Diego Ottolini

The Family Conferencing

A Ground-breaking Practice for Community Based Child Protection in Kenya

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A retrospective exploratory study on 73 family group decision making conferences for children referred to institutional public services in Kenya to investigate the short, medium and long terms conference outcomes on child's safety, permanency and wellbeing

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Nairobi-Kenya

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P.O. Box 850-00606, Nairobi (Kenya).
diego.ottolini@libero.it

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ACRONYMS AND ABBREVIATIONS

ACRWC	African Charter on the Right and Welfare of the Child
CA	Children Act
CEFA	European Committee For Agricultural Training
CPS	Child Protective Services
DCO	District Children Officer
DCS	Department of Children Services
FC	Family Conferencing
FGC	Family Group Conference
FGDM	Family Group Decision Making
FGM	Female Genital Mutilation
GOK	Government of Kenya
ILO	International Labour Organization
MDG	Millennium Development Goals
NCRH	Nairobi Children Remand Home
NGO	Non Governmental Organization
OAU	Organization of African Unity
UNCRC	United Nations Convention on the Rights of the Child
UNICEF	United Nations Children's Fund
VCOs	Volunteer Children Officers

ABSTRACT

This research illustrates the findings of a retrospective analysis on 73 Family Group Decision Making (FGDM) conferences conducted in Nairobi (Kenya) between July 2005 and January 2008.

The conferences addressed the well-being of 73 children referred as welfare cases by the Nairobi Children Remand Home, a temporary government residential centre for children pending adjudication or final disposition by the Nairobi Children's Court.

Families were invited to participate in the decision-making process, engaging both the maternal and paternal sides together with various partners from their local communities.

This was done in response to concerns on a legislative gap of the Kenya Children's Act 2001 (cap 586) which recommends speedy exit of children from Remand Homes without stipulating the exit strategies to be followed. As a result, the child's repatriation order used to be carried out with inadequate case assessment and ineffective institution-centred case planning.

Since no testing had ever been done locally on family conferencing models, the research question analysed the relevance of the FGDM in an African context and evaluated its impact on the target group of children 24 to 54 months after their family reintegration through the conference by asking: "How does the Family Group Decision Making Model respond to the risk factors of children in need of care and protection held in the Kenyan Juvenile Justice System and how does it contribute to strengthen their resiliency within the family and community?"

In response to the question, the study

- provides an in depth overview of the risks assessment analysis utilized for the experimental group of 73 children home reintegrated using the FGDM model. It identifies their most prevalent risk factors and accumulation;
- describes the FGDM model applied in an African urban context, being a culturally sound tool able to respond to the identified risk factors and to prompt positive transformation in families through community support;
- explores the 73 FGDM conferences to evaluate its effectiveness as a community-based protective service for children at risk through a longitudinal analysis of all cases to identify the conference short, medium and long terms outcomes by looking at the post-conference child's safety, permanency and wellbeing.

Data was collected by examining case files, meeting notes, records from the FGDM such as the Family Statement of Commitment, besides follow-up visits and progress reports. The USA Federal Administration for Children and Families (ACF, 1999) performance indicators coded into categories representing the main 3 domains of permanency, safety and wellbeing were used to gauge the impact of the FGDM as a family reintegration model.

The methodology is explorative since this is the first long-term follow-up study of FGDM done in East Africa to date.

The study results indicate elevated exposure to unsafe life conditions among children of the experimental group with most cases having critical accumulations of risk factors. The emerging risks profile of the experimental group provides a useful guide to some of the salient risk factors which relate to child vulnerability. By unpacking links to child's psychosocial outcomes, the study also suggests that, being under constant emotional threat by the caregiver is the primary aggregate which quantifies most of the differential risk factors effects, followed

by child's exposure as victims of abuse or unsafe conditions. Consequently, the study hints to practitioners to improve child's resilience and permanency through effective interventions primarily by supporting families in dealing with the identified accumulation of risk markers.

On the FGDM model, the study indicates that it as an effective planning approach for families involved with the public child welfare agency by facilitating family and community participation at the conference and with case planning. Through the FGDM, the family group appears to offer a tremendous amount of support including placement options, respite care, and material assistance. This reinforces the suggestion that the FGDM may be effective in linking relatives and reinvigorating support networks for family decision-making, and thereby restore confidence in the traditional extended family system, still recognised by parents as their primary partner in child care. In this sense, the FDGM positions the *family group* as leader in decision making on children's safety, permanency, and well-being, increasing the likelihood of networking with communities to identify unique strategies and resources to face different types of risks.

In relation to child's welfare, the study indicates a greater permanency rate of children in justice exited from institutional care through the FGDM conference than through the standard repatriation procedures applied by the Kenyan Juvenile Justice system. Children who had a conference experienced high rates of family reunification, lower rates of relapse and a 20% higher long term successful permanency compared with the control group. Risk accumulations in children's life appeared to be addressed and reduced as a result of FGDM plans, with a positive impact on the long-term wellbeing of most children in the experimental group. These findings generally remained stable as long as 24 to 54 months post-conference.

Ultimately, family conferencing appears to be an innovative and effective approach to move beyond the metaphor of the child protection pendulum still unevenly swinging in Kenya from institutional to family care.

In particular, it brings an improved reintegration model for children held within the Kenya Juvenile Justice System by providing a clear protocol or method for involving families in case planning and management, in a context where public child welfare services fall short of adequate strategies to ensure child, parents and community participation in exiting children from statutory institutions.

Consequently, the study findings are used to influence attitude change and national reforms of the repatriation model currently applied by the Kenya public institutional services.

Being locally applied, the FGDM model would need to be integrated into a whole-of-system approach if it were to be used appropriately and effectively. From this perspective, FGDM could become a process of state-supported family self-regulation that seeks to avoid escalation up to a more coercive regulatory response of decision-making processes unilaterally imposed by the state.

INTRODUCTION

This paper is the result of a study based on data collected through the Children Safety Nets project implemented by CEFA Ngo within the Nairobi Children Remand Home (NCRH) between July 2005 and May 2011, in partnership with the Department of Children Services, Kenya (Ministry of Gender, Children and Social Development). At the project inception, the NRCH was greatly relying on a child protection system which was drifting apart children and their communities. Reframing the institutionalisation approach towards family and community based care was the response to a situation which had come from far and had created a wide rift between institutional and field protective services. In mid 1980s, statutory child protection services throughout Kenya were already struggling to cope with ever-increasing numbers of referrals of children at risk of mistreatment, abuse or *in need of discipline* as institutionalization had been adopted as the preferred protective response. This widespread approach heavily affected child protection practices, ending up in children separated from their family and community, with the outcome to cast child protection services as the *expert* and to alienate essential community partners and families from a collaborative approach to the prevention, support and protection of children.

Besides, while in the child protection systems of most western countries, the occurrence of child maltreatment seems to be substantiated in only 40 to 50 per cent of notifications which are directly investigated (Little, 1995; Tomison, 1996; Armytage et al., 1998), in Nairobi Province clinical practice was showing the opposite, with only a small proportion of child abuse and neglect cases notified, referred and handled with appropriate interventions. Oddly enough, the inadequacy of the local protection system seemed also resulting in a substantial

proportion of children referred to private or government institutional services to be cases from families not being maltreating their child but affected by more generic problems, such as unemployment, financial or housing difficulties, an incapacitated caregiver, or serious illness and stress problems. Other cases were also referred for institutionalization being inappropriately labelled as alleged child misconduct. Such cases needed assistance but did not require child institutionalization. The inappropriate labelling of cases as child abuse, neglect or in need of discipline, further taxed generally limited child protection institutions where children were held for excessive span of time, being separated from their families and communities and with provision of inadequate psychosocial support.

Hence, the accurate identification of children who have experienced, or are at risk of, significant harm was recognized to be a primary concern for caseworkers operating in child protection. As a result, suitable case assessments and appropriate exit strategies appeared to be the major gap the project was encountering within the institutional services. On one end, referred cases were not being properly screened out by field protection services, while on the other end, though serious enough to warrant an investigation and an assessment, many institutionalized cases were left unattended and dropped by haste repatriation, hence reinforcing a vicious cycle of relapse. Accordingly, the appropriate identification and disposal of children who had experienced, or were at risk of, significant harm became a fundamental concern. Adequate assessments became critical for shifting scarce available resources away from cases not in need to those affected by significant harm and to focusing on effective interventions in terms of meeting child and family needs. Further concerns in relation to both *gatekeeping practices* and the nature and availability of broader preventive and early intervention services in the community started off an intervention on protective services delivery at field level.

Under these circumstances, the project developed appropriate risks child and family assessments and piloted the family conferencing model, in order to deliver responses matched to child and family needs and effectively reintegrate children back to their communities.

CHAPTER ONE

EXPLORING THE SHIFT FROM INSTITUTUONAL TO FAMILY-COMMUNITY BASED CHILD PROTECTION SERVICES

1. BACKGROUND INFORMATION ON THE KENYA CHILD PROTECTION POLICY AND PRACTICE

In Kenya, the past decade has seen major changes on how child welfare practitioners think about the needs of children and how children should be served. This evolution has resulted in refined definitions of best practice and a challenge to policy makers and practitioners to do a better job for children.

As in the eighties and nineties institutionalization was believed to be the best response to children in need, at the turn of the century, while the country struggled with rising numbers of street children, orphans and children at risk, mainstream organizations gradually began to reconsider institutionalization, and called for renewed attention to family and community child care, borrowing from the African tradition and practice. This was in response to the domestication of the UNCRC which Kenya signed on 26 January 1990 and ratified on 30 July of the same year. A decade later, on 25 July 2000, Kenya ratified also the African Charter on the Right and Welfare of the Child. Accordingly, the Kenya government formulated a set of specific laws, regulations, policies and guidelines related to child protection issues. In particular, the

landmark Children Act (2001) represented a shift towards government policies which promoted efforts to prioritize the safety of various categories of vulnerable children through a variety of services rather than focusing exclusively on children in justice. In this legislative context, custodial care of children in justice and in need of care and protection became also regulated (CA. Part V; Part VII and National Standards, 2003). By recommending exiting of children from residential rehabilitation institutions after a maximum of three years the Children Act paved the way for deinstitutionalization, however, it stipulated no exit strategies thereof.

Meanwhile, as the legislative set up and the definition of best practices was evolving, the needs of families grew more complex and the child welfare system was stretched thin and not able to keep up with the multiple needs of children. It became clear to policy makers that more attention needed to be paid to the root causes of child abuse and neglect through active efforts aimed at prevention and intervention with children and families. As a result, reforms slowly entangled the Department of Children Services (DCS) and its institutionalized child protection system.

In August 2005, a stakeholders' forum spearheaded by the DCS was held in Nairobi, launching the initiative of drafting a document on exit strategies for institutionalized children, realizing that most of the practice was not documented and where present, it was very sketchy, and offered no clear guidelines to the reintegration process. The document (DCS, Consultative Forum on Exit Strategies, 2006) aimed at providing an overview of what was existing and wanted to improve the collective understanding and ability to develop and implement sound exit strategies. Based on individual organization practices, it documented community based and residential rehabilitation approaches and made recommendations. Though never published, the document provided a forum of reflection both for Government bodies and Civil Society Organizations to gradually consider shifting from institutional placement practice to policies and programs focused on timely home-based care.

Since then, at policy level, consensus has been built on family and community care, recognized as the most-rewarding strategy to reduce the high rate of children drifting in institutional care, highlighting the connection between child welfare and family preservation. In fact, though swift child removal and termination of parental rights may be needed under extreme circumstances, for most children the situation has been more complex and major service providers have been realizing the need to work with families to respond to child's long-term developmental needs while providing for the child's immediate safety.

In the process, a critical component has been the re-establishment of the traditional notion of family, which includes the network of extended family bonds, friends and neighbours.

In support of the policy of non-institutionalisation, Kenya began witnessing key programmes put in place to provide community-based alternatives for rehabilitation, support and development of children. These programmes have strived to demonstrate viable community alternatives to institutional-based care. The success of these programmes however, has been hindered by a myriad of direct and underlying constraints mainly at the community level. The constraints include inadequate service provision capacity by the government at field level as well as instability of the family set-up because of accumulation of risk factors, which remain a stumbling block to retention of children within the community.

To date, family reunification has become the advocated choice while institutionalization is believed to be the last resort. Yet, regardless of this general notion, the common child protection practice lags behind and changes so far are only partially captured, as the local legislation (Children Act, 2001) also needs amendments to refocus on family-based care as opposed to institutionalization. As a result, the proliferation of Children Charitable Institutions concentrated in the same geographical areas appears to be a symptom of a culture nevertheless leaning to-

wards children institutionalization rather than community and family-based care, keeping the welfare practice swinging between child institutionalization and family preservation.

2. PROBLEM STATEMENT

Nairobi's county population is currently about 3.138.000 million (KNBS, 2010) against the 1993 estimate of about 2.5 million people and, with an estimated 4% annual growth rate (CIA – The World Factbook, 2010), it has one of the highest growth rates in the world.

Primarily because of an unforeseen and unplanned demographic explosion, Nairobi has faced severe problems in coping with urbanization, a result of the heavy movement of indigenous Africans from rural areas to the capital city to escape rural poverty. This migration set in motion Kenyans, as they were being driven from their homes by landlessness, drought and unemployment. As a result, a sprawling collection of slum settlements currently spreads over the outskirts of Nairobi, including the areas of Kibera, Mathare Valley, Huruma, Dandora, Kariobangi, Korogocho, Mukuru and Ngara. These low income areas account for half of Nairobi population, children from 0 to 14 yrs being in the forefront, representing a critical 43% sub-set of the entire population and of the city residents (KNBS, 2010). Furthermore, they are one of the groups whose rights have been marginalized, either violated or abused. They bear the brunt of poverty, ethnic clashes, sexual abuse, denial for education, hunger as well as domestic violence and the impact of HIV and AIDS. Consequently, the number of children in need of care and protection present in the city is dramatically high. Street children are a specific concern as they are defined by the The United Nations to include "any boy or girl… for whom the street in the widest sense of the word… has become his or her habitual abode and/or source of livelihood, and who is inadequately protected, supervised, or directed by responsible adults" (Panter-Brick, C., 2002). In the Kenya context,

they can be more specifically defined under four categories:

a) Children who work and live on the street full time gathering in groups in temporary makeshift shelters or dark alleys.

b) Children being in the streets by day to work, have fun, and spend time or due to overcrowding in their homes, but link up with their families in the evenings. They constitute the majority of street children.

c) Street families' children, whose parents (sometimes adolescents themselves) are also on the streets.

d) Children who are on the streets occasionally, for instance, having run away from home or moving out at weekends and during school holidays. These are often victims of domestic violence, abuse, discrimination or severe parental neglect. It is difficult to obtain exact figures of how many fall into this last group, but estimates from clinical practise indicate that their number is continuing to increase year on year, with no sign of rebate.

According to recent research, currently there might be between 250,000 and 300,000 children living and working on the street across the country, with more than 60,000 in Nairobi alone (CRADLE, The Undugu Society of Kenya, 2003).

In Kenya, existing responses for them have been usually inclined towards institutional rather than community-based care as they are rescued and put in institutions which are run by the government, NGOs, Community or Faith based organizations. After admission, a cycle of dependency for them and their families is often triggered preventing adequate reintegration. Lack of family involvement, working in isolation from communities of origin and misconceptions on child developmental needs foreclose the identification of proper exit strategies. Hence, children's long term detachment from their families and com-

munities deprives them of their roots, enhances an identity crisis and renders them less prepared for life outside the institution. Moreover, children in justice, admitted into statutory institutional care, are surrounded by an ubiquitous stigma which hinders the retention process as they feel ostracized.

This study finds its way into the Kenya child protection system unevenly swinging between the advocated family-community care and the still predominant institutionalized care, by analyzing practice and data drawn from a 6-year pilot project (2005-2011) focused on the Kenya Juvenile Justice System reforms carried out by the CEFA NGO in partnership with the Department of Children Services.

Indeed, the situation of Children in Justice has been an excellent setting to identify institutional child protection systems gaps and pilot best practices in relation to case management and child's reintegration. Due to the inadequate legal framework, limited infrastructure and scarce human resources, both children in conflict with the law and in need of care and protection still equally fall into the Juvenile Justice System at disproportional rate. They are targeted by the Kenya government through 25 children statutory institutions, eleven being Children Remand Homes. According to the Children Act (Sec. 50), a Children's Remand Home is a temporary protection centre, under the administration of the Children's Department, in which children stay pending adjudication or final disposition of their cases by the court. They include child offenders as well as any kind of rescued child such as children lost and found, street children and runaways. Some of them have physical or mental disabilities. The current facilities do not separate the different categories by reasons they came into remand and provide inadequate environments such as child friendly spaces or integrated psychosocial support in education and protection.

The study analyses cases found in the Nairobi Children Remand Home between July 2005 and January 2008 among a population made mainly of male children (mean 67.5%), as table 1 shows.

Table 1: NCRH children subdivided by gender

CHILDREN ADMITTED AT NCRH	MALE	%	FEMALE	%	TOTAL
YEAR 2005	333	68.4	154	31.6	487
YEAR 2006	442	65.7	231	34.3	673
YEAR 2007	294	68.5	135	31.5	429

A further subdivision by category shows that in the government financial year 2007-2008, out of all admitted children, 76.5% were in need of care and protection, while the remaining 23.5% were in conflict with the law. Similarly, in the year 2008-2009 the proportion was of 69.8% against 30.2%.

At the project inception, the Nairobi Children Remand Home used to apply three basic methods on child reintegration:

1. Home repatriation for children in conflict with the law or for rescue cases acquitted by Court order, through caregiver picking the child at the institution or at the Court, or through children officers who accompany and leave the child at his/her home with no other concurrent intervention.
2. Statutory Rehabilitation for child offenders committed to Borstal Institutions or Rehabilitation Schools by court order. The court committal curtails the child's freedom for a defined period that cannot exceed three years.
3. Residential Care and/or Rehabilitation referrals to Private Residential Care Centres for further treatment.

Due to the prevalent situation, the disengagement of a child from the Remand Home was affected by a number of challenges:

- Caseworkers had scarce capacity to detect and prioritize cases in risk-related groups in order to identify danger signals, and avoid inconsistency in their management.
- It didn't involve the child's family, hence violating the child's basic right to protection, development and parental care.

- It didn't' involve the community, hence hindering the cultural principle that a child belongs to it.
- It was focused on the needs of the institution to decongest the structure rather than on the need of the child to reintegrate back to society.
- It was unduly delayed hence prolonging the child's institutionalisation.
- It was an expensive delivery service to the family due to the high frequency of relapse rather than a community based strategy which could make it sustainable.

Hence, a sound reintegration model was needed to

- protect the right of the child to parental care;
- enhance the child sense of belonging to the community;
- enhance community ownership over the child;
- nurture the child in a safe environment to achieve quality personal development;
- disengage the child from institutional services or welfare programmes, and
- enhance sustainability of the rehabilitation process.

Provision of reintegration services needed to take into consideration this composition and it necessitated the identification of a model which could help the Juvenile Justice System to apply appropriate exit strategies, alleviate the limited infrastructures and increase the likelihood that given services would be more culturally appropriate.

The provision of a model able to expand the definition of family and its commitment to engage in the case management process was the concept behind the application of the Family Conferencing (FC), being one distinctive way to address the protection of children's rights in the context of a permanent connection with families. As practiced for children held in the Nairobi Children Remand Home, it was tested as an exit strategy to enhance the family protective network surrounding the child and provide for immediate safety, long-term family permanence and parental connections.

3. JUSTIFICATION

The rationale of this study arises from the fact that there is no research on the coverage of institutionalized children's family reintegration models in Kenya.
By analyzing cases of children exited from the Juvenile Justice System, it proposes to close gaps which other studies have not accomplished and to add literature to related research, by focusing on a specific family and community based reintegration methodology and testing its impact for analysis of innovative practice.

The enactment of the Children Act (2001) had brought a new approach to children held within the Kenya Juvenile Justice System, in particular for what concerns the rights of those in need of care and protection, however it had left room for major gaps. On child's reintegration, it recommends exit of children from remand homes but it doesn't purport to define any period which would qualify as amounting to "without unnecessary delay" (Children Act, Fifth Schedule, 12 (1)). It is more specific for child offenders who can be kept in custody for a period not exceeding three months or until attaining 18 years of age, while capital offenders can be in custody up to six months or one year (Fifth Schedule, 10(4)). However, it doesn't stipulate the exit strategies that should be followed and, along the years, practice has also been unable to develop child friendly and effective methodology to achieve timely reintegration and appropriate retention of children by the family and community.

In response to this vacuum, an alternative family-community based reintegration approach was piloted through the Family Group Decision Making (FGDM) being a variation of the Family Conferencing model. Being an innovative decision-making strategy for child welfare cases, research was needed to explore the impact of the FGDM model and evaluate its outcomes on the experimental group of children being reintegrated with their families and communities to regain high level of personal and social functioning.

The Nairobi Children Remand Home was chosen being the entry point of a wider pilot programme targeting the national reform of Kenya statutory institutions, and therefore a possible agenda setter on this issue. As Wenje and Bwire (2000) argue, placing children as the focus of collecting data and information was part of the effort of putting children in the focus of social policy.

4. PURPOSE OF THE STUDY

The purpose of this study was to obtain data in order to explore family and child risk factors and their accumulation, being precursors to institutionalization of children in the Nairobi Children Remand Home and to evaluate how the FGDM model provides the relevant actors of deinstitutionalization, namely the child, the family, the community and the state, with an effective tool for decision making and provision of services to such children through strengthening family and social networks to protect their welfare within the natural family and community.

5. RESEARCH QUESTIONS

The research question which led to the present study analyzes the effectiveness of a methodology used in the reintegration of institutionalized children back to their family and community by asking:

How does the Family Group Decision Making Model respond to long term safety, permanency and wellbeing needs of children admitted at the Nairobi Children Remand Home and threatened by accumulation of risk factors?

The following questions expand the main query and draw further from the study objectives.

In relation to the children's and families' risks factors:

1. What are the main risk factors and their accumulation affecting children admitted in the NCRH and reintegrated through the FGDM conference?

In relation to the FGDM conference immediate, intermediate and long term outcomes:

1. What are the patterns of usage related to timing, format, purpose, and facilitation of the FGDM used for families with children in institutional care?
2. Who attended the conference, in terms of the composition of the family system, its support network and of service providers?
3. Who was involved and at what degree in the FGDM's plan formulation and implementation?
4. What was the content of the FGDM conference both in terms of topics discussed and core domains included in the FGDM plan?
5. What are the processes by which plans were monitored and revised?
6. Were there any substantiated relapses or re-referrals over the long term?
7. Was there any increase in parental reunification or relative care placement options at and after the FGDM?
8. Was the child's placement stability achieved over the long-term?
9. Were the child's long-standing safety, permanency, and well-being achieved?

6. OBJECTIVES OF THE STUDY

This study attempts to identify risk factors and their accumulation in children committed to institutional care in the NCRH by the Nairobi Children's Court and the effectiveness of the FGDM model in relation to their family reintegration and outcomes. It also creates a profile of average practice on the use of Family Group Decision Making Conferences.

In relation to the children's and families' risks factors, the study developed a risk factors analysis across all the experimental group cases having the following short and long term objectives:

1. Establish the risk factor profile of children reintegrated through the FGDM model.
2. Improve the ability of workers to detect and prioritize cases in risk-related groups prior to the FGDM in order to identify danger signals, and avoid inconsistency in the management of cases.
3. Help classifying situations where FGDM has been utilised.
4. Help determine the appropriate priorities within the FGDM conference.
5. Promote FGDM consistency in addressing issues identified as risk factors and subsequent community and family centred service provision.
6. Provide scientific knowledge for workers' training and supervision.

In relation to the FGDM conference specific objectives were:

1. Establish the incidence, timing and frequency of a sample of Family Group Decision Making conferences.
2. Gather information regarding the format, purpose and attendance from a representative sample of Family conferences.
3. Determine the degree to which Family Group Decision Making conferences result in plans that address children's risk factors and respond to their safety, permanence and well being.
4. Determine the degree to which Family Group Decision Making conferences achieve significant family and community members' involvement in planning and intervention, including service delivery, monitoring and evaluation.
5. Understand the extent to which follow-through occurs and the processes by which plans are monitored and revised.
6. Measure the FGDM model impact by adopting criteria referred to its short, intermediate and long term outcomes and by analyzing multiple aspects of the process in order to establish the feasibility of the FGDM approach being used in cases with high-risk factors accumulation.

7. HYPOTHESIS

1. Institutionalization of children in the Kenya Juvenile Justice System is less related to the child risk profile than to the dysfunctionality of their family system.
2. Appropriate Risk Assessment helps practitioners to explore more explicitly with families what needs to change if children are to be kept safe and experience healthy outcomes.
3. The variables for assessing children in the contexts of their families are so complex that greater consistency in decision-making by professionals is the cornerstone of best practice only in conjunction with families' decision making.
4. Families' decision making through the FGDM is applicable and has beneficial effects on vulnerable children and families with both low risk profile and highly dysfunctional system due to accumulation of risk factors.
5. The FGDM is a culturally sound tool which facilitates the strengthening of dysfunctional family through social networking.
6. FGDM enables professionals and family to identify more precisely actions, resources and services needed to diminish the identified risk factors and boost the strength and range of child protective factors.
7. The greater is the implementation of the FGDM resolutions, the higher is the child's permanency (retention) in the family.
8. The greater is the involvement of the community in the FGDM conference, the higher is the child resiliency after exiting the institution.
9. In most cases the decision-making involved in the FGDM and its management can prevent child's relapse, protect children from abuse and enhance their wellbeing.
10. Families who experienced FGDM are significantly more likely to receive certain services for children and caregivers than families who do not experience FGDM.

8. SIGNIFICANCE OF THE STUDY

Even after the enactment of the Children Act (2001), inadequate child case management and institutionalization practices have continued unabated in Kenya. This indicates that child protection services in place to deinstitutionalize children are not sufficient or efficient. Also, most Civil Society Organizations have maintained their traditional approach of perpetuating children separation from their families and communities. Thus, this study seeks to awaken and highlight existing gaps and to provoke the relevant policy makers and practitioners to explore models that facilitate protection of the best interest of the child within the natural family and community.

9. ASSUMPTIONS

1. The Nairobi Children Remand Home, being the institution which held the children, will allow for gathering of data.
2. The researcher will maintain confidentiality on the investigated cases.
3. Parents of reintegrated children will allow for further data collection.
4. The sampling and the research method will be scientifically correct.

10. SCOPE AND LIMITATIONS OF THE STUDY

The study was conducted in the Nairobi Children Remand Home and targeted 73 children reintegrated through FGDM conferences comprised between July 2005 and January 2008.

Among the two main categories of children admitted into the Remand Home, the study focused on those committed by the Nairobi Children Court being in need of care and protection.

The Children's Act (2001) - Section 119(1) defines as being in need of care and protection the child

- Who has no parent or guardian or has been abandoned by his parent or guardian.
- Whose parent has been imprisoned or whose parents/guardians find difficult to take care of.
- Who is homeless or a beggar.
- Who is getting into bad company.
- Who is prevented from receiving an education.
- A girl who is likely to be forced into female circumcision or early marriage.
- Who is forced to practice customs which are harmful to his life, education and health.
- Who is being kept in an overcrowded, unhealthy or dangerous place.
- Who is exposed to domestic violence.
- Who is pregnant.
- Who is terminally ill, or whose parent is terminally ill or who has a disability and is being unlawfully confined or mistreated.
- Who is engaged in the use or trafficking of drugs or any other substance that may be declared harmful by the minister responsible for health.
- Who does work that could harm his/her health and development or could interfere with education.
- Who has been a victim of a sexual offence.

The selected target group included children with the common feature of having been rescued from Nairobi streets by police or well-wishers. Most of them had ended up in Nairobi Children Remand Home from the Nairobi Children Court after being held in police stations. A small group had been brought to Remand Home directly by Children Officers from the Children Department H/Q in Nairobi. The FGDM conference was applied only for children coming from the Nairobi region. It couldn't include children from other geographical areas due to the excessive complexity of such cases in relation to distance, communication and follow up.

CHAPTER TWO

LITERATURE REVIEW: WHAT HAS BEEN SAID ON CHILDREN IN JUSTICE

1. REVIEW OF INTERNATIONAL AND LOCAL LEGAL AND POLICY FRAMEWORKS ON CHILDREN RIGHTS

The passage of the 1948 Universal Declaration of Human Rights was the first document that recognized the rights of the child. Though it was not specific, it did recognize the child's rights as a human being. Earlier, the world had witnessed the installation of other instruments such as the Minimum Age (Industry) Convention in 1919 that defined 14 years as the minimum age for children to work in the industry. This was followed by the 1930 International Labour Organization (ILO) Convention No 29 that called on the suppression of use of forced or compulsory labour.

Since then, there have been other legislative landmarks, which addressed the rights of children either specifically or in general. These include the 1966 International Convention on Civil and Political Rights, The International Covenant on Economic, Social and Cultural Rights, and the ILO Minimum Age Convention No 138 passed in 1973.

The most substantive legislative landmark, which remains a milestone for the world's children, was the adoption of the Convention on the Rights of the Child (CRC -November 1989) by the United Nations' member states. The convention is also unique as it is the first human

rights instrument to specifically address children's issues. It defines certain principles to guide political decision-making affecting the child. The convention stipulates that any such decisions should take into consideration the best interest of the child. The convention became an international instrument on September 2, 1990, and since then, 191 countries have ratified it. This is with the exception of the United States and Somalia.

The African Charter on the Rights and Welfare of the Child (ACRWC) is an instrument of the former Organization of African Unity now transformed into the African Union. The OAU members adopted it in 1990. The charter defines the right for the child, but it goes further to contextualize them to the African situation. The argument is that the African child lives in special circumstances some of them far different from other children. Hence, his or her rights need to be defined in such a context. The rights in this charter, however, do not differ significantly from the ones in the CRC. The ACRWC is the first regional treaty protecting the civil, political, economic and cultural rights of children. Its provisions on juvenile justice, enshrined in article 17, apply to all children under the age of 18.

According to Murungi (1988), in Kenya the first legislation dealing with children was the Custody of Children Ordinance (1926) which applied only to the European settlers' children. African children were treated according to various customary laws, while Muslims were under Islamic law. In the early 1960s, with independence, Kenya's formal child protective system developed specific legislation addressing children's issues by including the Children and Young Persons Act (Cap.141) the Guardianship of Infants Act (Cap.144), and the Adoption Act (Cap.143).

In the 1990s, the Kenya Government directed the law reform commission, which had been formed in 1984, to look into children's issues and ways of implementing the Children Rights Convention. Following its ratification by Kenya in 1990, a concerted effort ensured its domestication. The commission formed a task force, which began work in 1991.

In 1994, the task force recommended the enactment of the Children's Bill. After deliberations involving all the stakeholders the task force drafted a new Children Bill, which in early 2002 was enacted into law and became an Act of Parliament. It is cited as the Children Act 2001. With it, a Children's Court was set, which is a subordinate court to the High Court of Kenya, and has a presiding magistrate. In addition, the Chief Justice gazetted 73 magistrates to handle children cases throughout the country.

Besides the UNCRC and ACRWC, Kenya also ratified the Hague Convention on Inter-Country Adoptions, Perlamo Protocol, the Millennium Declaration 2000 on MDGs as well as the ILO Conventions 138 (minimum age) and 182 (worst forms of child labour), among other international instruments on children. These treaties prohibit specific and general aspects of violence against children and have been domesticated in Kenya under different pieces of legislation such as the Employment Act, the Sexual Offenses Act, Trafficking in Persons Bill, the Education Act and the Female Genital Mutilation (FGM) policy adopted in June 2010.

The national legislation and regulations are to a certain extent clear with respect to the handling of juvenile cases, but there are serious issues with understanding the provision, its compliance and enforcement.

There is comprehensive legislation in relation to child sexual abuse. The Act grants children at risk of sexual abuse, or subjected to or witnessing sexual abuse, with certain rights, e.g. to file complaints and to have those complaints resolved. The legislation provides services to children who are at risk of or subjected to sexual abuse.

Corporal punishment has been outlawed in schools and is prohibited upon child offenders by the Children Act, section 191(2). However, the Prison Act, section 55(1) and Part VI Rule 72(a) allows the administration of corporal punishment on child offenders under the age of sixteen years. On the contrary, The Criminal Law Amendment Act, 2003 outlaws corporal punishment.

Custodial care of children in justice and in need of care and protection is regulated by the Children Act in a number of sections (e.g. Part V e Part VII). Institutional custody of children in justice is furthermore regulated by the National Standards.

2. LITERATURE REVIEW ON JUVENILE JUSTICE IN KENYA

In Kenya, much has been documented about the juvenile justice system and, in particular, concerning statutory children institutions over the years. An annotated bibliography of research (Mugo, J., Musembi, D., Kamau-Kang'ethe, R., 2006) spanning from 1958 to 2005 lists 38 key documents covering the area under review. The vast majority of research is represented by theses, papers, articles and books, but this rich collection of data including results findings and recommendation has hardly been availed to practitioners or policy makers and it has remained within the university/college libraries.

Four major thematic areas and final recommendations are outlined by the above body of research:

a. Historical background of the juvenile justice system in Kenya

According to research, it appears that a substantial amount of historical information is unaccounted for reconstructing the development of approved schools and juvenile remand homes in Kenya. However, there is an agreement that the history of the Kenyan juvenile justice system dates back to the colonial government. Mugo (2004) traces the origin of the children rehabilitation system at the beginning of the past century and notes that the first rehabilitation institution was built at Kabete (near Nairobi) between 1909 and 1912 to cater for antagonistic and deviant children and youth who were in conflict with the colonial law. The most common charge was failing to register and carry identity cards. Several other Approved Schools came up in the late 1950s

(Colony and Protectorate of Kenya, 1958) , also to cater for rising numbers of children having been orphaned as a consequence of the Mau Mau war.

Similarly, the history of the Department of Children Services dates back to the colonial time when it was known as the Juvenile Correctional Institution, as it was meant to deal with administration of Approved Schools. Only in 1955 their management was transferred from the commissioner of prisons to a new department specifically created under the name of Department of Approved Schools. It was not until 1969 that this Department was re-named the Department of Children Services. According to Mugambi (1988), in the 1970s the functions of the Department of Children Services were to investigate cases of children both being in need of care and protection and delinquent. It was also supposed to train, discipline and finally settle them back to society through after care once released. However, it is only in the 1990s that, following the ratification of the UNCRC by Kenya, the DCS started considering child welfare interventions outside the scope of statutory institutions. In spite of the advancing children rights reform wave, by the year 2000, the government had not evolved any eligible strategy to tackle the national crisis affecting vulnerable children, as those in need of care and protection were simply arrested and charged with vagrancy, loitering and related misdemeanours. The Court environment was also hostile and made particularly difficult for sexually abused children (Namwamba, A., 2001).

b. **Establish socio-demographic characteristics of children in the Juvenile Justice system.**

Human Rights Watch (1997) analysed the hardship of street children, including detention in statutory institutions. Various types of street children were identified, majority of them being from single-parents households or living with a relative before deserting their homes. Some had left on their own choice due to the inability of their families to provide and care for them or for tense relationships with parents, others had been abandoned or orphaned. Most of them were 1st, 2nd, 3rd born

in families ranging from 1-12 siblings (80.8%), while only 4.7% were last borns (Maru, 1988). Another study (Ndirangu, L.N., 2001) found that most of institutionalised children were from broken families. Parents were low income earners, most of them working as casual labourers, watchmen, barmaids with scores being jobless. A baseline report made by Save the Children UK in 2002 (Gitau, J.K., 2002), found also that children being in government institutions were victims of HIV/AIDS, child abuse and neglect, poor parenting and peer group influence. By the year 2004, a survey (The Cradle, Rajjn, 2004) established that most children appearing before the court were from the street, informal settlement or from female-headed households. Other contributing factors were displacement due to ethnic conflicts, demolition of slum dwellings, abusive environment and lack of clear child protection policies.

Research done by the Kenya NGO-CRC Coalition (2001), found that, in 1997, 85% of the children exposed to juvenile justice didn't deserve to undergo the criminal process. Only 15% of them had committed serious offences. Out of 1863 children taken to the Nairobi Juvenile Court in that year, about 80% were charged with vagrancy and in almost 60% of the cases, the court had not indicated what the child had done. Another study (Wakanyua, S. N., 1995) analysed the population of four approved schools and gave a profile of the children held at that time. 63% of them had both parents while 32.2% were brought up by single mothers. Other studies linked delinquency to problematic socio-economic backgrounds. In 1992, the Kenya Medical Association (Muita, J., Nduati, R., et al.) established that orphanhood was a problem in Kibera slum and it was associated with antisocial behaviour. Other studies found that the majority of child offenders came from poor or broken families and for those who lived in Nairobi, 62% came from slums areas, while 64.4% of the respondents had dropped out of school. Petty theft was the most common offence, attributed to negative peers and poverty (Nyamato, R.K., 1997). About their mental health, a study (Gitang'i, A.S.M., 1987) done at the Kabete Approved School found that 24.7% of the boys displayed some sort of psychiatric morbidity. The most common cases involved neurotic depression,

hypochondriasis and anxiety neurosis. According to Maru (1988), the high prevalence of morbidity was attributed to low socio-economic status, poor family support system, low education levels and substance use. Majority had low ambition for their future, hoping to get manual jobs. Few aspired for other careers demanding high professional attainment (Nyamato, R.K., 1997). After leaving the institution most were unable to get formal employment, lacking adequate qualifications, skills and resources. Stigma crippled their reintegration into society. Most parents admitted to never visiting their children in the institution.

c. Impact of the statutory institutions rehabilitation process

Research shows that case assessment, treatment and reintegration to society were not understood as a concept nor practiced (Mugo, J.K., 2004). Until the time of the research, there existed no special treatment or rehabilitation programme in rehabilitation schools. Change of behaviour was left to various activities, similar to those offered to children in regular schools, like through the 8-4-4 school curriculum and vocational training, which was expected to positively transform child offenders (Lavera Levi, W., 2002). Academic achievement appeared to be the most emphasised activity. Besides, the term rehabilitation and discipline were used almost interchangeably and discipline mostly implies punishment (Nyamato,1997; Namwamba, A., 2001). Mugo (2004) found that children kept escaping from the institutions largely due to insistence on corporal punishment. In Borstal institutions, the most common mode of punishment was caning as it had been utilised by the juvenile system through various decades. Segregation was also used as a last disciplinary measure and consisted of hard labour and deprivation of certain privileges (Treatment of Offenders Annual Report, 1958; Human Rights Watch, 1997). However, studies also found that most children viewed punishment and hard rules positively and recognised its contribution to change of behaviour. In contrast, one study found that misuse of punishment was counterproductive to behaviour change (Lavera Levi, W., 2002).

Exit strategies were explained in the 1959 Treatment of Offenders

Annual Report. Early release could be granted to boys who had been in institutions for over three years and whose home environment was suitable. Wakanyua (1995) concluded his study stating that approved schools seemed unable to provide an alternative to a poor home, which might predispose children to delinquency. He reports that majority of the respondents (68.8%) did not find the rehabilitation programme offered useful at all. Recidivism was quite high affecting 75% of male compared with 37.5 % of female. Likewise, Ayora (2003) found that 30% of child offenders went home unreformed. As Human Rights Watch (1997) stated, correctional institutions failed to rehabilitate children in a manner that would enable them to fit in the society.

d. Gaps of the statutory institution system

Most of the studies (Wakanyua, S.N., 1995; Njuguna, D.W. 2003; Government of Kenya, 2004) listed the lack of appropriately trained personnel by the Department of Children Services among major shortcomings. According to one study, only 36.4% of the staff members had received basic training. Most lacked academic grounding and professional training to handle child offenders. The quality of training and academic qualification of staff was below minimum requirements. Most welfare staff had no professional qualification, some had attended only short courses while staying at the institution. Generally, the motivation of the staff was low due to low pay, lack of professional growth opportunities, being overworked and understaffed (Grobbel, L., 2002; Lavera Levi, W., 2002). Inadequacy of personnel was confirmed by The Directorate of Personnel Management which reports that in 2004, the Children's Department had only 474 posts filled against the huge children population in the country.

An earlier study (GOK/UNICEF, 1992) provides data on the number of children in the 11 remand homes in 1990 (771) and in the 10 approved school (1790). A major issue was overcrowding while children's reintegration was acknowledged to be a problematic area. Overcrowding was still identified as a challenge by The Kenya NGO-CRC Coalition

(2001) which found that, in 1997, 4800 children were housed in the 11 approved schools. At that time, the Nairobi Children Remand Home was found with a population of 369 against a capacity of 80 children.

Moreover, the same study confirmed that there was general over reliance on institutional care, even for children who were not offenders. Lavera (2002) found that 64.2% of the interviewed parents had the same belief and would rather their children remain in approved schools, even if they were given a chance to go back home. Other studies as well found that institutionalisation was used as a corrective measure for child offenders, but children were legally deprived of their liberty, even when they were not in conflict with the criminal law (Nagri, Y., Carafone L., 2001; Lavera Levi, W., 2002). Studies show that 85% of children who underwent the rehabilitation process did not deserved to be exposed to the criminal judicial system (Namwamba, A., 2001). A number of them were abused physically, sexually and emotionally at the police station or at the institution (Kenya Alliance for the Advancement of Children, 2002).

Minimal community/family participation and difficulties in being accepted back in the community due to the stigma of *inmates* or *young rascals* was also noted as a great challenge in reintegration (Mugo, J.K., 2004). Although the state reports indicated that there was more awareness on community based alternatives, little was being done to change the system.

Other challenges included inadequate facilities and absent or inadequate separation of child offenders and welfare cases with no distinction made between the two groups in remand homes and approved schools (Save the Children - UK, 2001; The Kenya NGO-CRC Coalition, 2001; Grobbel, L., 2002), lack of community based preventive programmes, lack of effective after care and follow up activities. Other gaps referred to children being held in remand homes for indefinite periods as a study found that in 1998, 58% of the children remanded during that period spent more than six months in custody (Namwamba, A., 2001). As a result, they were facing further abuse and

neglect, lack of adequate child development programmes and poor living conditions. The realization that children who had not committed crimes were taken to remand homes and approved schools confirmed the need to find alternatives for cases that could be resolved at community level (Save the Children - UK, 2001).

The lack of tangible government policy and strategies specific to vulnerable children was found to be a major constraint to efforts aimed at addressing their needs (Cradle, et al., 2004).

e. Major recommendations

Studies recommended improvement of the juvenile justice system, from the legal framework (Namwamba, A., 2001) to infrastructure development and implementation of specific care programmes, starting with proper case assessment and provision of counselling, ensuring that fundamental rights of children are protected (Lavera Levi, W., 2002). Training of government staff working at different levels was emphasised as well being a major needed component (Njuguna, D.W. 2003; The Cradle, Rajjn, 2004). On categories of children to be admitted into rehabilitation schools, it was stressed that these centres should not be used for first offenders or children in need of care and protection (Lavera Levi, W., 2002). Institutionalisation should be applied sparingly, while family empowerment to carry out parental responsibilities should be emphasised through child/family assessment and needs based interventions (Mugo, J.K., 2004). About exit strategies, reintegration was highlighted as crucial alongside with increased community participation, also in relation to diversion programmes to remove children in need of care and protection from the juvenile justice system (Gitau, J.K., 2002).

As none of the studies has shed light on the post-institutional phase, some researchers noted that there is need to research on how to trace children who were at these institutions to determine the rate of post institutional success or failure. Research on the effectiveness of exit strategies was also stressed as necessary particularly if reintegration of children into society is to succeed.

CHAPTER THREE

METHODOLOGY

1. RESEARCH METHODOLOGY

The research took place in 2010 and was carried out by the researcher. The methodology used in the study was explorative and it involved multiple techniques of data gathering and analysis. The explorative approach was due to the fact that no research has been done locally on family conferencing; hence it was the first study to deal with it in the region. Furthermore, the research refers to a social phenomenon in a children population that was too vast to be analyzed in full.

1.1 Study Sample and Procedures

The research defines a child as any person below 18 years of age, in line with the UN Convention of the Rights of the Child.

A Family Group Decision Making conference was included in the study being defined as such in the programme database or in the case file. Selected conferences were analyzed for consistency with the general principles and guidelines of the FGDM model (American Humane Association & FGDM Guidelines Committee, 2010). Conferences held at the exclusive presence of the child's family household were not considered as a family group conference based on the principle that households are nested in wide family systems and need their mobilization and support.

The sample for this study included conferences that were conducted by two FGDM facilitators in the urban and suburban area of Nairobi Province. The conferences were also attended in turn by the three agency counsellors and two caseworkers. All cases involved formal planning and a structured conference. Descriptive data and outcome information on FGDMs dating back to the start of the project in July 2005 were tracked.

Because the intent of the study was to explore long-term outcomes, only cases 24-54 months post-FGDM (occurring from July 2005 through January 2008) were included in the analysis. The research consequently reflects outcome information on 73 FGDM conferences held for a total of 73 children exited from the Nairobi Children Remand Home within that given period. All cases were coming from Nairobi Province representing 5 districts of the city and they were all included in the study experimental group.

The control group was made of 42 children who had been repatriated by the Nairobi Children Remand Home after being issued with a repatriation order by the Nairobi Children's Court during the same period. While FGDM conferences could be performed for cases which were geographically easily accessible being within Nairobi region, most cases repatriated with no FGDM were selected by the institution management because of their remote geographical location.

Hence, they had been picked by caregivers from the Children's Court or from the Remand Home with no intervention done in terms of case assessment and family engagement at decision making level. They were cases with no follow up done by the caseworker and contacts to know their current status were possible only through phone calls. Ninety three cases were identified as suitable for the research and telephone contacts were extracted from the database. However, most of them (n=51) were outdated and it was impossible to establish any contact while the remaining 42 were successfully contacted.

Various sources of information were utilized for the research. One

source was family plans prepared by the families at the conference, outlining the steps families agreed upon to assure the well-being of the child. A content analysis of the family plans provided information on the immediate outcomes of the conferences. Attached to these plans were case files, including social enquiry reports that the institution's counsellors had routinely recorded during the child staying at the institution, meeting notes, reasons for referral, date of placement and names of key people involved in the case. The social enquiry included also demographic, risk, needs and strengths assessment, environmental information and the child's case history. All gathered information was compared for consistency with the programme software database which contained similar data on each case.

An additional source was the aftercare report on the FGDM outcomes recorded by the caseworkers attached to the case for follow up. Their reports included case-by-case information received by the child, family and community members. The information from the aftercare reports allowed us to address the most central questions in this paper, whether the immediate outcomes resulted in sustained long-term benefits and stability for the children after the conference.

The successful phone interviews of the 42 caregivers of the control group gathered information on the child's present case status, in relation to the child's permanency at home. No further confirmation on the accuracy of responses was possible. Additional data on them was gathered from the children's files and the programme software database.

The researcher gained access to the database and the family plans only after identifying client information was removed, thereby assuring protection of client confidentiality. A coding scheme was established that allowed for the database and plans to be linked while maintaining the clients' anonymity.

1.2 Data Collection and Instruments

Data were collected through reading cases documentation dated from July 2005 to January 2008, to gather information on opening, tracing

and conference date, cause for referral, timing, frequency, format, purpose, facilitation of conferences, attendance, types of needs addressed, degree of involvement of family members and community providers in the plan, aftercare monitoring and evaluation, and degree to which timelines, benefits and consequences of compliance/noncompliance were specified in meeting notes.

All data were entered into a structured questionnaire, which fed the SPSS data editor.

The content of the database in children's files were entered prior to the conception of this research, thus limiting what questions could be addressed. Furthermore, sometimes there was a problem with missing information, because the caseworkers' priority understandably focused on preparing and convening conferences rather than tracking all the conference data.

1.3 Data Analysis

Data analysis consisted largely of counts, frequencies, cross tabs and correlations. These descriptive statistics provided quantitative information regarding the timing, frequency, attendance, and many other characteristics of meetings and plans. Quantitative data was also regarding follow through on plans.

Qualitative data, in the form of statements of commitment by the families were coded into categories representing the main themes of the planning. Qualitative data, in the form of performance indicators applied to the FGDM outcomes, were also coded into categories representing the main 3 domains of permanency, safety and wellbeing. The USA Federal Administration for Children and Families (ACF, 1999) performance indicators were used to gauge the impact of the FGDM as a family reintegration model. In preparing the framework of core outcome indicators, the researcher also used The Casey Outcomes and Decision-Making Project (Fisher, H. et al., 1999) which presents the review of many related documents including indicators drawn from the work of several projects linked to the child welfare system practi-

tioners, administrators, judges, researchers, legislators, and family and child advocates.

The qualitative data was helpful in providing richer description and some depth of understanding of the quantitative results.

However, in terms of methodological considerations, it was extremely difficult to isolate the effects of FGDM from the influence of other services which are typically offered alongside this decision-making approach. In addition, achieving complete clarity on measuring the associated outputs was at times problematic due to difficulty in establishing the current status of the child.

The FGDM impact was measured analyzing its outcomes at three different levels by means of specific indicators:

1. Short term outcomes
    - FGDM conference timeframe
    - Conference timing and location
    - Content of the conference: purpose, core domains, topics
    - Patterns of attendance: parents, family, community service providers and children
    - Plan formulation
    - Plan involvement
    - Child placement at the FGDM: family versus institution

2. Intermediate outcomes
    - Degree of community involvement in FGDM plan implementation
    - Effective FGDM plan implementation

3. Long term outcomes
    - Re-referral rate
    - Stability of placement
    - Safety outcome from abuse and neglect
    - Permanency outcome: retention and relationships within the family network
    - Well being outcome

CHAPTER FOUR

RISK FACTORS ANALYSYS
THEORY AND PRACTICE

1. RISK FACTORS IDENTIFICATION AND ASSESSMENT TOOLS

1.1 Literature Review

1.1.1. Definitional issues

It appears that globally, many abuses and cases of neglect still remain undetected or are not reported, so it is likely that official statistics underestimate their incidence (Ards & Harrell, 1993; Trocmé, McPhee, Tam, & Hay,1994; Wolfner & Gelles, 1993). Similar patterns are evidenced by clinical practice in Kenya as well.

Questions concerning whom and how to help confront every practitioner and agency striving to provide effective psychosocial services to children and families at risk in settings where widespread needs outstrip scarce resources. Yet, there is little unanimity in terms of defining fundamental terms in the field of child vulnerability, e.g. what is risk ? (Hutchison, 1990; Zuravin, 1991; Lyons, Doueck & Wodarski, 1996). Being *at risk* is not an objective state, but a complex, multidimensional concept that is both socially and professionally constructed and whose

meaning has evolved over time (Freeman, 1983; Douglas, 1992; Parton, 1996). However, there remains a clear need to develop uniform means of quantifying the levels of risk and to establish clear parameters for the appropriate actions to be taken with each level of risk and type of maltreatment (Wald & Woolverton, 1990).

To this end, an adequate risk assessment provides '…the systematic collection of information to determine the degree to which a child is likely to be abused or neglected in the future. [It also refers] … to an estimation of the likelihood that there will be an occurrence of child maltreatment in a case where maltreatment has not occurred …' (English & Pecora, 1994:452).

Hence, the risks assessment is intrinsic to the child protection role, beginning with Kempe et al.'s (1962) who discussed the decision to return an abused child to her/his family and the inherent risks involved: '….the physician should not be satisfied to return the child to an environment where even a moderate risk of repetition [of abuse] exists' (Kempe et al., 1962:24).

Researchers investigating child protection decision making have usually utilized one of two alternative methods, traditionally referred to as the *statistical* and *clinical* approaches (Wiggins, 1981; Ruscio, 1998).

The *statistical approach* commonly consists of controlled experimental and quasi-experimental studies that result in the development of a statistical decision model which identifies the factors which account for the variance (or a proportion of the variance) in making a particular decision. It is argued that a statistical decision model provides greater accuracy (i.e. a better *hit rate*) and less judgment errors (i.e. *false positives* and *false negatives*). It is not claimed that all decision errors are able to be eliminated by statistical modelling of decisions, rather that the '…levels of accuracy are higher than we could achieve if we did not possess the risk assessment tool in question' (Johnson, 1996:14). Such experimental, decision modelling studies were initially used to determine the factors which influence decisions. In the 1980s and 1990s, most model-

ling studies had been designed to construct structured risk assessment scales to predict case outcomes for use in child protection practice.

In contrast, the *clinical approach*, is associated with a desire to develop causal explanations for decision making, involving '…nothing more than a human judge evaluating available information and arriving at a decision' (Ruscio, 1998:145). The clinical approach generally utilizes *qualitative-descriptive* methods of data collection to describe the decision making process, such as self-report measures, behavioural observational techniques, case tracking, and the content analysis of case records. Such methods are ecologically valid and their flexibility enables their application to a variety of research questions. However, the generalization of their results and their ability to empirically test cause and effect relationships are hampered by their lack of experimental control (Ruscio, 1998).

1.1.2 Research findings

Efforts to build accurate risk assessment models have formed a growing knowledge base focused on improving the methodological rigor of research on the impact of risk factors affecting children, originating both from within and outside their family setting.

Many researchers suggest that interactional style and parenting variables, such as discipline practices, are important predictors of child outcomes (Hart & Risley, 1995; Rutter, 1989; Werner, 1993).

In a variety of longitudinal prospective studies with large cohorts (Sameroff & Fiese, 1990; Garmezy, 1987; Egeland & Erickson, 1990) and, in a smaller study of high risk families (Greenspan, Wieder, Nover, Lieberman, Lourie, & Robinson, 1987), the later impact of early parent-child interactions on development has been found to be highly significant. Lack of sensitivity and responsiveness as well as negative affect towards the child can lead to the development of an insecure attachment, a known risk factor for the development of later emotional

and social difficulties (Ainsworth, Blehar, Waters, & Wall, 1978; Main & Goldwyn, 1984). Also, lack of knowledge about expected developmental milestones and parenting techniques can lead to difficulties with discipline and failure to encourage language and other areas of development (Crockenberg & Litman, 1990).

Parent characteristics that can place the child at risk include families with significant levels of stress and depression in a parent, particularly the mother. This can increase the child's vulnerability to both anxiety and behavioural disorders (Beardslee, Bemporad, Keller, & Klerman, 1983; Carro, Grant, Gotlib, & Compas, 1993; Pape, Byrne, & Ivask, 1996). Other significant risk factors include severe family dysfunction, especially if it results in spousal abuse (Fergusson, Horwood, & Lynskey, 1992; Pedersen, 1994), drug or alcohol abuse (Reich, Earls, Frankel, & Shayka, 1993), and criminality of either parent (Fisher, 1995; Gabel & Shindledecker, 1993). It is also clear that some less obvious or latent variables, such as the parents' experience of their early relationships and upbringing, especially if it was traumatic and included abuse, neglect or significant loss, can impact dramatically on their ability to parent and the attachment security of their children (Benoit & Parker, 1994; Main & Goldwyn, 1984).

Variables that are more socio-demographic or relate to the family environment can also significantly increase the risk for later child problems. Low socio-economic status, particularly if the family is living below the poverty line or in *deep poverty* has been shown frequently to be a significant risk factor (Offord & Lipman, 1996; Zyblock, 1996). The effects of chronic poverty have been reported to be twice that of poverty that is more transient. In a study, young children living in persistent poverty were twice as likely to have lower IQ levels and to have behaviour problems (Brooks-Gunn, Klebanov, & Duncan, 1996; Duncan, Brooks-Gunn, & Klebanov, 1994). Living at this level of poverty means that the family is constantly struggling to provide children with their basic needs for food, shelter, and clothing. Poverty may also mean living in substandard housing and in violent neighbourhoods. This has

been found to be an important predictor of later child psychopathology (Dubrow & Garbarino, 1989; Offord et al., 1989). Not only do parents living in poverty find it difficult to meet their children's basic needs, they often find it difficult to talk to and spend time with their children. Nurturing interactions may be difficult to provide as they may be depleted and have feelings of hopelessness and depression (McLoyd & Wilson, 1991). Isolation and lack of social supports can also result from such situations and can contribute to the family's ongoing social difficulties (Allen, Brown, & Finlay, 1992; Moroney, 1987).

Perhaps, the most important and consistent finding from longitudinal studies of development has been the understanding that one or two risk factors, unless they are extreme, rarely negatively impact on development. However, as the number of risk factors increases, the negative effect has been found to enlarge disproportionately. For example, having four or more risk factors, which relate to the child, parent, and socio-demographic situation, can lead to a ten-fold increase in difficulties, a result that has been replicated in a number of studies (Sanson, Oberklaid, Pedlow, & Prior, 1991; Rutter, 1979; Sameroff, Seifer, Barocas, Zax, & Greenspan, 1987). These *risk factor caravans* consist of clusters of risk factors that co-occur and *travel* with their host across development.

In his research work with high risk adolescents, Garbarino (1999) explains that community violence has a detrimental impact on children's development. Drugs, guns and gangs conspire to create dangerous environments for children and youth in urban neighbourhoods and, increasingly, elsewhere in our society. These violent external threats often are added to the risk of violence inside the family and to a number of other risk factors such as poverty, parental substance abuse, absent fathers and maternal incapacity.

The result is a social environment for children that is *toxic* in the sense of being poisonous and putting the child at risk for impaired development (Garbarino, 1995).

As negative influences increase, the child may exceed his or her breaking point. Conversely, as positive influences increase, the probability of recovery and enhanced development increases.

In relation to antisocial behaviour, also Kazin (1994) speaks of *packages* of risk factors that interact to produce chronic patterns of bad behaviour in boys. When children's need for care, protection and love is absolutely violated, some will seek out a negative universe on the grounds that anything is better than nothing. This may bring about extreme negative behaviour later in life such as exhibited by serial killers or brutal child abuse that leads to a descent into evil to provide some structure of meaning (Douglas & Olshaker, 1995).

Although the literature identifies a general dose-response effect between magnitude of exposure and associated child and adolescent distress reactions, evidence of differential effects is also emerging. For instance, nearly all studies on the psychological effects of exposure to risk factors indicate that girls are more likely to manifest higher levels of anxiety and mood symptoms than boys are. In contrast, boys appear to be at higher risk for disruptions in behavioural adaptation including externalizing behaviour (Zahn M. A. et al., 2010).

Taken together, these studies constitute important progress in conceptualizing and testing hypotheses relating to the mechanisms and processes that underlie the etiology and course of clinically significant dysfunction following risk factor exposure. Such efforts should revolve around the central question, "How can we conceptualize, measure, and model the multidimensional features of risks exposure in ways that best inform theory building, improve risk detection, and increase the effectiveness and efficiency of our interventions?"

The most commonly used model of clustering co-occurring risk factors identifies risk markers and global risk status, thus it assists in identifying who needs help. However, its utility diminishes as one *drills down* to deeper questions regarding *why, how, where, and when to help*. Its ability to explain *which* types of exposure are most harmful, for *which* outcomes,

for *whom, how* they transmit their effects, and *how* this knowledge should guide intervention, is much more limited (Layne, Warren, Watson, & Shalev, 2007; Layne, Beck et al., 2009). Consequently, an improved capacity to aggregate risk factors will help to quantify the differential effects of different risk factors on specific outcomes.

For this reason, it is critical to reconsider the way in which risk factor exposure is typically conceptualized, measured, and modelled. Developing enhanced risk assessment methods and tools for quantifying the potency and differential effects of specific types of trauma exposure that are valid and useful across diverse settings carries great promise for advancing the field, especially through building theory and interventions, and guiding policy-making (Kraemer et al., 1999).

The composite-based approach addresses this need by unpacking risk factors exposure into dimensions that model the occurrences of specific types of trauma and their differential links to key psychosocial consequences. The resulting knowledge base increases the effectiveness and efficiency of interventions by ranking risk factors according to their respective magnitudes for specific outcomes. Such rankings can guide risk identification and improve clinical decision-making by helping to prioritize and triage differentially exposed groups to intervention modules that specifically target the types of distress for which the members are at greatest risk (Layne et al., 2008). Last, this method promotes intervention by identifying *whom* and *how* to help, such as by improving the accuracy of risk detection and triage instruments, and discovering key causal risk factors, mediators, and moderators of persisting distress, dysfunction, and developmental derailment that can be targeted in treatment (Layne et al., 2007).

1.2 Risk Factors Assessment analysis

1.2.1 Risk factors assessment and tools

As clinical practice shows that proper case assessment appears to be one of the major gaps of the Kenya child protective services, the accurate identification of children who have experienced, or are at risk of, significant harm is of fundamental concern to child protection actors.

In the context of the project which motivated this research, the identification of risk factors associated with children entering the local juvenile justice system became a critical exercise to assure proper intervention and referral. As the project developed, children admitted at the Nairobi Children Remand Home were assessed accordingly. The child and family risk factor assessment was carried out by consolidating disaggregated data gathered on each case through child's individual and family counselling sessions, social enquiry reports, environmental adjustment reports and clinical observation.

Initially, the Intranet Risk Assessment (IRA) in the use of The Texas Child Fatality Study (1998) and the British Columbia Risk Assessment Model for Child Protection were used as reference (B.C.Family Health Services, 1997). A structured assessment tool was progressively built by clustering risks factors under 4 main areas and related sub-areas as shown in table 2 (see Appendix n. II to view the complete Risk Assessment tool).

Table 2: Risk Assessment tool 1

Child's Characteristics	Parental/Family Condition	Degree of Abuse/Neglect	Degree of parental cooperation
Child's physical health and development	Family composition	Severity of abuse/neglect	Ability to Protect
Child's mental health and development	Physical ability to care for child	Premeditation of abuse/neglect	Willingness to protect
Child's vulnerability	Mental/emotional ability to care for child	Duration of abuse/neglect	
Child's behavioural history	Family behavioural history		
Education and leisure	Parenting ability		
Peer relations	Living environ-ment/ conditions		

In a further development, a more comprehensive assessment tool for children and their families was built. The California State Family Strengths and Needs Assessment and the Case Management System Service Objectives Map were used as a blueprint (California Department of Social Services, 2008). Its structure was modified to accommodate assessment components relevant to the local situation. Indicators were also expanded to provide a wide-ranging assessment prospective to caseworkers by including both the child and family.

The reviewed tool (see Appendix n. III to view the complete tool) was split into four columns as it is summarised in table 3.

Table 3: Risk assessment tool 2

CHILD/FAMILY RISK ASSESSMENT			
Risk/Problem Areas	**Risk Level**	**Needs Areas**	**Strengths**
It provides a detailed list of risk areas	It indicates the risk level corresponding to each identified risk factor	It provides a check list of what is required to respond to the identified risk factors	It suggests a check list of the corresponding strengths on which to build the intended care plan.

1.2.2 Risk factors study definitions

The present study developed a risk factors analysis across all the experimental group cases making use of assessments carried out with the above tools to gather disaggregated data.

While most of the identified risk factors are self-explanatory, for clarity they are hereby briefly defined in line with the research perspective in table 4. Definitions are based on clinical practice and are strictly intended as outlined by the researcher to serve the purpose of the study. They were used in the drafting of the research questionnaire and in the process of collecting data. Risk factors were identified by analysing cases records and documentation, which reflected the assessment made by various staff involved in the case.

Table 4: Risk factors definition

RISK FACTORS	DEFINITION
CAREGIVER'S RISK FACTORS	
Physical ability to care for child	
Parent impaired physical/medical condition	Being severely sick (HIV/AIDS, physical disability, etc.)
Mental/emotional ability to care for child	
Parent impaired mental condition	Having been diagnosed with any mental disorder

Emotional inability to care for child	Being in an overwhelming emotional state of anger, stress, depression
Family behavioural history	
Prior neglect/abuse within extended family	Caregiver having been subject to neglect or abuse
Parent criminal activity/incarce-ration	Having been involved in crimes and incarcer-ated
Domestic violence	Caregiver being subject to physical, sexual, and/or psychological abuse perpetrated by the partner
Prostitution by mother	Being a commercial sex worker
Alcohol addiction by parents	Being severely addicted
Homelessness/poverty	Caregiver being living under severe poverty
Parents' unemployement	Not having a permanent, temporary or causal job
Conflict with extended family	Experiencing fights, struggles within the enlarged family
Parenting ability	
Neglect/ failure to protect	Inability/refusal to provide safety to the child
Parents' inconsistency in discipline	Use of conflicting parental disciplinary methods
Violent punitive discipline	Use of abusive disciplinary approach
Inadequate acceptance of child by caregiver	Limited recognition and appreciation of the child
Inadequate caretaker's perception of the child's needs	Limited understanding of the child's develop-mental needs and rights in relation to age
Parents' blaming of the child and refusal to accept identified family needs	Identifying in child the scapegoat/victim to avoid dealing with family problems
Refusal of parental responsibility	Rejecting any liability towards the child
CHILD'S RISK FACTORS	
Child's health and development	
Child impaired physical/medical condition	Being severely sick (HIV/AIDS, physical dis-ability, etc.)

Child impaired mental/emotional condition	Having been diagnosed with any mental disorders
Violent/aggressive	Having displayed hostile and destructive behaviours
withdrawn – depressed	Having displayed symptoms of depression
Child safety	
Emotional abuse	Child having been subject to various forms of threat, humiliation, blame or emotional mistreatment
Physical abuse	Child having been subject to physical injury or maltreatment, e.g. beatings, burnings, etc.
Mistreatment	Child having been subject to rough treatment
Sexual abuse	Child having been subject to various forms of sexual exploitation
Suicidal attempts	Child having attempted suicide
Child attachment	
Separation by mother at early age	Child (0-4 yrs old) having been removed from mother's care
Parent-child conflict	Severe hostility between caregiver and child
Rejection	Caregiver displaying severe refusal of the child
Child's behavioural history	
Child criminal behaviour	Having been breaking the law
Runaway	Having willingly moved out of home
Previously under alternative residential care	Having been residing in a care or rehabilitation centre
Previously under alternative day care	Having been attending a care programme for children at risk
Street life	Having lived in the streets for more than one month
Spleeping outside	Spending the night out with no caregiver's permission
Scavenging	Collecting scraps metal, paper, plastic and other material for sale
Lying	Being constantly deceitful

Truancy	Frequently skipping classes with no reason
Inappropriate sexual behaviour	Having promiscuos risky behaviour
Prostitution	Being directly engaging in prostitution
Stealing	Mostly pilfering without being caught
Going home late	Going home after 9.00PM with no permission
Going to video	Attending video shows in the suburbs during day and night time rather than engaging in constructive occupations
Drugs or alcohol abuse	Being severely addicted
ENVIRONMENTAL CONDITIONS	
Environmental hazard/slum area	Family living in a very low income area in the Nairobi suburbs
Disconnection of family from community social support	Family being isolated and with no community connections
Negative peer pressure	Child being affected by harmful peers, such as friends from street, drugs addicts, scavengers, etc.

1.2.3 Risk factors accumulation

Although literature provides compelling evidence that exposure to risk factors is generally deleterious to child adjustment, its ability to explain *which* types of exposure are most harmful, for *which* outcomes, for *whom, how* they transmit their effects, and *how* this knowledge should guide intervention, is much more limited (Layne, Warren, Watson, & Shalev, 2007; Layne, Beck, et al., 2009). These shortcomings recently led the APA Presidential Task Force on Posttraumatic Stress Disorder in Children and Adolescents (APA, 2008: 6) to conclude that 'The limited research assessing risk for ongoing distress after trauma exposure has identified some *indicators of risk* but no reliable way to gauge whether a

given child will recover on his or her own or will require some intervention'. Members then called for the development of "practical predictors of youth's psychological outcomes" in the form of "well-validated risk assessment tools that can be feasibly implemented in diverse settings and for diverse traumatic events and that will help identify the high-risk youth and families who are in need of clinical services." (Layne, C., Olsen, J.A., et al., 2010).

In line with this view, after exploring the occurrence of risk factors, their accumulation was analyzed by applying the composite-based approach, which aims to capture the *causal consequences* of specific types of trauma exposure. After the researcher had identified the broad range of pre-institutionalisation related correlates in children, including family characteristics, antisocial behaviour, disruptions in relationships with caregiver and environmental factors, they were grouped into clusters of indicators of risk including those identified by the researcher as contributors to the composite. Risk factors not necessarily co-occurent were aggregated in the same group composite to unpack trauma exposure dimensions that model the occurrences of specific types of trauma and their differential links to key psychosocial consequences..

A more frequent approach based on the *common factor* (risk factors are homogeneous i.e., emanate from the same causal origin) (Borsboom, Mellenbergh, & Van Heerden, 2003) attempts to aggregate risk factors into dimensions internally consistent according to a perceived event co-occurrence (child, family, environment). Here, the researcher goal was to identify relations among events/situations and their psychosocial consequences (selected according to their importance with regard to preventive and rescue interventions), as exposure to severe psychosocial hazard generates groups of traumatic events or situations which add to one another. As a result, focal psychosocial outcomes which are not necessarily co-occurent could be aggregated in the clusters/composites shown in table 5.

Table 5: Clusters of Indicators of risk

CLUSTER 1 Direct exposure as victims of abuse or unsafe conditions	Neglect/failure to protect by caregivers
	Mistreatment
	Violent punitive discipline by caregivers
	Physical abuse*
	Emotional abuse
	Child impaired mental/emotional condition
	Child being withdrawn – depressed
	Sexual abuse*
	child labour
	Child suicidal attempts
	Prostitution
	Child impaired physical/medical condition
CLUSTER 2 Witnessing continu-ous external threat	Living in environmental hazard/slum area
	Affected by negative peer pressure
	Disconnection of family from community social support
	Alcohol addiction – parents*
	Homelessness/poverty
	Parents' unemployment
	Prostitution by mother*
	Domestic violence
	Marital conflict
	Conflict with extended family
	Parent criminal activity/incarceration
	Parent impaired physical/medical condition
	Parent impaired mental condition
	Drugs addiction – parents*
*overrides: very severe incidents or conditions raising the risk factor to very high level.	

CLUSTER 3 Engaging in direct antisocial behaviour	Runaway
	Truancy
	Stealing (without incrimination)
	Going home late at night
	Sleeping outside at night
	Lying constantly
	Street life (more than one month)
	Scavenging
	Violent/aggressive
	Inappropriate sexual behaviour
	Going to video
	Criminal behaviour (with court case)
	Drugs or alcohol abuse
CLUSTER 4 Exposure to caregiver loss, separation and attachment threats	Abandonment/separation from mother at early age
	Biological parents separation
	Presence of stepmother
	Orphan of one parent
	Single mother
	Presence of stepfather
	being under previous alternative residential care
	Orphan of both parents
	Single father
CLUSTER 5 Being under constant emotional threat by caregiver	Inadequate caretaker's perception of the child's needs
	Caretaker blaming of the child and refusal to accept identified family needs
	Caregiver-child conflict
	Refusal of parental responsibility
	Inadequate acceptance of child by parent
	Child's rejection
	Inadequate acceptance of child by stepparent
	Parents' inconsistency in discipline
	Emotional inability to care for child (anger, stress, depression)
	Prior parental neglect/abuse within extended family

Then, each child of the experimental group was graded and entered into a specific accumulation level according to his/her risks frequency in each of the 5 clusters, using the grading system indicated in table 6.

Table 6: Risk accumulation grading system

1. Low risk level: when the child accumulated 1-2 standard risk factors in single clusters
2. Medium risk level: when the child accumulated 3-4 standard risk factors in single clusters
3. High risk level: when the child accumulated 5 and above risk factors in single clusters
4. Overriding: when a present risk factor was individually very high the whole cluster was graded as high risk
5. Non existing: when there was no risk factor within that cluster

As on the initial risk assessment, the researcher determined that there are certain conditions that are severe enough to assign to a cluster a risk level of *high* regardless of other risk factors presence. The overrides referred to very severe incidents or conditions that had occurred to the child. If one or more override conditions existed, the researcher marked the cluster risk level as *high*, due to the child vulnerability concerns.

In line with the California Family Risk Assessment (Wagner, D., Johnson, K., 1999), the following three policy overrides were identified and they were incorporated in the risk factors scoring system:

- Sexual abuse, where the perpetrator was likely to have access to the child.
- Physical abuse identified through non-accidental injury to a child.
- Alcohol and drug addiction by caregiver.

Due to clinical experience, prostitution by the caregiver was added, being a condition which in the local context implied very high child vulnerability. Following this methodology, each child of the experimental group was graded according to the accumulation and intensity of risk levels in the respective clusters.

CHAPTER FIVE

EXPERIMENTAL GROUP RISK FACTORS ANALYSIS

1. INTRODUCTION

In the following presentation of the risk factors analysis, risk factors were classified by the researcher using the case assessment found in the each case file, as it had been drafted by the caseworker in collaboration with the counsellor and welfare staff through child and family interviews, counselling sessions, home visits and clinical observation.

The experimental group cases are explored according to their risk factors being identified in relation to three main levels:

1. Community level
2. Family level
3. Child's level

Finally, the risk factor accumulation of all children cases in the experimental group was explored.

2. COMMUNITY LEVEL

In Kenya, as ever larger numbers of children display signs of experiencing serious threats to their development, we analyzed aspects of the local community identified by research as raising the potential for child's maltreatment: hazard neighbourhoods, poverty, inadequate so-

cial support due to isolation, peer influence (Daro, 1988). The combination of these and other ingredients builds *socially toxic environments* in which children grow up, a poisonous context for their development comparable to physical toxicity, a threat to human well being and survival, and a matter for public policy and private concern (Garbarino, 1995).

2.1 Environmental Conditions

Families do not exist in a vacuum and numerous environmental factors can contribute to their children vulnerability. Some of these include community and society characteristics, poverty, access to social networks and external peer pressure. These factors may be interrelated (e.g., families who are poor often live in high-risk or unsafe communities or lack social supports).

2.1.1 Community Characteristics

According to research, children who live in hazard neighbourhoods have been found to be at higher risk for neglect than children in safer neighbourhoods. One study suggests a relationship between unsafe or dangerous housing conditions and the adequacy of children's physical needs being met in the areas of nutrition, clothing, and personal hygiene (Ernst, Meyer & DePanfilis, 2004). Other characteristics of these distressed neighbourhoods include high levels of truancy, low academic achievement, high juvenile arrest rates, and high teen birth rates. When stressful living conditions continue over time, families in these neighbourhoods are more likely to be reported to child protective services for child neglect (DePanfilis, 2002).

Data analysis revealed that 75% of families of children in the experimental group lived in urban slum areas, widely known as environments where people live under the level of poverty and where families and children are at greater risk. No child came from affluent neighbour-

hoods. The analysis also found that living in such low income areas correlated to lack of parental abilities leading to neglect and failure to protect, Pearson's r (73)=.28, p=.007 and to child deprivation of parental attachment, having been separated from the mother at early age, Pearson's r (73)= .21, p= .037. Children residing in such areas strongly correlated with having run away from home, being arrested and admitted at the Remand Home, Pearson's r (73)=.30, p=.005.

2.1.2 Poverty

It is essential to note that many poor families are well adjusted and competent. They have healthy marriages and do not express their stress in violent or otherwise hurtful ways. Many children who live in poverty are able to perform well in school, are socially well-adjusted, do not engage in illegal activities, and are not poor as adults. These children may have protective factors, such as affectionate parents, high self-esteem, or a role model, that help them to achieve these positive outcomes (Seccombe, 2002). However, as a variety of studies found, it is equally true that within economically disadvantaged samples, the level of child well-being is strongly negatively associated with the rate of child/family poverty (Ozawa, Joo, & Kim, 2004; Smeeding, Torrey, & Rein, 1992) and that particular aspects of poverty, such as lack of shelter, are more strongly correlated with physical neglect reports than others (Slack et al., 2004).

Simply by considering that ¾ of the experimental group families were located in Nairobi low income areas, it clearly appeared that poverty was a crosscutting risk factor. In particular, severe homelessness or poverty affected 21% of the families' sample. The study also found that poverty was strongly combined with factors like parents' unemployment, Pearson's r (73)=.78, p<.001. Since casual work is a common working condition in Kenya, in the present study it was considered as an employment status. Hence, the 13.7% of unemployment rate among the caregivers refers only to people who had not been working at all

for long time. Such situation of total unemployment strongly correlated with emotional inability to care for the child, Pearson's $r(73)=.36$, $p=.001$, and with the child being sleeping outside of the home, Pearson's $r(73)=.32$, $p=.002$.

Poverty strongly correlated as well with parents' impaired physical or medical condition, Pearson's $r(73)=.33$, $p=.002$. A status which appeared to strongly connect with parental criminal activity/incarceration, Pearson's $r(73)=.38$, $p<.001$, child sexual abuse, Pearson's $r(73)=.38$, $p<.001$, and with child sleeping out of the home, Pearson's $r(73)=.29$, $p=.006$. No other particular forms of child neglect or abuse seemed to be directly associated with poverty or its correlates. Hence, our research suggests that poverty is just one among other factors to affect child safety and wellbeing.

2.1.3 Social Support

Social support can be emotional, material, on decision-making or problem-solving assistance, related to social companionship (DePanfilis, 1996) and it can be provided by relatives, neighbours, friends, schools, employers, health service agencies, religious and community groups or organizations (Hodges, 2000). Families with healthy support networks have more access to models of suitable parental behaviour. In addition, they have more friends or neighbours who may be willing to act as alternative caregivers or to provide additional support or nurturance to both the parent and the child. Impoverished communities often lack positive informal and formal support systems for families (Cash & Wilke, 2003). Studies on social isolation and child neglect found that parents who maltreat their children report more isolation and loneliness, less social support, have smaller social networks, receive less social and emotional support and have scarce interaction in them (Polansky et al.,1985; Connell-Carrick, 2003; Gaudin et al., 1993). The study confirms that 34.2% of the sample families were severely disconnected from community social support. Furthermore, a strong correlation was

found between families residing in slum areas and disconnection from social support, Pearson's r (73)=.30, p=.009.

2.1.4 Peer Pressure

Peers are the individuals with whom a child or adolescent identifies, who are usually but not always of the same age-group. Peer pressure occurs when the individual experiences implicit or explicit persuasion, sometimes amounting to coercion, to adopt similar values, beliefs, and goals, or to participate in the same activities as those in the peer group (Feller, Robyn, M., 1995). Peer groups provide a sense of security and they help adolescents to build a sense of identity. Feeling part of a group, be it the stereotypical jocks, or punks, allows adolescents to feel like they are on the way to answering some of their need of social identity (Castrogiovanni, 2002).

Children and teenagers in the experimental group were assessed by caseworkers as being affected by negative peer pressure when their case history presented evidence of conforming to groups of peers with whom they socialized and which were engaging in risky behaviours such as scavenging, truancy, living in the streets, stealing. However, the intensity of peer pressure differed from situation to situation.

The study showed that 35.6% of the children in the experimental group was affected by negative peer pressure. This condition strongly correlated with a list of child's antisocial behaviours which were drawing them farther from parental care and socially accepted duties such as education by being truant, Pearson's r (73)=.43, p<.001, and dragging them towards disruptive means of self-reliance like stealing, Pearson's r (73)=.33, p=.002, going home late at night, Pearson's r (73)=.34, p=.002, and scavenging, Pearson's r (73)=.38, p<.001.

Table 7: Summary of main correlations between environmental conditions versus parental competence and child antisocial behaviour

Environmental conditions	Parental competence	Pearson's correlation coefficient *r*	two-tailed P value
Extreme poverty	Emotional inability to care for the child	.232*	.024
Unemployment	Emotional inability to care for the child	.361**	.001
Disconnection from community support	Caretaker blaming of child and refusal to acknowledge family needs	.230*	.025
Hazard area	Separation from primary care-giver at early age	.327**	.000
	Neglect and failure to protect	.286**	.007
Environmental conditions	**Child antisocial behaviour**		
Extreme poverty	Sleeping out of home	.260*	.013
	Truancy	.249*	.017
Unemployment	Sleeping out of home	.327**	.002
Disconnection from community support	Sleeping out of home	.391**	.000
Negative peer pressure	Violent/aggressive	.197*	.047
	Scavenging	.380**	.000
	Lying	.203*	.043
	Truancy	.403**	.000
	Stealing	.332**	.002
	Going home late	.341**	.002
	Going to video	.298**	.005

** Correlation is significant at the 0.01 level

* Correlation is significant at the 0.05 level

3. FAMILY LEVEL

Several family characteristics are associated with children being at risk. Some life situations, such as marital problems, domestic violence, a *chaotic* family life, early mother-child separation, or family stressors such as divorce/separation, death of a close friend/family member, as well as family composition such as single parenthood or blended/reconstituted families with the presence of stepparent, can increase the likelihood that vulnerability will occur. Although these characteristics may not cause maltreatment, they are possible risk factors affecting children wellbeing. Risk factors are also found in parent-child communication and interaction harmful patterns, such as inadequate parental attachment to the child, inadequate child management skills, lack of parenting skills, inconsistent use of discipline, sole responsibility for all parenting tasks, and inability to control anger (Daro, 1988).

The study analyzed quantitative data to identify family and parental characteristics found within the 73 cases of the experimental group and correlated them with children vulnerability.

3.1 Family Demographics and Ecology

3.1.1 Family ethnicity

According to the 2009 national census (KNBS, 2010. Kenya 2009 Population & Housing Census Results), the top ethnic communities by numbers are Kikuyu (6.62 million), Luhya (5.33 million), Kalenjin (4.96 million), and Luo (4.04 million). Others are Kamba (3.89 million), Kenyan Somali (2.38 million), Kisii (2.21 million), Mijikenda (1.96 million), Meru (1.65 million), Turkana (0.99 million), Maasai (0.84 million), Teso (0.33 million) and Embu (0.32 million) among others.

The analysis of the ethnic groups to which families of children in the experimental group belonged showed this cultural diversity. However,

families mostly belonged to few specific ethnic groups, which appear to be more involved than others with the child welfare system. More than 38.3% of them were of Kikuyu origin, while 24.7% e 23.3% were Luo and Luhya respectively. Fewer or no families represented most of other communities. In comparison to the percent distribution of the same ethnic communities in the country, the three above ethnic groups represent 41.5% of the Kenya population (49.0% according to CIA World Factbook, 2010), contrary to this research where they comprise 86% of all children's families in the experimental group.

Proportionally, they scored higher numbers if compared to their regional representation in the country, probably because the experimental group originated from Nairobi, the capital city highly affected by migration by some communities. However, due to lack of official demographic data on Nairobi ethnic population, our analysis was not able to account for the potential ethnic variations within families. Moreover, cultural factors might be taken into consideration by future research in relation to involvement of specific ethic groups with the child welfare system, as general statistics in institutions show that very few children are admitted into statutory institutions from nomadic communities such as Masai, Samburu, Pokot, Turkana.

The following table compares demographics on ethnic communities drawn from the study sample, the Kenya Population & Housing Census Results (KNBS, 2010) and the CIA World Factbook (2010).

Table 8: Ethnic demographics comparison between the experimental group and the Kenya general population

	Ethnic community	Experimental group %	2009 CENSUS %	2010 CIA %
Child's family ethnic community	Kikuyu	38.3	17.2	22
	Luo	24.7	10.5	13
	Luhya	23.3	13.8	14
	Kamba	9.6	10.1	11
	Ugandan	2.8	0.0	0.0
	Kisii	1.3	5.7	6
	Kalenjin	0	12.9	12
	Meru	0	4.3	6

3.1.2 Family Composition

The following tables describe the construction sample of families in the experimental group, identifying some major characteristics on their composition.

About the number of children per family, the study shows that 12.3% of them had one child, 17.8% had two children and 27.4% had 3 children listed as part of the household. 39.7% had 4 children or more. The fact that 42 families (57.3% of 73) have 1 to 3 children suggests that having numerous children doesn't constitute a relevant factor contributing to vulnerability of children in the experimental group.

Table 9: Number of children per family

Characteristics of sampled families			
		N	%
Total sample		73	100.0
Number of children	1	9	12.4
	2	13	17.8
	3	20	27.4
	4	14	19.2
	5	10	13.7
	6	2	2.7
	7	1	1.4
	8	2	2.7
	No response	2	2.7

Analyzing the type of caregiver living with the child, a parent or guardian was identified in all the sampled families. In the majority of cases, prior to admission in the institution, the child was under the custody of birth parent(s) (90.5%) while a minority was under the custody of relatives (8.2%). Only 1.4% had a guardian being a non biological relative. Among all children in the sample, 64.4% had the mother and 45.2% the father present in the family, while 39.8% had a stepparent. However, the family composition of their physical abode showed that 74% of the children physically lived with their parent(s), while 24.7% lived with relatives, indicating a customary circulation of children within the extended family.

The family composition showed that a high percentage of children belong to reconstituted families having their biological father or mother living with a partner (39.8%). Children living alone with the mother, being single, widow or separated constituted 31.5% of all cases. Only19.2% of them was living with both biological parents, while total orphans were 8.2%.

Table 10: Child's family ecology and child-caregiver relationship

Characteristics of sampled families			
		N	%
Total sample		73	100.0
Child's family ecology	Biological parents separation	29	39.8
	Presence of stepmother	19	26.8
	Orphan of one parent	14	19.2
	Child of single mother	13	17.8
	Presence of stepfather	10	13.7
	Orphan of both parents	6	8.2
Type of child-caregiver relationship	Father & stepmother	18	24.7
	Both parents	14	19.2
	Separated mother	10	13.7
	Mother & stepfather	10	13.7
	Single mother	9	12.3
	Orphan under a relative	5	6.8
	Widow mother	4	5.5
	Widow father	1	1.4
	Not orphan under a relative	1	1.4
	Stepmother	1	1.4

The study analysed correlations between the family ecology and child safety within the family setting. In particular, the presence of stepparents in families was investigated as little research on child neglect has explored it to date, perhaps because stepmothers typically are not seen as the person primarily responsible for provision of children needs or because single parents are typically more accessible to researchers (Dubowitz & Black, 2001; Garbarino & Collins, 1999).

However, empirical observation indicated that as the presence of a positive stepparent decreased the likelihood of neglect in the home, having a stepparent in the household could provide children with an additional source of vulnerability. To this end, the study confirmed that biological parents' separation is correlated with inadequate acceptance by the

incoming stepparents, Pearson's $r(73)=.23$, $p=.024$, being both a stepmother, Pearson's $r(73)=.52$, $p<.001$ or a stepfather, Pearson's $r(73)=.30$, $p=.004$. A similar correlation with poor acceptance was found when the surviving parent remarries, Pearson's $r(73) = .19$, $p=.047$. Stepmothers' presence also correlated with child's mistreatment, Pearson's $r(73) =.24$, $p=.020$, and with physical abuse, Pearson's $r(73)=.24$, $p=.019$. One the other hand, the child-caregiver conflict showed stronger correlation with the presence of stepfathers, Pearson's $r(73)=.30$, $p=.005$. This suggests what studies have found about chronically neglecting families, which often are characterized by a chaotic household with changing constellations of adult and child figures (e.g. a mother and her children who live on and off with various others, like the mother's mother, temporary partners, or a boyfriend) (Polansky et al.,1992).

Research usually associates single parenthood with higher incidences of child's vulnerability. One study found that being in a single-parent household increased the risk of child neglect by 87% (Connell-Carrick, 2003). Many factors may account for this when there is only one parent or caregiver, such as less time available to accomplish the household tasks, including monitoring and spending time with children and earning sufficient money. Single parents often have to work outside the home, which might mean they are not always available to supervise their children.

This research found that, out of the whole experimental group, children living alone with a separated biological mother were 31.5%, while children of a single mother accounted only for 13.7% of the cases. These latter cases were found to be strongly correlated with inadequate maternal acceptance, Pearson's $r(73)=.31$, $p=.004$, and with severe exposure to sexual exploitation such as sexual abuse, Pearson's $r(73)=.23$, $p=.022$, prostitution, Pearson's $r(73)=.23$, $p=.024$, and child street life, Pearson's $r(73)=.32$, $p=.003$.

Table 11: Correlations between child's family ecology and child safety

Family ecology	Child safety	Pearson's correlation coefficient r	one-tailed P value
Biological parents separation	Inadequate acceptance by stepparent	.232*	.024
	Mistreatment	.197*	.048
Presence of stepmother	Inadequate acceptance by stepparent	.527**	.000
	Physical abuse	.244*	.019
	Mistreatment	.241*	.020
	Caregiver-child conflict	.194*	.050
Presence of stepfather	Inadequate acceptance by stepparent	.305**	.004
	Caregiver-child conflict	.303**	.005
Orphan of one parent	Inadequate acceptance by stepparent	.198*	.047
Orphan of both parents	No specific correlation found		
Child of single mother	Inadequate acceptance by parent	.312**	.004
	Sexual abuse	.236*	.022
	Prostitution	.232*	.024
	Street life experience	.325**	.003

** Correlation is significant at the 0.01 level

* Correlation is significant at the 0.05 level

3.2 Parents or Caregivers characteristics

Several individual characteristics are associated with children being at risk. In research, they are identified as parental characteristics such as mental illness, disability, depression, substance abuse, history of abuse as a child, unwanted pregnancy, sudden illness/chronic health problem (Daro, 1988). They are also featured as individual child characteristics

like *abuse-provoking* problems/traits, behavioural problems/hyperactivity, physical illness, physical/developmental disabilities (Daro, 1988).

3.2.1 Behavioural history

As with all risk factors, the presence of one or more risk behaviours does not mean that a parent or caregiver will be neglectful, but their identification is useful for targeting prevention and intervention services to address the challenges faced by at-risk families.

The study reviewed characteristics of parents and caregivers in the experimental group, in relation to main areas of investigation such as their individual behavioural history, which potentially contributed to their child's vulnerability.

The most prevalent individual parental characteristic identified as risk factor was alcohol abuse. Approximately one fifth (21.9%) of the caregivers had that condition, while 8.2% of cases were sexual workers mothers, and 6.8% had conflicts within the extended family or within the couple, and history of domestic violence.

Table 12: Caregivers' behavioural history

Characteristics of caregivers			
		N	**%**
Total sample		73	100.0
Caregivers behavioural history	alcohol addiction by parent/guardian	16	21.9
	prostitution by mother	6	8.2
	Prior neglect/abuse within extended family	5	6.8
	conflict within extended family	5	6.8
	domestic violence	5	6.8
	marital conflict	5	6.8
	Parent criminal activity/incarceration	3	4.1
	drugs addiction by parent	1	1.4

3.2.2 Substance Abuse

There is an established relationship between parental alcohol abuse and child vulnerability because substance abuse impairs one's mental functioning and can affect decision-making. Parents who are abusing substances often cannot make appropriate decisions, such as supervising their children adequately. They also often put their own needs ahead of the needs of the child, such as spending money on drinks rather than for the child needs (Donahue, 2004; Gottwald & Thurman, 1994). Reported rates of substance abuse by parents in the sample showed that child vulnerability has a strong association with substance abuse. Our study found that alcohol was the substance most likely to be abused by caregivers (21.9% of all cases), mostly alone and rarely in combination with other illicit drugs.

Substance abuse often co-occurred with other conditions, which were likely to co-occur and made it difficult to assess its impact on child maltreatment: high rate of domestic violence, Pearson's r (73)=.51, p<.001, marital conflict, Pearson's r (73)=.38, p<.001, and prostitution by the mother, Pearson's r (73)=.20, p=.042. Besides, caregivers with substance abuse dependency were more likely to present an inadequate acceptance of their children, Pearson's r (73)=.21, p=.037, who were exposed to exploitative labour, Pearson's r (73)=.22, p=.028, and suicidal patterns, Pearson's r (73)=.31, p=.003. Their children similarly appeared more likely to be affected by drug abuse, Pearson's r (73)=.22, p=.028.

3.2.3 Life Stressors

Parental stress alone needs not indicate significant risk to a child. However, if a parent's mental stress is associated with other risk factors, such as substance abuse, domestic violence or social isolation it may exacerbate characteristics in the family, such as hostility, anxiety, or depression, which may increase levels of family conflict and child maltreatment (Goldman & Salus, 2003; Milner, & Dopke, 1997).

Caregivers in the experimental group seemed to suffer from stressful life conditions which blocked the emotional capacity to provide for the basic needs of their children. In particular, the study found a very strong correlation between parents' unemployment, which affected 13.7% of the caregivers sample, and their emotional inability to care for the child (indicated by anger and depression), Pearson's r (73)=.36, p=.001, conflict within the extended family, Pearson's r (73)=.31, p=.003, child sexual abuse and prostitution, Pearson's r (73)=.46, p<.001, alcohol abuse, Pearson's r (73)=.28, p=.008, and child's rejection, Pearson's r (73)=.20, p=.039.

3.2.4 Family history

The way parents were reared can greatly affect the way they rear their own children. People who did not have their needs met by a parent when they were children may not know how to meet the needs of their own children. In line with other studies which found that neglectful parents have been maltreated as children (Zuravin, S., & DiBlasio, F. 1996; Weston, J., et al., 1993), this study found that parents who had experienced neglect or abuse within their extended family strongly correlated with single motherhood, Pearson's r (73)=.39, p<.001, and prostitution, Pearson's r (73)=.31, p=.003. Moreover, neglected parents were more likely to have children correlated with exposure to sexual abuse, Pearson's r (73)=.21, p=.033, or criminal behaviour, Pearson's r (73)=.21, p=.033, such as stealing, Pearson's r (73)=.27, p=.010. They also correlated with negative behaviours such as going to video rather than to school, Pearson's r (73)=.31, p=.003, abusing drugs, Pearson's r (73)=.21, p=.033, and going home late, Pearson's r (73)=.21, p=.037.

According to research, a troubled childhood may negatively affect one's ability to take care of one's own children (Gershater-Molko & Lutzker, 1999). Growing up in unstable, hostile, non-nurturing homes can lead to unstable personalities, to stressful marriages and abusive parenting practices with children (Gaudin, 1993).

Conflict within the extended family was present in 6.8% of the experimental group cases and it strongly associated with domestic violence, Pearson's r (73)=.35, p=.001, marital conflict, Pearson's r (73)=.35, p=.001, and emotional inability to care for the child, Pearson's r (73)=.31, p=.003. Children of this group of caregivers seemed more likely to be exposed to sexual abuse, Pearson's r (73)=.21, p=.033, and to have already been previously referred for alternative residential care, Pearson's r (73)=.28, p=.008.

Other studies found that parents' prior involvement with Child Protection Services (CPS) has been linked to subsequent reports of neglect. These parents may be discouraged, less likely to think that their situation will change, less willing to receive services, or less motivated to change. However, families who have been involved with CPS and had positive experiences may be more motivated and open to receiving services (Baird,Wagner & Neuenfeldt, 1993; Jones, 1987).

In this study, prior involvement of families with service providers such as alternative residential care (7 cases amounting to 9.6% of the total sample) was found to be strongly correlated with difficult family relationships, in particular related to domestic violence, marital and extended family conflicts, Pearson's r (73)=.28, p=.008.

3.2.5 Domestic violence

Children living in a home where domestic violence (6.8% of the experimental group) is present are at a greater risk. Our study found that domestic violence is correlated to all cases of marital conflict, Pearson's r (73)=.78, p<.001. It was likely to be present in families affected by alcohol addiction, Pearson's r (73)=.51, p<.001, and where parents suffer from impaired mental condition, Pearson's r (73)=.28, p=.007. It also connected to wider conflicts within the extended family, Pearson's r (73)=.35, p=.001.

Caregivers who are victims of domestic violence may be abused to

the point of being unable or unwilling to keep their abusers from also abusing the children because doing so might put theirs or their children's lives in danger or provoke more abuse. This type of neglect is often referred to as "failure or inability to protect the child from harm" (Lemon, 1999) and it may also be considered a form of emotional abuse. In line with these findings, the study revealed a strong correlation between the presence of violence in families and refusal of parental responsibility, Pearson's r (73)=.27, p=.010, which was also coupled with high likelihood of child's rejection in case of marital conflict, Pearson's r (73)=.27, p=.009. This condition correlated also with a caregiver's history of use of alternative residential care for the child, Pearson's r (73)=.28, p=.008.

In addition, studies show that in 30 to 60 percent of homes with identified cases of domestic violence, child maltreatment and other types of abuse are likely to exist (Bragg, 2003; Hughes, Parkinson & Vargo, 1989). We also found that domestic violence correlates with child's mistreatment, Pearson's r (73)=.25, p=.015, as well as with child exploitation through child labour, Pearson's r (73)=.21, p=.033.

Some research also suggests that exposure to domestic violence increases the likelihood that children will engage in delinquent and criminal behaviours as teenagers and adults and will have problems with violence in future relationships (Zuskin, 2000). However, we did not find any specific and significant correlation on this in the experimental group.

3.2.6 Criminal behaviour

Research found that parents who have committed a crime may be more likely to neglect their children (Gershater-Molko & Lutzker, 1999).

Though our study identified only three parents with such condition, it seemed to suggest that there is a strong correlation between parents criminal activity and incarceration and children difficult conditions such as being living in the streets, Pearson's r (73)=.34, p=.002, hav-

ing gone through previous alternative protective day care, Pearson's r (73)=.56, $p<.001$, and having inappropriate sexual behaviour, Pearson's r (73)=.40, $p<.001$. An additional correlation was identified with child's truancy, Pearson's r (73)=.24, $p=.020$, and spending the night outside the home, Pearson's r (73)=.20, $p=.043$. Again, some of this behaviours could find a tentative explanation in the fact that criminal activity strongly correlated to conflicting parent-child relationship, Pearson's r (73)=.28, $p=.008$.

Table 13: Parental competence

Parental competence		N	%
	Total sample	73	100.0
Parents/caretakers parenting failures	Inadequate caretaker's perception of child's needs	73	100.0
	Neglect/failure to protect	52	71.2
	Caretaker blaming of child and refusal to acknowledge family needs	41	56.2
	Violent punitive discipline	33	45.2
	Refusal of parental responsibility	24	32.9
	Inadequate acceptance by parent	23	31.5
	Inadequate acceptance by stepparent	20	27.4
	Inconsistency in discipline	17	23.3
	Emotional inability to care for the child	12	16.4

Inadequate caretaker's perception of child's needs was the most prevalent parenting failure found in the experimental group. According to all family assessments drafted by the caseworkers, every single child had caregivers with inadequate awareness of their needs (100%). This finding corroborates what has been established by other studies observing that the most common response given by neglectful mothers was that there was nothing wrong with their behaviour (Coohey, 2003; Jones, 1987) and that there are links between child neglect, poor parenting skills, and inadequate knowledge of childhood development (Azar & Soysa, 2000). Parents who are unaware of the developmental abilities and

needs of their children may have unrealistic expectations and be more likely to neglect them. This appeared in some of the experimental group cases, where parents expected that their children could be left alone at night having inadequate understanding of their needs and abilities.

The study identified other high frequency parenting failures such as neglect/failure to protect the child (71.2%), putting the blame on the child and being unwilling to acknowledge deeper family needs (56.2%), adopting violent punitive discipline (45.2%), as well as downplaying parental responsibility in the child's care (32.9%).

Inadequate child's acceptance was found both in parents (31.5% of cases) and stepparents (27.4% of cases). In particular, this happened among 70% of all stepparents. A strong correlation was found between inadequate acceptance and stepmothers, Pearson's $r\,(73) = .52$, $p < .001$, as well as stepfathers, Pearson's $r\,(73) = .30$, $p = .004$, suggesting that separated and recomposed families raise higher risks of rejection. Single mothers also appeared to be a category of caregivers which strongly correlated with inadequate parental acceptance, Pearson's $r\,(73) = .31$, $p = .004$, and with parental rejection, Pearson's $r\,(73) = .35$, $p = .001$. Inadequate acceptance by parent correlated with child's street life experience, Pearson's $r\,(73) = .19$, $p = .050$.

The caregiver-child conflict appeared to be affecting half of the cases (52.1%), emerging as one of the most relevant risk factors in the experimental group. In percentage, mothers seemed to be the caregiver who most exposes the child to conflict (20.5% of cases) and rejection (15.1% of cases) but a strong correlation between conflict and caregiver pointed to the relationship between the child and the stepfather, Pearson's $r\,(73) = .30$, $p = .005$, while a weaker correlation was found in the conflict between child and stepmother, Pearson's $r\,(73) = .19$, $p = .050$. These conflicts seemed to be one of the main factors connected with child's physical abuse, Pearson's $r\,(73) = .30$, $p = .005$. The study also found that 23.3% of caregivers were inconsistent with discipline, alternating harsh and excessive punishment with soft or no care attitude.

3.2.7 Physical and Mental Health

Only two certified cases of caregivers' severe impaired physical condition were found. Physical ailment was strongly correlated to parents unemployment, Pearson's r (73)=.42, p<.001, poverty, Pearson's r (73)=.33, p=.002, parental incarceration, Pearson's r (73)=.38, p<.001, and child's sexual abuse, Pearson's r (73)=.38, p<.001. Though the number of cases identified was not significant, there is a strong suggestion for physical impairment to be correlated to lack of resources and to inability to protect the child from abuse.

Mental disorders were also affecting two mothers and this condition was strongly associated with domestic violence, marital conflict and conflict within the extended family, (all correlations scored Pearson's r (73)=.28, p=.007). However, this mental condition did not correlate with other parenting failures. Likewise, the caregiver's emotional inability to care for the child due to anger, stress or depression was recognized in 12 cases (16.4%), and was strongly correlated with conflict within the extended family, Pearson's r (73)=.31, p=.003, suggesting the possibility for poor mental health to be connected to unhealthy relationship, in particular within the extended family.

4. CHILD LEVEL

4.1 Child characteristics

The following table shows the main characteristics of children in the experimental group, which the study explored to identify their risk profile.

Table 14: Children characteristics

Child characteristics			
		N	%
Total sample		73	100.0
Children's gender	Male	43	58.9
	Female	30	41.1
Age cohorts	7-9	10	13.7
	10-13	49	67.1
	14-17	14	19.2
Number of siblings	1	9	12.3
	2	13	17.8
	3	20	27.4
	4	14	19.2
	5 or more	15	20.5
Position among siblings	First born	39	53.4
	Second born	17	23.3
	Third born	9	12.3
	Fourth born	5	6.8
Child's class attended	Std 1 – std 3	27	37.0
	Std 4 – std 6	37	50.7
	Std 7 – std 8	5	6.8
	Form1 – form 3	2	2.8

4.1.1 Gender

Male children appeared to be more represented in the sample (58.9%), though the percentage of the female child was higher than the average 30% representing the usual presence of female children among the general population of the Nairobi Children Remand Home.

Male children appeared to strongly correlate with domestic violence and marital conflict, both with Pearson's r (73)=.32, p=.005. A strong correlation was also found between them and alcohol addiction by care-

giver, Pearson's r (73)=.36, p=.001, lying, Pearson's r (73)=.23, p=.046, scavenging, Pearson's r (73)=.29, p=.012, and going to video, Pearson's r (73)=.25, p=.033.

Female children strongly correlated with inadequate acceptance by stepparent, Pearson's r (73)=.30, p=.008, child sexual abuse and child labour, Pearson's r (73)=.24, p=.035.

4.1.2 Age

Children within the 6-9 age bracket represented 13.7% of the experimental group, while adolescents between 14 and 17 years of age represented 19.2% of the same. Children from age 10 to 13 were 67.1%, being the highest representation rate, with 42.2% of the total sample between the age of 10 and 11. This appeared to be the most numerous age cohort, suggesting that this might be the age bracket with greatest vulnerability. The study confirmed that this was the only age group which correlated with specific risk factors such as drugs/alcohol abuse, Pearson's r (73)=.29, p=.011, inappropriate sexual behaviour, Pearson's r (73)=.26, p=.022, and suicidal attempts, Pearson's r (73)=.24, p=.041.

An additional finding from the research was that age and gender didn't correlate with permanency after the conference, suggesting that the child's stability could be developed at any point in life and regardless of gender.

4.1.3 Number of siblings

One-child families were a minority (12.3%), while families with five or more children represented 20.5% of the sample. The mean was about three children per family. The largest group, representing 64.4% of the families, had between 2 to 4 children contradicting the general perception that numerous families are more correlated with child vulnerability, as other studies suggest that families with vulnerable children tend to have more children or greater numbers of people living in the household when compared to similar non-neglecting families (Sedlak & Broadhurst, 1996; Polansky et al., 1985).

Correlations were explored to find if the number of siblings was connected with specific risk factors. Children of the experimental group were subdivided into three cohorts according to the number of their siblings: cohort 1-2 siblings, cohort 2-4 siblings and cohort 5-8 siblings. As indicated in table 15, it was found that a low number of siblings (1-2) corresponded to FGDM plan not being implemented and less community involvement in it. However, this group seemed to be safer by inversely correlating to child sexual abuse.

The group with high number of siblings (5-8) correlated with satisfactory FGDM plan implementation and community involvement on it. It appeared to positively correlate with low accumulation of risk factors (1-5), but on the other hand children in this group seemed to be highly exposed as victims of abuse/unsafe conditions.

These findings suggest that families with high number of children correlate with low accumulation of risk factors and seem to be more successful in the FGDM plan implementation through networking with their communities, contrary to what seemed to happen to families with few children.

Table 15: Siblings groups' correlations summary

Siblings groups	**Factors**	**Pearson's correlation coefficient *r***	**two-tailed *P* value**
Group 1-2	Biological parents separation	.289*	.006
	Child sexual abuse	-.315*	.004
	FGDM plan not implemented	.295*	.006
	Community members involved in the FGDM plan implementation	-.287*	.007
Group 3-4	Single mother	-.319**	.003
	Going home late	.288*	.006
	Community members involved in the FGDM plan implementation	.277*	.009

Group 5-8	FGDM plan fully implemented	.232*	.024
	FGDM plan fully implemented by community	.265*	.011
	Low accumulation of risk factors (1-5)	.232*	.023
	High exposure as victims of abuse/ unsafe conditions	.239*	.022

** Correlation is significant at the 0.01 level

* Correlation is significant at the 0.05 level

4.1.4 Position among siblings

The study identified first born children as the most exposed to vulnerability, representing 53.4% of the total sample. Second born followed being 23.4%. Other positions among siblings represent only 20.5% of the whole sample. No significant correlation was found between their birth position and specific risk factors.

4.1.5 Level of education

Almost all children in the sample were within the primary school education system, most of them being between std.1 and std.6 (87.7% of the total). Half children of the sample were between Std.4 and Std.6. On the whole, they match the 67.1% of children being between 10 and 13 years old, an age bracket corresponding to the mentioned classes. Only two children had never attended school.

4.1.6 Internalized and Externalized Behaviour Problems

Children can exhibit difficulties or problems by expressing them internally or externally. Internalizing behaviours or feelings means directing them inwardly, such as through depression, which was assessed to be present in 11.0% of the experimental group. Externalized behaviours or feelings are characterized by outward expressions which are easily observable, such as in displaying aggression, found in 11.0% of the experimental group. These children often receive more attention than

those who internalize and rarely act out, because their behaviour is often disruptive to others (Sherman & Holden, 2000). The child's age and developmental level was considered as a relevant variable when assessing a child for behavioural problems.

A distinct set of antisocial behaviours was identified in the children's sample, though it remains unclear the causal connection: children developed behavioural problems because they were vulnerable or were they vulnerable because they had behavioural problems? Besides, when considering the relationship between antisocial behaviour and child vulnerability, we kept in mind that most information came from the caregiver and it was difficult to assess whether the child actually had more behaviour problems or if the parent merely believed that the child had them. Parental difficulties, negative feelings, life style and behaviour can also affect children, resulting in children exhibiting a variety of behaviour problems. The study showed that a correlation appeared to exist between children with impaired mental condition and parental dysfunctions such as prostitution by mother, Pearson's $r\,(73)=.21$, $p=.034$. Since these children were likely to sleep outside the home, Pearson's $r\,(73)=.30$, $p=.004$, this suggest a degree of neglect by their caregivers. Impaired physical condition correlated with alcohol addiction by parents, Pearson's $r\,(73)=.22$, $p=.029$. Prostitution by mother correlated with child early separation from her, Pearson's $r\,(73)=.25$, $p=.014$.

Child's antisocial behaviours were analyzed in correlation with three distinct parental factors: family ecology, parents' behaviour history and parental competence. It was found that parental behaviour history had the greatest number of correlation with the child's antisocial behaviour.

Family ecology correlated with 6 antisocial behaviours. Single motherhood had the highest numbers of correlations with child's difficult behaviour, in particular street life, Pearson's $r\,(73)=.32$, $p=.003$, and drugs abuse, Pearson's $r\,(73)=.40$, $p<.001$.

Inadequate parental competence correlated with 9 antisocial behaviours, most of which resulting in a progressive exiting of the child

from the home. Blame on the child was associated with child's scavenging, truancy, negative peer pressure and street life. Blame and refusal of parental responsibility correlated with sleeping outside at night. Parental inadequate acceptance of the child was linked to street life and drugs abuse. Prostitution was correlated with inconsistent discipline and emotional inability to care

Parents' behavioural history correlated with 11 antisocial behaviours. Prostitution by mother was strongly correlated with numerous negative behaviours such as the child's criminal behaviour, Pearson's r (73)=.44, p<.001, prostitution, Pearson's r (73)=.39, p<.001, drug abuse, Pearson's r (73)=.44, p<.001, and aggressiveness or violence, Pearson's r (73)=.37, p=.001.

Strong correlations were also found between prior neglect/abuse within the extended family and the child's stealing, Pearson's r (73)=.27, p=.010, or going out for video shows, Pearson's r (73)=.31, p=.003. Parental criminal past strongly correlated with the child's street life experience, Pearson's r (73)=.34, p=.002, and inappropriate sexual behaviour, Pearson's r (73)=.40, p<.001.

Table 16: Family ecology and child anti-social behaviour correlations

Family ecology	Child anti-social behaviour	Pearson's correlation coefficient *r*	one-tailed *P* value
Biological parents separation	Street life experience	.206*	.040
	Going to video	.267*	.011
Orphan of one parent	Scavenging	.386**	.000
Child of single mother	Criminal behaviour	.236*	.022
	Street life experience	.325**	.003
	Scavenging	.256*	.014
	Prostitution	.232*	.024
	Going to video	.218*	.032
	Drugs abuse	.407**	.000

** Correlation is significant at the 0.01 level

* Correlation is significant at the 0.05 level

Table 17: Parents behavioural history and child anti-social behaviour correlations

Parents behavioural history	Child anti-social behaviour	Pearson's correlation coefficient *r*	one-tailed *P* value
Prior neglect/abuse within extended family	Criminal behaviour	.217*	.033
Prior neglect/abuse within extended family	Lying constantly	.207*	.039
Prior neglect/abuse within extended family	Stealing	.272**	.010
Prior neglect/abuse within extended family	Going to video	.314**	.003
Prior neglect/abuse within extended family	Drug abuse	.217*	.033
Parent criminal activity/ incarceration	Street life experience	.342**	.002
Parent criminal activity/ incarceration	Sleeping outside of home	.202*	.043
Parent criminal activity/ incarceration	Truancy	.241*	.020
Parent criminal activity/ incarceration	Inappropriate sexual behaviour	.401**	.000
Domestic violence	Sleeping outside of home	.222*	.029
Prostitution by mother	Criminal behaviour	.441**	.000
Prostitution by mother	Inappropriate sexual behaviour	.241*	.020
Prostitution by mother	Prostitution	.394**	.000
Prostitution by mother	Drug abuse	.441**	.000
Prostitution by mother	Violent/aggressive	.374**	.001
Alcohol addiction by parent/guardian	Prostitution	.222*	.029
Alcohol addiction by parent/guardian	Drug abuse	.224*	.028
Drugs addiction by parent	Sleeping outside of home	.206*	.040
Emotional inability to care for the child	Prostitution	.266*	.012
Emotional inability to care for the child	Drug abuse	.281*	.008

** Correlation is significant at the 0.01 level

* Correlation is significant at the 0.05 level

Table 18: Parental competence and child anti-social behaviour correlations

Parental competence	Child anti-social behaviour	Pearson's correlation coefficient *r*	one-tailed *P* value
Caretaker blaming of child and refusal to acknowledge family needs	Street life experience	.247*	.017
	Sleeping outside of home	.249*	.017
	Scavenging	.222*	.030
	Truancy	.200*	.045
	Stealing	.266*	.012
	Under negative peer pressure	.196*	.048
	Violent/aggressive	.222*	.030
Violent punitive discipline	No specific negative behaviour		
Refusal of parental responsibility	Sleeping outside of home	.209*	.038
Inconsistency in discipline	Prostitution	.214*	.035
	Under negative peer pressure	.267*	.011
Emotional inability to care for the child	Prostitution	.266*	.012
	Drugs abuse	.281**	.008
	Violent/aggressive	.199*	.045

** Correlation is significant at the 0.01 level

* Correlation is significant at the 0.05 level

4.1.7 Child's safety

Child's unsafe conditions were analyzed to identify their related risk factors. Eleven risk factors correlated with sexual abuse, while 8 with suicidal attempts, 7 with mistreatment and 6 with emotional abuse. Sexual abuse scored the highest correlation frequency with factors indicating failure to protect due to physical, emotional and parenting inability, alongside with internal family conflicts and history of abuse. Family

ecology involving parents' separation and presence of stepmothers was associated with physical abuse and mistreatment. Crosscutting risk factors were violent punitive discipline found in emotional, physical abuse and mistreatment, child caregiver conflict found in physical, sexual abuse and mistreatment. History of child's institutional care associated with conflicting relationship within the family

Very strong correlations were found between emotional abuse and suicidal attempts, Pearson's r (73)=.29, p=.006, physical abuse and violent punitive discipline, Pearson's r (73)=.39, p<.001. Sexual abuse strongly correlated with emotional inability to care for the child, Pearson's r (73)=.46, p<.001, parents impaired physical condition, Pearson's r (73)=.38, p<.001, child's suicidal attempts Pearson's r (73)=.38, p<.001, prostitution, Pearson's r (73)=.56, p<.001, and drugs abuse, Pearson's r (73)=.30, p=.004.

Table 19: Child safety and risk factors correlations

Child safety	Risk factors	Pearson's correlation coefficient r	one-tailed P value
Emotional abuse	Violent punitive discipline	.247*	.018
	Suicidal attempt	.293**	.006
	Impaired medical condition	.206*	.040
	Withdrawn/depressed	.206*	.040
	Prostitution	.206*	.040
	Drugs abuse	.202*	.043
Physical abuse	Child-caregiver conflict	.246*	.018
	Violent punitive discipline	.396**	.000
	Presence of stepmother	.244*	.019
Mistreatment	Parents separation	.197*	.048
	Presence of stepmother	.241*	.020
	Domestic violence	.253*	.015
	Marital conflict	.253*	.015
	Neglect/failure to protect	.195*	.049
	Violent punitive discipline	.241*	.020
	Child-caregiver conflict	.258*	.014

Sexual abuse	Single mother	.236*	.022
	Parent impaired physical condition	.388**	.000
	Emotional inability to care for child	.467**	.000
	Prior neglect/abuse within extended family	.217*	.033
	Conflict within extended family	.217*	.033
	Parents' inconsistency in discipline	.212*	.036
	Child's suicidal attempt	.388**	.000
	Child-caregiver conflict	.199*	.046
	Sleeping outside of home	.202*	.043
	Child's prostitution	.569**	.000
	Child's drugs abuse	.305**	.004
Child labour	Domestic violence	.217*	.033
	Marital conflict	.217*	.033
	Alcohol addiction by parent	.224*	.028
Suicidal attempt	Prostitution by mother	.255*	.015
	Alcohol addiction by parent	.317**	.003
	Child's impaired physical/medical condition	.702**	.000
	Chil'd emotional abuse	.293**	.006
	Child's sexual abuse	.388**	.000
	Inappropriate sexual behaviour	.230*	.025
	Child's prostitution	.702**	.000
	Child's drugs/alcohol abuse	.388**	.000
History of child placement under residential care	conflict within extended family	.280**	.008
	domestic violence	.280**	.008
	marital conflict	.280**	.008
	drugs addiction by parent	.362**	.001
	Neglect/failure to protect	.207*	.039

History of child place-ment under day care	parent criminal activity/ incarceration	.569**	.000

** Correlation is significant at the 0.01 level

* Correlation is significant at the 0.05 level

4.1.8 Caregiver-child's Attachment

A long tradition of research suggests that the quality of parent–child attachment is related to children's developmental outcomes (e.g., Bowlby, 1969; Ainsworth, Blehar, Waters & Wall, 1978; Bohlin, Hagekull, &Rydell, 2000; Laible & Thompson, 1998).

It also confirms that adolescents who have not developed secure attachment behaviours are more prone to depression or anxiety and more likely to get involved with drug abuse, antisocial behaviour/aggression, or engage in risky sexual activities (Doyle & Moretti, 2000).

The study revealed that children who had experienced separation from their primary caregiver at early age (0-4) due to abandonment, death or separation were 41.1% of the sample. They appeared to be at high risk of vulnerability being more exposed than the rest of the sample to withdrawal and depression, Pearson's r (73)=.24, p=.020. They were still undergoing severe bonding disconnection being subject to refusal of parental responsibility, Pearson's r (73)=.24, p=.018. After the family conference they tended to be sent to upcountry relatives for care, Pearson's r (73)=.20, p=.040, rather than been kept at home by parents. They correlated with mothers engaging in prostitution as well, Pearson's r (73)=.25, p=.014.

Environmental conditions such as living within hazardous areas were also found to highly correlate with child separation from primary caregiver at early age, Pearson's r (73)=.32, p=.002, suggesting an environmental pressure on mothers who early separated from their children.

The study confirmed findings on the correlation between negative attachment and child's antisocial behaviours. Instances of separation, inadequate acceptance, rejection and conflict with caregiver, correlated

with drugs abuse, inappropriate sexual behaviour and prostitution, as well as with a tendency of exiting the parental home.

Conflicting relationship between parent and child indicated presence of significant risk factors such as physical abuse, Pearson's r (73)=.24, p=.017, sexual abuse, Pearson's r (73)=.19, p=.046, and mistreatment, Pearson's r (73)=.25, p=.014.

Table 20 : Negative attachment and risk factors correlations

Negative Attachment	Risk factors	Pearson's correlation coefficient *r*	one-tailed *P* value
Abandonment/ separation by primary caregiver at early age	withdrawal and depression	.242*	.020
	drugs abuse	.248*	.017
	going home late at night	.203*	.043
Inadequate acceptance by parent	street life experience	.194*	.050
	drug abuse	.305**	.004
Caregiver-child conflict	inappropriate sexual behaviour	.283*	.031
	physical abuse	.246*	.018
	Mistreatment	.258*	.014
	sexual abuse	.199*	.046
Rejection	being under previous residential care	.204*	.042
	Prostitution	.243*	.019
	drug abuse	.247*	.017

** Correlation is significant at the 0.01 level

* Correlation is significant at the 0.05 level

5. ACCUMULATION OF RISK FACTORS

Five risk factors caravans were identified to cluster the already analysed risk factors into five dimensions to model the occurrences of specific types of risks exposure, unpack them into specific categories and find their differential links to key psychosocial consequences. Here, the researcher goal was to identify relations among events/situations and

their psychosocial consequences. The previous risks analysis facilitated in picking risks factors and clustering them, by looking at whether they fell into the following broad areas in relation to the child:

1. direct exposure to abuse or unsafe conditions;
2. witnessing continuous external threat;
3. engaging in direct antisocial behaviour;
4. exposure to caregiver loss, separation and attachment threats, and
5. being under constant emotional threat by caregiver.

These clusters were analyzed to establish their frequency and level of accumulation.

5.1 Frequency analysis

A frequency analysis of the risk factors identified by the researcher as contributor to the composite and gathered within five composite clusters is shown in the following table.

Table 21: Risk factors clusters frequency

		N	%
Total sample		73	100.0
CLUSTER 1 Direct exposure as victims of abuse or unsafe conditions	Neglect/ failure to protect by caregivers	52	71.2
	Mistreatment	39	53.4
	Violent punitive discipline by caregivers	33	45.2
	Physical abuse*	21	28.8
	Emotional abuse	18	24.7
	Child impaired mental/emotional condition	8	11.0
	Child being withdrawn – depressed	8	11.0
	Sexual abuse*	3	4.1
	child labour	3	4.1
	Child suicidal attempts	2	2.7
	Prostitution	1	1.4
	Child impaired physical/medical condition	1	1.4

CLUSTER 2 Witnessing continuous external threat	Living in environmental hazard/ slum area	50	68.5
	Affected by negative peer pressure	26	35.6
	Disconnection of family from community social support	25	34.2
	Alcohol addiction – parents*	16	21.9
	Homelessness/poverty	15	20.5
	Parents' unemployment	10	13.7
	Prostitution by mother*	6	8.2
	Domestic violence	5	6.8
	Marital conflict	5	6.8
	Conflict with extended family	5	6.8
	Parent criminal activity/incarceration	3	4.1
	Parent impaired physical/medical condition	2	2.7
	Parent impaired mental condition	2	2.7
	Drugs addiction – parents*	1	1.4
CLUSTER 3 Engaging in direct antisocial behaviour	Runaway	68	93.2
	Truancy	31	42.5
	Stealing (without incrimination)	24	32.9
	Going home late at night	19	26
	Sleeping outside at night	18	24.7
	Lying constantly	10	13.7
	Street life (more than one month)	9	12.3
	Scavenging	8	11.0
	Violent/aggressive	8	11
	Inappropriate sexual behaviour	7	9.6
	Going to video	6	8.2
	Criminal behaviour (with court case)	3	4.1
	Drugs or alcohol abuse	3	4.1

CLUSTER 4 Exposure to caregiver loss, separation and attachment threats	Abandonment/separation from mother at early age	30	41.1
	Biological parents separation	29	39.7
	Presence of stepmother	19	26.0
	Orphan of one parent	14	19.2
	Single mother	13	17.8
	Presence of stepfather	10	13.7
	being under previous alternative residential care	7	9.6
	Orphan of both parents	6	8.2
	Single father	0	0.0
CLUSTER 5 Being under constant emotional threat by caregiver	Inadequate caretaker's perception of the child's needs	73	100.0
	Caretaker blaming of the child and refusal to accept identified family needs	41	56.2
	Caregiver-child conflict	38	52.1
	Refusal of parental responsibility	24	32.9
	Inadequate acceptance of child by parent	23	31.5
	Child's rejection	21	28.8
	Inadequate acceptance of child by stepparent	20	27.4
	Parents' inconsistency in discipline	17	23.3
	Emotional inability to care for child (anger, stress, depression)	12	16.4
	Prior parental neglect/abuse within extended family	5	6.8

*overrides: very severe incidents or conditions raising the risk factor to very high level

Clusters having high frequency of risk factors (> 40% of all cases) were explored. The most recurrent risk factors were found in cluster 5, having children under constant emotional threat by caregiver. Here, the most recurrent risk factors found in the experimental group were inadequate caretaker's perception of their children needs (100% of all cases), caretaker blaming of the child and refusal to accept identified

family needs (56.2%) and caregiver-child conflict (52.1%). Cluster 1, having children under direct exposure as victims of abuse or unsafe conditions followed. Here, most frequent risk factors were neglect/failure to protect by caregivers (71.2%), mistreatment (53.4%) and violent punitive discipline by caregivers (45.2%). Cluster 3, children engaging in direct antisocial behaviour, came third. Here, most frequent risk factors were children being runaways (93.2%) and truant (42.5%). Cluster 2, witnessing continuous external threat, had living in environmental hazard/slum area (68.5%) as its most recurrent risk factor.

In cluster 4, exposure to caregiver loss, separation and attachment threats, experiencing abandonment/separation from mother at early age affected the highest percentage of cases (41.1%), immediately followed by biological parents' separation (39.7%).

The risk factors mean percentage for individual clusters was calculated to confirm their frequency ranking. Again, cluster 5 on being under constant emotional threat was established to be first, achieving the highest average (37.5% of all cases) in frequency of risk factors. On the other hand, cluster 3, engaging in antisocial behaviour appeared to come before cluster 1, direct exposure as victims of abuse.

Table 22: Risk factor clusters frequency ranking

Frequency Ranking	RISK FACTOR CLUSTERS		Risk Factors Mean Percentage
1	CLUSTER 5	Being under constant emotional threat by caregiver	37.5%
2	CLUSTER 3	Engaging in direct antisocial behaviour	22.6%
3	CLUSTER 1	Direct exposure as victims of abuse or unsafe conditions	21.6%
4	CLUSTER 4	Exposure to caregiver loss, separation and attachment threats	19.5%
5	CLUSTER 2	Witnessing continuous external threat	16.7%

Correlations were explored according to the five risk factor clusters. Overriding risk factors such as sexual and physical abuse as well as alcohol, drug addiction and prostitution by caregiver were considered in the analysis.

A first finding was a strong correlation (up to Pearson's $r(73)=.41, p<.001$) between all the clusters (with the only exception of cluster 1) and a high accumulation of risk factors (16 >), suggesting a quite high extent of child's exposure to a consistent amount of unsafe life conditions.

Although the literature identifies a general dose-response effect between magnitude of exposure and associated child distress reactions, evidence of differential effects emerged. The analysis on the kind of exposure to vulnerability indicates that girls are more likely to be direct victims of abuse or unsafe conditions, Pearson's $r(73)=.23$, $p=.050$, and to be witnessing continuous external threat, Pearson's $r(73)=.39$, $p=.001$, than boys are. In contrast, boys appeared to be at higher risk for disruptions in behavioural adaptation including externalizing antisocial behaviour, Pearson's $r(73)=.24, p=.038$. To this end, living alone with a mother being widow, separated or single appeared to be unpacking the child's engagement in antisocial behaviour, Pearson's $r(73)=.28$, $p=.015$. In line with this, the persistence of this kind of distress reactions may be associated with the severity of exposure to single headed families and it may be maintained by parenting dysfunctions such as child rejection, Pearson's $r(73)=.25$, $p=.031$, as well as by additional stressors, indicated by a contingent over accumulation of > 16 risk factors, Pearson's $r(73)=.35, p=.002$.

Furthermore, an analysis was done to unpack associations with the FGDM conference.

On FGDM participation it was found that specific risk clusters related with the attendance of diverse participants. Child's direct exposure as victims of abuse or unsafe conditions, having physical abuse as a critical component, Pearson's $r(73)=.33, p=.004$, brought into the FGDM conference village elders, Pearson's $r(73)=.23$, $p=.046$, and

religious leaders, Pearson's r (73)=.34, p=.003. Similarly, being under constant emotional threat by caregiver engaged village elders, Pearson's r (73)=.33, p=.004. The attendance of personnel from the provincial administration could be justified by concerns on children safety being citizen's security its mandate, while ethical concerns were brought about by faith based organizations.

Besides, children witnessing continuous external threat brought into the conference more powerful representatives of the provincial administration such as chiefs or their assistants Pearson's r (73)=.38, p=.001, as well as public officers such as class teachers, Pearson's r (73)=.24, p=.035, and also influenced the FGDM venue, being shifted from family homes to chiefs offices, Pearson's r (73)=.21, p=.016, in a mutually agreed and yet critical move, possibly meant both by families and caseworkers to protect children from harmful overriding threats such as parents' alcohol addiction, Pearson's r (73)=.29, p=.012.

Child's engagement in direct antisocial behaviour unfolded that the related families positively associated with participating in the case planning and identified as their major FGDM goal the development of a family reintegration plan. This family concern was confirmed as well by the FGDM conference attendance by fathers, Pearson's r (73)=.24, p=.037, and family friends, Pearson's r (73)=.24, p=.036. Class teachers also correlated with participation, Pearson's r (73)=.23, p=.048. This finding suggests a conference cultural connection with traditional and current figures primarily concerned with behaviour correction being principally a family issue, e.g. the male parent attendance, but also a community concern being represented by teachers, as well as by people close to the family such as family friends.

Likewise, child's exposure to caregiver loss, separation and attachment threats unfolded the participation of mothers, Pearson's r (73)=.31, p=.006, traditionally being delegated to bond with children at emotional and affective level, as well as of religious leader/representative, Pearson's r (73)=.24, p=.040, being habitually concerned with internal family connections and relationships.

About **child's needs explicitly addressed at the FGDM conference,** cluster 1, being victims of abuse or unsafe conditions and cluster 2, been witnessing continuous external threat, correlated with child's safety, both scoring Pearson's r (73)=.33, p=.004. Cluster 5, being under constant emotional threat by caregiver scored a similar correlation with child's safety, Pearson's r (73)=.28, p=.015, (see its association with child's sexual abuse, Pearson's r (73)=.24, p=.040), but it also included the child's wellbeing and development, Pearson's r (73)=.25, p=.030. In spite of this overt inclusion of needs, this very cluster unfolded a negative **implementation of the FGDM plan**, Pearson's r (73)=.36, p=.002, suggesting that related risk factors may negatively affect the carrying out of family commitments promised at the FGDM. To this emotional threat by caregivers, children may have responded by engaging in self-protective strategies such as going home late, Pearson's r (73)=.24, p=.034.

On the contrary, cluster 2, been witnessing continuous external threat, correlated with successful long term child's stability after the FGDM conference, Pearson's r (73)=.27, p=.020. This finding was as well confirmed by a correlation with positive permanency with parents/extended family 2 yrs after the conference, Pearson's r (73)=.29, p=.011, suggesting that the related risk factors may be positively dealt with by this methodology. An additional unique feature which might have been critical to achieve FGDM long term positive results, was found in the correlation between this cluster and the FGDM plan when including community participants to check on aftercare, Pearson's r (73)=.26, p=.025.

On plan implementation, cluster 3, referring to child's direct antisocial behaviours, revealed the reliable involvement of the community in it, Pearson's r (73)=.23, p=.048, suggesting that child's negative behaviours may be taken as an important concern by community members, being willing to provide direct intervention. On the other end cluster 4, Exposure to caregiver loss, separation and attachment threats, being more related to internal family issues strongly correlated with family

members involved in the plan implementation, Pearson's r (73)=.33, p=.004. Reasonably, this risk factor cluster strongly correlated with children living with stepparent, Pearson's r (73)=.44, p<.001, and missing both parents, Pearson's r (73)= -.27, p=.017.

On the FGDM outcomes, cluster 4 again emerged to positively correlate with at least fair changes of abusive patters, Pearson's r (73)=.27, p=.019, and with reduction of harm, Pearson's r (73)=.26, p=.021, in the child's family after the FGDM conference. On the contrary it was inversely correlated with match of services in the community, Pearson's r (73)= -.27, p=.018, and positively strongly correlated with child attending boarding school at the time of research, Pearson's r (73)=.31, p=.006, suggesting that the FGDM may bring positive effects to children affected by loss and separation and living in family settings with abusive patterns but have less impact or require less community engagement for provision of services to the same child, since the boarding school opportunity as well was provided by the family.

A similar negative outcome was found between cluster 2, witnessing continuous external threat, and the child-parent/caregiver quality relationship, Pearson's r (73)=.24, p=.040, the stability of current placement with family Pearson's r (73)=.24, p=.036, and provision of educational needs, Pearson's r (73)=.27, p=.017.

These findings may suggest that cluster 2 unfolds threats to the child able to override FGDM long term outcomes, an effect that needs to be further understood to assess the FGDM suitability for such cases.

Taken together, these findings constitute some progress in conceptualizing and testing hypotheses relating to the mechanisms and processes that underlie the etiology and course of clinically significant dysfunctions following accumulation of risks exposure and their relations with the FGDM conference and outcomes, as they are presented in table 23.

Table 23: Risk factor clusters and their correlations

Children's Risk Factor Clusters	Correlated Factors	Pearson's correlation coefficient *r*	two-tailed *P* value
CLUSTER 1 Direct exposure as victims of abuse or unsafe conditions	Female	.230*	.050
	FGDM participants: village elder	.234*	.046
	FGDM needs addressed: child's safety stated	.331**	.004
	Physical abuse	.337**	.004
	FGDM participants: religious leader/ representative	.345**	.003
CLUSTER 2 Witnessing continuous external threat	Female	.396**	.001
	Successful FGDM	.273*	.020
	FGDM participants: chief/assistant chief	.385**	.001
	FGDM held at Chiefs/DCOs office	.281*	.016
	FGDM needs addressed: child's safety stated	.331**	.004
	FGDM plan: community participants to check on aftercare	.263*	.025
	FGDM outcome: P2 - positive relation child-parent/caregiver	-.241*	.040
	FGDM outcome: WB2-provision of educational needs	-.277*	.018
	Positive permanency with parents/ extended family after 2 yrs	.295*	.011
	Accumulation of 16-20 risk factors	.335**	.004
	Alcohol addiction by parent/guardian	.292*	.012
	FGDM participants: class teacher	.248*	.035
	FGDM outcome: P1-stability of current placement with family	-.246*	.036

<table>
<tr><td rowspan="10">CLUSTER 3 Engaging in direct antisocial behaviour</td><td>Male</td><td>.243*</td><td>.038</td></tr>
<tr><td>Living with only mother, widow, separated, single</td><td>.284*</td><td>.015</td></tr>
<tr><td>FGDM participant: father</td><td>.245*</td><td>.037</td></tr>
<tr><td>FGDM goal: develop family reintegration plan</td><td>.251*</td><td>.032</td></tr>
<tr><td>FGDM outcome: WB1-family participation in case planning</td><td>.275*</td><td>.018</td></tr>
<tr><td>Accumulation of 16-> risk factors</td><td>.359**</td><td>.002</td></tr>
<tr><td>Child’s rejection</td><td>.252*</td><td>.031</td></tr>
<tr><td>FGDM participants: family friend</td><td>.246*</td><td>.036</td></tr>
<tr><td>FGDM participants: class teacher</td><td>.232*</td><td>.048</td></tr>
<tr><td>FGDM plan: implemented by community all of it</td><td>.232*</td><td>.048</td></tr>
<tr><td rowspan="10">CLUSTER 4 Exposure to caregiver loss, separation and attachment threats</td><td>Living with both parents</td><td>-.279*</td><td>.017</td></tr>
<tr><td>Living with stepparent present</td><td>.445**</td><td>.000</td></tr>
<tr><td>Currently attending boarding school</td><td>.319**</td><td>.006</td></tr>
<tr><td>FGDM participant: mother</td><td>.316**</td><td>.006</td></tr>
<tr><td>FGDM participants: religious leader/representative</td><td>.241*</td><td>.040</td></tr>
<tr><td>FGDM plan: family members involved in the plan implementation</td><td>.334**</td><td>.004</td></tr>
<tr><td>FGDM outcome: S1-abusive patterns in family have changed</td><td>.275*</td><td>.019</td></tr>
<tr><td>FGDM outcome: S2-risk of harm has been reduced</td><td>.269*</td><td>.021</td></tr>
<tr><td>FGDM outcome: WB1-match of services in the community</td><td>-.277*</td><td>.018</td></tr>
<tr><td>Accumulation of 16-20 risk factors</td><td>.312*</td><td>.007</td></tr>
</table>

<table>
<tr><td rowspan="7">CLUSTER 5 Being under constant emotional threat by caregiver</td><td>FGDM participants: village elder</td><td>.336**</td><td>.004</td></tr>
<tr><td>FGDM needs addressed: child’s safety stated</td><td>.283*</td><td>.015</td></tr>
<tr><td>FDGM plan: implemented not at all</td><td>.364**</td><td>.002</td></tr>
<tr><td>Accumulation of 16-20 risk factors</td><td>.413**</td><td>.000</td></tr>
<tr><td>Child’s sexual abuse</td><td>.241*</td><td>.040</td></tr>
<tr><td>Going home late</td><td>.248*</td><td>.034</td></tr>
<tr><td>FGDM needs addressed: child’s wellbeing & development</td><td>.255*</td><td>.030</td></tr>
</table>

** Correlation is significant at the 0.01 level

* Correlation is significant at the 0.05 level

5.2 Risk factors accumulation analysis

A computation of risk factors accumulation was done by summing up all risk factors identified for each child and grouping them within five frequency risk factors accumulation groups, as shown in the following table.

Table 24: Risk factors accumulation groups

Risk factors accumulation group	Number of risk factors	Number of children	%
1	0-5	1	1.4
2	6-10	13	17.8
3	11-15	41	56.2
4	16-20	16	21.9
5	>20	2	2.7
	Total	73	100.0

The number of risk factors piling up in the lives of individual children varied dramatically; however, it was found that most cases (80.8%) had an accumulation of 11 factors and above. 74% of all children were affected by an accumulation of 6 to 15 risk factors. Moreover, thirty two (43.8%) of all cases were affected by overriding factors. Most prevalent overrides were physical abuse (28.8%), alcohol and drug addiction by

caregiver (21.9%) and prostitution by mother (8.2). Sexual abuse had 4.1% while drug addiction by caregiver had 1.4% of all cases.

Then, correlations were explored according to the five accumulation groups.

Accumulation group 1 (0-5 risk factors) correlated with the FGDM goal of identifying family strengths/resources, Pearson's r (73)=.26, p=.023.

Accumulation group 2 (6-10 risk factors) highly correlated with caretaker blaming of the child and refusal to accept identified family needs, Pearson's r (73)=.31, p=.008. It also correlated with child mistreatment, Pearson's r (73)=.28, p=.015, abandonment/separation from the mother at early age, Pearson's r (73)=.24, p=.038, and with family disconnected from community social support, Pearson's r (73)=.26, p=.026.

Accumulation group 3 (11-15 risk factors) correlated with children age-group 10-13, Pearson's r (73)=.26, p=.024. About the FGDM main goals, this group correlated with need for child's placement, Pearson's r (73)=.28, p=.015, and network/coordination with stakeholders, Pearson's r (73)=.34, p=.003.

Accumulation group 4 (16-20 risk factors) correlated with implementation of follow up meetings after the FGDM conference, Pearson's r (73)=.28, p=.017, the inclusion in the FGDM plan of community participants to check on aftercare, Pearson's r (73)=.24, p=.047, and of family members to be involved in the plan implementation, Pearson's r (73)=.27, p=.020.

Accumulation group 5 (> 20 risk factors) correlated with the FGDM not being implemented at all, Pearson's r (73)=.28, p=.014. It also inversely correlated with achieved changes of abusive patterns in the family, Pearson's r (73)= -.24, p=.037, and with reduction of risk of harm to the child, Pearson's r (73)= -.24, p=.040.

Furthermore, each of the 5 clusters was graded according to its risk factors accumulation level by computing the risk factors frequency which

had occurred in all cases of the experimental group. Here, the accumulation was graded as low when risk factors present in each cluster were 1-2, medium when 3-4, high when 5 and above, or with overrides.

Table: 25: Clusters and their risk factors accumulation level

RISK FACTORS ACCUMULATION	**cluster 1** direct exposure of children as victims of abuse or unsafe conditions		**cluster 2** witnessing continuous external threat		**cluster 3** engaging in direct antisocial behaviour		**cluster 4** exposure to caregiver loss, separation and attachment threats		**cluster 5** being under constant emotional threat by caregiver	
	N	%	N	%	N	%	N	%	N	%
Low accumulation 1-2 factors	30	41.1	32	43.8	28	38.4	45	61.6	14	19.2
Medium accumulation 3-4 factors	16	21.9	17	23.3	28	38.4	18	24.7	42	57.5
High accumulation 5 > factors or overrides	23	31.5	17	23.3	13	17.8	0	0.0	17	23.3
no factors present	4	5.5	7	9.6	4	5.5	10	13.7	0	0.0
Total	73	100	73	100	73	100	73	100	73	100

Analysing clusters having an accumulation of 3 or more risk factors in each case, it was found that cluster 5, being under constant emotional threat by caregiver, scored the highest frequency (80.8%) of cases from the experimental group. It was followed by cluster 3, engaging in direct antisocial behaviour, with an accumulation of three or more risk factors in 56.2% of all cases. Cluster 1, direct exposure of children as victims of abuse or unsafe conditions, had the highest percentage of cases (31.5%) with an accumulation of 5 or more factors or with overrides. Cluster 4, exposure to caregiver loss, separation and attachment threats, scored a 61.5% of cases with low accumulation of 1 – 2 risk factors.

A further analysis was done looking for correlations between the five risk factor clusters and child gender, specific risk factors, and child's antisocial behaviours. Specific investigation was done differentiating medium and high accumulation of risk factors within the 5 clusters.

5.3 Accumulation of risk factors and gender

Female children correlated with medium accumulation of risk factors in cluster 1, being subject to direct exposure as victims of abuse or unsafe conditions, Pearson's r (73)=.23, p=.050. Female children also strongly correlated with high accumulation of risk factors in cluster 2, witnessing continuous external threat, Pearson's r (73)=.39, p=.001. These correlations suggested high vulnerability for the girl child, easily becoming victim and being under external threat. Male children correlated with high accumulation of risk factors in cluster 3, engaging in direct antisocial behaviour, Pearson's r (73)=.24, p=.038, suggesting more externalization of behavioural problems by the male child.

5.4 Accumulation of risk factors and specific risks

Medium accumulation of risk factors in cluster 1, direct exposure as victims of abuse or unsafe conditions, strongly correlated with child's physical abuse, Pearson's r (73)=.33, p=.004.

Medium accumulation of risk factors in cluster 2, witnessing continuous external threat, correlated with alcohol addiction by caregiver, Pearson's r (73)=.29, p=.012, with child's emotional abuse, Pearson's r (73)=.24, p=.041, and with child's mistreatment, Pearson's r (73)=.26, p=.023.

High accumulation of risk factors in cluster 5, being under constant emotional threat by caregiver, strongly correlated with high accumulation of risk factors in cluster 1, direct exposure as victims of abuse or unsafe conditions, Pearson's r (73)=.32, p=.005, suggesting that the two

conditions are found together. This was confirmed by the correlation found between medium accumulation of risk factors in cluster 5 and child's sexual abuse, Pearson's r (73)=.24, p=.040, suggesting that unhealthy relationship with caregiver connect with sexual abuse. Cluster 5 also correlated with children going home late, Pearson's r (73)=.23, p=.048, suggesting that avoidance of the threat could be a reason for spending odd hours out of the home.

5.5 Accumulation of risk factors and antisocial behaviour

Accumulations of risk factors were also analyzed to establish whether the level of antisocial behaviour increased as the accumulation of risks factors increased.

Correlations between risk factors accumulation groups as earlier identified (group 1 < 5 risk factors; group 2 = 6-10 factors; group 3 = 11-15 factors; group 4 = 16-20 factors; group 5 >20 factors) and antisocial behaviours were explored.

No specific correlation was found between accumulation group 1 (0-5 risk factors) and antisocial behaviours.

Children in accumulation group 2 (6-10 risk factors) correlated with specific antisocial behaviours such as sleeping outside at night, Pearson's r (73)=.26, p=.023, truancy, Pearson's r (73)=.25, p=.029, and stealing, Pearson's r (73)=.25, p=.033. A strong correlation was found between this group and child's criminal behaviour, Pearson's r (73)=.37, p=.001.

Children in accumulation group 3 (11-15 risk factors) strongly correlated with high accumulation of risk factors in cluster 3, child's engagement in antisocial behaviours, Pearson's r (73)=.35, p=.002. This group also highly correlated with children being runways, Pearson's r (73)=.30, p=.008, as this was the main reason for them to be in the Nairobi Children Remand Home.

No specific correlation was found between accumulation group 4 (16-

20 risk factors) and antisocial behaviour suggesting that the 21.9% of children represented in this group were overwhelmed by psychosocial risk factors, namely witnessing continuous external threat and being under constant emotional threat by caregiver which both scored high risk level for the same children (>5 risk factors in each of the two clusters). Accumulation group 5 (> 20 risk factors) had very few cases to produce consistent results.

5.6 Findings

Results suggest that cluster 5, being under constant emotional threat by caregiver, is the primary risk factors accumulation and it has some important correlations with risk factors from other clusters. This suggests that a complex mixture of caregivers' inadequate parenting abilities as listed in this cluster may be connected with adverse outcomes.

The study also found that the level of children's behavioural problems increased as the number of their risk factors increased, with a precipitation of negative behaviour in correspondence to children clustered in accumulation group 2 (6-10 risk factors) and 3 (11-15 risk factors) who represented 74% of the whole experimental group.

Male children were more prone to externalize negative behaviour than female children.

CHAPTER SIX

THE FAMILY GROUP DECISION MAKING MODEL THEORY AND PRACTICE

1. PILOTING THE FGDM MODEL

The challenge of having to deal with a large number of welfare cases in a short span of time and the recognition that most of their families reported to the Nairobi Children Remand Home required specific interventions with regard to a complexity of needs, led us to consider the adoption of *new* models of child protection and family support. As a matter of fact, such approaches were not new, but a re-visiting or recapitulation of solutions previously tried and tested, given that we borrowed concepts and principles well established both within the local African culture and the family conferencing model widely used worldwide. The latter was taken up being a broad methodology to encompass different but related practice of family involvement in decision-making differently named as Family Group Conference, Family Group Decision Making conference, and so on. Accordingly, family conferencing was adopted as a model for resolving, or attempting to resolve, family issues in relation to child protection by bringing together various sets of people – the child, members of their immediate and extended family, community members and child protection professionals – to air issues, come to a resolution and develop a plan for future action.

The uniqueness of this approach was based on the fact that family con-

ferencing had not previously been applied systematically in the region, neither in Kenya nor to our knowledge in East Africa. In the Family Group Decision Making (the US variant of FGC) model, we identified a methodology which could enable families and communities to regain prominence in child protection. Its application allowed for welfare cases no longer to be seen in purely child protection terms but in the overall community context, where the alleged problem had occurred, starting from a comprehensive needs assessment of the family that had put a child *at risk* or had a detrimental effect on the child's long-term welfare. Once identified, they were addressed adopting a wider prospective on family strengths and community resources. Thus, the balance between child protection services and the role of family and community support was altered such that child protection no longer drove the system but became just one component in an overall welfare assessment and intervention, following the way paved by previous research (Little, 1995; Tomison, 1996, Armytage,1998).

The model allowed recognizing that child protection services are part of the wider child and family support system and it reinforced the need for effective collaboration among child protection services, families and communities in order to provide a response that could positively affect family wellbeing and ensure the protection of children from abuse and neglect. A role which families in Kenya had been unable to perform substantially since the 1980s due to a distorted culture promoting institutionalization of children as a primary response for those considered being at risk because in conflict with the law, subject to various forms of violence and exploitation or simply living under poverty constraints. A trend exacerbated by high demands for child's institutionalization that has been accompanying the recession of the current decade 2000s. Furthermore, the regrettable reality is that children's charitable institutions have been mushrooming all over the country, most of the times being unregistered and unlicensed to operate. Hence, children's institutionalization compounds the adverse consequences that child's risk factors and inadequate care have on the child's vulnerability and ability to cope.

To effectively provide alternatives to this trend, we tested a model of service delivery focused on child centred, family and community based practice principles. These principles affirm the primary importance of ensuring the safety and wellbeing of children, recognize the mutual significance of the child, family and community to each other, and promote the importance of service professionals developing a strengths based partnership with client families (Tomison, Burgell & Burgell, 1998).

Focusing on the positive aspects of family functioning does not imply that family problems and/or the protection of the child are forgotten. The FGDM child and family centred philosophy ensures that the child protection and care remain paramount, while drawing attention on building family members' competence and self-esteem in order to tackle protective concerns and other family issues effectively. Pioneered in the early 1960s by Otto (as cited in DePanfilis & Wilson, 1997), the underlying principle of this perspective is that all families have strengths and capabilities (De Jong & Miller 1995).

As it is applied to *at risk* and abusive populations (Saleebey, 1992, as cited in De Jong & Miller, 1995), this approach can be summarised as:

- all people and environments possess strengths that can be marshalled to improve the quality of clients' lives. These strengths and the ways in which clients choose to apply them should be respected by caseworkers;
- client motivation is fostered by a continued emphasis on client defined strengths;
- discovering strengths requires a cooperative exploration between clients and caseworkers;
- a focus on strengths reduces the caseworker temptation to *blame the victim* and enables the discovery of the means by which clients have survived in even the most inhospitable of circumstances; and,
- all environments, even the most bleak, contain resources.

Its objective is to develop a true partnership between family members and caseworkers, involving families as much as possible in case management by encouraging them both to set their own goals and to take responsibility for achieving them. Besides, by including people important to the family's life, key community support services for children and families are comprehensively assessed, and decision-making regarding a child's safety, well-being, and permanency is promoted, while planning and coordination of service delivery is achieved. This focus on client strengths means to address issues and achieve positive change until families reach a level of functioning above the threshold for protective intervention.

2. LITERATURE REVIEW

The introduction of Family Conferencing (FC) into child welfare systems has internationally gone hand-in-hand with the publication of evaluation and research reports designed to test or demonstrate its effectiveness. Unfortunately, while New Zealand introduced the practice, its innovatory legislation has not been underpinned by longitudinal research to inform practice, and critical data have not been captured (Worrall, 2001). During the period of early take-up in the 1990s in other countries, the *good news* of generally promising results had to be weighed against the fact that these early studies were of pilot or demonstration projects and lacked comparison or control groups.
Since the year 2000, evaluations of system-wide implementations of Family Conferencing, conducted in partnership with universities or by independent evaluators, have become more common. In an international survey conducted by Nixon et al. (2005), 135 out of 225 respondents indicated they have either carried out or are involved in some form of evaluation. Most are implementation studies, using a variety of quantitative and qualitative methods. A minority look at the longer-term outcomes for children and young people. However, numbers studied are often smaller than originally anticipated by the researchers. Evaluations also adapt to local variations in the process, which makes

comparability of research more difficult. A small number of studies are prospective and/or report a comparison between Family Conferencing and traditional casework models, using a randomised sample from child protection records or matched controls.
The Family Conferencing historical background, four of its major areas and critics are outlined below, drawing by research which has analysed the basic Family Conferencing model and some of its variants.

2.1 Family Conferencing historical background

Historically, Family Conferencing is a participatory approach to case planning that was originally developed in New Zealand in response to concerns that the child welfare system was removing Maori children from their homes and cultural ties at a disproportional rate. Based upon the success of this approach that in 1989 become a legal framework in New Zealand with the introduction of *The Children, Young Persons and Their Families Act*, the practice of including families as part of the decision making team has grown tremendously over the past decades and the FC has been utilized as a case planning approach in the United Kingdom (Lupton & Nixon, 1999), Australia (Swain, 1993), Canada (Immarigeon, 1996) and in parts of the United States, including Colorado, New Hampshire, New York, Massachusetts, California, Oregon, and Washington (Merkel-Holguin, L., et al., 2002).

A number of attempts have been made to help define or refine the theoretical framework for family conferences either at an academic level (see for example Hudson, Maxwell, Morris & Galaway 1996, Burford & Hudson 2001, Marsh & Crow 1998, McCold 1999, Lupton & Nixon 1999), or at a policy or developmental level (see for example Nordic FGC network, Family Rights Group UK, Morris 1995, American Humane Association USA).

It is a fact that currently several distinct practice models use family-centred principles in combination with family group meetings to bring

families *to the table* to discuss and solve problems and to support each other. They are widely different in definition as a survey found an excess of 50 different names for *conferencing* practices (Nixon, P., Burford, G. Quinn, A., Edelbaum, J., 2005).
Several features distinguish these practice models from each other, including: the purpose and goals of each family meeting, how the meeting agenda is set, preparation prior to the meeting, responsibility for facilitation and reaching consensus during the meeting, the authority for decision making, and the extent of family involvement.
Yet, all of the practice models for family meetings share basic common elements, including: similar beliefs and values about families, broadly defined team membership, and expectations that child welfare practice will improve as a result of deeper family involvement.

2.2 Suitability of Family Conferencing

Some studies examine the types of cases that are suitable for referral to FC. For example, its use in some cases involving sexual abuse has been found to work well (Crampton, 2000). Other studies have examined its suitability for Indigenous and other communities finding that it is highly adaptable across cultures as long as local people are very involved in the adaptation process (Vesneski, 1998; Shore et al, 2001; Santa Clara County FCM, 2002). In an international survey of models of Indigenous child protection, Cuneen and Libesman (2002) indicate that the Family Group Conferencing (FGC) model, emphasising the concept of restorative justice, has been fairly widely used with Indigenous Australians in the area of juvenile justice but not so widely in the areas of family violence and child protection. It was found that some Indigenous communities in Australian have responded well but that considerable preparatory work is required if positive outcomes are to be achieved (Burford & Pennell, 1995). Research thus far provides no basis for categorical exclusion of families. According to Crampton (2000: 325), 'there are no types of maltreatment that are especially inappropriate for FGDM and

there are not certain types of cases that should be excluded. But individual characteristics of each case should be taken into account.'

2.3 Roles and attitudes of participants

The three sets of participants in FC are the family, including immediate and extended family, the child or young person and child protection professionals. Strong participation by extended family was found in some conferences (Kiely 2002; Shore et al, 2001; Sundell, 2000), although numbers attending conferences varied widely and sometimes professionals outnumbered family members.

Studies have found that family members generally have a positive response to FGC, and professionals also feel positively towards it but are often not satisfied with its longer-term outcomes (Cashmore and Kiely, 2000; Pennell and Burford, 1995; Trotter et al, 1999; Sundell and Vinnerljung, 2004).

Many felt that communication within their family had improved, that family conflict had reduced after the conference, and that children were safer as a result. Some expressed surprise at the level of commitment shown by family members during the conference (Cashmore and Kiely, 2000; Mandell et al, 2001; Pennell and Burford, 2000b; Holland et al, 2003; Rasmussen, 2001; Sandau-Beckler, 2003; Shore et al, 2001; Walton et al, 2003). In the international survey conducted by Nixon et al (2005), most stated that children attended conferences most of the time, but in a minority of cases children attended few conferences. Some researchers feared that the wishes of the family may take priority over the needs of the child in a family group conference and believed that children should be taking a greater part in decision-making (Gill et al., 2003: 58).

2.4 Outcomes and long-term effects

Marsh & Crow (1998) present evidence from a number of studies (Lupton et al: 1995, Barker & Barker: 1995, Rosen: 1994) stating that

between 43 and 83 per cent of family members viewed FGDM plans as being successfully implemented. Marsh & Crow themselves rated 78 plans, concluding that in 75% the general aims had been achieved. Grimshaw & Sinclair's (1997) review of 180 plans indicated that 68% had been implemented. In comparison, Lupton et al. (1995) report that according to caseworkers' assessments 66% of child protection plans were fully implemented.

Most studies have looked at FC outcomes between six months and two years post-conference, and focus on child permanency and child and family safety. The validity of results is compromised by the often poor quality of case record-keeping (Northwest Institute for Children and Families, 2002; DePanfilis and Zuravin, 2002). Only one study was found following up a small sample of FGC and matched non-FGC families five years post-conference, while another assessed outcomes exactly three years after the conference (Kiely, 2002, 2005; Sundell and Vinnerljung, 2004). Though there is a lack of reliable long-term studies on FGC, some consistent points are raised in the literature.

While developing a plan of action at a conference is usually a successful process (Cashmore and Kiely, 2000; Holland et al, 2003; LeCroy & Milligan Associates, 2003; Mandell et al, 2001; Marsh and Crow, 1998; Pennell and Burford, 2000; Sandau-Beckler, 2003; Shore et al, 2001; Trotter et al, 1999; Walton et al, 2003), implementation of plans is less so (Lupton, Barnard & Swall-Yarrington, 1995). Other studies found that FC tends to lead to increased placement of children with extended family members (Trotter et al, 1999; Sundell, 2000; Kiely, 2002, 2005; LeCroy & Milligan Associates, 2003; Mandell et al, 2001; Crampton, 2000; Shore et al, 2001; Worrall, 2001; Gill, et al., 2003; Marsh and Crow, 1998; Santa Clara County FCM, 2002; Crampton, 2004; Jones and Finnegan, 2003). There is also some evidence that placements were more stable after FGC (Marsh and Crow, 1998; Gill et al., 2003; Merkel-Holguin, Nixon & Burford, 2003), though this is questioned in few studies (Kiely, 2005; Worall, 2001). There are confusing responses as well regarding reporting of abuse after FGC, e.g. increased reporting

may be due to higher abuse or to better communication (Sundell and Vinnerljung, 2004).

2.5 Overall effectiveness of Family Conferencing

A number of studies have focused on the overall effectiveness of the model, and both positive and negative aspects have been identified. Among the positive aspects are high participant satisfaction, more placements with extended family, improved communication within families, and more respect among families for child protection professionals. Research has also shown that, if practitioners take the time to identify and build on family strengths, rather than focusing on the correction of skills deficits or weaknesses, families are more likely to respond favourably to interventions and thus the likelihood of making a positive impact on the family unit is considerably enhanced (Dunst, Trivette & Deal, 1988).

Among the negative aspects are problems in ensuring confidentiality, deciding on who is to be involved in conferences, lack of effective follow-up to implement plans, and high staff turnover causing lack of continuity. Some research has also raised concerns that child centred family focused, and solution focused work may not adequately protect children, because they focus too much on the family as a whole, rather than being primarily concerned with the protection of the child. A comment is made that the lack of suitable, long-term research on FGC makes definitive conclusions on FGC difficult to reach (Brown, 2003:336).

2.6 Critics to the Family Conferencing model

It has been noted that there is, 'a dearth of rigorous research evidence … no studies [with] an experimental design to test the FGC model against other more traditional types of decision-making processes …' (Brown, 2003:336). Hence, a number of issues remain uncertain:

- There is no strong evidence that the implementation of case plans is better as a result of FC, and some evidence that it may be worse.
- Critics such as Bartholet (1999) also question the effectiveness of the FGDM model, contending that it results in an abdication of the state's responsibility to protect children from abusive families and communities.
- The belief of many advocates that private family time is an essential feature of the FGC process is not supported. Some family members liked it, others wanted professionals/ convenors to be there or invited them to stay, and others felt it made no difference.
- Research on the long-term effects of FGC on child placements and child wellbeing is almost completely lacking. It is also clear that evaluations are blunt instruments when it comes to the analysis and interpretation of outcomes. Only rigorous research methods and techniques of analysis such as those used in the Sundell and Vinnerljung study (2004) are able to tease out variables that significantly affect the process and outcomes of FGC.

On this last point, however, Crampton (2004) suggests that rigorous clinical trials are a mistake at this stage because there is a need for developing theory behind these interventions and an understanding of how they should be adapted in different contexts, with randomised trials to come later. There is a need to determine which elements of FGC relate to its effectiveness. He did not find a correlation between preparation time for a conference and diversion of children from foster care into kinship care. And while private family time is viewed by many advocates of FGC as essential, no outcome evidence so far proves its value. When some consensus around which practices are critical has been achieved, then rigorous clinical trials can be considered.

3. BASIC CONCEPTS AND VALUES OF FAMILY CONFERENCE APPROACHES

Beside the use of a strength-based approach instead of a deficit-based model, the FC underscores the critical relevance of natural families in taking responsibility for their children as the following beliefs are applied (Merkel-Holguin, L. et al., 2002):

- All families have strengths;
- families are the experts on themselves;
- families can make well-informed decisions about keeping their children safe when supported;
- a team is often more capable of creative and high-quality decision making than an individual
- families deserve to be treated with dignity and respect;
- families are encouraged and supported to make decisions and plans;
- outcomes will improve when families are involved in the decision making process;
- openness and honesty between agency and family members is a priority for the success of the conference; and,
- families define their own members, which may extend beyond the primary birth family, as the *family team* concept is broad and inclusive.

Looking at the FC model, it is important to recognize that it is not a linear process of engagement, assessment, planning, and implementation. Rather it is a cyclical and dynamic process, which should grow and change over the life of a case. Each core function is supported in the family team decision making process. In conducting a family team meeting the family is further engaged through the facilitation of a meeting where the family's opinions are respectfully considered and their natural support system is included. The family team which includes informal as well as formal support persons provide further assessment and understanding of the family and their circumstances as

strengths, needs, and underlying factors are considered and discussed. The family team is most familiar with the family's strengths and needs, knows the history of the issues endangering the child, the attempts made to resolve the issues in the past, and the extent and limitations of their own strengths and resources.

As the family plan is developed by the team, interventions, supports, and services are planned, resources are considered, and implementation of the plan begins. Here, the family's resources are put into place first, demonstrating the value of the family and its strengths, and the acknowledgement that they are the primary experts regarding their family system.

The primary utilization of the family and their kinship system allows the service provider to tailor interventions to the individual strengths and needs within each family.

As the family team is reconvened to monitor progress, further assessment of what's working or not working is conducted, and services are adapted or changed as the model allows for movement back down the pyramid when a family demonstrates its capacity to assure the child's safety. If this process fails, then other forms of case planning, involving more decision-making by the child protection workers can be used.

4. FAMILY GROUP DECISION MAKING CONFERENCING IN THE KENYAN CONTEXT

4.1 Family Conferencing in the Children in Justice context

Prior to the advent of the family conference model, the management of the Nairobi Children Remand Home used to make decisions about children and families with little or no input from families and their communities. The need for a turning point referred to the basic assumption that all families can harness their strengths and capabilities to

enter into partnership with formal child welfare agencies and the juvenile justice system in order to make decisions that protect and nurture their children. Hence, family and community engagement was prioritised given the high stakes for parents, children, and extended family and the short timeframes legally allowed.

As a result, in 2005, the FC concept was introduced in Nairobi Province through the CEFA NGO which entered into a partnership with the Department of Children Services (then under the Ministry of Home Affairs) to implement a pilot reform programme targeting Children in Justice and having the Nairobi Children Remand Home as its entry point. By then, the institution was overcrowded with a daily average of about 150 children and reintegration procedures were not meeting the minimal required standards. The most sensitive shortfall was related to the clumsy execution of Children Court repatriation order done by dropping children at their homes once tracing of their respective families had been achieved. Lack of environmental and family assessment as well as absence of planning with families and communities to address the child's needs used to result in a high number of relapse cases.

To respond to this situation, a component of the programme was built to pilot the effectiveness of the FC by extending the responsibility for child safety and permanency to families, including kin, natural and community support systems through engaging and empowering them to make decisions and develop plans in culturally appropriate ways. Among the variety of FC models, the FGDM was identified as the most culturally appropriate for the Nairobi region being a variant of the basic model prevalent in the United States, which underscores the view that preparation and follow-up of the conference are of equal importance than the conference itself, requiring very careful planning and follow-up if the process is to succeed.

To carry out the programme, two professional counsellors and three caseworkers were hired and trained accordingly for the programme implementation.

Initially, all cases dealt with were for care and protection, needing permanency planning services through repatriation or further institutional referral. The primary reason for families' referral to the child welfare system was the child's rescue and committal to the Children Remand Home after having run away from home. Hence, most of the conferences operated in areas of high conflict where managing risk was an integral part of the work. No criteria for inclusion or exclusion were put, since the main criteria for referral to FGDM was built around agreement and voluntary acceptance of the conference process by the family.

When key family and community members, formal and informal supports, and Statutory Institutions representatives joint together in mutual respect, better decisions and integrated plans for families seemed to result, as families could raise the commitment, resources and capacity to create and implement safe and caring plans for their children. In particular, engaging the family group in child welfare (in assessment, case planning and service delivery), as key stakeholder for system improvement, became critical for enhancing the safety, permanency, and well-being of children.

Following those positive results, the original FGDM pilot program was later on extended and included in the standardised reintegration practice of other two Children Statutory Institutions, Thika Children Rescue Centre and Dagoretti Rehabilitation School. Accordingly, the above mentioned institutions established reintegration sections in order to support exchange of information, arrange for reintegration and provide best practice knowledge and direction for FGDMs. Then, weekly case conferences were arranged being the forum where members of the reintegration section could meet with the counselling and education teams to build the reintegration process and make plans for the FGDM under the institution management.

Initial testing of the model through simple clinical observation was suggesting positive outcomes regarding children's safety, permanency, and

well-being when engaging and empowering family groups and those with whom they are connected, confirming previous research (Merkel-Holguin, Nixon, & Burford, 2003). However, prior to claiming the success of Family Conferences as a child protective intervention in the Kenyan context, there was need to understand whether these immediate results were confirmed and sustained over time.

For this purpose, the present study analyses the effectiveness of the Family Conferencing by reporting the long-term outcomes of an ethnically diverse group of 73 children family reintegrated from the Nairobi Children Remand Home through the FGDM model.

The study explores whether obtaining the involvement of family groups and communities in developing plans to keep children safe, and achieve permanency is predictive of better outcomes for children and families, and whether it resulted in placements that continued to be stable and safe for reintegrated children in the long-term, such as after 24 to 54 months.

Though more work is needed with larger sample sizes and in other settings to gain a greater understanding of long-term outcomes for families, the actual outcomes of the study are presented.

4.2 Structure of the family group conference in the Kenyan context

The term *Family Group Decision Making* (FGDM) is the US version of a broad banner to encompass different but related practice models to family conferencing. Still, the practice is designed to establish a process for families, relatives, friends and community members to develop a plan that ensures the care and protection of children from future harm.

Conceptualizing the FGDM as a process emphasizes how specific efforts are required to

- prepare for the conference;

- facilitate the conference, and
- provide support to the families after the conference.

This conceptualization of the process moves us beyond viewing the conference as a single act that can be successfully performed without careful preparation work or adequate support after the family meets. In looking at a critique of the New Zealand experience with FGC, lack of follow-up to monitor and ensure service delivery was cited as a major concern (Mason Report as cited in (Lupton & Nixon, 1999)). Hence, the FGDM is to be delivered through the above three-stage process whereby families play a central role in planning for their children within the mandated authority of an agency.

The FGDM process here described closely reflects those used internationally, but it also includes variations due the local context.

4.2.1 Role of agency personnel involved in FGDM

According to the practice locally applied, three staffs are usually involved in the FGDM preparation and implementation process: the child's counsellor, the child's primary caseworker and the conference facilitator. A first variation to the original model was introduced at this stage, since in FGDM processes, an individual known as the *coordinator* is responsible both for preparing and guiding the family meeting. In fact, according to FGDM literature (American Humane Association & FGDM Guidelines Committee, 2010), the term *coordinator*, rather than *facilitator*, is more reflective of FGDM principles. The coordinator's purpose is to convene and guide a family-led process, to ensure that the agency representatives share all critical information with the family group that is essential to the decision-making process. The term facilitator implies that a professional will have a more elevated, active and central role in the family meeting, rather than someone who guides the process.

In the local context, the caseworker coordinates the FGDM process

before the conference, then, the facilitator guides the conference itself to focus participants on the central issues to be addressed. As a matter of fact, conferences were inclined to become very lengthy and cumbersome unless the facilitator took a more directive role in bringing forward significant pieces of information as quickly as possible. This could allow for a more rapid transition to private family time. The caseworker being the coordinator could later on coordinate activities for the aftercare process. However, in some instances both roles may be combined by the caseworker acting at the same time as a coordinator and facilitator. An advantage of this approach is to minimize the use of personnel and reduce costs by combining two roles in one person.

Whatever the case, staff engaged in the process perform their individual tasks for the conference by working as a team and exchanging all relevant information on the case. In particular, few days before the actual family conference, they meet together to summarize their findings and to prepare their strategic approach for the family meeting.

The following is clearly identified and agreed upon before the conference takes place:

- child's and family's presenting risk factors;
- child's and family needs (openly expressed and/or identified through the dysfunctional symptoms displayed);
- child's and family strengths; and
- community resources available to respond to the identified needs.

In the FGDM study sample, almost all conferences were carried out through the expertise of the child's primary caseworker and the facilitator. The child's primary caseworker acted as the coordinator, playing a role designed to facilitate child/family/community involvement in the process and being responsible for preparatory work with the family and the community, for the actual meeting arrangements and later on for monitoring the plan implementation. The facilitator, being inde-

pendent from the person who coordinated the process was included for assurance of not preset outcome, impartiality and integrity of practice to the principles of the model. He chaired the meeting being assisted by the child's counsellor. This arrangement was to ensure the facilitator was seen to be completely neutral to the outcome and participants. From 2009, due to later developments, the District Children Office (DCO) has been represented in the conference by the location Volunteer Children Officer (VCO), called to play a strong coordination role to grant sustainability to the programme, especially in relation to provision of aftercare services.

4.2.2 FGDM Preparation Procedures

The institution weekly case conference identifies children due for tracing and refers them to their primary caseworker. Once the family tracing is achieved in conjunction with government field services officers (DCOs), the case is usually referred to the location VCO who assists the caseworker for immediate FGDM preparation. Meanwhile, the family is invited at the institution level for two-three sessions with the child's counsellor in order to make an in-depth assessment of the child's and family needs and introduce the idea of the conference.

The **counsellor** has to:

- explain its purpose and process;
- consult with the family about who should be invited to take par and how;
- facilitate the family to arrange where and when to hold the conference; and
- determine how participants can be helped to feel safe and be able to present their views.

The counsellor explains to the family members that their task is to arrange for their family meeting in order to develop their own family plan that addresses the safety and well-being of the child. Family ownership of the conference is emphasized.

At field level, the task is to prepare community members and service providers for their role in the conference. The **caseworker,** in collaboration with the location VCO, does an environmental assessment to identify the family and community profile outlining weaknesses and strengths, and produce an adjustment report. In team with the child's counsellor, they also assist child's parents or caregiver to identify other extended family members and community support people who should be invited to the conference.

Service providers are contacted to explain their role during the family conference and how they are to provide information to family members, but not to express an agenda or an outcome.

It is stressed that the culture of the family has to be respected and that family group members should dominate in numbers.

The **involved professionals,** who can provide pertinent information regarding the well-being of the child, are usually teachers, elders, church leaders, chiefs, etc. They are people from the community who have community responsibility, possible resources to avail for the case and an interest in it. They are coached on how to express themselves at the conference in a way that is both clear and respectful in order to be ready to:

- state directly their concerns about safety and any *bottom lines* to which the plans must adhere, without telling the family what to put in the plan;
- give enough information so that the family group understands the situation, while not revealing unnecessary details or legally confidential reports;
- state their commitment to the case and the kind of support they can provide, and
- express themselves in words that the family can understand and not feel intimidated by.

Other participants are identified with the aim of gaining as wide a

perspective as possible on the family's situation, and spreading as wide a net as possible for community members to assist in carrying out the plan that will be agreed to at the conference.

Exclusions would be justified when there is a serious safety concern, because the individual's presence would pose a significant threat to others, or cause a major strain on the child or other relevant caregivers, or when, because of a serious behavioural problem, that person would be unable to function at the conference.

In case of severe neglect or abuse, or in instances of caregivers' reluctance to take responsibility on the child, the meeting is held at a public office such as at the District Children Officer or local Chief, in agreement with the family.

4.2.3 FGDM Stages

Typically, the facilitator engages the participants in the conference by leading them through the following stages:

1. opening
2. information giving
3. private family time
4. finalizing the plan

Due to the fact that the FGDM is rather a process than a single act, adequate follow up is included as an additional stage beyond the family conference.

1. Opening

Starting *in the culture of the family* is crucial if they are to *own* the conference. This may mean having a family member greet each person arriving, sharing an opening prayer, or just having people seat themselves in a way that feels right to them.

The meeting begins with introductions and a statement of purpose by the facilitator to make sure that everyone knows:

- each other's name and their relationship to the concerned child;
- the purpose of the conference (e.g., "We are here to see if there is a way that Mary can live safely with her family."); and
- the conference process and ground rules (e.g., confidentiality, no violence or interrupting).

The facilitator makes sure that all names, relations to the child and contacts are documented by entering them in the appropriate form.

2. Information Gathering

The facilitator moves the group into the information-giving stage in which the situation is identified and assessed. Then, ideas are developed through brainstorming:

- the child's counsellor sets forth the issues of concern to be addressed;
- other invited professionals give information on the child's and family according to their capacity (e.g. education, behaviour, parental responsibility, traditional practices);
- all brainstorm on underlining issues which cause the child's difficult behaviour; and
- on possible ways the family can undertake to modify the dysfunctional child and family patterns.

Contributions can include evidence leading to the concerns for the child and family well-being, a description of the services currently provided and other community resources, supports a child welfare agency can provide, explanations of the permanency planning options.

3. Private Time

The aim of this stage is to provide the family group with the privacy to develop a plan of their own to address the concerns laid out during the information stage and develop action steps.

After hearing all the information and discussing related issues, the fam-

ily and their support network meet privately to develop a plan aimed at assuring the well-being of the child. At this time all of the professionals, including the facilitator, leave the room so that the family group can confer together. The facilitator, the child's counsellor, the caseworker and any other involved persons who can stay, remain nearby the venue to wait and provide information and support if required (e.g. writing the plan in case they are illiterate).

Often the focus is to develop a safe permanent plan, but other times the family may choose to focus on other more immediate needs, such as feeding or education.

4. Finalizing the Plan

Once the family group has developed the plan, they ask the facilitator and other participants to return to the meeting room.

The facilitator reviews the plan with the family group to ensure that it:

- covers all areas of concern;
- is clear about what needs to be done, who is to do it and when;
- provides for a contact person to check that the plan is being carried out;
- indicates the date of the follow up FGDM meeting to reconvene the family group for evaluation of the plan implementation.

The written plan is approved if it meets the following criteria:

- it provides for safety and well-being of the child for whom the conference was held;
- it is realistic and specific in term of actions;
- it is in line with the family and community resources.

To help everyone carry out the plan, the family, the facilitator and the location VCO receive a written copy of it, being part of the child's record in the DCOs aftercare folder.

5. Post-conference follow-up

Post conference follow-up is an important stage of the FGDM process as the plans needs to be monitored to ensure that children remain safe, families receive adequate support, and that services are being delivered. Follow-up occurs so that conferences are not seen simply as a *one-off* event. In line with research (see for example Thornton, 1993; Lupton, Barnard & Swall-Yarrington, 1995; Jackson, 1998; Sundell, 2001) and practice, the Family Conferences are seen as an ongoing process, allowing the family to come back together to review their progress. Monitoring arrangements and review conferences are one way of ensuring that plans from the conference have every opportunity of working. A second conference takes place usually two months after the FGDM to assess the family, how they are adhering to the service plan, to provide an opportunity to make major changes to it or to address new issues. Monitoring needs to be carried out in a variety of ways by the caseworker, the family or community members in line with the FGDM plans. Family visits carried out by the caseworker according to the case risk level allow evaluation and feedback, being another way of following up the conference and ensuring a quality control process.

CHAPTER 7

FAMILY GROUP DECISION MAKING OUTCOMES ANALYSIS

1. EXPERIMENTAL AND CONTROL GROUP COMPARISON

1.1. Bio-social characteristics

A matched quasi-random control group was analysed using research instruments such as documentation available from children's interviews and Court records. The experimental and the control group of children were compared to assure they were statistically identical except for the single variable of being reintegrated through the FGDM conference whose effect was being tested. The two groups were found to have no statistically significant ($p<.05$) differences in regard to the analysed variables such as gender, ethnicity, level of education and pre-institutionalisation placement. However, comparison showed two variations referred to children's family composition and place of abode. First, within the experimental group 19.2% of the children had both parents against 40.5% of the control group.

Table 26: Bio-social characteristics - experimental and control group comparison

		Experimental Group		Control Group	
		N	**%**	**N**	**%**
Total sample		73	100.0	42	100.0
Children's gender	Male	43	58.9	21	50.0
	Female	30	41.1	21	50.0
Age cohorts	7-9	10	13.7	4	9.5
	10-13	49	67.1	28	66.7
	14-17	14	19.2	10	23.8
Ethnic community	Kikuyu	28	38.3	18	42.9
	Luo	18	24.7	10	23.8
	Luhya	17	23.3	9	21.4
	Kamba	7	9.6	2	4.8
	Meru	0	0	1	2.4
	Kisii	1	1.3	2	4.8
Child's class attended	Std 1-3	27	37.0	9	21.4
	Std 4-6	37	50.7	15	35.7
	Std 7-8	5	6.8	8	19.1
	Form1-3	2	2.8	1	2.4
	Not known	0	0	9	21.4
Family composition	Both parents	14	19.2	17	40.5
	Single mother	9	12.3	2	4.8
	Father & stepmother	18	24.7	9	21.4
	Mother & stepfather	10	13.7	3	7.1
	Orphan with relative	5	6.8	4	9.5
	Separated mother	10	13.7	7	16.7
	Widow (man)	1	1.4	0	0.0
	Living with relative	1	1.4	0	0.0
	Widow (woman)	4	5.5	0	0.0

Second, the children's area of abode indicated that 75.3% of the experimental group against 47.6% of the control group originated from Nairobi low income areas. This major difference was related to the high number of upcountry cases which represented 50% of all children in the control group, while only 24.7% cases of the experimental group came from semi-rural and rural areas close to Nairobi.

The reason being that FGDM conferences could be performed only for cases which were geographically easily accessible, while cases originated from remote geographical locations could not undergo FGDM due to the complexity of logistic arrangements.

Table 27: Urban area of abode - experimental and control group comparison

Nairobi Low Income Areas	Experimental Group		Control Group	
	N	%	N	%
Total sample	73	100.0	42	100.0
Embakasi	8	11.0	6	14.3
Kasarani	18	24.7	5	11.9
Kibera	14	19.2	4	9.5
Dagoretti	5	6.8	1	2.4
Ngong	3	4.1	2	4.8
South B	4	5.5	2	4.8
Westland (Kangemi)	3	4.1	1	2.4.
Total	55	75.3	20	47.6

Table 28: Rural area of abode - experimental and control group comparison

Experimental group			Control Group		
Semi-rural and rural areas	**N**	**%**	**Rural Areas**	**N**	**%**
Total sample	73	100.0	Total sample	42	100.0
Uthiru/Gachie/Wangige	5	6.8	Kakamega	3	7.1
Kikuyu	3	4.1	Kiambu	3	7.1
Kiserian	1	1.4	Western	2	4.8
Kabete	1	1.4	Meru	2	4.8
Kiambu	1	1.4	Kisii	2	4.8
Thika	1	1.4	Kirinyaga	2	4.8
Runda	1	1.4	Machakos	2	4.8
Ruai	1	1.4	Molo	1	2.4
Ongata Rongai	1	1.4	Naivasha	1	2.4
Limuru	1	1.4	Vihiga	1	2.4
Mlolongo	1	1.4	Thika	1	2.4
Ruiru	1	1.4	Banana	1	2.4
Total	18	24.7	Total	21	50.0

1.2 Modality of reintegration

All children from the experimental group were exited from the institution through the FGDM model.

Children from the control group were exited by the institution using different modalities according to the specific case. 50% of cases were picked by their caregiver directly from the NCRH while 33.3% were taken back to their homes by the NCRH management. No FGDM or other particular reintegration or aftercare method was carried out for them, except for some casual talking between the institution staff and the caregiver at the time of release, and the signing of the repatriation order.

Table 29: Control group exit modalities

Control group	N	%
Total sample	42	100.0
picked by parent/relative from NCRH	21	50.0
repatriated home by NCRH	14	33.3
repatriated by NCRH to other Remand Home	2	4.8
picked by parent/relative from Court	4	9.5
repatriated by other stakeholders	1	2.4

2. FGDM LONGITUDINAL OUTCOMES ANALYSIS

The FGDM results were clustered according to a longitudinal prospective which included the followings:

1. Short term outcomes

In relation to the immediate impact the FGDM had on the institution, the child's family and the surrounding community the study explored

- FGDM conference timeframe
- conference timing and location
- content of the conference: purpose, core domains, topics
- patterns of attendance: parents, family, community service providers and children
- plan formulation
- plan involvement
- child placement at the FGDM: family versus institutional care

2. Intermediate outcomes

In relation to the participants' engagement in implementing the FGDM plan the study analysed the

- degree of community involvement in FGDM plan implementation
- effective FGDM plan implementation

3. Long term outcomes

In relation to effective responses to the identified risk factors, assessed on a long-standing protection and retention of children of the experimental group in comparison to the control group the study investigated

- re-referral rate
- stability of placement
- safety outcome from abuse and neglect
- permanency outcome: retention and relationships within the family network
- well being outcome

2.1 SHORT TERM OUTCOMES

2.1.1 FGDM Conference timeframe

Legislation requires that children are exited from Remand Homes "*without unnecessary delay*" (Children Act, Fifth Schedule, 12 (1)). Hence, a comparison was made between the time-span needed between children's admission at the institution and typical repatriation and the time-span needed between children's intake and their reintegration applying the FGDM model.

The analysed data consider only children admitted at the Nairobi Children Remand Home for care and protection. Children in conflict with the law were not included since their cases disposal depended mainly on Court's orders.

As can be seen in Table 30, a typical repatriation procedure required between 26 to 29 days calculated on the total population of children exited from the NCRH in the years 2004 and 2007.

Calculation done on the 73 children study sample showed that reintegration through the FDGM conference took almost 41 days from the time of the case intake. However, by deducting the 17.8 % (13) of cases

which needed 60 days and above for the whole process to be completed, the numbers of days needed to achieve reintegration through the FGDM decreased to 30.8 days. A further analysis of disaggregated data of the same sample showed that 10 to 14 days were needed between the child's first interview and the family tracing. This time interval was mainly due to build a trusting relationship with the child in order to disclose the family location. The remaining 20 to 27 days between the tracing and the actual FGDM conference indicated the time needed for the FGDM preparation and implementation, which included the family environmental assessment, the engagement of extended family, neighbours and relevant stakeholders (e.g. school teachers, village elders, chiefs, pastors, etc.) for the conference and 2 or 3 counselling sessions to be provided to the child's caregivers at the Remand Home.

An additional examination done on the 39 FGDM cases processed in 2007 showed that an average of almost 5 days were spent between the child's admission and the first interview.

By reducing this interval, a further reduction of the days spent within the institutions could be achieved. As shown by Tables 30 and 31, excluding unusually long cases, the average number of days needed for FGDM reintegration runs from 30-31 days against the 27-29 days needed by typical repatriation procedures which do not involve the family and the community in the exiting process.

Table 30: Timeframe for typical exit process

Typical Repatriation	NCRH overall number of Care & Protection children repatriated or transferred to other institutions	Average number of days from admission to repatriation
Year 2004	181	28.86
Year 2007	84	26.84

Table 31: Timeframe for FGDM exit process

Reintegration Through FGDM	Number of cases	Days from interview to tracing	Days from tracing to FGDM conference	Days from interview to FGDM
2005-2007	73*	13.8	27.1	40.9
2005-2007	60**	10.2	20.6	30.8

*all cases

** cases not exceeding 60 days period

A detailed analysis of the time-bracket needed between the cases intake and the FGDM conference (see Table 32) showed that 64.4% of all cases had an FGDM from 10 to 40 days after the intake, 17.8% took from 41 to 60 days and 17.8% from 61 to 160 days. Among the 10 cases which took beyond 71 days, 6 of them were delayed by the family tracing achieved after 30 days. In addition, 8 of them were delayed by the FGDM preparation which also took beyond 30 days. The fastest case took 3 days for tracing and 7 days for FGDM preparation, while the most delayed took 62 days for tracing and additional 98 days for FGDM preparation due to challenges in getting the family involved.

Table 32: Time-bracket from date of case intake to FGDM reintegration

Days time-bracket from intake to FGDM	Number of cases	%	Days time bracket	%
10-20	12	16.4	10-40	64.4
21-30	20	27.4		
31-40	15	20.5		
41-50	8	11.0	41-60	17.8
51-60	5	6.8		
61-70	3	4.1	61-160	17.8
71-80	4	5.5		
81-90	2	2.7		
100-160	4	5.5		
Total	73	100.0		100.0

The considerable variation cited in the duration over which the conference preparation took place was dependent upon both the number of people involved and the nature of conference itself. Indeed, those organized quickly responded to specific incidents or event that has just happened and above all had prompt family collaboration. By contrast, conferences for more entrenched or serious problems and with dysfunctional families took more weeks of planning and work to get all the right people together, and to manage any risks that needed to be considered in the process.

2.1.2 Conference timing and location

A guiding principle of conferencing practice is that the family participants will have a key influence over the process of the conference. This includes planning where and when the conference will be. The study showed that many of the conferences were held in the morning at weekdays and this could indicate that this practice suits families best in a number of cases. A central practice issue here is balancing the needs and wishes of different groups –families and professionals - while maximizing everyone's participation.

Most conferences were held in the family home (63%), a venue that strongly correlated with the FGDM goal of networking and coordinating with stakeholders, Pearson's r (73)=.31, p=.007, suggesting that the family was the most convenient setting to connect with the local community, though sometimes physical space was not large enough to comfortably accommodate all the FGDM participants. The child's school and the chief's office scored 27.4% (n=20) of this rating. Schools as conference locations correlated with the FGDM goal of identifying child and family needs and concerns, Pearson's r (73)=.31, p=.007. Chiefs and DCOs offices correlated with the FGDM goal to develop a child intervention plan, Pearson's r (73)=.26, p=.021, often related to facilitation of school attendance, suggesting that some endorsement by external authorities was needed to respond with a structured intervention to the child's needs.

When held in homes, the family preferred to undertake hosting responsibilities and provided hospitality, which most of the times was translated in some refreshment like tea and bread, and lunch occasionally.

Table 33: FGDM meeting location

Meeting location	N	%
Total sample	73	100.0
Child's family home	46	63.0
Child's school	10	13.7
Chief's office	10	13.7
DCO office	5	6.8
Family Church	1	1.4
Residential centre	1	1.4

Whatever the venue, it was always selected and agreed upon by the family. The family convened the meeting and participants included close and extended family members, family neighbours and friends, local service providers, the primary caseworker, the child's counsellor, the conference facilitator. The facilitator usually chaired the meeting, unless the caseworker was required to cover this role.

2.1.3 Content of the conference: purpose, core domains, topics

2.1.3.1 Purpose of the FGDM conference

The most common purpose for all conferences (n = 72) was identifying child's and family needs and concerns (98.6%). The least common purpose for all conferences (n = 35) was info sharing (47.9%). Relevant purposes for the conference were also the need to identify family strengths (83.6%), develop a reintegration plan (82.2%) and establish a service plan (80.8%) for the child (e.g. readmission in school).

With regard to placement,

- 57.5% of all the conferences (n = 42) had to decide on a permanent placement for the children with their parents at home.

- Both kinship care and referral for placement in temporary residential care was the purpose of 16.4% of the conferences, representing each 12 of all cases.
- The least common placement goal for all conferences (n = 73) was the transferral of the child upcountry to join the extended family (n = 7, 9.6% of all meetings,).

Table 34: FGDM purpose and placement goal

	N	%
Total sample	73	100.0
FGDM purpose		
Identify child & family needs/concerns	72	98.6
Identify child & family strengths/resources	61	83.6
Develop family reintegration plan	60	82.2
Develop child intervention/service plan	59	80.8
Network and coordinate with stakeholders	38	52.1
Info sharing	35	47.9
FGDM placement goal		
permanent placement with parents	42	57.5
temporary placement in residential centre	12	16.4
kinship placement	12	16.4
transfer to upcountry extended family	7	9.6

2.1.3.2 Core domains addressed at FGDM

Four interdependent core domains, being permanency/continuity of care, safety, well-being and attachment are commonly interrelated at every level of service and were evaluated in terms of having been addressed as needs at the conference. Together, these four domains provide the framework for a set of comprehensive outcomes that can be applied across all systems serving children. They are underscored by the core values and principles of child welfare and are necessary for the healthy development and functioning of all children, regardless of the *gate* through which they or their families access services.

As shown in Table 35, the rating scale of *1-low* to *5-high*, was scored by the researcher for each case, examining the relevance of the four domains when the corresponding 4 major children's core needs were addressed and stated at different degrees in the FGDM conference: permanency, safety, wellbeing and development, attachment to caregivers.

Table 35: Rating and frequency of 4 core domains in FGDM conferences

FGDM CORE DOMAINS	Child's Permanency		Child's Safety		Child's Wellbeing & Development		Child's Attachment	
	N	%	N	%	N	%	N	%
Total sample	73	100.0	73	100.0	73	100.0	73	100.0
value 1	3	4.1%	7	9.6%	0	0	0	0
value 2	14	19.2%	20	27.4%	11	15.1%	1	1.4%
value 3	12	16.4%	13	17.8%	9	12.3%	6	8.2%
value 4	7	9.6%	14	19.2%	17	23.3%	10	13.7%
value 5	37	50.7%	19	26.0%	36	49.3%	56	76.7%

Overall, meetings were quite substantial as far as addressing all the identified needs. The most frequent core domain appeared to be the attachment between the child and the significant caregiver, followed by the child wellbeing, permanency and safety.

1. Safety needs were considered addressed if issues and reasons for referrals were discussed at the conference and the plan included services or activities to remedy the issues or protect the children from the effects of these issues (e.g., intervention to address alcohol abuse and prostitution, provision of counselling services). Safety was valued 5 in 26% of cases and valued 1 in 9.6% of cases.
2. Permanency needs were considered to be addressed if a concurrent plan or a transition home plan was made, or if a permanent placement was discussed or decided, or if some kind

of stable situation for the child was explicitly expedited by the implementation of the plan. Permanency was valued 5 in 50.7% of cases and valued 1 in 4.1% of cases.

3. Wellbeing and development were considered addressed when lack of basic needs was considered during the conference and if the plan explicitly included provision of basic services such as feeding, health, education, etc. Wellbeing and development were valued 5 in 49.3% of cases and value 1 in no case.
4. Attachment needs were considered addressed if the importance of maintaining or developing healthy relationships with family members or significant people in the child's life was reflected in the plan (e.g., placement with relative, regular visitation or contact, interventions for parenting capacity improvement). Attachment was valued 5 in 76.7% of cases and valued 1 in no case.

However, topics discussed at the conference didn't necessary become part of the FGDM plan, as it appeared that while attachment and safety had the highest topics frequency during the FGDM information sharing, it was attachment and wellbeing that scored the highest marks when analysis was done on related needs explicitly stated within the FGDM plans.

2.1.3.3 FGDM Conference topics

Conferences were focused on the identified core domains. Table 36 indicates topics discussed within the conference as they combined with corresponding risk factors, with prevalence on the core domains of child-caregiver attachment where combined topics had a frequency of 267 times, followed by safety with 239, permanency with 141 and wellbeing with 129 respectively. Main topics discussed during the 73 conferences were inadequate caregiver's perception of child's needs (97% of all conferences), neglect/failure to protect (69.9%), caregiver-child conflict (54.8%), parents blaming the child & refusing to accept family identified needs 53.4%, inadequate acceptance by parent/stepparent (52.1%), child's mistreatment (46.6%), and violent punitive discipline (45.2%).

Table 36: FGDM conferences topics frequency

ATTACHMENT	N	%	PERMANENCY	N	%
Total sample	73	100.0	Total sample	73	100.0
inadequate caregiver's perception of child's needs	71	97.3	negative peers pressure	24	32.9
caregiver-child conflict	40	54.8	family disconnection from community social support	24	32.9
parents blaming the child & refusing to accept family identified needs	39	53.4	presence of step-mother	19	26.0
child's inadequate acceptance by parent/step-parent	38	52.1	running away from home	18	24.7
child's abandonment by mother at early age	30	41.1	biological parents separation	13	17.8
Refusal of parental responsibility	28	38.4	single mother	12	16.4
child's rejection by caregiver	21	28.8	presence of step-father	10	13.7
			orphan of one parent	9	12.3
			orphan of both parents	6	8.2
			child under previous alternative residential care	6	8.2
Total	267		Total	141	

WELLBEING	N	%	SAFETY	N	%
Total sample	73	100.0	Total sample	73	100.0
environmental hazard/ slum area	28	38.4	neglect/failure to protect	51	69.9
child's truancy	27	37.0	child's mistreatment	34	46.6

child going home late	10	13.7	violent punitive discipline	33	45.2
homelessness/ poverty	8	11.0	child's physical abuse	19	26.0
child sleeping outside	8	11.0	child's emotional abuse	18	24.7
child with street life experience	7	9.6	parents' inconsistency in discipline	18	24.7
child stealing	7	9.6	alcohol addiction by parent	15	20.5
child's impaired mental/ emotional condition	6	8.2	caregiver's emotional inability to care for child	12	16.4
child withdrawn/ depressed	5	6.8	inappropriate sexual behaviour	5	6.8
child scavenging	4	5.5	conflict within extended family	5	6.8
child violent/aggressive	4	5.5	marital conflict	5	6.8
parents' unemployment	3	4.1	domestic violence	5	6.8
child lying	3	4.1	child's drugs/alcohol abuse	3	4.1
parent's impaired mental condition	2	2.7	child's sexual abuse	3	4.1
Others	7	9.6	Others	13	17.8
Total	129		Total	239	

2.1.4 Patterns of Attendance: parents, family, community services providers and children

2.1.4.1 Paternal and Maternal participation

Family involvement was explored to learn about the degree of participation by the maternal and paternal sides of the family at the conferences. For all cases within this study, information was available regard-

ing maternal and paternal participation. Across the 73 cases, there were 88 maternal and 54 paternal relatives, resulting in an average of 1.2 maternal and 0.7 paternal relatives attending a conference. Examining the meeting notes for parents attendance, it appears that 42.5% (n=31) of the meetings had only the mother present and 23.2% (n=17) of the meetings had only the biological father present. While 19.3% (n=14) of them had both parents present, 65.7% (n=48) of all conferences had 1 biological parent present. However, if we consider stepparents among the parental caregivers, 87.7% of all conferences had parental representation.

Table 37: Frequency of parents at FGDM conferences (n = 73)

Kind of parental participation	Frequency	%
Total sample	73	100.0
only biological mother present at meeting	31	42.5
biological father and stepmother present at meeting	15	20.5
2 biological parents present at meeting	14	19.3
only biological father present at meeting	2	2.7
only stepmother present at meeting	2	2.7
no parents or stepparents present at meeting*	9	12.3

*5 of these cases represented children orphans of both parents and living with relatives. Eight cases out of nine were represented at the FGDM conference by family relatives.

2.1.4.2 Family versus community service providers' attendance

Participation at the FGDM was considered an indicator of whether extended family members mobilized around the planning for the child's well-being. Data show that each conference drew a high number of family members, and that family members out-numbered service providers from the community. Across the 73 FGDMs, there were 410 family members (not including the concerned children) and 262 service providers in attendance, resulting in an average of 5.6 family members

and 3.6 providers at each conference, indicating that meetings were dominated in attendance by family participants.

Including children, the average number of participants in each conference was of 10 people.

Family members include fictive kin, neighbours and friends of the family, or anyone the family identified as a support person, such as religious leaders. Excluding the child, the average number of biological family relatives attending was 3.7, while the average number of community members was 1.9.

Types of providers attending the conferences include school teachers, chiefs, village elders, police officers, community social services workers, District Children Officers (DCOs) and project providers.

Table 38 shows the range and mean for total attendance and attendance of family members and of providers/professionals. Project caseworkers and counsellor are included in the count of providers, but facilitators are not counted as participants.

Table 38: Range and Mean of Meeting Participants (n = 73 meetings)

	Range	Mean
Meeting size (# of total participants)	5-19	10.2
# of family members at meeting	1-16	5.6
# of professionals/providers at meeting	2-7	3.6

Table 39 shows the comparison between conference participation by family members and by professionals. It appears that 69.9% of the conferences in this sample had more family members than providers, 8.2 % had equal numbers of each and only 21.9% of the meetings had professionals outnumbering family members.

Table 39: Ratio of Family Members to Professionals at Meetings (n = 73 meetings)

# of family members > # of professionals	69.9%	(n=51)
# of family members = # of professionals	8.2%	(n=6)
# of family members < # of professionals	21.9%	(n=16)

2.1.4.3 Child's participation

Children and young people occupied a unique position within the FGDM process and their conference experience was likely to reflect a range of factors such as their perception of the problem, reactions of other family members and outcomes from the planning process.

The study didn't analyse reactions of children who were involved in a FGDM, as other studied did by identifying feelings such as confusion, hope and anger (Heino, 2003), relief, amazement and gratefulness (Velen & Devine, 2005). Certainly, the FGDM conference could be a particularly intense and emotional experience for children (Horan & Dalrymple, 2003).

The presence of the child at the conference was considered critical for direct participation to the planning and for the child to appreciate the family and community concern on the case. Hence, during the FGDM process the issue was not *whether to involve children* but *how to do so effectively*. The extent of children's participation in FGDM was shaped by a range of cultural and organizational factors as well as by the child's wishes and characteristics and families expectations.

Restrictions on children's attendance at conferences fell broadly into two main areas, either the child's age and understanding, or concerns about the nature of the discussion and situation that was being handled.

All 73 children were listed as being physically present at the conference. For child's developmental and local cultural reasons the physical presence at the meeting was usually limited to the *introductive* stage and when *finalizing the plan*. During the *information giving* phase and the *private family*

time the child was not present. Typically, the counsellor represented the child so children's voices were shared always by her participation. Other possibilities were that members of the family or an external person (e.g. class teacher) close to the child could speak on their behalf. The child could also write a letter for the conference to express concerns and needs. The letter was read during the *information giving*.

At times, depending on age and personal characteristics, children attended the last part of the *information giving* to speak on their own behalf so to

- have a say in their own affairs;
- inform others about the impact family issues or parental attitudes had on them; and
- learn about the impact their behaviours had on others.

All children, regardless of the age, attended the *finalising the plan* stage in order to

- gain a sense of belonging to their family and community;
- feel that their family cares about them;
- learn how to take part responsibly in decision making;
- become invested in the conference plan; and
- begin the process of healing.

2.1.5 FGDM plans formulation and kind of services included

A family plan, outlined during the family's private time and approved by the caseworker, is the primary goal of the FGDM. The study found that all of the identified plans were approved by the caseworker indicating that the plans met agency standards for child safety and well being.

Satisfactorily concluding a conference with family and professional agreement upon a plan is a significant measure of the success of the FGDM process, though the term *plan agreement* is often ambiguous (Lupton & Nixon, 1999), as agreement might be reached at different points e.g. following consultation with service providers. Not-

withstanding this ambiguity about how plans are agreed, all 73 FGDM conferences formulated a plan which was accepted by the agency and viewed positively by families. 45.2% (n=33) of the plans were agreed upon and signed by parents and relatives, 39.8% (n=29) by parents alone and 15% (n=11) only by relatives.

This development confirmed previous studies which had found that the majority (in most studies as high as 90-95%) of families are able to identify a plan, and that these plans are approved by the referring caseworker (Crowe & Marsh, 1997; Simmonds, Bull, & Martyn, 1998; Lupton & Sheppard, 1999). There is a range of studies demonstrating a high rate of plan agreement:

- New Zealand - 92% plans agreed (Paterson & Harvey: 1991; Mason et al: 1992);
- New Zealand (youth justice) - 95% plans agreed (Maxwell & Morris: 1993);
- Australia (New South Wales) - 95% plans agreed (Cashmore & Kiely: 2000);
- Canada - 97% plans agreed (Burford & Pennell: 1995);
- USA (Washington state) - 99% plans agreed (Shore et al: 2001);
- Northern Ireland - 100% plans agreed (Gribben: 2005);
- UK - 93% plans agreed (Marsh & Crow: 1998).

Possibly, an overall agreement on the plan was achieved also by facilitating families with high level of disfunctionality to hold the FGDM at the chief/DCOs office in order to support their decision making processes and prevent the inability to resolve their differences.

The study also examined whether the 73 FGDM plans had implementation timelines specified. It was found that only 12.3% (n=9) of the plans had a comprehensive timeframe for implementation. Slightly more than half of them (54.8%, n=40) indicated some specific timelines while 32.8% (n=24) of them had no implementing timeframe specified at all.

As the families are empowered to create their own plans, the FGDM process is more likely to reflect the variations in family and cultural approaches to care-giving and problem-solving.

An analysis of who signed the plan showed that family relatives played a relevant role in taking responsibility of the drafted plan. While 39.8% (n= 29) of plans were signed by parents alone, 45.2% (n=33) of them were signed together with relatives and 15% (n=11) were signed only by relatives.

The family plans created at the FGDM were also reviewed to determine whether they included routine services provided in case plans where a FGDM did not occur, and additional services that were unique to the family. All 73 plans were available for analysis.

Services were categorized into three main groups:

1. Government driven

The government was committed to provide mental health services, such as emotional support and counselling (15%, n= 11), beside monitoring and supervision (9.6%, n=7) through appropriate offices (chiefs, DCOs).

2. Community partners driven

Community partners were included in plans for services provisions. School teachers appeared in 13.7% (n=10) of all plans, being called to assist in educational and monitoring services, while residential service providers were listed in 8.2% (n=6) of the plans for provision of temporary shelter accommodation.

3. Family driven

In addition to the more *official* services, families also identified resources that tapped into their own strengths. In 98.6% (n=72) of the plans reviewed, at least one family-driven support was listed. These services were to be provided through extended family support. They are presented in table 40, including their percentages out of all 73 plans.

Table 40: Family driven support included in FGDM plans

Parenting skills improvement: positive alternative discipline, communication, acceptance of parental responsibility	Provision of formal education	Building of caregiver-child relationship	Provision of child's monitoring and supervision	Provision of family long term placement	Provision of food, clothing and basic necessities	Provision of counselling-emotional support
60.3 %	50.7%	47.9%	43.8%	32.9%	21.9%	17.8%

Other family plans included less frequent services such as extended family members helping with financial support (6.8%, n=5) and sustaining parents' behavioural change (5.4%, n=4)).

In terms of content, as the literature suggests that plans are positive, robust and utilise a mixture of family and professional resources (Marsh & Crow, 1998), we found that most FGDM plans included more elements of assistance from the family itself (characterised as wide-ranging and practical in nature) rather than from service providers, and that plans utilised and increased the availability of family resources. This shift toward a strengths-based approach, with emphasis on resilience and protective factors and a movement away from focusing solely on risk factors, particularly for addressing child vulnerability and its recurrence, emphasizes on the belief that intervention plans are most effective when they involve building up children and family's strengths. Hence, plans need to address both risk and protective factors to provide the most help for child's resilience to be strengthened.

The FGDM model allowed for both the family and child's strengths to be identified and included in the plan of action, thus putting in the forefront protective factors.

2.1.6 FGDM Plan Involvement

Family Group Decision Making conferences can be defined as *"designed to build and strengthen the natural caregiving system for the child"* (Rodgers, A., 2000, 8). This implies that resources in the family should be sought and employed whenever possible.

Descriptive studies, primarily focusing upon process measures and immediate results, show that Family Conferences engage more family members than other case-planning methods, result in high degrees of family and professional satisfaction, and expand the quality of support available to families who have participated (Lupton, 1999). On the contrary, absence of active family involvement in case planning and decision-making was found to create a barrier to achieving permanence (Gleeson et al., 1997).

Though this study could not compare its results with other methods in relation with family satisfaction and involvement, plans drafted by the families at the FGDM were analyzed to identify the number of extended family members and service providers (see Table 41) engaged in them, as a way of strengthening the natural caregiving system of the child.

It was found that in 98.6% (n=72) of the cases 1 or more family members were involved in the FGDM plan. In only one case no family members was involved. In 78% (n=57) of the cases biological parents were involved and in 19.2 % (n=14) of the cases stepparents were involved. In 42.5% (n=31) of the cases, one or more extended family members were involved in the plan. In 5.5% (n=4) of the cases, grown up children were directly involved in the plan implementation, in particular by committing themselves to attend school (2.7%, n=2), regularly reporting to the chief and improving personal family relationship (both 1.4%, n=1).

Stakeholders from the community were also involved in 30.1% (n=22) of all cases in the plan, school teachers having the largest share in 16.4% (n=12) of cases. However, 69.9% (n=51) of all drafted plans did not include any community service providers.

Table 41: Frequency of Family Members and service providers Involved by the FGDM Plan draft (n =73)

Family members involved in plan	**Frequency**	**%**
any family members	72	98.6
children	4	5.5
biological parents	57	78.1
stepparents	14	19.2
extended family members	31	42.5
Service providers involved in plan		
teachers	12	16.4
civil society organizations	6	8.2
village elders, police	4	5.5
Drafted plans with no service provider involved	51	69.9

Extended family involvement only partially took the form of a relative placement when the child was to exit the Remand Home (16.4%, n=12). Other roles were supervising, making home visits, maintaining a relationship with the child, providing counselling and education.

Since the balance of power between service providers and family members was viewed as critical on partnership based relationships and recognition of family strengths (Dartington Social Research Unit, 1995; Little, 1995; Tomison, 1996; Armytage et al. 1998), the ratio of extended family members to providers involved in plans was calculated. One conference was found to have a larger number of providers involved in the plans than extended family members, one had the same number of providers and extended family members involved, and 71 had fewer providers than family members involved in plans. Out of the 73 plans, 52 had only family members involved, 20 had both family members and providers, 1 had only providers.

Table 42: Ratio of Extended Family Members to Professionals/ Providers Involved in FGDM plan (n = 73)

# of family members > # of professionals	97.2% (71)
# of family members = # of professionals	1.4% (1)
# of family members < # of professionals	1.4% (1)

The FGDM plans had 191 family members involved, with a mean of 2.7 family members involved across 72 plans. The 21 plans involving service providers saw the engagement of 24 providers with a mean of 1.2 per plan. This indicates that plans engagement was dominated by family members.

Table 43: Range and mean of Extended Family Members and Community Providers Involved in the FGDM Plans for Each Case (n = 73)

	RANGE	MEAN
Extendedf amilyme mbersin volvedin F GDMp lans	0-6	2.7
Communityp rovidersin volvedin F GDMp lans	0-3	1.2

Building social support through FGDM meant to include a resilience factor important not only for children but also for parents. Social supports could offer parents both emotional and physical resources to help in responding to their child vulnerability or to achieve better outcomes in readjusting their family system. In some instances, supportive adults who were present at the conference could serve as substitute attachment figures if a child's parents or other caretakers were unable to fill this role. Research shows that the presence of one or more positive and significant individuals in a child's life may act as a buffer against negative outcomes due to child abuse or neglect. Supportive adults may be able to look out for children and possibly protect them from neglect (Thompson, R. A., 2000).

2.1.7 Child placement at the FGDM: family versus institutional placement

Being the children experimental group under the jurisdiction of the Nairobi Children's Court for placement committal, during the FGDM conference the child's placement was included in the plan as a matter of priority. Permanent placement included residing at parental and relatives' home or getting alternative residential care.

Table 44 compares the distribution of cases by type of placement pre and at the time of FGDM. Information relating to the 73 children sample (whose information regarding pre-conference living arrangements was wholly available) indicated a decreased 11% (from 74%, n=54, to 63%, n=46) proportion of children living with parents after a FGDM while the proportions of those living with relatives remained almost the same (24.7%, n=18 pre-FGDM against 23.2%, n=17 post-FGDM). The decreased likelihood of family network accommodations and the increased placement into residential care (13.7%, n=10) of children among FGDM families, after comparing pre and post FGDM child's placement, can be justified as Lupton & Nixon (1999) do by observing that findings may be influenced by the characteristics of the children and families involved, as for instance, 93.2 % (n=66) of the children had run away from home and were in need of specialised support, which could not be met by their families or communities. Hence, placements in or out of home care occurred as a result of FGDM plans, being consistent with the best interests and special needs of the child.

Table 44: Distribution of Placement by Type of Placement Pre and at the time of FGDM (n = 73)

Pre FGDM placement	Frequency	%	Cumulative %
living with parent(s)	54	74.0	74.0
living with relatives	18	24.7	98.6
living with non relatives	1	1.4	100.0
Total	73	100	

Type of placement at FGDM	Frequency	%	Cumulative %
family home	46	63.0	63.0
with relative	12	16.4	79.5
with relatives upcountry	5	6.8	86.3
residential care	10	13.7	100.0
Total	73	100	

2.2 INTERMEDIATE OUTOCMES

2.2.1 Degree of community involvement in FGDM plan implementation

Examining intermediate outcomes, first attention was given to the involvement of community partners in the FGDM plan implementation. With regard to retention within, or return to, the family network, placement following family conferences was analysed to see whether family placement increased after FGDM. FGDM plans implementation was also scrutinized to confirm whether and how they were put into practice after the conference.

Though as previously seen the FGDM drafted plans officially engaged only 24 community service providers, plans implementation had to involve more, mainly because after the FGDM conference families had to interact with various partners within their communities to accomplish their commitments. As a result, 68.5% (n=50) of all plans implementation saw 1 partner being engaged by the family, while in 19.2% (n=14) of plans the family had the collaboration of two partners. The engagement of three partners happened just once, while 11% (n=8) of plans had no community partner involved. The counting of partners considered only Civil Society Organizations mostly operating within local communities.

Table 45: Frequency of Community involvement in FGDM plan implementation (n=73)

Community involvement	Frequency	%
Total	73	100.0
1 partner	50	68.5
2 partners	14	19.1
3 partners	1	1.4
None	8	11

Schools were involved in the implementation of 57.5% (n=42) of all plans, while Faith Based Organizations engaged in 15.1% (n=11) and Provincial Administration in 12.3% (n=9) of all plans.

Table 46: Service providers involved in FGDM plan implementation

Services Providers	Frequency	%
Schools	42	57.5
Faith Based Organizations	11	15.1
Provincial Administration	9	12.3
Residential Homes	8	11.0
Local Service Providers	5	6.8
District Children Offices	3	4.1
Police	1	1.4
None	8	11.0

Though the project personnel facilitating the conference were directly engaged in monitoring the plan implementation, it was not counted among the participating partners in order to allow the real calculation of local resources having been mobilized.

2.2.2 Effective FGDM plan implementation

Effective plan implementation is one of the major indicators of FGDM effectiveness. Assessing whether plans have been implement-

ed was done by examining actual execution of the FGDM plans by the involved actors. Caseworkers reports helped in identifying implementation success and failures encountered after the FGDM.

As table 47 indicates, the study revealed that more than half of the plans made during the conferences were almost entirely carried out (57.6%, n=29), while almost all of them (93.2%, n=68) were at least partially implemented.

Table 47: degree of FGDM plan implementation (n=73)

Was The FGDM Plan Implemented?	Frequency	%	Cumulative %
all of it	13	17.9	17.9
most of it	29	39.7	57.6
Partially	26	35.6	93.2
not at all	5	6.8	100
Total	73	100	

Correlations were analysed to understand whether the degree of plan implementation was associated with other variables, as table 48 indicates.

Table 48: FGDM plan implementation and correlated factors

Level of plan Implementation	Correlated factors	Pearson's correlation coefficient *r*	two-tailed *P* value
All of it	Biological parents separation	-.244*	.037
Most of it	Neglect/failure to protect	.288*	.013
	Child scavenging	-.253*	.031
Partially	Successful child's permanency	.354**	.002
	Orphan of one parent	.290*	.013
	Child scavenging	.261*	.026
	FGDM participant: class teacher	.236*	.044
	Family disconnection from community support	.238*	.044

Not implemented at all	Total lack of community involvement in plan implementation	.280*	.016
	Being orphan of one parent	-.281*	.016
	Prostitution by mother	.341**	.007
	Child's rejection	.307**	.008
	Inadequate acceptance by parent	.283*	.015
	Refusal of parental responsibility	.272*	.020
	Child being violent/aggressive	.252*	.031
	Child's suicidal attempts	.287*	.014
	Child's prostitution	.435**	.000
	Child's drug/alcohol abuse	.490**	.000

Plans not being implemented at all correlated with total lack of community involvement in the implementation, Pearson's r (73) =.28, p=.016. Strong correlations were found also with specific caregivers or child's problematic behaviours prior to institutionalization such as child's rejection by the caregiver, Pearson's r (73)=.30, p=.008, prostitution by the child's mother, Pearson's r (73)=.34, p=.007, child's drugs abuse, Pearson's r (73)=.49, p<.001, and prostitution, Pearson's r (73)=.43, p<.001. Plans totally implemented inversely correlated with biological parents' separation, Pearson's r (73)= -.24, p=.037, while plans adequately implemented correlated with previous caregiver's neglect/failure to protect, Pearson's r (73)=.28, p=.013, and inversely with previous child's scavenging behaviour, Pearson's r (73)= -.25, p=.031. Participation of the class teacher to the FGDM conference correlated with partially implemented plans, Pearson's r (73)=.23, p=.044. Long term child's permanency strongly correlated with plans partially implemented, Pearson's r (73)=.35, p=.002, suggesting that even minimal FGDM plan implementation could have been sufficient to provide stability to the child.

Other correlations suggest that internal and external causes might have prevented plans being put into practice as envisaged. Family disconnection from community social support was found to have affected

community involvement in the family conference as this condition was strongly associated with scarce community participation in implementing plans derived from the same conference, Pearson's r (73)=.44, p<.001. As shown in table 48, plan non-completion seemed to be connected also to lack of community engagement in the plan implementation, Pearson's r (73)=.28, p<.016, as well as to caregiver's negative attitudes to the child such as being rejectful, Pearson's r (73)=.30, p<.008, or to failure among family members to change negative behaviours, like prostitution by the mother, Pearson's r (73)=.34, p<.007, alongside with specific child's negative behaviours such as being addicted to drug/ alcohol, Pearson's r (73)=.49, p<.001. This corresponds to Lupton & Nixon (1999) findings stating that plans were implemented with some success but often several components, particularly those involving behavioural change, were not put in place.

No data were available to assess whether plans were not implemented due to inadequate resources delivery as agreed, commitment from service providers, slowness or inability to perform duties.

2.3 LONG TERM OUTCOMES

2.3.1 The re-referral rate

An indicator to measure the achievement of long term results is the child's re-referral to the NCRH after the FGDM.

As shown in table 49, out of the 73 children in the experimental group, six had a NCRH re-committal after the conference, resulting in 8.2% re-referral rate, being slightly lower than for those belonging to the control group (9.5%). However, out of 6 relapsed cases in the experimental group, 4 (66.6%) achieved long term permanency and stability after being re-reintegrated through a revision of the FGDM arrangements, while out of 4 relapses in the control group, 2 (50%) were said to be stable after the second repatriation occurred.

Table 49: Re-referral rate at NCRH - experimental and control group comparison

	Experimental Group		Control Group	
	N	%	N	%
Total sample	73	100	42	100
Re-referral to NCRH	6	8.2	4	9.5

Further analysis of the FGDM re-referred cases showed that re-referrals only temporarily disrupted the child's permanency, as only one case after being re-reintegrated had relapsed back to the streets at the time of the study. For another child there was a shift to a secondary plan that had been identified at the conference, being the provision of long term residential care. After being re-reintegrated, the remaining four children seemed to be doing fairly well and were stable within their families.

2.3.2 Stability of Placement

As reported, all families of children in the experimental group were able to identify a placement plan for their kids. However, it was important to look beyond whether a placement plan was identified to determine whether or not the plan remained stable over time. Hence, cases were categorized according to type of placement to examine whether or not the child was still in permanent placement at the time of the research, namely 24-54 months after the FGDM. The placement was considered successfully achieved when the reintegrated child was stable in it at the time of research.

Information regarding placement location prior to admission at the NCRH was available for all 73 children. This allowed exploring how placement location changed after the conference. Table 50 lists where the children were placed pre-admission at the NCRH, at the time of FGDM and post-FGDM.

Table 50: Type of placement pre, at and after FDGM (n=73) – experimental group

Type of placement	Pre-Admission at NCRH		At the Time of FGDM		At the Time of Research	
	Frequency	%	Frequency	%	Frequency	%
parental care	54	74.0	46	63.0	39	53.5
relatives' care	18	24.7	17	23.3	19	26.0
residential care			10	13.7	3	4.1
foster care	1	1.4			1	1.4
independent life					2	2.7
run away					6	8.2
not known					3	4.1
Total	73	100.0	73	100.0	73	100.0

The greatest shifts in placement between pre-admission in the institution and the FGDM conference can be seen between children living with parents and in residential care. At the time of the conference there was a decrease in the percentage of children living with parents and a surge in the number of those being placed in residential care facilities. The number of children living with relatives remained stable over the time with a slight increase after the conference. This shift needed further investigation to understand its meaning.

The type of placement at the time of research indicates that 24-54 months after the FGDM the majority of children were in the placement identified in the conference plan. Specifically, 79.5% (n=58) were still in parents or relatives care versus 86.3% (n=63) who had that type placement at the time of the FGDM. Few variations were noted since it appeared that 7 (9.6%) children had left parental care, 2 (2.7%) had moved to relatives, while 3 (4.15%) of the 10 (13.7%) placed in residential care were still in a shelter, indicating a sharp decrease in the number of children placed in temporary institutions by the FGDM conference. However, a deeper analysis showed a more complex scenario.

Among children living with their parents, 5 had moved back with them from institutional care while other 2 had been placed in residential care for further intervention. Six (6) had been transferred to relatives while 3 had been received back from relatives. Two (2) had moved out of home to independent life being over eighteen and 3 had run away to the streets. The whereabouts of other 2 placed by the FGDM with parents were unknown.

Among children in relatives' care, 1 had been received from institutional care, 1 had been placed in foster care, 6 had been placed with relatives by their parents, while 3 had been sent back by relative to their parents. The whereabouts of 1 placed by the FGDM with relatives was unknown.

Among children in institutional care, as already mentioned, 5 had been reunited to their parents and 1 with relatives, 3 had been admitted for further care from their placement with parents, while 3 had run away to the streets.

Further investigation looked at correlations between the type of family composition and the child's stability rate at the time of the research. It was found that the presence of single mothers was inversely correlated to successful long term permanency (Pearson's r (73)= -.25, p=.032).

It was also noted that transfer of children from Nairobi to upcountry was a frequent move which involved 28.7% (n=21) of the experimental group cases, most of them being placed with the upcountry extended family. As table 51 indicates, further investigation revealed that out of the 21 cases, 9 (42.9%) had been transferred upcountry according to the FGDM plan and 3 (14.3%) had moved later on following their parents. However, the remaining 7 (33.3%) had a later placement in upcountry relatives care as part of further adjustments to the family plan, due to being unstable in parental home placement in 5 cases (23.8%) or to provide safety to the child in 2 cases (9.5%).

Table 51: Reasons for child's transferral upcountry (n=21) – experimental group

Reasons for being transferred upcountry	Frequency	%
being part of FGDM plan	9	42.9
family transferred upcountry	3	14.3
being unstable in placement	5	23.8
for child's safety	2	9.5
to join parent	2	9.5
Total	21	100.0

This mobility shows an ongoing children circulation within families in response to identified needs. The FGDM may help to demonstrate the efficacy of linking relatives and reinvigorating networks of support for family decision-making and thereby restore confidence in the traditional family system still recognised as the primary partner in child care.

Despite a lack of evidence on culture recognition and the difficulties of measuring concepts such as *responsibility*, findings indicate that FGDM mobilises family support effectively.

On the whole, most of these re-placements had been identified by the family as their secondary plan, which could be arranged during the FGDM follow up or through consultations with the caseworker.

In summary, only 6 (8.2%) of the 73 children in the experimental group had experienced severe difficulties with the intended primary plan and consequently had indefinitely moved out of their placement to run to the streets. Other three (4.1%) children had moved with their families to unknown locations and it was impossible to trace them.

A comparison with the control group was done to analyse the long term success rate in child's placement stability between the two groups. In relation to the experimental group, out of 70 cases whose whereabouts were known, failure was considered for 9 cases (12.9% of 70), being of children who had permanently run away from placement (6 cases), being in residential care due to their instability (2 cases) and

unsteady in independent life (1 case). The third child still being in institutional care was not included in this group being very stable and in the process of being reunited with his parents.

Accordingly, the placement was considered successfully achieved for 61 children (87.1% of 70) whose placement was stable at the time of research.

The control group cases were rated according to the report given over the phone by their caregiver at the time of research. Among the 42 who responded and provided the required information, no case could be further verified through additional investigations.
In relation to this group, out of 42 cases whose whereabouts were known, failure was identified in 13 cases (31% of 42), while success was found in 29 cases (69% of 42).

To sum up, the permanency success rate of the experimental group was of 87.1% against 69.0% of the control group, while the failure rate was respectively 12.9% against 31%.

Table 52: Success rate of placement stability - experimental and control group comparison

Placement stability	Experimental Group		Control Group	
	N	%	N	%
	70	100	42	100
Success	61	87.1	29	69.0
Failure	9	12.9	13	31.0

As table 53 indicates, the control group and experimental group had no significant ($p<.05$) differences in regard to the type of placement prior to their admission to the NCRH and at the time of research. In particular, the similarity of placement trends within the two groups appeared in relation to parental versus relatives care. In fact, at the time of the research, as in the experimental group, the percentage of

cases under parental care had decreased by 20.5% reaching 53.5% of the total, in the control group, the proportion also decreased by 19.0% stabilising at 50.0%.

The significant difference between the two groups at the time of the research was related to the runaway cases. Here, a lower rate of runaway cases was observed among FGDM children with 8.2% (n=6) of the experimental group when compared with 28.6% (n=12) of non-FGDM children from the control group. The 20.4% variance indicates a statistically significant difference between the groups and it draws attention to the likelihood of higher permanency probability for cases which underwent FGDM. Accordingly, the 9.4% decrease of children in the control group under relatives care at the time of the research (19.0% of 42) compared with that same placement prior to admission at the institution (28.6% of 42) suggests that some of them may be part of the runaway group.

Table 53: Type of placement pre NCRH admission and at the time of research - experimental and control group comparison

Type of placement	Pre-Admission at NCRH				At the Time of Research			
	Experimental group		Control Group		Experi-mental group		Control Group	
	N	%	N	%	N	%	N	%
Total sample	73	100.0	42	100.0	73	100.0	42	100.0
parental care	54	74.0	29	69.0	39	53.5	21	50.0
relatives' care	18	24.7	12	28.6	19	26.0	8	19.0
residential care					3	4.1		
foster care	1	1.4	1	2.4	1	1.4		
independent life					2	2.7	1	2.4
run away					6	8.2	12	28.6
not known					3	4.1		

2.3.3 Safety, permanency, and well-being

Based on the principle that every child has the right to appropriate care and a permanent home, the long term FGDM outcomes measured in the study fall into three domains which correspond to child's safety, permanency, and well-being. Each of them having roots in the international standards agreed for children in the United Nations Convention on the Rights of the Child (United Nations, 1989).

We broadly defined the goal of **safety** as the protection of children from harm in their placement, including physical, sexual, and emotional abuse, as well as neglect.

Permanency is achieved when a child is reunified with his or her family, placed with a legal guardian, or adopted. Its effectiveness depends on the timeliness of achieving these actions and how lasting they are, i.e., the children do not re-enter the institutional care system. In the study, permanency was conceptualized as achieved when children had stable and consistent living situations and when continuity of family relationships and community connections were preserved. Hence, the FGDM conference focused on ensuring that children did not stay in the NCRH longer than needed and on returning them as much as possible to their original family. The ultimate goal was to provide a safe and nurturing home so that the child could develop and sustain meaningful relationships.

Child **well-being** measured the quality of children's lives. However, as simple as the concept sounds, there is no unique, universally accepted way of actually measuring child well-being that emerges from the academic literature. For the purposes of this study, child well-being was measured using the three dimensions which cover the major aspects of children's lives: families having the capacity to provide for their children's needs, children having educational opportunities and achievements appropriate to their abilities, and children receiving adequate physical (e.g. food, clothing, shelter, medical) and mental (emotional, psychological) health services.

The above domains were picked as an integrated framework to measure the long term conference outcomes. The research analysed each domain according to the following components as they are defined by the USA Federal Administration for Children and Families (ACF, 1999):

Safety

- Children are, first and foremost, protected from abuse and neglect.
- Children are safely maintained in their own homes whenever possible.

Permanency

- Children have permanency and stability in their living situations.
- The continuity of family relationships and connections is preserved for children.

Well Being

- Families have enhanced capacity to provide for their children's needs.
- Children receive appropriate services to meet their educational needs.
- Children receive adequate services to meet their physical and mental health needs.

Quantitative and qualitative data from the experimental group aftercare files and documentation, such as caseworkers' observation, reports and records, were analysed by the researcher using the above USA Federal Administration for Children and Families (ACF, 1999) performance indicators to gauge the impact of the FGDM as a family reintegration model by quantifying the achievement of the desired outcomes and indicating percentage of cases rated as substantially achieved.

2.3.3.1 Safety outcome from abuse and neglect

Safety Outcome 1:

Children are first and foremost, protected from abuse and neglect.

Performance Indicator:
How effective is the FGDM in reducing the recurrence of abusive patterns to reintegrated children?

Table 54 - FGDM outcome: S1-abusive patterns in family have changed

	Frequency	%	Cumulative %
very much	21	28.8	28.8
fairly enough	21	28.8	57.6
a little	10	13.6	71.2
not at all	2	2.7	73.9
not known	18	24.7	98.6
not applicable	1	1.4	100.0
Total	73	100.0	

Safety Outcome 2:

Children are safely maintained in their homes when possible and appropriate

Performance Indicator:
How effective is the FGDM in reducing the risk of harm to reintegrated children, including those under parental and relatives care?

Table 55 - FGDM outcome: S2-risk of harm has been reduced

	Frequency	%	Cumulative %
very much	29	39.7	39.7
fairly enough	14	19.2	58.9
a little	13	17.8	76.7
not at all	2	2.7	79.4
not known	14	19.2	98.6
not applicable	1	1.4	100.0
Total	73	100.0	

Child's safety stated in the FGDM plan strongly correlated with high accumulation of risk factors in cluster 2, witnessing continuous external threat, Pearson's r (73)=.33, p=.004, and Cluster 1, direct exposure as victims of abuse or unsafe conditions, Pearson's r (73)=.33, p=.004. This confirmed that safety was a particular concern in most families, since their children were affected by various forms of harm.

The analysis of the safety outcome for all families of the experimental group highlights that the FGDM was particularly effective in helping families to change in relation to their internal patterns of abuse, with a cumulative percentage of change reaching 71.2%. In relation to the experimental group risks frequency analysis, which had identified the children's safety being at high risk due to mistreatment (53.4%, n=39), physical abuse (28.8%, n=21) and emotional abuse (24.7%, n=18), the study suggests that the conference assisted the family network to assess family dynamics and functioning, develop a pertinent plan to protect the child from harm or abuse and help the family change. As a result, the family plan for remedying the situation reduced the children risk of harm up to 76.7%.

A further analysis to investigate correlations between Safety Outcomes and other FGDM outcomes found that Safety Outcomes 1 and 2 were strongly associated with Permanency Outcome 2, that's the children's preserved continuity of family relationships and culture, as shown in the table 56. This finding suggests that where FDGM succeeded in

maintaining the child's proximity to the natural family, the cultural connection and the child's placement with the community, these outcomes became a resiliency factor to reduce abuse and harm to the child.

Table 56: Correlation between Safety and Permanency outcomes

FGDM S1-2 outcomes	Correlations with FGDM outcomes	Pearson's correlation coefficient *r*	one-tailed *P* value
S1-abusive patterns in family have changed	FGDM outcome: P2 - proximity to parents/ext. family	.295*	.011
	FGDM outcome: P2 - cultural connection with community	.287*	.014
	FGDM outcome: P2 - placement related to child's community	.284*	.015
S2-risk of harm has been reduced	FGDM outcome: P2 - proximity to parents/ext. family	.295*	.011
	FGDM outcome: P2 - cultural connection with community	.288*	.014
	FGDM outcome: P2 - placement related to child's community	.284*	.015

** Correlation is significant at the 0.01 level

* Correlation is significant at the 0.05 level

2.3.3.2 Permanency outcome: retention and relationship within the family network

Permanency Outcome 1:
Children have permanency and stability in their living situations

Performance Indicator:

How effective is the FGDM in providing placement stability for children in care (that is, minimizing placement changes for children)?

Table 57 - FGDM outcome: P1-stability of current placement (n=70) – experimental group

	Frequency	%	Cumulative %
very stable with parents	15	21.4	21.4
fairly stable with parents	24	34.3	55.7
very stable with relatives	2	2.9	58.6
fairly stable with relatives	17	24.3	82.9
unstable in long term institutional care	2	2.9	85.7
stable in long term institutional care	1	1.4	87.1
stable in independent life	1	1.4	88.6
unstable in independent life	1	1.4	90.0
fairly stable in foster care	1	1.4	91.4
not in family – streets	6	8.6	100.0
Total	70	100	

Stability was assessed being based on the risk level of relapse the child had at the time of the research, according to the caseworkers' assessment indicated in the aftercare records. Very stable corresponded to low or very low risk level, fairly stable to moderate risk and poorly stable to high risk.

As previously analysed, in terms of stability, not considering 3 children whose whereabouts were unknown, the overwhelming majority of them (87.1%, n= 61 out of 70) was stable in the placements identified in their FGDM plan or in subsequent variations drawn at FGDM follow up meetings. At the time of research, 12.9% (n=9) of the 70 children were still experiencing severe difficulties. Among them, 8.6% (n=6) had subsequently moved out of home placements to the streets, 2.9% (n=2) were in residential care due to their instability at home and 1.4% (n=1) was unsteady in independent life.

Besides, out of all 73 children of the experimental group, a low rate

(8.2%, n=6) of re-referrals to NCRH was found to have happened between their reintegration and the time of research.

This indicates a relevant variation compared with the risks frequency analysis, which had identified high rates of permanency instability among children of the experimental group who used to display severe incapacity of being stable at home by running away (93.2%, n=68), going home late at night (26%, n=19), sleeping outside at night (24.7%, n=18) and being subject to negative peer pressure (35.6%, n=26) prior to their admission at the NCRH.

Further investigation found that high accumulation of risk factors in cluster 2, witnessing continuous external threat, correlated with successful long term child's permanency after the FGDM, Pearson's r (73)=.27, p=.020, suggesting that the FGDM conference may have supported retention of the child by the family even in the presence of a toxic external environment.

Permanency Outcome 2: The continuity of family relationships, culture, and connections will be preserved for children.

Table 58 - FGDM outcome: P2 - proximity to parents/ extended family preserved

	Frequency	%	Cumulative Percent
Yes	59	80.8	80.8
No	11	15.1	95.9
not known	3	4.1	100
Total	73	100	

Performance Indicator:

How effective is the FGDM in preserving important connections for reintegrated children, such as connections to neighbourhood, community, school, and friends?

Table 59 - FGDM outcome: P2 - cultural connection with community

	Frequency	%	Cumulative Percent
Yes	57	78.1	78.1
No	7	9.6	87.7
not known	9	12.3	100
Total	73	100	

Performance Indicator:

How effective is the FGDM in promoting or helping to maintain the parent-child relationship for reintegrated children?

Table 60 - FGDM outcome: P2 - placement related to child's community

	Frequency	%	Cumulative Percent
Yes	56	76.7	76.7
No	8	11.0	87.7
not known	9	12.3	100
Total	73	100	

Table 61 - FGDM outcome: P2 -quality relation child- parent/ caregiver

	Frequency	%	Cumulative Percent
very good	13	17.8	17.8
fairly good	29	39.7	57.5
slightly good	8	11.0	68.5
not good at all	3	4.1	72.6
absent	9	12.3	84.9
not known	11	15.1	100.0
Total	73	100.0	

The children's physical proximity with their caregiver represented 80.8% (n=59 out of 73) of all cases, while the quality of the child-caregiver relationship was estimated to be at least slightly good in 68.5% (n=50 out of 73) cases. However, calculating the same quality of relationship against the known cases (n=62) it reaches 80.6%. A very or fairly good relationship is achieved in 57.5% (n=42 out of 73) cases. Hence, child-caregiver relationship and parenting showed improvements if measured in comparison with the risk factors frequency analysis of the experimental group, where the child – caregiver attachment was found to be highly threatened by parent-child conflict (52.1%, n=38), abandonment/separation by caregiver at early age (41.1%, n=30) and caregiver rejection (28.8%, n=21).

The use of parental and kinship (relative) placements (80.8%, n=59) also corresponded to preservation of the child's social (76.7%, n=56) and cultural (78.1%, n=57) connection with the community. Hence, FGDM appeared to be a tool which, while able to maintain children's connection to family and community, it also improved quality child-caregiver relationships.

On the impact the preservation of community connections may provide, it was found that extended community involvement in FGDM plan implementation correlated with medium accumulation of risk factors in cluster 3, child's engagement in antisocial behaviour, Pearson's r (73)=.23, p=.048, suggesting a role the community accepted to play in dealing with child displaying difficult behaviour, when not excessive. Similarly, holding the FGDM at the chief camp's correlated with high accumulation of risk factors in cluster 2, witnessing continuous external threat, Pearson's r (73)=.28, p=.016, suggesting an active role the family requested the chief to play when the threat was external. On the other hand, holding the conference in the school was correlated with high accumulation of risk factors in Cluster 3, engaging in direct antisocial behaviour, suggesting a role teachers were to play in relation to negative child behaviour.

As the table 62 indicates, a further analysis to investigate correlations between Permanency Outcomes 2 and the other FGDM outcomes found that preservation for children of **the continuity of family relationships, culture, and connections,** beside showing strong intertwined internal correlations, revealed a strong association with Wellbeing Outcomes 1 and 2, such as matching services in the community, family participation in case planning and provision of educational needs. This finding suggests that the FGDM results of granting child's proximity to the natural family, culture and community facilitates family responsibility in decision making and community engagement in responding to the child's identified needs.

Furthermore, the same P2 outcomes strongly correlated with positive quality relationship between child and caregiver suggesting that the environmental proximity and connection also facilitates internal family bonding.

Table 62: Correlation between Permanency Outcomes 2 and S1-S2-P2-WB1-2-3 Outcomes

FGDM P2 outcome	Correlations with FDM outcomes	Pearson's correlation coefficient r	one-tailed P value
P2 - proximity to parents/ ext. family	P2 - cultural connection with community	.972**	.000
	P2 - placement related to child's community	.958**	.000
	P2 - quality relation child-parent/caregiver	.530**	.000
	S1-abusive patterns in family have changed	.295*	.011
	S2-risk of harm has been reduced	295*	.011
	WB1-match of services in the community	.572**	.000
	WB1-family participation in case planning	.489**	.000
	WB2-provision of educational needs	.552**	.000
	WB3-basic physical needs provided	.702**	.000
	WB3-emotional needs & services provided	.566**	.000

P2 - cultural connection with community	P2 - proximity to parents/ ext. family	.972**	.000
	P2 - placement related to child's community	.957**	.000
	P2 -quality relation child-parent/caregiver	.541**	.000
	S1-abusive patterns in family have changed	.287*	.014
	S2-risk of harm has been reduced	.288*	.014
	WB1-match of services in the community	.558**	.000
	WB1-family participation in case planning	.463**	.000
	WB2-provision of educational needs	.545**	.000
	WB3-basic physical needs provided	.669**	.000
	WB3-emotional needs & services provided	.567**	.000
P2 - placement related to child's community	P2 - proximity to parents/ ext. family	.958**	.000
	P2 - cultural connection with community	.957**	.000
	P2 - quality relation child-parent/caregiver	.499**	.000
	S1-abusive patterns in family have changed	.284*	.011
	S2-risk of harm has been reduced	284*	.011
	WB1-match of services in the community	.513**	.000
	WB1-family participation in case planning	.450**	.000
	WB2-provision of educational needs	.530**	.000
	WB3-basic physical needs provided	.652**	.000
	WB3-emotional needs & services provided	.523**	.000
P2 - quality relation child-parent/ caregiver	P2 - proximity to parents/ ext. family	.530**	.000
	P2 - cultural connection with community	.541**	.000
	P2 - placement related to child's community	.499**	.000
	WB1-match of services in the community	.659**	.000
	WB1-family participation in case planning	.604**	.000
	WB2-provision of educational needs	.763**	.000
	WB3-basic physical needs provided	.806**	.000
	WB3-emotional needs & services provided	.837**	.000

** Correlation is significant at the 0.01 level

* Correlation is significant at the 0.05 level

2.3.3.3 Well being outcome

Well Being Outcome 1: Families have enhanced capacity to provide for children's needs

Performance Indicators:

How effective is the FGDM in involving parents and children in the case planning process?

Table 63 - FGDM outcome: WB1-family participation in case plan implementation

	Frequency	%	Cumulative Percent
very good	13	17.8	17.8
fairly good	29	39.7	57.5
slightly good	8	11.0	68.5
not good at all	3	4.1	72.6
absent	9	12.3	84.9
not known	11	15.1	100.0
Total	73	100.0	

How effective is the FGDM in assessing the needs of reintegrated children and in providing to them needed services drawn from the community?

Table 64 - FGDM outcome: WB1-match of services in the community

	Frequency	Percent	Cumulative Percent
Yes	39	53.4	53.4
No	19	26.0	79.5
not known	15	20.5	100.0
Total	73	100.0	

FGDM effectively supported parental and extended family participation in case plan implementation in 83.5% (n=61) of all cases (n=73)

by giving them control in the development of safety, placement, and service plans. A very or fairly good family participation was achieved by 67.1 (n=49) of all cases. The involvement of families and community (clergy, community members, service providers) who came together in a collaborative and coordinated planning process, strengthen the matching process of the child's needs to services available in the community in 67.2% (n=39) of all known cases (n=58).

Family engagement appeared to be a key strategy for families to address their children's needs, and FGDM was found to be a specific family engagement methodology for plan implementation after the FGDM conference.

Well Being Outcome 2: Reintegrated children receive services to meet their educational needs and attain educational achievements appropriate to their abilities.

Performance Indicators:

How effective is the FGDM in addressing the educational needs of reintegrated children?

Table 65 - FGDM outcome: WB2-provision of educational needs

	Frequency	Percent	Cumulative Percent
Yes	50	68.5	68.5
No	7	9.6	78.1
not known	16	21.9	100.0
Total	73	100.0	

Performance Indicators:

How effective is the FGDM in promoting or helping reintegrated children in performing well at school?

Table 66 - FGDM outcome: WB2-child's school performance

	Frequency	Percent	Cumulative Percent
very good	4	5.5	5.5
quite good	26	35.6	41.1
sufficient	14	19.2	60.3
not attending school	10	13.7	74.0
not known	19	26.0	100
Total	73	100.0	

Educational needs were met by families in 68.5% (n=50) of all 73 FGDM cases, or else in 87.7% (n=50) of all known cases (n=57), in general by provision of immediate school enrolment after the conference. School performance of children reintegrated through FGDM could be established to be very, quite or sufficiently good, according to their ability, in 60.3% (n=44) of all cases(n=73), or else in 81.5% (n=44) of all known cases (n=54). Even the 13.7% (n=10) of children of the experimental group not attending school at the time of the research suggests a positive improvement when measured against the truant behaviour which had previously affected 42.5% (n=31) of the same group sample.

A relevant finding was that among all family characteristics (e.g. composition) or child's factors (e.g. age and gender) whose correlations with child's stability 24-54 months after the conference were explored, only being enrolled in a boarding school showed to be a strong protective feature associated with successful child's permanency at home, Pearson's r (73)=.30, p=.009, suggesting that such condition may positively influence the FGDM long term outcome and the child's resiliency.

Table 67 confirms the strong correlations found between Permanency

Outcomes 2 and Wellbeing Outcomes 1 & 2, as previously presented. To be noted that no correlation was found between matching of services in the community and provision of educational needs suggesting that response to this need was left as a major responsibility to the child's family.

Table 67: Correlation between Well Being Outcomes 1-2 and P2-WB1-2-3 Outcomes

FGDM WB 1-2 outcomes	Correlations with FDM outcomes	Pearson's correlation coefficient r	one-tailed P value
WB1-match of services in the community	P2 - proximity to parents/ ext. family	.572**	.000
	P2 - cultural connection with community	.558**	.000
	P2 - placement related to child's community	.513**	.000
	P2 -quality relation child-parent/ caregiver	.659**	.000
	WB1-family participation in case planning	.645**	.000
WB1-family participation in case planning	P2 - proximity to parents/ ext. family	.489**	.000
	P2 - cultural connection with community	.463**	.000
	P2 - placement related to child's community	.450**	.000
	P2 -quality relation child-parent/ caregiver	.604**	.000
	WB1-match of services in the community	.645**	.000
	WB2-provision of educational needs	.663**	.000
	WB3-basic physical needs provided	.745**	.000

WB2-provision of educational needs	P2 - proximity to parents/ ext. family	.552**	.000
	P2 - cultural connection with community	.545**	.000
	P2 - placement related to child's community	.530**	.000
	P2 -quality relation child-parent/ caregiver	.763**	.000
	WB1-match of services in the community	.724**	.000
	WB1-family participation in case planning	.663**	.000
	WB3-basic physical needs provided	.776**	.000

** Correlation is significant at the 0.01 level

* Correlation is significant at the 0.05 level

Well Being Outcome 3 : Children receive services to meet their physical and mental health needs

Performance Indicator:
How does the FGDM promote or help that the physical health and medical needs of reintegrated children are provided for?

Table 68: FGDM outcome: WB3-basic physical needs & services provided

	Frequency	**Percent**	**Cumulative Percent**
very much	24	32.9	32.9
fairly enough	26	35.6	68.5
a little	4	5.5	74.0
not known	19	26.0	100
Total	73	100.0	

Performance Indicator:

How does the FGDM promote or help that the emotional needs of reintegrated children are provided for?

Table 69: FGDM outcome: WB3-emotional needs & services provided

	Frequency	Percent	Cumulative Percent
very much	4	5.5	5.5
fairly enough	30	41.1	46.6
a little	14	19.2	65.8
not at all	2	2.7	68.5
not known	23	31.5	100.0
not applicable	0	0.0	100.0
Total	73	100.0	

Performance Indicator:

How does the FGDM promote or help that the mental health needs of reintegrated children are identified and provided?

Table 70: FGDM outcome: WB3-basic mental health needs & services provided

	Frequency	Percent	Cumulative Percent
a little	1	1.4	1.4
not known	11	15.1	16.5
not applicable	61	83.5	100.0
Total	73	100.0	1.4

Among physical, emotional or mental needs, those matched by provision of services were primarily physical and they were very or fairly well provided in 92.6% (n=50) of all known cases (n=54). They included food, shelter and health. Emotional needs, including attachment, ac-

ceptance and protection, were met very or fairly well in 68% (n=34) of all known cases (n=50). Mental health services could be applied only to one assessed case.

Table 71 confirms the strong correlations found between Permanency Outcomes 2 and Wellbeing Outcomes 3, as previously presented. To be noted the correlation found between provision of basic needs and matching of services in the community suggesting a role the community played in response to these needs. Emotional needs being met also appeared to be strongly correlated with family and cultural proximity, as well as with positive child-caregiver relationship and provision of basic/educational services, suggesting that emotional wellbeing was part and possibly the result of an integrated approach facilitated by the FGDM, which responded to a diversity of child's developmental needs.

Table 71: Correlation between Well Being Outcomes 3 and P2-WB1-2-3 Outcomes

FGDM WB 3 outcomes	Correlations with FDM outcomes	Pearson's correlation coefficient r	one-tailed P value
WB3-basic physical needs provided	P2 - proximity to parents/ ext. family	.702**	.000
	P2 - cultural connection with community	.669**	.000
	P2 - placement related to child's community	.652**	.000
	P2 -quality relation child-parent/caregiver	.806**	.000
	WB1-match of services in the community	.733**	.000
	WB1-family participation in case planning	.745**	.000
	WB2-provision of educational needs	.776**	.000

WB3-emo-tional needs & services provided	P2 - proximity to parents/ ext. family	.566**	.000
	P2 - cultural connection with community	.567**	.000
	P2 - placement related to child's community	.523**	.000
	P2 -quality relation child-parent/caregiver	.837**	.000
	WB1-match of services in the community	.720**	.000
	WB1-family participation in case planning	.628**	.000
	WB2-provision of educational needs	.738**	.000
	WB3-basic physical needs provided	.819**	.000

3. COMPARING FGDM AND ROUTINE REPATRIATION PROCEDURES COSTS

The true costs of implementing and administering a FGDM conference are difficult to determine. Start-up and operational costs are here incorporated alongside estimates of savings (including actual/possible outcomes and their associated costs) for the two group samples of children exited from the NCRH using FGDM or repatriation procedures. Collating and analysing budgetary data provides a view of the costs and savings associated with FGDM. No family members or other participants at any FGDM conference were given any tangible support for attending such as travel, accommodation costs, etc.

Table 72: Budgetary data – comparison between one FGDM conference and one routine repatriation in Nairobi

1 FGDM Conference	Cost	Quantity		Total Cost	1 Routine Repatriation	Cost	Quantity		Total Cost
Human resources	*Kshs*	*number*	*type*	*Kshs*	**Human resources**	*Kshs*	*number*	*Type*	*Kshs*
Facilitator/ Coordinator	1500	1	day	1500	Welfare staff	1000	1	Day	1000
Caseworker	1000	5	day	5000	Driver	1000	1	Day	1000
Counsellor – child & family counselling	500	8	session	4000					
Logistics					**Logistics**				
Transport &lunch for staff	800	7	unit	5600	Transport &lunch for staff	1000	2	Unit	2000
Telephone	500	1	unit	500					
TOTAL				16600					4000

According to the budget indicated in table 72, 1 FGDM conference cost appears to be around Kshs. 12.600/= higher than costs met by the Department of Children Services in Nairobi for 1 routine repatriation. However, notably, the higher costs are not mainly due to additional services provided to children for the FGDM conference, but for provision of counselling (8 counselling sessions) and field (visits for home and environmental assessment, telephone) services, which correspond to international minimum standards for any reintegration procedure. By deducting costs incurred for counselling (8 sessions = Kshs.4000/=), a minimum of 2 home visits (2 days = Kshs. 2000/= plus 2 transport Kshs. 2000/=) and telephone expenses (Kshs.500/=), it appears that the additional FGDM conference costs are reduced to Kshs. 4,100/= per child. An amount mainly due to expenses strictly associated with holding the FGDM conference itself (e.g. travel expenses, lunch and staff time). Nevertheless, a minimum difference if compared with improved long term stability of FGDM cases and subsequent increased benefits for families and communities which cannot be quantified.

With regard to the period following a conference, costs varied and might have been initially high in the short-term (e.g. because follow ups were required), to subsequently decrease in the long term. However, aftercare

is also to be considered as a running cost to be met by the government field services independently of the FGDM. Overall, also the costs of institutional care for children exited through FGDM or repatriation are basically the same, due to the fact that the average span of time needed for FGDM reintegration runs from 30-31 days against the 27-29 days needed by typical repatriation procedures. Hence, no excess cost savings on avoidance of *in-care* days could be found for repatriated children. On the contrary, through the FGDM, some savings might have resulted from reduced time spent by families looking for their lost children, in court, due to reduced family legal fees and other court costs.

Overall, in the Kenya context, the expectation that the FGDM conference will reduce after reintegration expenditure on resource provision by promoting care within the family remains contradictory. Evidence suggested that FGDM plans tend to bring in both family and social welfare resources, but it results in a reduction in demand for the latter. In fact, though the study found that in 30.1% (n=22) of the FGDM plans, social welfare services were identified for support (most frequently education services), in 98.6% (n=72) of the 73 agreed plans a family-driven resource was listed. However, as a result of the conference, 13.7% of the children (n=10) had received institutional placement for further intervention. In other words, though the nature of the services requested by families tended to shift from interventions focused on out-of-home care to in-home support, still there was demand for external support.

CHAPTER EIGTH

DISCUSSION

1 RISK FACTOR ANALYSIS

The assumption underlying this research was that evidence-based practice, not the use of imported structured risk assessment measures, should form the basis of effective child protection and child welfare practice. Consequently, all *downstream* intervention activities require a sound knowledge concerning who is at risk, for what outcomes and via which pathways of influence to make good evidence-based clinical decisions. This approach clearly acknowledges a reliance on effective identification of risk factors to assist decision making and to achieve positive change in families through rigorous observation and assessment of the child and family and the subsequent development of an action plan which can deal effectively with the child's vulnerability.

Accordingly, the first part of this study constitutes an attempt at conceptualizing and testing hypotheses relating to the mechanisms and processes that underlie the aetiology and course of clinically significant child dysfunction following risk factor exposure before coming in contact with a statutory institution.

The main effort revolves around the central question, "How can we conceptualize, measure, and model the multidimensional features of risk exposure in ways that best inform theory building, improve risk detection, and increase the effectiveness and efficiency of our interventions?"

To attempt an answer, the study looked at characteristics associated with children and families having gone through the FGDM conference. The analysis provided a useful guide to some of the salient risk factors which relate to child vulnerability. The clustering of such co-occurring features allowed for the identification of risk markers and global risk status of the experimental group and generated a risks profile of children and families who underwent the reintegration process through FGDM.

However, a deeper analysis was needed to answer questions regarding why, how, where, and when to help. The critical question was, "Which types of exposure are most harmful, for which outcomes, for whom, how do they transmit their effects, and how should this knowledge guide intervention?" (Layne, Warren, Watson, & Shalev, 2007; Layne, Beck et al., 2009).

The need for an improved risk assessment method and tool able to aggregate risk factors to quantify the differential effects of different risk factors on specific outcomes required us to expand the way in which risk factor exposure is typically conceptualized, measured, and modelled. For this reason, the composite-based approach was used to unpack risk factor exposure into dimensions that model the occurrences of specific types of trauma or distress and their differential links to key psychosocial consequences. The resulting knowledge allowed the ranking of risk factors according to their respective magnitudes for specific outcomes, with the aim of increasing the effectiveness and efficiency of interventions. Such rankings can guide risk identification and improve clinical decision-making by helping to prioritize and triage differentially exposed groups to intervention modules that specifically target the types of distress for which the members are at greatest risk (Layne et al., 2008).

Furthermore, the study investigated interventions provided through the FGDM identifying *who* was helped and *how,* to improve the accuracy of risk detection and discover key causal risk factors and mediator

of persisting distress, dysfunction, and developmental derailment that can be targeted in treatment (Layne et al., 2007), but particularly along the decision-making process achieved through the Family Conference.

The risk factor profile of children reintegrated through the FGDM model presented an outline which was first related to **gender**. Male children were the majority (n.43, 58.9%), while girls (n.30, 41.1%) had a higher representation than in the average institution's population. In this respect, although the literature identifies a general dose-response effect between magnitude of exposure and associated child distress reactions, evidence of *differential effects* emerged.

The analysis on the kind of exposure to vulnerability indicates that girls were more likely to be direct victims of sexual abuse or unsafe conditions and to be witnessing continuous external threat (e.g. inadequate acceptance by stepparent) than boys were. In contrast, boys appeared prone to express their problematic status (e.g. victims of domestic violence and conflict) displaying higher risk for disruptions in behavioural adaptation including externalizing antisocial behaviour.

The **age** cohort most represented was from 10 to 13 yrs-old, with almost half of the children being between the age of 10 and 11. They appeared to represent the most vulnerable section within the experimental group with high accumulation of risk factors (n.11-15) and being affected by severe antisocial behaviour such as drugs/alcohol abuse and inappropriate sexual behaviour.

Only for half of them the **education** level corresponded to their age (between std.4 and std.6), but for most of them the FGDM goal was the provision of protective placement through network/coordination with community actors.

Looking for associations between the child's **antisocial behaviour** and family/child characteristics, the family ecology, parental competence and parents' behaviour history clearly emerged in the background. Single motherhood unfolded children's exposure to street life, while

inadequate parental competence indicated a progressive exiting of the child from home by scavenging, being truant, spending the night outside until graduating to street life and prostitution. This finding suggests that the persistence of behavioural distress may be associated with the severity of exposure to single headed families and it may be maintained by parenting dysfunctions such as child rejection as well as by additional stressors, indicated by a contingent over accumulation in the child's life of > 16 risk factors.

One third of the children were also affected by negative peer pressure which was dragging them farther from parental care and socially accepted duties such education, and pulling them into disruptive means of self-reliance like stealing.

Reasonably, the frequency of children's behavioural problems appeared to increase as the number of their risk factors increased, with a precipitation of negative behaviour in correspondence to children clustered in the accumulation groups having more than 6 factors, but in particular scoring from 11 to 15 risk factors.

Parents' dysfunctional behavioural history as well, in particular prostitution by mother, practiced by almost 1 out of 10 mothers, associated with most of child's antisocial behaviours, such as aggressiveness or violence, engaging in criminal behaviour and drugs abuse.

Analysing **child's safety** status and prevalent risk factors accompanying it, sexual abuse scored the highest correlation frequency with caregiver's failure to protect due to physical, emotional or parenting inability, alongside with internal family conflicts and history of abuse.

Physical abuse and mistreatment were associated with family ecology involving parents' separation and presence of stepmothers. Violent punitive discipline and child-caregiver conflict found in emotional, physical and sexual abuse and mistreatment were crosscutting issues.

The risk factor profile of families engaged in the FGDM presented a quite composite characteristics outline. The examination of ethnic

groups to which families belonged to showed their cultural diversity. Few specific ethnic groups appeared to be consistently represented, being Kikuyu, Luo and Luhya respectively. Though no significant findings on correlations between ethnicity and child vulnerability was found in the present study, future research may look into the involvement of specific ethnic groups with the child welfare system, as general statistics show that very few children from nomadic communities such as Masai, Samburu, Pokot or Turkana are found in statutory institutions. A greater understanding of the racial and cultural component may be relevant to assure that practice efforts will be culturally responsive. Recall that FC originated from the Maoris' efforts to make the New Zealand child welfare system more culturally responsive. Contrary to suggestions that families with vulnerable children tend to have more kids compared to non-neglecting families (Sedlak & Broadhurst, 1996; Polansky et al., 1985), the study found that the mean number of children in families from the experimental group was of about three per family unit. Interestingly, though the group of families with highest number of children (n.5-8) matched that perception of child's unsafe and abusive conditions prior to institutionalization, on the other hand, the same group seemed to be more successful in the FGDM plan implementation through networking with their communities. In contrast, families with few children showed less FGDM plan implementation capacity and less community involvement in it.

On **family composition**, the study found that while 9 out of 10 children had at least one birth parent alive, 1 out of 4 children lived with relatives. Only one out of five was living with both biological parents though total orphans represented just 8.2% of the total. About 40% of them belonged to reconstituted families having their biological father or mother living with a partner. One out of three lived with the mother alone being single, separated or widow.

The study suggests that **separated parents and blended/reconstituted families** with the presence of stepparents in the household increase the likelihood that vulnerability will occur, in particular, due to

inadequate child acceptance by them. Specifically, stepmothers were found associating with child's mistreatment and with physical abuse, while stepfather correlated to child-caregiver conflict. The presence of stepparents in families needs to be further investigated as little research on child neglect has explored it.

However, these findings are in line with other studies (Polansky et al.,1992) on chronically neglecting families, which seemed to be often characterized by a chaotic household with changing constellations of adult and child figures (e.g., a mother and children living on and off with various others such as temporary partners, or a boyfriend).

On **single parenthood**, 31.5% of children where living alone with the mother, being single, widow or separated. We found that they associated with higher incidences of vulnerability and at high risk of inadequate maternal acceptance, parental rejection and severe exposure to sexual exploitation. Besides, single motherhood and prostitution strongly correlated with parents who had experienced neglect or abuse as children within their family, suggesting, in line with other studies (Zuravin, S., & DiBlasio, F. 1996; Weston, J., et Al., 1993), that the way they were reared greatly affected the way they rear and parent their own children.

Only two certified cases of caregivers' severe **impaired physical condition** were found. Though the number of cases identified was not significant, there is a strong suggestion for physical impairment to be correlated to lack of resources and to inability to protect the child from abuse.

As 3/4 of the children's families resided in the low income areas of Nairobi, it clearly appeared that **poverty** was a crosscutting risk factor. This seemed to increase stressful life conditions and a result seemed to affect the emotional capacity to provide for their children. We found, for instance, that parents' total unemployment, which affected 13.7% of them, strongly correlated with emotional inability to care for the child, with child sexual abuse and prostitution. Moreover, families liv-

ing in shanty slums were found to associate with severe disconnection from community social support. However, the study suggests that poverty is just one among other factors to affect child safety and wellbeing, as additional family risk conditions were identified as affecting children from the experimental group.

A major overriding risky behaviour was identified in **alcohol abuse**, which affected about one out of five caregivers, rarely in combination with other illicit drugs. This condition appeared to likely co-occur with high rate of domestic violence, marital conflict, prostitution by the mother, and inadequate acceptance of the child. Since there is an established relationship between parental alcohol abuse and child vulnerability, because substance abuse impairs one's mental functioning and can affect decision-making, its identification is useful for targeting prevention and intervention services to address the challenges faced by at-risk families.

Criminal behaviour seemed also to expose children to vulnerable conditions. Though our study identified few parents (3, 4.1% of all families) with criminal history, findings were in line with research suggesting that parents who have committed a crime may be more likely to neglect their children (Gershater-Molko & Lutzker, 1999), as they correlated with living in the streets, exposed to inappropriate sexual behaviour and having previously been in need of alternative protective day care.

The in-depth analysis of **child-caregiver relationship and parenting skills** found that inadequate caretaker's perception of the child's needs was the most prevalent failure of all caregivers. This finding corroborates what has been established by other studies observing that the most common response given by neglectful mothers was that there was nothing wrong with their behaviour (Coohey, 2003; Jones, 1987) and that there are links between poor parenting skills and child neglect (Azar & Soysa, 2000).

Other high frequency parenting failures were identified in neglect/fail-

ure to protect the child (n.52 , 71.2%), putting the blame on the child and being unwilling to acknowledge deeper family needs (n.41, 56.2%), adopting violent punitive discipline (n.33, 45.2%), being inconsistent with discipline, alternating harsh and excessive punishment with soft or no care attitude (n.17, 23.3%).

Furthermore, the caregiver-child conflict appeared to be affecting half of the cases, emerging as one of the most relevant risk factors in the experimental group. Mothers seemed to be the caregiver who most exposes the child to conflict (15, 20.5% of cases) and rejection (11, 15.1% of cases). Conflicting relationships seemed to be one of the main factors connected with child's physical abuse, alongside with sexual abuse and mistreatment.

On the same line, presence of violence in families was associated with refusal of parental responsibility suggesting, in agreement with other research (Lemon, 1999), that caregivers who are victims of domestic violence may be abused to the point of being unable or unwilling to keep their abusers from also abusing the children.

1.1 Accumulation of risk factors

The number of risk factors piling up in the lives of individual children varied dramatically. However, it was found that most cases (n.59, 80.8%) had an accumulation of 11 factors and above. Moreover, thirty two (43.8%) of all cases were affected by overriding factors. The most prevalent overriding factors were physical abuse (n.21, 28.8%), alcohol and drug addiction by caregiver (n.16, 21.9%) and prostitution by mother (n.6, 8.2%). Sexual abuse represented 4.1% (n.3) of all cases.

The correlation analysis of accumulation groups, classified according to their risk factors incidence, found that the level of positive FGDM outcomes decreased as the number of risk factors increased. In fact, as the group of children having an accumulation of 16 to 20 risk factors, still correlated with positive FGDM outcomes such as implementation

of follow up meetings after the FGDM conference, the inclusion in the FGDM plan of community participants to check on aftercare, and with family members to be involved in the plan implementation, the group of children accumulating > 20 risk factors correlated with the FGDM not being implemented at all. They also inversely correlated with achieved changes of abusive patterns in the family, and with reduction of risk of harm to the child.

Further, a more in-depth analysis of risk accumulation classified five caravans that clustered risk factors into five dimensions able to model the occurrences of specific types of risk exposure. Taken together, the findings constitute some progress in conceptualizing and testing hypotheses relating to the occurrence of specific categories of risk factors representing clinically significant dysfunctions and unpacking their differential links to key psychosocial consequences as well as to the FGDM conference components and outcomes.

The five risk factor clusters included

1. Child's direct exposure to abuse or unsafe conditions;
2. witnessing continuous external threat;
3. engaging in direct antisocial behaviour;
4. exposure to caregiver loss, separation and attachment threats, and
5. being under constant emotional threat by caregiver.

A first strong correlation was found between the above clusters (with exception of cluster 1) and a high accumulation of risk factors (16 >), confirming a general high extent of child's exposure to a consistent amount of unsafe life conditions among children of the experimental group.

The analysis of individual clusters to unpack their links to **psychosocial outcomes**, suggested that **cluster 5**, being under constant emotional threat by caregiver, is the primary aggregate which quantifies most of the differential effects of various risk factors on specific outcomes.

Ranking clusters having high frequency of risk factors (> 40% of all

cases), we found cluster 5 to be the most significant. Its most recurrent identified risk factors were inadequate caretaker perception of their children's needs (100% of all cases), caretaker blaming of the child and refusal to accept identified family needs (56.2%) and caregiver-child conflict (52.1%). The risk factor mean percentage for individual clusters was calculated to confirm cluster frequency rankings. Again, cluster 5 achieved the highest average (37.5% of all cases) in frequency of risk factors. Also, analysing clusters having an accumulation of 3 or more risk factors each, it was found that cluster 5 scored the highest frequency (80.8%) of cases from the experimental group.

In addition, it unpacked differential links to key psychosocial consequences by scoring significant correlations with risk factors included in other clusters, suggesting that a complex mixture of caregivers' inadequate parenting abilities as listed in this cluster may be connected with adverse outcomes. For instance, correlations were found between this cluster and child's sexual abuse suggesting that unhealthy relationship with caregiver associate with it. Again, this cluster correlated with children going home late, suggesting that avoidance of the emotional threat could be a reason for spending odd hours out of home.

Additionally, high accumulation of risk factors in this cluster strongly correlated with high accumulation of risk factors in cluster 1 regarding child's direct exposure as victims of abuse or unsafe conditions. This finding suggests that being under emotional threat and being victim of abuse are conditions which may be found together.

Cluster 1, grouping risks of children directly exposed as victims of abuse or unsafe conditions followed in frequency (> 40% of all cases). Here, most frequent risk factors were neglect/failure to protect by caregivers (71.2%), mistreatment (53.4%) and violent punitive discipline by caregivers (45.2%). Analysing clusters having an accumulation of 3 or more risk factors in each case, it was found that among all other clusters, direct exposure of children as victims of abuse or unsafe conditions had the highest percentage of children carrying (23, 31.5%) an accumulation of overriding factors.

Cluster 3, gathering risks of children engaging in direct antisocial behaviour, came third on frequency of risk factors (> 40% of all cases). Here, most recurrent risk factors were being runaways (93.2%) and truant (42.5%). However, on mean risk factors frequency ranking, cluster 3 appeared to come before cluster 1, indicating that risk factors related to child's negative behaviour had lower prevalence but were more widespread than those related to being under direct exposure as victims of abuse or unsafe conditions. Cluster 3 also outdid cluster 1 in the ranking of accumulation of 3 or more risk factors in each of the 73 case, where it scored three or more risk factors per cluster in 56.2% of all cases.

The lowest accumulation of risks in children was found in **cluster 4**, grouping risk factors related to exposure to caregiver loss, separation and attachment threats, which scored 61.5% of cases with low accumulation of 1 to 2 risk factors. Among its internal risk factors, it was noted that abandonment/separation of the child from primary caregiver at early age (0-4) scored the highest percentage of cases (41.1%), immediately followed by biological parents' separation (39.7%). The high frequency of separation from mother in early childhood raised a concern on the quality impact of this low risk factor accumulation combined to a high intensity separation exposure, yet to be fully understood as it reqires more investigation, in line with a long tradition of research on attachment suggesting that the quality of parent–child attachment relationships deeply affects children's developmental outcomes (Ainsworth, Blehar, Waters, & Wall, 1978; Main & Goldwyn, 1984).

Furthermore, the present study found that children who had experienced early separation from their primary caregiver appeared to be at high risk of vulnerability being more exposed than the rest of the experimental group to withdrawal and depression. At the time of admission at the Nairobi Children Remand Home, they were still undergoing severe bonding disconnection being subject to refusal of parental responsibility, and after the family conference they tended to be sent to relatives upcountry for care, rather than been kept at home by parents.

The study also confirmed findings on the correlation between negative attachment and child's antisocial behaviours, as instances of separation, inadequate acceptance, rejection and conflict with caregiver, correlated with drugs abuse, inappropriate sexual behaviour and prostitution, as well as with a tendency of exiting the parental home.

Cluster 2, witnessing continuous external threat, had living in environmental hazard/slum area (68.5%) as its most recurrent risk factor. Negative peer pressure affected 35.6% of the children. Two major overrides were included in this cluster, alcohol addiction by parents (21.9%) and prostitution by mother (8.2%).

In unpacking links between the 5 risk accumulation clusters and **components of the FGDM conference**, we found that **in relation to FGDM participation** specific risk clusters associated with the attendance of diverse participants. Children's direct exposure as victims of abuse or unsafe conditions brought into the FGDM conference religious leaders and village elders, the latter being engaged also for cases of children being under constant emotional threat by caregiver. The attendance of personnel related to the provincial administration could be justified by concerns on citizen's security, while ethical concerns were brought about by faith based organizations.

Moreover, cases of children witnessing continuous external threat brought into the conference more powerful representatives of the provincial administration such as chiefs or their assistants, as well as public officers such as class teachers. This also influenced the FGDM venue, being shifted from family homes to chiefs offices, in a mutually agreed and yet critical move, possibly meant both by families and caseworkers to protect children from harmful overriding threats such as parents' alcohol addiction.

Child's engagement in direct antisocial behaviour unfolded that families positively associated with participating in case planning and identified as their major FGDM goal the development of a family reintegra-

tion plan. The apparently family-focused concern on child's antisocial behaviour was confirmed by the FGDM conference attendance by fathers, family friends and class teachers. This finding suggests a conference cultural connection with traditional and current figures primarily concerned with behaviour correction being principally a family issue to be dealt internally (see attendance of fathers and close family friends) but also a concern of the community being represented by teachers.

Likewise, child's exposure to caregiver loss, separation and attachment threats unfolded the participation of mothers, traditionally being delegated to bond with children at emotional and affective level, as well as of religious leader/representative, being usually concerned with the wellness of internal family relationships.

About **children's needs explicitly addressed at the FGDM conference,** child's safety associated with being victims of abuse or unsafe conditions, witnessing continuous external threat and being under constant emotional threat by caregiver. However, in spite of the overt discussion that happened at the conference, the latter cluster unfolded a negative **implementation of the FGDM plan** suggesting that related risk factors may adversely affect the fulfilment of family commitments agreed upon at the FGDM. In connection to this, self-protecting strategies applied by children, such as going home late, pointed out at this very accumulation of risk factors of being under constant emotional threat by caregivers.

On the contrary, witnessing continuous external threat, correlated with successful long term stability and permanency with the family 2 years and beyond after the conference, suggesting that the related risk factors may be positively dealt with by the FGDM meeting.

Besides, a unique feature found with this cluster was its correlation with the inclusion of community participants to check on aftercare in the FGDM plan, suggesting a possible ground for the achieved positive outcome.

Moreover, on FGDM plan implementation, a consistent involvement of the community, was found in relation to risk factors clustered under child's antisocial behaviours, suggesting that child's negative behaviours may be an important concern of community members, willing to provide direct intervention. Conversely, risks factors clustered under exposure to caregiver loss, separation and attachment threats, strongly correlated with family members involvement in the FGDM plan implementation probably being risks more related to internal family issues, such as for children being orphans of both parents or living with step-parent.

2. THE FAMILY GROUP DECISION MAKING MODEL (FGDM)

This study considers the FGDM not just as an isolated event but as a process which leads to a specific event (the conference), which further promotes the same process by identifying interventions plans and modalities for its development. The risk factor assessment analysed in the first part of the study was explored being the first step to inform proper decision making developed at the conference. Next, in the absence of robust evidence of beneficial long-term outcomes for children reintegrated from statutory institutions through family conferencing, the second part of the study attempts to provide for more data and insights to describe the FGDM conference, as a tool able to respond to the identified risk factors by promoting partnership in working with parents, enhancing family involvement in decision-making, re-focusing services towards family support or maintaining the child's permanency. These *process* objectives would be expected to produce better outcomes for children, so demonstrating that they have been met might well indicate that children's needs are being effectively catered for. Hence, the FGDM process was analysed in its various components to measure its impact at three different levels by means of specific indicators which clustered short, intermediate and long term outcomes. However,

in terms of methodological considerations, it was extremely difficult to isolate the effects of FGDM from the influence of other services which are typically offered alongside this decision-making approach. In addition, achieving complete clarity on measuring the associated outputs was in few cases problematic due to difficulty in establishing the current status of the child.

2.1 FGDM Preparation Procedures

2.1.1 Conference timeframe and location

It is recognized that the FC model is a time-consuming one, and that some workers have found this difficult to manage. Moreover, the resource involved in the co-ordination and preparation of conferences is seen to be one of the major challenges in attempts to extend the model more widely. All the same, though maintaining that human resources remain a challenge for the model sustainability, this study found that excluding unusually long cases, the average time span needed to prepare and carry out the FGDM conference ran from 30-31 days against the 27-29 days needed by typical government repatriation procedures, which did not involve the family and the community in the exiting process. This minimal variation needs to consider that, in accordance with international standards, when a child was due for repatriation through the FGDM, the focus of service delivery was on safely reunifying the family as soon as possible, but only if appropriate. Yet, contrary to procedures normally carry out by the government system, returning children to their families too quickly was avoided not to increase, in some instances, the risk of harm and relapse. Because of this concern, children were only returned home when the agency was confident that the risk of harm to the child had been minimized.

On the conference timing and location, the guiding principle was that the family participants will have a key influence over the conference

process. This included planning where and when the conference was to be held. The study showed that most of the conferences were held in the morning session during weekdays, indicating a practice which suited families best. In some cases, a practical issue was balancing the needs and wishes of different groups –families and professionals - while maximizing everyone's participation.

Most conferences were held in the family home (63%), a venue that strongly correlated with the FGDM goal of networking and coordinating with stakeholders, suggesting that the family was the most convenient setting to connect with the local community, though sometimes physical space was not large enough to comfortably accommodate all the FGDM participants.

2.2. FGDM short terms outcomes

2.2.1 Patterns of attendance

Including children, the average number of participants in each conference was 10 people. The high level of involvement of family members at the FGDM reflects the model's focus on the importance of family mobilization and family involvement in the decision-making process as 64.4 % (n=47) of all conferences had at least 1 biological parent present, while 19.2% (n=14) had 2 parents present. However, if we consider stepparents among the parental caregivers, 87.7% (n=64) of all conferences had parental representation, indicating that nuclear families had high level of active participation at the conference. In particular, the rate of paternal involvement (n=31, 42.5% of the 73 children in the experimental group, but 93.9% of the 33 fathers actually present in their life at the time of the conference) for the families within this study contrasts sharply with previous studies showing very few fathers being involved in case-planning, even for family preservation services (O'Donnell, 1999).

The study considered as family members also fictive kin, neighbours and friends of the family, or anyone the family identified as a support person, such as religious leaders. Providers attending the conferences included school teachers, chiefs, village elders, police officers, community social services workers, District Children Officers (DCOs) and project providers.

Data show high numbers of family members mobilized around the planning for the child's well-being at each conference (n= 410 in 73 conferences) as they out-numbered service providers (262 in 73 conferences), resulting in an average of 5.6 family members (3.7 being biologically related) and 3.6 providers at each conference.

As a result, evidence suggests that relationships between family members and between the family and community members improved following a FGDM. In fact, mere participation in FGDM often brought about unintended and unplanned positive outcomes for families in terms of improved family functioning, renewed contact with relatives and more open communication. Building social support through FGDM meant to include a resilience factor, important both for children and parents. In some instances, supportive adults who were present at the conference could serve as substitute attachment figures if a child's parents or other caretakers were unable to fill this role. This appeared to be in line with research showing that basic systems such as supportive adults, social support networks, protective services that foster human adaptation and development work well and can help children to build resilience (Thompson, R. A., 2000). Moreover, social support provided parents with both emotional and physical resources to respond to their children's needs or to achieve better outcomes in readjusting their family system.

Regarding children's participation, conferencing is predicated on principles of participation and empowerment as the FGDM presents a real opportunity for children and young people to voice their perspectives. Typically, in meetings largely controlled by adults, children's perspec-

tives and contributions can be easily overlooked, so the study set out to explore if and how children were being involved. In regards to their rate of attendance, 100% of the experimental group of children was listed as being physically present, though, for the child's developmental and local cultural reasons the physical presence at the meeting was usually limited to the introductory stage and when finalizing the plan. Children's participation varied also according to age and capacity, but where there was good planning and the use of a support person such as the counsellor, children experienced good levels of participation. In comparison with the control group, the study found that while all children in the experimental group attended and participated in FGDMs, those in the control group were not include in the decision making process, in line with current government case management procedures.

2.2.2 Content of the conference

The most common **purpose** for all conferences was identifying the child's and family's needs and concerns (n=72, 98.6%). identifying family strengths (83.6%), developing a reintegration plan (82.2%) and establishing a service plan (80.8%) for the child (e.g. readmission in school). 57.5% (n = 42) of all the conferences had to decide on a permanent placement for the children with their parents at home The most common kind of placement (83.5%) was done within the child's natural family, including the upcountry extended family.

The frequency analysis of **four core domains** corresponding to 4 major children's needs including permanency, safety, wellbeing and development, and attachment to caregivers found that the most frequent core domain discussed during conferences appeared to be the attachment between the child and the significant caregiver, followed by the child's wellbeing, permanency and safety.

Topics discussed within the conference mainly related to the identified core domains, with prevalence on the thematic area of child-caregiver

relationship (attachment) having a frequency of 267 times, followed by safety with 239, permanency with 141 and wellbeing with 129, respectively. Prominent topics were inadequate caregiver perception of child's needs, neglect/failure to protect, caregiver-child conflict, parents blaming the child & refusing to accept family identified needs, inadequate acceptance by parent/stepparent, child's mistreatment, and violent punitive discipline.

Core domains discussed at the conference didn't necessarily become part of the FGDM plan, as it appeared that while attachment and safety had the highest frequency during the FGDM information sharing, it was attachment and wellbeing that scored the highest marks when analysis was done on related needs explicitly stated within the FGDM plans. To be noted that in spite of the low accumulation of risks in children found in cluster 4, grouping risk factors related to exposure to caregiver loss, separation and attachment threats, the high frequency of separation from mother in early childhood raised an intense concern in the FGDM participants as the child-caregiver relationship scored the highest frequency on issues related to inadequate attachment.

2.2.3 FGDM plan formulation

Satisfactorily concluding a conference with family and professional agreement upon a plan was a significant measure of the success of the FGDM process. All 73 FGDM formulated a plan accepted by the agency and viewed positively by families. 45.2% of the plans were agreed upon and signed by parents and relatives, 39.7% by parents alone and 15.1% only by relatives, indicating that the extended family played a relevant role in taking responsibility of the drafted plan.

This outcome confirmed previous studies (Crowe & Marsh, 1997; Simmonds, Bull, & Martyn, 1998; Lupton & Sheppard, 1999) which had found that the majority (in most studies as high as 90-95%) of families are able to identify a plan, and that these plans are approved by the referring caseworker. In terms of content, as the literature suggests that

plans are positive, robust and utilise a mixture of family and professional resources (Marsh & Crow, 1998), we found that most FGDM plans included more elements of assistance from the family itself (characterised as wide-ranging and practical in nature) rather than from service providers and that plans utilised and increased the availability of family resource tapped from their own strengths. In 98.6% (72 of 73) of the plans reviewed, at least one family-driven support was listed. These services were to be provided through extended family support. Primarily, they referred to improving the child-caregiver relationship by supporting better parenting skills such as positive alternatives discipline, communication and parental responsibility (60.3% of all plans), building of caregiver-child bond (47.9%), provision of child's monitoring and supervision (43.8%), family long term placement (32.9%) and of counselling- emotional support (17.8%). Meeting child's basic needs followed through provision of formal education (50.7%), provision of food, clothing and basic necessities (21.9%).

This shift toward a family strengths-based approach with emphasis on resilience and protective factors and a movement away from focusing solely on risk factors, particularly for addressing child vulnerability and its recurrence, emphasizes on the belief that intervention plans are most effective when they involve building up child and family strengths. The study confirmed this approach as plans could identify and include both family and child strengths in the plan, thus putting in the forefront protective factors to strengthen child resilience.

A gap was found in FGDM plan operational outlines as only 12.3% of them had a comprehensive timeframe for implementation. Slightly more than half of them indicated some specific timelines while 1/3 of them had no implementing timeframe specified at all.

2.2.4 Involvement in the drafted FGDM plan

In agreement with other studies (Dartington Social Research Unit, 1995; Little, 1995; Tomison, 1996; Armytage et al., 1998), the balance

of power between service providers and family members was viewed as critical on partnership based relationships and recognition of family strengths as they emerged from the respective involvement in the drafted FGDM plan. Our findings showed that plan engagement was dominated by family members.

Out of the 73 plans, 98.6% (n = 72) FGDM plans outlined 1 or more family members involved in it, being mostly biological parents (n=57, 78%). In 42.5% (n=31) of the cases, one or more extended family members were involved in the plan. Conversely, service providers from the community were involved in 30.1% (n=22) of all plans, school teachers having the largest share (16.4%, n=12) and appearing to be most frequent community partner working with families at the conference.

The finding confirmed descriptive studies showing that Family Conferences engage more family members than service providers and expand the support available to families who have participated (Lupton, 1999).

2.2.5 Child placement at the FGDM

The comparison between the distribution of cases by type of placement pre and at the FGDM conference indicated a decrease of 11% (from 74% to 63%) in the proportion of children living with parents after a FGDM, while the proportions of those living with relatives remained almost the same (24.7% pre-FGDM against 23.2% at the FGDM). The decreased likelihood of family network accommodations and the increased placement into residential care (13.7% of the children involved) among FGDM families can be justified as Lupton & Nixon (1999) do, by observing the highly disfunctional characteristics of some of the children and families involved, needing specialised care which could not be met by families or communities.

2.3 FGDM intermediate outcomes

2.3.1 Community involvement in FGDM plan implementation

Examining intermediate outcomes, community partners involved in the FGDM plan implementation were found to have increased in numbers with respect to those officially listed in the drafted FGDM plans. This was due mainly because, after the FGDM conference, families had to interact with various partners within their communities to accomplish their commitments. 68% of all plans implementation saw 1 partner being engaged by the family, while in 19.2% of plans the family had the collaboration of two partners.

Again, school teachers had the lion share being involved in the implementation of 57.5% of all plans, becoming to be most consistent community partner in working with families after the conference. FBOs engaged in 15% of all plans and Provincial Administration in 12%.

2.3.2 Effective overall FGDM plan implementation

With regard to actual plan implementation, being one of the most relevant indicators of FGDM effectiveness, the study indicated that the overwhelming majority of plans (n=68, 93.2%) were at least partially implemented, with more than half (n=42, 57.6%) almost entirely carried out. Total failure in the plan implementation (n=5, 6.8%) seemed to be associated with disruptive family characteristics such as previous caregiver's negative attitudes towards the child (e.g. refusal of parental responsibility) and existence of overriding behaviours (e.g. prostitution by mother), alongside specific child antisocial behaviours (being violent, prostitution, drug abuse). Biological parents' separation appeared also to inversely correlate with failure to implement the plan. Furthermore, plans non-completion seemed to associate with lack of community engagement in the plan implementation, in particular when

family disconnection from community social support was found to b a pre-existing risk factor, suggesting a critical role the family-community ties could play in its accomplishment. On the contrary, participation of the class teacher to the FGDM conference correlated with plans partially implemented. All the same, as long term child permanency strongly correlated with plans partially implemented, there was a suggestion that even minimum FGDM plan implementation might be sufficient to provide some stability to the child, even though affected by a previous caregiver's neglect/failure to protect.

Further research is needed to assess whether plans were not implemented due to conditions the study couldn't investigate such as scarce resources delivery as agreed in the plan, inadequate commitment by service providers, slowness or inability to perform duties.

2.4 FGDM long term outcomes

In relation to long-term outcomes, the study indicates existing links between FGDM plans and outcomes relating to whether child permanency was promoted, how they were protected from abuse and neglect and how their welfare was enhanced.

2.4.1 Relapse and re-referral rate

The re-referral rate in our study counted any substantiated re-committal to the Nairobi Children Remand Home since the date of the conference, in stretch of time which could have been as long as 24 to 54 months.

In relation to effective responses to the identified risk factors, assessed on the long-standing retention of children, the 8.2% (n=6) re-referral rate to the NCRH of the experimental group after the conference was just slightly lower than the 9.5% (n=4) of the control group. However, while 4 (66.6% of 6) relapsed cases in the experimental group achieved

long term permanency and stability after being re-reintegrated through a revision of the FGDM arrangements, only 2 (50% of 4) in the control group were said to be stable after the second repatriation occurred. This result suggests that FGDM may provide for a child care protective system which reinforces the long term family-service provider relationship in the provision of aftercare services, hence supporting permanency.

The comparison between the distribution of cases by type of placement pre and at the FGDM conference indicated a decrease of 11% (from 74% to 63%) in the proportion of children living with parents after a FGDM, while the proportions of those living with relatives remained almost the same (24.7% pre-FGDM against 23.2% at the FGDM). The decreased likelihood of family network accommodations and the increased placement into residential care (13.7% of the children involved) among FGDM families can be justified as Lupton & Nixon (1999) do, by observing the highly disfunctional characteristics of some of the children and families involved, needing specialised care which could not be met by families or communities.

2.4.2 Stability of placement

The placement comparison between **pre-admission in the institution and at the FGDM conference** indicates a shift from parental to residential care as at the conference there was a decrease in the percentage of children living with parents and a surge in the number of those being placed in residential care facilities. On the contrary, the number of children placed with relatives remained stable over time.

Children's placement was considered successfully achieved when proved stable **24-54 months after the FGDM.** Using these criteria, the experimental group reached 87.1% success rate against the 69.0% of the control group. However, both groups scored a similar 20% shift in placement from parental to family relative care between the time of

FGDM or repatriation and of research. This finding confirms the culturally based children circulation within extended families more than other research results, indicating that the FC tends to lead to increased placement of children with extended family members (Trotter et al, 1999; Sundell, 2000; Kiely, 2002, 2005; LeCroy & Milligan Associates, 2003; Mandell et al, 2001; Crampton, 2000; Shore et al, 2001).

On placement stability, the other significant variance between the two groups was related to runaway cases, as a lower rate (20.4% variance) of runaway cases (n=6, 8.2% against n=12, 28.6%) was observed among FGDM children. This finding indicates a statistically significant difference between the groups and it draws attention to the likelihood of higher permanency probability for cases which underwent FGDM, in agreement with some evidence that placements were more stable after FC (Marsh and Crow, 1998; Gill et al., 2003; Merkel-Holguin, Nixon & Burford, 2003).

Though the FGDM placement stability appears a success, child circulation brought in a more complex scenario as after the conference children were still being transferred to relatives and received back from them, others had been reunited with their parents from institutional care while new entries were added. Furthermore, 28.7% (n=21) of all cases had been transferred upcountry in relatives' care after the conference, almost half of them as a result of the FGDM plan, while about 1/3 of them as part of further adjustments to the FGDM plan, being unstable in parental home or to provide safety to the child.

This mobility indicates ongoing child circulation within families and identifies guardianship by relatives as the most frequent options chosen by families in response to upcoming needs. To this end, the study suggests that the FGDM may be effective in linking relatives and reinvigorating networks of support for family decision-making, and thereby restoring confidence in the traditional extended family system, apparently still recognised by parents as their primary partner in child care. In fact, despite a lack of evidence on culture recognition and the difficul-

ties of measuring concepts such as *responsibility*, findings indicate that FGDM mobilised family support during and after the conference. On the whole, most of these re-placements had been identified by the family as their secondary plan, which could be arranged during the FGDM follow up or through consultations with the caseworker.

On balance, these findings are generally positive, particularly taking account of the fact that most children originated from families at the *hard* end of the child welfare spectrum.

Hence, in terms of avoiding reception into further care, court proceedings and reducing re-referral, the FGDM outcomes seemed favourable.

2.4.3 Safety, permanency, and well-being outcomes

Based on the principle that every child has the right to appropriate care and a permanent home, the FGDM outcomes were measured according to three main domains corresponding to child's conditions on **safety, permanency, and well-being 24-54 months after the conference.** The domains were picked as an integrated framework to measure the significant long term impact of the FGDM as a family reintegration model, though it remains difficult to isolate the effects of FGDM from the influence of other possible variables such as additional services received by the family alongside.

a. Safety from abuse and neglect outcome

The outcomes referred to child safety and measured how they were first and foremost, protected from abuse and neglect and safely maintained in their homes, when possible and appropriate.

The analysis of the outcome highlights that the FGDM was particularly effective in helping families to change in relation to their internal patterns of abuse on the child with a cumulative percentage of change reaching 71.2%. The family plan for remedying the situation appeared to have reduced the children's risk of harm up to 76.7%.

Besides, safety outcomes strongly associated with permanency outcome 2, referring to children's preserved continuity of family relationships and culture. The finding suggests that where FDGM succeeded in maintaining the child's proximity to the natural family, the cultural connection and the child's placement with the community, these became family resiliency factors to reduce abuse and harm to the child.

Changes of abusive patterns and reduction of harm after the FGDM, correlated also with accumulation of risks factors grouped in cluster 4, indicating **exposure to caregiver loss, separation and attachment threats. Besides,** these changes positively strongly correlated with child attending boarding school at the time of research and inversely correlated with matching of services in the community, suggesting that the FGDM may be effective within family settings affected by loss and separation but have less impact or require less community engagement for provision of services to the same child. Correlation with the boarding school opportunity appeared to be a family internal solution to fix the need of missing caregivers.

b. Permanency outcome

The outcomes referred to children permanency and stability in their living situations and measured how the continuity of family relationships, culture, and connections for children was preserved after the FGDM.

In terms of stability, the overwhelming majority of children (n=61 87.1%) out of all those whose whereabouts were known (n=70) were stable in the placements identified in their FGDM plan or in subsequent variations drawn in FGDM follow up meetings.

Hence, placements remained stable over time with few children moving out of home (n=6) or returning to unplanned institutional care (n=2), and even fewer children being re-referred 24-54 months after the conference.

Besides, the use of parental and kinship placements (n=59, 80.8%)

also corresponded to preservation of the child's social (n=56, 76.7%) and cultural (n=57, 78.1%) connection with the community. This indicates a relevant variation compared with the risk frequency analysis, which had identified high rates of permanency instability among children of the experimental group prior admission at the NCRH, who used to display severe incapacity of being stable at home by running away (93.2%), going home late at night (26%), sleeping outside at night (24.7%) and being subject to negative peer pressure (35.6%.).

With regard to this, a relevant finding was that among family or child's characteristics which were correlated with child permanency at home 24-54 months after the conference, only being enrolled in a boarding school showed to be a strong protective feature associated with successful child's permanency, suggesting that such condition may positively influence the FGDM long term outcome and the child's resilience.

The child-caregiver quality relationship appeared to be from very to fairly good in 67.4% (n=42) of the 62 known cases. An improved relationship if compared with the risk factors frequency analysis of the experimental group, where the child–caregiver attachment was found to be highly threatened by neglect/ failure to protect by caregivers (n=52, 71.2%), caregiver-child conflict (n=38, 52.1%), mistreatment (n=39, 53.4%) and abandonment/separation by caregiver at early age (n=30, 41.1%). Moreover, a positive quality relationship between child and caregiver strongly correlated with permanency outcomes, suggesting that environmental proximity and connection facilitates internal family bonding.

However, a negative correlation was found between accumulation of risk factors in cluster 2, witnessing continuous external threat, and both the positive child-parent/caregiver relationship and the stability of current placement with family. This finding may suggest that cluster 2 exposes threats to the child that can override some of the major FGDM long term positive outcomes, an effect that needs to be further understood to assess the FGDM suitability in such cases.

The study also found that preservation for children of **the continuity of family relationships, culture, and connections,** in addition to showing strong intertwined internal correlations, revealed a strong association with Wellbeing Outcomes 1 and 2, such as matching services in the community, family participation in case planning and provision of educational needs. This finding suggests that FGDM, by sustaining the child's proximity to the natural family, culture and community, facilitates family responsibility in decision making and community engagement in responding to the child's identified needs.

c. Well being outcome

The outcomes referred to child wellbeing in their living situations measured whether the FGDM supported families to have enhanced capacity to provide for children's needs, including educational services to achieve academically according to their abilities.

FGDM was found to facilitate families' engagement in plan implementation and provision of needed services after the conference. FGDM effectively supported parental and extended family participation in plan implementation in 83.5% (n=61) of all cases by giving families control over the development of safety, placement, and service plans.

Educational needs were met through the FGDM in 87.7% of all known cases (n=57), in general by provision of immediate school enrolment after the conference. This result appeared to go beyond the 50.7% (n=37) of plans, which had expressly included the provision of formal education. However, no correlation was found between matching of services in the community and provision of educational needs, suggesting that response to this need was left as a major responsibility to the child's family.

Equally, the 13.7% (n=10) of children in the experimental group not attending school at the time of research, compared with the truancy rate which had previously affected 42.5% (n=31) of the same sample, indicated a positive improvement. School performance of children re-

integrated through FGDM could be established to be at least sufficiently good in 60.3% (n=44) of all cases.

With regard to physical, emotional or mental needs, matched by provision of services, the physical ones were very or fairly well provided for in 92.6% (n=54) of all known cases. They included food, shelter and health. Besides, the correlation found between provision of basic needs and matching of services in the community suggests a role the community played in response to them.

Emotional needs, including attachment, acceptance and protection, received a colder response being met very or fairly well in 96% (n=48) of all known cases, suggesting that the FGDM conference may equally provide responses for basic survival needs and more elaborated ones. However, emotional needs being met also appeared to be strongly correlated with family and cultural proximity, as well as with positive child-caregiver relationship and provision of basic/educational services, suggesting that emotional wellbeing was part and probably the result of integrated outcomes facilitated by the FGDM, in response to the diversity of child's developmental needs.

CHAPTER NINE

CONCLUSION

RECOMMENDATIONS AND FUTURE EVALUATION

The FDGM is an innovative approach that positions the *family group* as leader in decision making about children's safety, permanency, and well-being. Children and their parents are nested in a broader family group made by people to whom they are connected through kinship and other relationships. The model recognizes the importance of involving them in decision making about children in need of care and protection while statutory authorities agree to support family group plans that adequately address protective concerns.

FGDM appears to be an effective way to move beyond the metaphor of the pendulum still unevenly swinging in Kenya from institutional to family care. For the children within this study, the immediate and long-term outcomes suggest they were protected and the family unit was honoured. Both the maternal and paternal sides of the family participated at the conference and with case planning. The family group offered a tremendous amount of support that included placement options, respite care, and material assistance, reinforcing the belief that the FGDM may be effective in linking relatives and reinvigorating support networks for decision-making of families involved in the child welfare system, and thereby restore confidence in the traditional extended family system, apparently still recognised by parents as their primary partner in child care. In addition, this approach seemed to

balance level of need (highly at-risk groups receive more specialized services), effectiveness (providing necessary types of services), and efficiency (not providing unnecessary services).

After capturing these critical findings, there are important implications for practice that emerge from this longitudinal research.

1. IMPLICATIONS

First, different types of risk factors (individual, family and environmental) affect child vulnerability through qualitatively different pathways, and children with high accumulation of risk factors show considerable variation in the type and degree of risks they experience.

Most agency decision-making practices are presently planned and dominated by practitioners and focused narrowly on children's presenting needs, disregarding the integrated support and assistance of their family group and of key community partners in the child welfare process.

Besides, many current intervention programs are designed to improve child outcomes by addressing child's basic needs such as provision of food or school uniforms. Although this strategy is clearly valuable, as this study also found that enrolment in a boarding school may be a strong protective feature associated with successful child's permanency, this may not be enough to ensure that children exposed to severe risk factors are able to improve their resilience and permanency.

Furthermore, the public child protection system currently doesn't provide children officers with an official protocol on reintegration to ensure child, parents and community participation in developing the exit process from statutory institutions. This is attributed to the fact that for child protection officers it is more time-efficient and cost-effective to develop a case plan and then present it to the parents. However, if the outcomes from this study serve as an indicator of the FGDM effectiveness for children to be family reintegrated from institutional care, offering a FGDM to families may increase child long term suc-

cessful permanency by approximately 20% when compared with government repatriation practices.

In addition, the FGDM provides a clear protocol or method for involving families in case planning and implementation.

Besides, the study indicates that accumulations of risks in children's life have been addressed and reduced as a result of FGDM plans, with an impact on the long-term wellbeing of children for a significant majority of the families involved. Accordingly, practitioners are suggested that the most effective interventions are those that primarily address family risk factors and support families in dealing with their internal accumulations of risks prioritising responses to children being under constant emotional threat by caregiver and exposed as victims of abuse or unsafe conditions.

Moreover, intervention programs designed to promote strong, healthy relationships between caregivers and children need to empower families with appropriate strategies to reduce children's exposure to continuous external threats and work to build the child–caregiver attachment threatened by conflicts, loss or separation.

Hence, while FGDM enables children's environmental proximity and connection with family and community, it also appears to be a tool which gives more confidence to the family team becoming the main actor in the helping process. This increases the likelihood of networking with communities to identify unique strategies and resources to face different types of risks while practitioners are facilitated in achieving positive changes in the lives of family members and ensuring the safety of the child.

As such interventions require substantial human investments on the part of actors intending to use the FGDM model, results from this study indicate that such investments may improve the probability of positive outcomes in the child-caregiver relationship and in the resulting long term child's permanency.

Being locally applied, the FGDM model would need to be integrated into a whole-of-system approach if it were to be used appropriately and effectively. From this perspective, FGDM could become a process of state-enforced family self-regulation that seeks to avoid escalation up to a more coercive regulatory response of decision-making processes unilaterally imposed by the state (e.g. court committal to residential care or rehabilitation).

2. LIMITATIONS

However, while the families in this study appear to have benefited from a FGDM, these recommendations reflect some of the limitations of this research as well. For example, a reliance on pre-collected information restricted our ability to address the full range of questions regarding long-term outcomes.

Furthermore, general lack of suitable, long-term research on FC makes definitive conclusions difficult to reach. Hence, additional work is needed with larger sample sizes, in other settings and in comparison with other research methods such as collection of qualitative data gathered from families and practitioners (e.g. identifying family' satisfaction) to gain a greater understanding of long-term outcomes for families. Children participation also needs to be captured to reflect a range of factors such as their perception of the problem, reactions of other family members and outcomes from the planning process.

3. SUGGESTIONS FOR FUTURE RESEARCH

In the specific Kenya context, there is no research on the coverage of institutionalized children's family reintegration through family conferencing or on the effectiveness of other applied exit strategies. Moreover, there are no studies shedding light on the post-institutional phase, hence, there is need to research on how to trace children who were at these institutions to determine the rate of post institutional success or failure.

Ethnic and cultural variations might also be taken into consideration by future research in relation to involvement of specific ethnic groups with the child welfare system. Little research on child neglect has explored presence of stepparents in families as well, perhaps because they are not seen as the person primarily responsible for providing child care or because single parents are typically more accessible.

Finally, research is needed to understand its cost effectiveness, since the expectation that, once in place, FGDM will reduce expenditure on resource provision by promoting care within the family remains somewhat contradictory.

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APPENDIX I

DATA COLLECTION FORM
CASE FACT SHEET

NAIROBI CHILDREN REMAND HOME
Researcher reading file:
Date File is being read
Date Case Opened: Date of tracing: Date of FGDM :
Length of time the child has been under programme care (n° months)
Child's name gender M ( ) F( )
age (at time of case intake) ethnicity
Position among siblings: Last class attended:
Area of abode
Father's age education occupation Ethnicity
Mother's age education occupation Ethnicity
Family composition: both parents ( ) single mother ( ) single father ( ) father & stepmother ( ) mother & stepfather ( ) orphan living with relative (specify): .... orphan headed family( ) Widow : husband died ( ) wife died ( )
Type of placement (at time of FGDM) Family home ( ) Relative (specify) .... Residential Care ( ) Other (specify).................... ___________________

Current Case Status

permanency at parents' home	permanency at relatives' home	under alternative residential care	relapsed to NCRH	run away	taken upcountry by family	un-known

RISK FACTORS FOR RUNAWAY CHILDREN

Check all of the child protective issues listed below which are relevant to this case	**Issues identified**	**Addressed in the FGDM plan**
FAMILY RISKS FACTORS		
Family ecology		
Biological parents separation		

Presence of stepmother		
Presence of stepfather		
Orphan of one parent		
Orphan of both parents		
Single mother		
Single father		
Physical ability to care for child		
Parent impaired physical/medical condition		
Mental/emotional ability to care for child		
Parent impaired mental condition		
Emotional inability to care for child (anger, stress, depression)		
Family behavioural history		
Prior neglect/abuse within extended family		
Parent criminal activity/incarceration		
Domestic violence		
Marital conflict		
Prostitution by mother		
Alcohol addiction - parents		
Drugs addiction - parents		
Homelessness/poverty		
Parents' unemployement		
Conflict with extended family		
Parenting ability		
Neglect/ failure to protect		
Parents' inconsistency in discipline		
Violent punitive discipline		
Inadequate acceptance of child by parent, stepparent		
Inadequate caretaker's perception of the child's needs		
Parents' blaming of the child and refusal to accept identified family needs		
Refusal of parental responsibility		
Deviant behaviour (as perceived by family)		
CHILD RISK FACTORS		
Child's health and development		
Child impaired physical/medical condition		
Child impaired mental/emotional condition		
Violent/aggressive		

Child safety

Emotional abuse		
Physical abuse		
Mistreatment		
Sexual abuse		
Suicidal attempts		
Child attachment		
Abandonment by mother at early age		
Parent-child conflict (specify with whom)		
Rejection (specify by whom)		
Child's behavioural history		
Change of name		
Child criminal behaviour (with criminal court case)		
Runaway		
Previously under alternative residential care		
Previously under alternative day care		
Street life (more than one month)		
Spleeping outside		
Scavenging		
Lying		
Truancy		
Inappropriate sexual behaviour		
Prostitution		
Stealing		
Going home late		
Going to video		
Drugs or alcohol abuse (specify)		
ENVIRONMENTAL CONDITIONS		
Environmental hazard/slum area		
Disconnection of family from community social support		
Negative peer pressure: friends from street, drugs addicts, stealing		

FGDM CONFERENCE DATA

Attendance

Specify the number of each type of participant that attended the meeting. Type is based on the participant's relationship with the child(ren) for whom the meeting was held. If a relative attending is caring for the child(ren), write "Relative foster" in the space next to the participant type

category in which they fall (e.g. if the maternal grandmother is caring for the child and attended the meeting, write "grandmother relative foster" next to maternal grandparent.

Number Attending	**Type of Participant**	**Number Attending**	**Type of Participant**
	Child(ren) for whom the meeting was held		Family friend
	Sibling		Foster parent
	Mother		Chief/assistant chief
	Father		Police
	Stepmother		DCO
	Stepfather		Village elder
	Male partner (of female parent)		Community social service provider
	Female partner (of male parent)		Class teacher
	Maternal grandparent		School H/M
	Paternal grandparent		Religious leader/representative
	Maternal step grandparent		Neighbour
	Paternal step grandparent		
	Uncle - Mother's family		
	Uncle - Father's family		
	Aunt - Mother's family		CEFA SW
	Aunt - Father's family		CEFA Counsellor

Purpose or Goal
(check all that apply)
___Develop family reintegration plan
___Identify child & family needs/concerns
___Identify child & family strengths/resources
___Info sharing
___Develop child intervention plan (school, ...)
___Decide temporary alternative out of home placement (residential centre)
___Decide permanent placement with parent (s)
___ Decide kinship placement
___Decide permanent transfer and placement to upcountry extended family
___ Network and Coordinate services with stakeholders to create service

agreement (school,welfare program, etc.)
___Other
(specify)____

Meeting format

Location: _________________at family home ____ school ____ chief ____ church _____ other _____

Private family time? _____Yes _____No

Needs/concerns addressed at the conference

Rate the child's needs list on a scale of 1 (low) to 5 (high) for the following:

_____ Permanency specifically and explicitly stated
_____ Safety specifically and explicitly stated
_____ Wellbeing & development (provision of basic needs such as feeding, health, education, etc.)
_____ Attachment: Protection of parent-child attachment (to natural family) explicitly stated

Note: 1. Safety needs were considered addressed if issues were discussed and the plan included services to remedy the issues or protect the children from their effects (e.g., Chief/DCO intervention, drug and alcohol treatment, counselling…).
2. Attachment needs were considered addressed if the importance of maintaining or developing healthy relationships with family members was reflected in the plan (e.g., placement with relative, regular visitation or contact, providing services to maintain a placement).
3. Permanency needs were considered to be addressed if a transition home plan was made, or if a permanent placement was discussed or decided, or if some kind of stable situation for the child was explicitly expedited by the implementation of the plan.

Were all needs/concerns presented at the meeting addressed in the plan?
_______Yes ______No

Strengths addressed at the conference

Strengths listed:
____ Strengths of children explicitly stated
____ Strengths of primary family explicitly stated
____ Evidence that plan capitalizes on family strengths

The Plan: formulation, monitoring and effectiveness

Does the plan include any formal process for monitoring follow through?
_______Yes _______No
_______Follow up meeting scheduled
_______Participants or others designated to check on follow through/aftercare
(check all that apply)
Familymember(s)______Chief________DCO___Teacher(s)____Casework er/SW ______Service provider*(s)* ______ Neighbour ______Other ______

Does the plan specify timelines for accomplishing tasks/goals, completing services, etc.?
_____All are specified _____Some are specified ______None are specified

Who signed it? Parents ( ) Relatives ( )

Who was involved in the plan?
Complete the following tables indicating who was involved, and how, in the plan.

Example: Maternal aunt	Supervise mother's visits with child	Yes ( ) no ( ) partly ( ) in Process ( ) revised ( )
Paternal grandparents	Child to be placed with them, or remain in their care	
Who	**How Involved**	**Follow through** (check follow up records)
		Yes ( ) no ( ) partly ( ) in Process ( ) revised ( )

In general, has the plan been implemented as it was stated at the FGDM meeting?	1. Not at all ( ) 2. A little ( ) 3. Most of it ( ) 4. All of it ( )	

Has the community been involved in the implementation of the plan and to which degree
1. Not at all (no partner involved) 2. A little (1 partner)

3. Fairly enough (2 partners) 4. Very much (3 partners)

FGDM outcomes

Outcomes are evaluated according to three interdependent outcome domains and their quality performance indicators. Indicators are graded according to records entered in the child's follow up files.

1. Permanency

Outcome P1: Child has permanency and stability in living arrangements.

Performance Indicators:

- Stability of current family placement

1. Not at all (runaway) 2. A little (high risk)
3. Fairly enough (moderate risk) 4. Very much (low risk)

- Stability in long-term alternative residential care Yes ( ) No ( )

Outcome P2: The continuity of family relationships, culture, and connections are preserved for the child.

Performance Indicators:

- Proximity of current placement to parents and/or extended family Yes ( ) No ( )
- Cultural connections and preservation with the community Yes ( ) No ( )
- Use of placements related to the child's local community Yes ( ) No ( )
- Quality relationship between child and parents
  1.Absent 2. Not good at all 3. Slightly good
  4. Fairly good 5. Very good

2. Safety

Outcome S1: Child is protected from abuse, harm and neglect in the home

Performance Indicators:

- Abusive patterns in the family have changed
  1. Not at all 2. A little 3. Fairly enough 4. Very much
- Risk of harm to child has been reduced
  1. Not at all 2. A little 3. Fairly enough 4. Very much

3. Child and Family Well-Being

Outcome WB1: The family has enhanced capacity to provide for

the child's needs.

Performance Indicators:

- Match of services within the community to child/family needs.

  Yes ( ) No ( )

- Family/Child participation in case planning

  1. Absent 2. Sufficient 3. Fairly good 4. Very good

Outcome WB2: The child has educational achievements appropriate to their abilities.

Performance Indicators:

- Provision of educational needs and service Yes ( ) No ( )
- Child's school performance

  1. Not Attending School 2. Inadequate 3. Sufficient
  4. Quite Good 5. Very Good

Outcome WB3: Child receives adequate services to meet his/her physical and mental needs

Performance Indicators:

- Basic physical needs and services (feeding, clothing, shelter...)

  1. Not at all 2. A little 3. Fairly enough 4. Very much

- Basic physical/mental health needs and service (in case of confirmed sickness) 1. Not at all 2. A little 3. Fairly enough 4. Very much
- Emotional needs and services (acceptance, belonging, feeling loved, safety, self esteem & fulfilment -Maslow)

  1. Not at all 2. A little 3. Fairly enough 4. Very much

APPENDIX II
Risk Assessment Model for Child Protection and Family Reintegration

Quick Reference : Risk Factors			
Child's Characteristics ***Child's physical health and development***: - age of child - body scars, wounds - low weight/height compared to age - physical disability ***Child's mental health and development***: - verbally/physically aggressive - inflated self-esteem - withdrawn – depressed - with mental disability ***Child's vulnerability to*** - violence - abuse - neglect - mistreatment	**Parental/Family Condition** ***Family composition:*** - parents separation - single parent - stepparent - No extended family support ***Physical ability to care for child***: - sickness - disability ***Mental/emotional ability to care for child:*** - anger - inability to cope with stress and child's behaviour - depression - stress for marital conflict ***Family behavioural***	**Degree of Abuse/ Neglect** ***Severity/premeditation of abuse/neglect*** **Pattern/Chronicity/Frequency** - Location of Injury: head - Child's Fear of the caretaker - Access to child by person who has abused or neglected or may abuse, neglect a child - Intent and acknowledgement of responsibility - History of abuse/neglect	**Degree of parental cooperation** **Ability and willingness to protect*:*** - No parents/relatives' response after two weeks from tracing - Parents' blaming of the child and refusal to accept

Child's behavioural history within family*:** - running away: age of starting, frequency, length of time spent outside - stealing: age of starting, frequency, amount of stolen money and its use - Property destruction, others' and suicidal ideations and gestures - Inappropriate sexual behaviour - record of prior offences ***Education: - school problems - educational level compared with age - low achievement - school truancy ***Peer relations:*** - friends with history of running away, stealing, etc. - friends living in the street/base - taking glue, drugs - friends involved in criminal	***history:*** - abuse/neglect of parent as a child - domestic violence - alcohol or drug use - prior neglect/abuse within the extended family ***Parenting ability:*** - inadequate acceptance of child by parent, stepparent - inadequate parents expectations on the child - parents inadequate supervision and discipline by being unconcerned beating, shouting - parents' inconsistency/contradiction in discipline approach	committed by present parents	identified family needs - Lack of attendance at the FGDM conference - Parents inadequate implementation of FGDM plan of action - Inadequate caretaker's perception of the problem

activities ***Leisure***: - scavenging - going to video - eating in hotels - being home late ***Street experience***: - duration - sleep on the street - use of glue - change of name	***Living environment/ conditions***: - slum area - insufficient resources or not well managed for basic needs - unemployment - disconnection from their own extended family and from community social support		

APPENDIX III

CHILD & FAMILY WELFARE CASES
RISK, NEEDS AND STRENGTHS ASSESSMENT FORM

Start identifying the child's risk factors in the first column by checking the related boxes. Assess the level of each identified risk factor. Focus only on the identified risk factors and check the corresponding items in the columns of needs to identify what is required to respond to the risks. In this way you will be able to identify the objectives of the child's care/treatment plan. Finally, identify the corresponding strengths on which to build the intended care/treatment plan. Overruling factors require immediate action such as referral to alternative placement.

CHILD ASSESSMENT

Risk/Problem Areas		Risk Level	Needs Areas	Strengths
Child Abuse	Physical abuse	(High/ Medium /Low) H ☐ M ☐ L ☐	☐ Overruling condition (in case of "High")! Start action without delay ☐ Separate from abusers ☐ Provide Medical treatment / Allow disclosure and provide emotional care through counselling ☐ Provide legal support ☐ Provide awareness on the child's condition to family members ☐ Offer guidance and counselling to caregivers ☐ Find safe home in the community/ provide referral to Rescue Home ☐ Involve the extended family and community in the child's reintegration through a Family Conference	☐ Child reveals the abusive condition ☐ Child is willing to protect oneself ☐ Willingness of the child to accept alternative placement ☐ Child displays positive skills to deal with the condition ☐ Child trusts other caregiver to get needs met ☐ Caregiver/family has adequate

			☐ Provide follow up services to family in case of reintegration	awareness of child's condition and show concern ☐ Child has received some protection by one caregiver
	Sexual abuse	H ☐ M ☐ L ☐	☐ <u>Overruling condition (in case of "High")! Start action without delay</u> ☐ Separate from abusers ☐ Provide Medical treatment / Allow disclosure and provide emotional care through counselling ☐ Provide legal support ☐ Provide awareness on the child's condition to family members ☐ Offer guidance and counselling to caregivers ☐ Find safe home in the community/ provide referral to Rescue Home ☐ Involve the extended family and community in the child's reintegration through a Family Conference ☐ Provide follow up services to family in case of reintegration	☐ Child reveals the abusive condition ☐ Child is willing to protect oneself ☐ Willingness of the child to accept alternative placement ☐ Child displays positive skills to deal with the condition ☐ Child displays age-appropriate sexual behaviour ☐ Child trusts other caregiver to get needs met ☐ Caregiver/family has adequate awareness of child's condition and show concern ☐ Child has received some protection by one caregiver
	Emotional abuse	H ☐ M ☐ L ☐	☐ Allow disclosure and provide emotional carethrough counselling ☐ Provide legal support ☐ Provide awareness on the child's condition to family members ☐ Offer guidance and counselling to caregivers ☐ Find safe home in the community/ provide	☐ Child reveals the abusive condition ☐ Child displays positive skills to deal with the condition ☐ Child has positive bonding and get emotional support by other

			referral to Rescue Home ☐ Involve the extended family and community in the child's reintegration through a Family Conference ☐ Provide follow up services to family in case of reintegration	caregiver ☐ Caregiver/family has adequate awareness of child's condition and show concern
	Neglect	H ☐ M ☐ L ☐	☐ Medical treatment / Intensive emotional care ☐ Allow disclosure and provide emotional care through counselling ☐ Provide legal support ☐ Provide awareness on the child's condition to family members ☐ Offer guidance and counselling to caregivers ☐ Find safe home in the community/ provide referral to Rescue Home ☐ Involve the extended family and community in the child's reintegration through a Family Conference ☐ Provide follow up services to family in case of reintegration	☐ Child reveals the abusive condition ☐ Child displays positive skills to deal with the condition ☐ Child has positive bonding and get emotional support by other caregiver ☐ Caregiver/family has adequate awareness of child's condition and show concern
	Child labour	YES ☐	☐ Remove child from working environment ☐ Provide legal support ☐ Provide awareness and counselling on the child's condition to family members ☐ Find safe home in the community/ provide referral to Rescue Home ☐ Involve the extended family and community in the child's reintegration through a Family Conference ☐ Provide educational opportunities to the child	☐ Child is willing to resume education ☐ Caregiver/family has adequate awareness of child's condition and show concern ☐ Child's family has material resources

Physical/Mental Condition	Physical disease/ handicaps level	H □ M □ L □	□ Provide immediate physical check-ups/treatment □ Draw a long term physical treatment plan if needed □ Provide referral through networking to access resources to implement the plan	□ Caregiver shows concern about the child's health needs. □ Caregiver has been providing for adequate medical care □ Child is emotionally able to cope with the condition □ Resources are available to treat the condition □ Community doesn't discriminate the child/family and is available to support
	Physical hygiene level	H □ M □ L □	□ Physical check-ups □ Living skills education / Hygiene education	□ Child appreciates physical hygiene □ Child is willing to wash and be clean □ Child displays positive skills to deal with personal hygiene □ Caregiver/family has adequate awareness of child's condition and show concern
	Mental disorder level	H □ M □ L □	□ Mental diagnosis/treatment □ Mental treatment plan	□ Caregiver shows concern about the child's mental health needs. □ Caregiver has been providing for adequate mental health care □ Caregiver is able to cope with the condition

				☐ Resources are available to treat the condition ☐ Community doesn't discriminate the child/family and is available to support
Behaviour Problems	Runaway frequency	H ☐ M ☐ L ☐	☐ Trace the child's family members ☐ Through child and family counselling identify root causes of running away and facilitate for alternatives ☐ Involve the extended family and community in the child's reintegration through a Family Conference	☐ Child is readily available to trace the caregiver ☐ Child is first time runner ☐ Child has not been in the streets ☐ Child displays desire of permanency at home by wishing to be reunited with family or preferred caregiver ☐ Caregiver shows concern and takes part of the responsibility
	Display of street life behaviours: sleeping out of home, begging, scavenging, eating in hotels,	H ☐ M ☐ L ☐	☐ Through child and family counselling identify root causes of street life behaviour ☐ Facilitate change of attitudes and reconnection with family through showing the positive / pro-social models and the helpless and hopeless results of street life ☐ Involve the extended family and community in the child's home reintegration through a Family Conference ☐ Identify community resources to support the child in reconnecting with family and readjusting to	☐ Child is able to understand the root causes of liking street life ☐ The street life behaviour is not an habit ☐ The child still has constructive behaviour: e.g. Likes education ☐ Child regrets the street behaviours and shows desire for change ☐ Caregiver doesn't label the

	going to video show, change of name, spend spare time on the street and reaching home late.		positive style of life ☐ For older children identify places to learn (other than school) or work and facilitate vocational training	child, shows concern and takes part of the responsibility ☐ The community has resources available to support the child in adopting constructive behaviours
	Difficult behaviours: stealing, lying, defiance	H☐ M ☐ L ☐	☐ Through child and family counselling identify root causes and facilitate for alternatives ☐ Involve both child and the caregiver in the behaviour change process ☐ Involve the extended family and community in the child's reintegration through a Family Conference	☐ Child is able to understand the root causes of the behaviour ☐ The problematic behaviour has just started ☐ Child has been misbehaving only within the family setting ☐ Child regrets the misbehaviours and shows desire for change ☐ Caregiver doesn't label the child, shows concern and takes part of the responsibility ☐ The community has resources available to support the child in the behaviour change process

	Using illegal substances (drugs)	H☐ M ☐ L ☐	☐ Provide Medical & Mental check up ☐ Provide specialised drug abusers education and counselling ☐ Identify a drug rehabilitation centre or a suitable residential vocational training and make a referral	☐ Child admits using and has frank conversations with parents. ☐ Child is able to express concerns about personal use. ☐ Child is willing to be helped ☐ Caregiver doesn't label the child, shows concern and takes part of the responsibility ☐ The community has resources available to support the child in the rehabilitation process
	Emotional instability	H☐ M ☐ L ☐	☐ Diagnose the emotional condition / Analyze the causes of emotional instability ☐ Individual counselling / medication service ☐ Counselling programme planning ☐ Family counselling / Family Decision Making Conference	☐ Caregiver shows concern about the child's condition. ☐ Caregiver has been providing for adequate care ☐ Caregiver is emotionally able to cope with the condition ☐ Resources are available to treat the condition ☐ Community doesn't discriminate the child/family and is available to support
	Inappropriate sexual behaviour	H ☐ M ☐ L ☐	☐ Through child and family counselling identify root causes and facilitate in reconstructing adequate sexual behaviour	☐ Child is able to understand the root causes of the behaviour ☐ The problematic behaviour has

	level		☐ Provide HIV counselling ☐ Involve the extended family and community in the child's reintegration through a Family Conference ☐ Find a Rescue Centre possibly with vocational training facilities	just started ☐ Child regrets the misbehaviours and shows desire for change ☐ Caregiver doesn't label the child, shows concern and takes part of the responsibility ☐ The community has resources available to support the child in the behaviour change process
School Problems	Behavioural problems in school	H☐ M ☐ L ☐	☐ Through child and family counselling identify root causes and facilitate motivation and choice of alternatives ☐ Involve child, the caregiver and teachers in the behaviour change process ☐ Involve the extended family, the school and community in the child's reintegration through a Family Conference ☐	☐ Child is able to understand the root causes of the behaviour ☐ The problematic behaviour has just started ☐ Child regrets the misbehaviours and shows desire for change ☐ Caregiver doesn't label the child, shows concern and takes part of the responsibility ☐ The school shows concern and is willing to support the child in the behaviour change process
	Academic achievement difficulty	H☐ M ☐ L ☐	☐ Analyze intellectual level ☐ Provide proper academic support ☐ Enhance motivation and self-confidence through guidance and counselling	☐ Child enjoys some of the school activities ☐ Caregiver doesn't label the child, shows concern and takes part of the responsibility ☐ The school shows concern and

				is willing to support the child to achieve an age appropriate academic level
	School truancy problem	H □ M □ L □	□ Through child and family counselling identify root causes and facilitate motivation and alternative behaviour □ Involve child, the caregiver and teachers in the behaviour change process □ Involve the extended family, the school and community in the child's reintegration through a Family Conference	□ Child is able to understand the root causes of the behaviour □ The problematic behaviour has just started □ Child regrets the misbehaviours and shows desire for change □ Caregiver doesn't label the child, shows concern and takes part of the responsibility □ The school shows concern and is willing to support the child in the behaviour change process
Peer Relations	Preference of bad company	H □ M □ L □	□ Through child and family counselling identify root causes and facilitate the identification with positive supportive peer group □ Facilitate change of attitudes through showing the positive / pro-social models and the helpless and hopeless results of keeping the association with bad company □ Involve the extended family and community in the child's reintegration through a Family Conference □ Identify community resources to support the child in identifying with positive peer groups □ For older children identify places to learn (other	□ Child is able to understand the root causes of identifying with bad company □ The association with bad company has just started □ The child still associates with positive friends □ Child regrets the association and shows desire for positive peers □ Caregiver doesn't label the child, shows concern and takes

			than school) or work and facilitate vocational training	part of the responsibility ☐ The community has resources available to support the child in joining positive peer groups
	Associate with friends living in the street	H☐ M☐ L☐	☐ Through child and family counselling identify root causes and facilitate the identification with positive supportive peer group ☐ Facilitate change of attitudes through showing the positive / pro-social models and the helpless and hopeless results of keeping the association with bad company ☐ Involve the extended family and community in the child's reintegration through a Family Conference ☐ Identify community resources to support the child in identifying with positive peer groups ☐ For older children identify places to learn (other than school) or work and facilitate vocational training	☐ Child is able to understand the root causes of associating with street children ☐ The association with street children is scattered ☐ The child still associates with positive friends ☐ Child regrets the association and shows desire for positive peers ☐ Caregiver doesn't label the child, shows concern and takes part of the responsibility ☐ The community has resources available to support the child in joining positive peer groups
	Associate with friends involved in criminal activities	H☐ M☐ L☐	☐ Analyze children's recognition & attitudes toward delinquency ☐ Through child and family counselling identify root causes and facilitate the identification with positive friends ☐ Facilitate change of attitudes through showing the positive / pro-social models and the helpless and	☐ Child is able to understand the root causes of associating with delinquent friends ☐ The association with delinquent friends is scattered ☐ The child still associates with positive friends

			hopeless results of keeping the association with criminal friends ☐ Involve the extended family and community in the child's reintegration through a Family Conference or Restorative Conference ☐ Identify community resources to support the child in identifying with positive friends ☐ For older children identify places to learn (other than school) or work and facilitate vocational training	☐ Child regrets the association and shows desire for positive peers ☐ Caregiver doesn't label the child, shows concern and takes part of the responsibility ☐ The community has resources available to support the child in joining positive peer groups
	Family assessment			
Family Composition	Parents have separated	YES ☐	☐ Focus the parents on the child's best interest while addressing emotional, financial or legal issues ☐ Provide counselling to the child to deal with parents' separation and accepting it ☐ Assure maintenance is granted for the child's upkeep ☐ Assure that child's visitation is granted and doesn't affect the child	☐ Both parents have adequate awareness of child's condition and show concern ☐ Parents are able to differentiate their own issues and the child's welfare ☐ Child is granted the right to access both parents ☐ Separated parent who doesn't live with the child is supportive ☐ Extended family is supportive to the child

	Mother / Father is single parent	Mother ☐ Father☐	☐ Assure child care is provided while the parent is absent e.g. for work ☐ Provide for emotional support to parent if under stress ☐ Assist the child to cope with stressful situations through counselling	☐ Parent has positive and consistent relationship with child ☐ Parent-child attachment is strong ☐ Extended family is supportive
	Caregiver is a stepparent	YES ☐	☐ Assure the stepparent is willing to care for the child ☐ Assist parent and stepparent to form a united front and work together to develop effective parenting	☐ Stepparent is supportive and has positive bonding with child ☐ Both caregivers have consistent parental approach to the child
	Lack of extended family support	YES ☐	☐ Develop supportive family relationships through facilitating an extended family conference	☐ Some family members are concerned and supportive
Caregiver's Physical / Mental Condition	Sickness (HIV/AIDS) and Physical disability	YES ☐	☐ Assure adequate medical care ☐ Assure caregiver is able to provide for adequate child care	☐ Adequate medical care is already provided to caregiver ☐ Caregiver is emotionally healthy, able and willing to have custody ☐ The community has resources available to support child and caregiver in case of need
	Mental / Intellectually	YES ☐	☐ Assure adequate mental care ☐ Assure caregiver is able to provide for adequate child care	☐ Adequate mental care is already provided to caregiver ☐ Caregiver is able and willing to have

	disability			custody ☐ The community has resources available to support child and caregiver in case of need
Parents' Emotional Condition	Aggressive and easy get angry	H ☐ M ☐ L ☐	☐ Plan parents' support programmes (such as "Anger management programme") and monitoring programmes ☐ Facilitate Parents support network in neighbouring community	☐ Caregiver has social skills and willingness to change
	Inability to cope with life stress and problematic child behaviour	H ☐ M ☐ L ☐	☐ Plan parents' support programmes (family/couple counselling and guidance) and monitoring programmes ☐ Facilitate Parents support network in neighbouring community	☐ Caregivers are aware of how stress factors affect the relationship with child ☐ Caregivers are willing to dialogue and solve conflicts ☐ Extended family is supportive to the caregiver ☐ The community has resources available to emotionally support the caregiver
	Depression / Withdrawal	H ☐ M ☐ L ☐	☐ Assure Mental care treatment / medication ☐ Plan parents' support programmes and monitoring programmes ☐ Facilitate Parents support network in neighbouring community ☐ Monitor the child has not taken a parentified role in the family	☐ Extended family is supportive to the caregiver ☐ The community has resources available to emotionally support the caregiver

Parenting Ability	Lack of warm family bonding / Lack of understanding children' needs	H □ M □ L □	☐ Create opportunities for positive child-caregiver interaction and bonding though the methods such as plan family counselling and guidance ☐ Help to understand and take adequate care of child's needs	☐ One caregiver has good bonding with child
	Inadequate expectations and blaming on children	H □ M □ L □	☐ Enhance understanding of child development in order to set adequate goals for children ☐ accept responsibility for the child's situation	☐ Caregivers ready to adopt realistic age-appropriate expectation ☐ Caregiver shows concern and takes part of the responsibility
	Unable to supervise children	H □ M □ L □	☐ Improve ability and willingness to supervise children through, such as, teaching parenting methods	☐ One caregiver has appropriate involvement with the child
	Inconsistent / Abusive discipline	H □ M □ L □	☐ Plan parents' emotional support programmes ☐ Improve ability to provide consistent and alternative ways to discipline through teaching parenting methods	☐ Caregivers are aware of alternative way of discipline ☐ Caregivers agree to discipline the child appropriately and consistently

	Refusal of parental responsibility (No responding / cooperation after two weeks from tracing)	H □ M □ L □	☐ Plan parents' emotional support programmes ☐ Reinforce caregiver to take responsibility of the child Refer the case to public administration (chief, DCO) for caregivers to cooperate and take responsibility of child	☐ One caregiver responds immediately to invitation to visit the child ☐ Caregiver shows concern and takes part of the responsibility
Behaviours of Family Members	Prior criminal behaviours of family members	YES □	☐ Provide counselling and guidance services ☐ Assess the influence on the child of those with criminal history(e.g. child's identification with relative with criminal behaviour)	☐ There are law abiding caregiver with no prior records
	Domestic violence	H □ M □ L □	☐ Assess the risk levels by observing if • One parents is afraid of another adult within the family • Child expresses concern for parent's safety • Child attempts to intervene during a domestic violence incident • Child is injured during a domestic violence incident	☐ Parents are able to identify methods for non-violent resolution of conflicts and can provide examples of times they have successfully used these methods. ☐ Non-offending parent protects child by sending child to relatives, friends or a safe place ☐ willingness of caregiver to be helped

			☐ Protect children and other caregiver if necessary ☐ Provide counselling and guidance services for victims	and change
	Family members' alcohol / drug abuse	H ☐ M ☐ L ☐	☐ <u>Overruling condition (in case of "High")! Start action without delay</u> ☐ Assess the risk levels and protect child from unsafe caregiver and if necessary separate child from alcohol/drug abuser ☐ Provide counselling and guidance services for affected family members	☐ Other caregiver is free from alcohol, drug dependency ☐ Affected caregiver has joined a rehab. Programme ☐ Willingness of the child to accept alternative placement
	Premedita tion of abuse / neglect by caregiver	H ☐ M ☐ L ☐	☐ Assess the risk levels and protect children if necessary ☐ Provide counselling and guidance services for affected family members	☐ Child reveals the abusive condition ☐ Child is willing to protect oneself ☐ Child displays positive skills to deal with the condition ☐ One caregiver/family has adequate awareness of child's condition and show concern ☐ Child has received some protection by one caregiver
Living Environ ment of Family	Living in slum area	YES ☐	☐ Maintain safe home for children	☐ child's care is adequate, clean/safe home
	Insufficien t resources	YES ☐	☐ Acquire and manage adequate resources	☐ child's care is adequate: caregivers creatively find supports to meet child's

	or not well managed for basic needs			needs—have a strong sense of community options. ☐ Family is able to meet their basic needs either on their own or from their community.
	Unemployment of caregiver	YES ☐	☐ Acquire basic skills to seek employment	☐ Caregiver is proactive in looking for jobs opportunities ☐ One of the caregivers is employed
	Caregiver disconnected from own extended family	YES ☐	☐ Enhance family support systems through organizing family conference or providing family counselling sessions	☐ Members of the extended family are willing to attend the family conference ☐ there is some extended family support and caregiver can reach out to find family members who can provide relief
	Caregiver isolated form community social support	YES ☐	☐ Reduce personal and family isolation and increase family, faith-based and community support systems through family conference and community networking	☐ Members of the community are willing to attend the family conference ☐ The community has resources available to support the caregiver

This research illustrates the findings of a retrospective analysis on 73 Family Group Decision Making (FGDM) conferences conducted in Nairobi (Kenya) between July 2005 and January 2008 to investigate the short, medium and long terms conference outcomes on safety, permanency and wellbeing of children exited from institutional public services.

The outlined risks profile of the experimental group provides a useful guide to practitioners to assess some of the salient risk factor accumulations which relate to child vulnerability.

In response to it, the family conferencing model is introduced as an innovative and effective reintegration practice for families involved with the public child welfare agency to move beyond the metaphor of the child protection pendulum still swinging unevenly in Kenya towards institutional care. The study shows how children exited from the Nairobi Children Remand Home through a conference experienced high rates of family reunification, lower rates of relapse and a 20% higher long term successful permanency compared with the control group. These findings generally remained stable as long as 24 to 54 months post-conference.

The Family Conferencing

Diego Ottolini