangatahi and their whānau.

# Summary table of health models of care in residences and secure facilities

| Reference | Country | Model of care (Q1) | Advantages of the model (Q2) | Disadvantages of the model (Q2) | Young people's experiences (Q3) | Key disciplines (Q4) |
|---|---|---|---|---|---|---|
| **International Studies** | | | | | | |
| Collins[1] (2016)<br><br>*Integrative Review, Delivery of Healthcare Services to Adolescents and Young Adults During and After Foster Care* | Global | Integrated models including medical homes, multidisciplinary collaboration, and trauma-informed care. | Improves continuity, addresses social determinants, and supports transitions. | Fragmentation including lack of unified policy and interagency services, limited evidence-based interventions. | Mixed-valued relationships with providers but faced confidentiality issues and service loss post-care. | Social work, nursing, mental health, pediatricians, public health. |
| April et al.[2] (2023)<br><br>*Conceptualizing juvenile justice reform: Integrating the public health, social ecological, and restorative justice models* | United States of America | Integrated Model of Juvenile Justice (IMJ) combining Public Health Model, Social-Ecological Model, and Restorative Justice Model. | Holistic and multi-systemic, prevention-focused, ensures restorative practices, equity-oriented, and community-driven. | Requires coordination across multiple systems (education, health, justice, etc.), resource intensive, staff resistance to change, variability in restorative | Hypothetical youth experience including lack of trust in systems and youth from under-resourced communities may feel disconnected from schools, | Social work, mental health, public health, education, law enforcement, community advocates and cultural leaders, government agencies, |

[1] Collins, J. L. (2016). Integrative review: Delivery of healthcare services to adolescents and young adults during and after foster care. *Journal of Pediatric Nursing*, *31*(6), 653-666.
[2] April, K., Schrader, S. W., Walker, T. E., Francis, R. M., Glynn, H., & Gordon, D. M. (2023). Conceptualizing juvenile justice reform: Integrating the public health, social ecological, and restorative justice models. *Children and Youth Services Review*, *148*, 106887.

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| | | | | practices, potential for unequal access. | families, and services. | research and implementation scientists. |
| Johansen et al.[3] (2021)<br><br>*Social workers' perspectives on a medical home model for children and adolescents in out of home care– An interview study.* | Sweden | Hälsofam: A medical home model offering trauma-aware, multi-professional, coordinated care. | Holistic care across mental, physical, and dental domains; Strong collaboration between health and social services; Low-staff turnover fosters trust and continuity | Access depends on individual social worker's interest and workload, referral process can be time-consuming, inequities in usage across locations and cases. | Initial fear or mistrust due to lack of information. Young people become more responsive to care due to sensitive, committed staff, feeling seen and supported during visits. | Social work, nursing, paediatricians, child psychologists, dentists. |
| Kools & Kennedy[4] (2003)<br><br>*Foster Child Health and Development: Implications for Primary Care* | United States of America | Developmental and health-focused models, preventive care. | Early identification of issues promotes holistic development. | Inconsistent access, lack of coordination, disparities in care. | Frustration with fragmented services, appreciation for supportive providers. | Social work, mental health, pediatricians, developmental specialists. |
| Mather et al.[5] (1997) | United Kingdom | Basic health screening and | Ensures minimum health standards, | Lacks continuity, limited preventive | Often feel neglected or unheard; limited | Nursing, general practitioners, |

[3] Johansson, N., Fängström, K., & Warner, G. (2021). Social workers' perspectives on a medical home model for children and adolescents in out of home care–an interview study. *BMC Health Services Research*, *21*(1), 804.
[4] Kools, S., & Kennedy, C. (2003). Foster child health and development: Implications for primary care. *Pediatric Nursing*, *29*(1), 39.
[5] Mather, M., Humphrey, J., & Robson, J. (1997). The Statutory Medical and Health Needs of Looked after Children Time for a Radical Review? *Adoption & Fostering*, *21*(2), 36-40.

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| *The Statutory medical and health needs of looked after children: Time for a radical review* | | episodic care in secure residences. | identifies acute needs. | or mental health services. | trust in health services. | visiting specialists. |
| McLean[6] (2016)<br><br>*Report on Secure Care Models for Young People at Risk of Harm* | Australia | Therapeutic secure care model emphasising safety, trauma recovery, and developmental support. | Holistic, child-centered, supports long-term outcomes. | Resource-intensive, requires interagency collaboration. | Improved when care is stable and therapeutic; distress when care is custodial or coercive. | Social work, therapists, education, health professionals. |
| Ninan et al.[7] (2014)<br><br>*Developing a Clinical Framework for Children/Youth Residential Treatment* | Canada | Clinical framework trauma-informed, developmentally appropriate, and family-centered care. | Addresses trauma, promotes safety and emotional regulation, supports family engagement. | Requires intensive training, resource-heavy, variable implementation. | Positive when care is consistent and relational; challenges with transitions and staff turnover. | Clinical psychologists, therapists, residential staff, educators, family support workers. |

[6] McLean, S. (2016). Report on secure care models for young people at risk of harm. *Report to the SA Child Protection Systems Royal Commission*.
[7] Ninan, A., Kriter, G., Steele, M., Baker, L., Boniferro, J., Crotogino, J., ... & Dourova, N. (2014). Developing a clinical framework for children/youth residential treatment. *Residential Treatment for Children & Youth*, *31*(4), 284-300.

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| **Oranga Tamariki Publications** | | | | | | |
| Faasen et al.[8] (2023)<br><br>*Evidence Brief: Primary Healthcare Needs of Disabled Children in Care and Protection* | Aotearoa | Focus on equity of access and engagement with primary healthcare services for disabled children in care. | Need for GP registration, initial assessment, early intervention, and regular review. Importance of early intervention and collaboration. | Lack of registration, poor transition planning, limited inclusion of disabled voices, and low health literacy. | General experiences of barriers to accessing care, discrimination in healthcare settings, lack of inclusion in decision-making and planning. | Social work, mental health, General practitioners, pediatricians, education, Disability Support Services, cultural advisors / Indigenous practitioners |
| MartinJenkins[9] (2023)<br><br>*Specialist caregiving: Structure and effectiveness of international models* | Aotearoa | Various international models including therapeutic, trauma-informed, and culturally grounded care. Includes indigenous-led models. | Models address complex needs through structured environments, trained caregivers, and multidisciplinary support.<br><br>Examples include VACCA and | Recruitment, and retention, lack of indigenous-led evaluations, and legal implications of professionalisation. | Young people can experience placement breakdowns due to lack of appropriate caregiver support, there are positive outcomes when placed with trained, | Social work, specialist foster carers, education, health, cultural navigators, advocacy and support services. |

[8] Faasen, K., Martin, G., Potiki, M., & Jenkin, G. (2023). Evidence Brief: Primary Healthcare Needs of Disabled Children in Care and Protection. Wellington, New Zealand: Oranga Tamariki—Ministry for Children.
[9] MartinJenkins. (2023). Specialist caregiving: Structure and effectiveness of international models Wellington, New Zealand: Oranga Tamariki—Ministry for Children.

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| | | | Children Safe, Family Together. | | culturally competent caregivers. | |
| Matheson[10] (2022)<br><br>*International best practice and models for youth justice residences: Summary report.* | International | 8 Prominent Models of Care:<br><br>Missouri Model (USA), Close to Home (USA), Washington State Integrated Treatment Model (USA), MultifunC (Scandinavia), Secure Children's Homes (England & Wales), Sanctuary Model (USA), Three Pillars of Transforming Care (Australia), and CARE (USA). | Smaller, home-like units, Local placement, trauma-informed approaches, Integrated models, Evidence-based practices. | Lack of standardised, evidence-informed models, variability in implementation, resource intensity, limited comparative research on long-term outcomes. | While the report does not include direct youth voice, it highlights factors that shape positive experiences such as: Strong relationships with staff, access to education and training supports future prospects, and home-like environments. | Social work and youth workers, health, psychology, therapists, education, cultural advisors, policy. |

[10] Matheson (2022). International best practice and models for youth justice residences: Summary report. Oranga Tamariki—Ministry for Children.

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| Oranga Tamariki[11] (2020)<br><br>*Therapeutic Residential Care: Evidence Brief.* | Aotearoa | Therapeutic care for children with high and complex needs. Includes trauma-informed and attachment-based models. | Focus on safety, happiness, stability, and development. Importance of tailored care and therapeutic environments.<br><br>VACCA and Halls Creek models highlight cultural safety, connection to family and community, and Indigenous healing practices. | Seclusion and restraint have negative impacts. Barriers include lack of inter-agency collaboration and culturally appropriate models. | Feelings of fear, abandonment, and re-traumatisation due to seclusion, need for meaningful connections with family, community, and culture, experiences of stigma and lack of cultural safety, especially for Māori youth. | Social work, residential care, clinical psychologists, youth workers, cultural practitioners / Māori mental health, Education, Health. |

[11] Oranga Tamariki (2020). Therapeutic Residential Care: Evidence Brief, Wellington, New Zealand: Oranga Tamariki—Ministry for Children.

### Q1: What models of health care are used in secure facilities for young people?

Only a small number of international studies have examined health care models within secure residences. This means that there is limited understanding of which health services best meet the needs of young people worldwide, and what approaches are most effective in an Aotearoa context.

Secure facilities for young people employ a range of health care models designed to address complex needs. Integrated and trauma-informed approaches, such as medical homes and therapeutic secure care, are widely advocated for their ability to provide coordinated, holistic support across mental, physical, and developmental domains.

Multidisciplinary models involving social workers, nurses, pediatricians, and mental health professionals are common, ensuring care is both comprehensive and holistic. Some systems adopt developmental and preventive frameworks, focusing on early screening and intervention to promote long-term wellbeing. Additionally, restorative justice and public health models are emerging, particularly in youth justice contexts, offering community-driven, equity-focused care that aligns with Indigenous values and relational healing however this is mostly practiced in Aotearoa and Australia.

### Q2: What are the key differences between these approaches?

Models of health care in secure facilities differ significantly in their structure, philosophy, and outcomes. Some systems rely on fragmented, crisis-driven approaches, where care is reactive, episodic, and custodial—often resulting in poor continuity and limited therapeutic value. In contrast, integrated models offer coordinated, trauma-informed care that spans physical, mental, and developmental health, supported by multidisciplinary teams. Preventive frameworks focus on early intervention and holistic development, while restorative justice and public health models emphasise relational healing, community engagement, and equity. The most effective approaches prioritise continuity, cultural safety, and youth voice, leading to more positive and sustainable health outcomes for young people in secure settings.

### Q3: What are young people's experiences of receiving health services in secure facilities?

Young people's experiences of health services in secure facilities are varied, reflecting both positive and negative aspects of care. On the positive side, many youth value supportive relationships with providers who listen, offer coping strategies, and treat them with respect. These interactions can foster trust and encourage engagement with health services. Some also benefit from skill-building opportunities and education about personal health and community resources. However, negative experiences are common and include breaches of confidentiality, being required to retell traumatic stories repeatedly, and feeling dismissed or discriminated against by providers. Additionally, many face loss of services and insurance upon leaving care, and encounter systemic barriers such as lack of documentation, transportation, and stable housing, which further hinder access to ongoing health support.

### Q4: What disciplines are essential for service delivery?

Delivering effective health care in secure facilities requires the involvement of a multidisciplinary team that can address the diverse and complex needs of young people. Key disciplines include nursing, which plays a central role in care coordination

and assessing social determinants of health; mental health professionals, such as psychologists and psychiatrists, who provide trauma-informed support and therapeutic interventions; and social workers, who connect youth to services and support transitions. Pediatricians and general practitioners are essential for ongoing physical health care, while educators contribute to developmental and behavioural support. Importantly, cultural advisors and Indigenous practitioners ensure care is culturally safe and responsive, particularly for Māori and Pasifika youth. Collaboration across these disciplines is critical to delivering holistic, trauma-informed, and equitable care in secure settings.

# Implications for practice and policy

### Develop integrated health care models

Health services should be embedded within a broader, coordinated system that includes education, social work, and housing. This ensures continuity of care and reduces fragmentation, especially during transitions between placements or into adulthood.

### Embed culturally safe and kaupapa Māori health practices

Health care must reflect the cultural identities of tamariki and rangatahi, particularly Māori and Pasifika. This includes using kaupapa Māori frameworks, involving cultural practitioners, and ensuring services uphold Te Tiriti o Waitangi.

### Ensure continuity of care beyond age 18

Health care should not end when young people leave care. Systems must provide ongoing access to primary and mental health services, with clear transition planning and support into adult services.

### Prioritise Trauma-Informed and Strengths-Based clinical practice

All health professionals working in secure settings should be trained in trauma-informed care. This includes recognising the impact of trauma, avoiding re-traumatisation, and focusing on young people’s strengths and resilience.

### Strengthen multidisciplinary health teams

Effective care requires collaboration between nurses, mental health professionals, paediatricians, social workers, and cultural advisors. These teams should be well-resourced, trained, and supported to work cohesively.

### Improve access and equity in health services

Health care delivery must address systemic barriers such as lack of documentation, transport, and discrimination. Services should be designed to be accessible, inclusive, and equitable for all young people, especially those with disabilities or from marginalised communities.

### Monitor health outcomes and service quality

Implement better interagency data to track health outcomes, service access, and equity across different groups. This data should inform continuous improvement and ensure accountability in health care delivery.

**This report was prepared by Strategy, Insights and Performance, Oranga Tamariki. For more information, please email the team: research@ot.govt.nz**