TREATMENT OF JUVENILE OFFENDERS INVOLVED IN ALCOHOL AND DRUG ABUSE AT JUVENILE REHABILITATION INSTITUTIONS IN KENYA: SUCCESS OR RECIDIVISM

Beth N. Wambugu, PhD
Moi University
Kenya

Kinyua Joice
Karatina University
Kenya

Carolyne W. Kamau, PhD
Moi University
Kenya

A regional survey on alcohol and drug abuse among persons with disabilities established that they were abusing alcohol and drugs as much as the general population. Juvenile offenders are a category of persons with disabilities in Kenya. Children with special needs elicit empathy; on the contrary, offending children are blamed for their actions, leading to a spiral of exclusions. For instance, the study on 'alcohol and drug abuse among persons with disabilities in Kenya' excluded juvenile offenders in their sample. There is a need therefore to study some aspects of alcohol and drug abuse among children identified as juvenile offenders. The objectives of the study were to find out the number of children abusing alcohol and drugs, the treatment offered, and effectiveness of the treatment. The study involved children and service providers drawn from four institutions. Mixed research approach was utilized. The research established that 17.7% abused alcohol and drugs; they received no specific treatment, and the levels of recidivism were high. The study recommends the creation of exit strategies that support and prevent recidivism; enhancement of capacities of service providers at rehabilitation institutions, and policies facilitating proactive post-institutional lives.

Keywords: Juvenile offenders, persons with disabilities, alcohol and drug abuse, treatment, rehabilitation

A regional survey on alcohol and drug abuse (ADA) among persons with disabilities (PWD) by Kathungu, Mwaura, and Wambugu, (2013) established that PWD were abusing drugs as much as the general population. Juvenile offenders

are a category of PWD. According to the United States Department of Justice (2015) and the Government of Kenya (GoK) (2001) juvenile offenders are children below the age of eighteen years who perform criminal acts, often referred to as juvenile delinquency or offences. Normally, the sight of children with special needs elicits empathy and the willingness to help. On the contrary, offending children carry the burden of being blamed for their actions, based on the assumption that they can control their behaviors; this results in a spiral of exclusions. For instance, Kathungu et al. (2013) excluded juvenile offenders in their sample of PWD albeit the fact that some of the children are committed to rehabilitation institutions due to ADA.

According to Gargiulo (2012) and Kerr and Nelson (2010), many children stop offending when properly rehabilitated. Moreover, according to Kaba (2010) and Kauffman and Landrum (2009) the crime rate among youth and children including ADA has been on the rise in many countries despite the presence of juvenile rehabilitation programs. This increased offence rate raises doubts on the effectiveness of the current juvenile rehabilitation programs.

Furthermore, earlier studies by Mugo (2004) and Kinyua (2004) reveal that juvenile offenders are mishandled, resulting in low self-esteem in children, recidivism and frustration among service providers. The American Heritage Dictionary (2015) defines recidivism as a tendency to relapse into a previous condition or mode of behavior, after individuals have undergone or received treatment or rehabilitation for the condition or behavior.

Other studies show that the current rehabilitation institutions have undergone many unaudited reforms and changes (Kathungu, 2010). The researcher also observed that the rehabilitation institutions and their managing departments had undergone cyclic oscillations between various government ministries of education and social services among others over the years. This bogged down to the question on the function of the institutions and their effectiveness. There were therefore many research gaps necessitating a study to clarify varied aspects of ADA among children identified as juvenile offenders and undergoing rehabilitation.

OBJECTIVES

The objectives of the study were:

1. To find out how many children are committed to rehabilitation institutions due to ADA;
2. To establish the kind of treatment offered at rehabilitation institutions to children involved in ADA; and
3. To establish if the treatment was successful in deterring recidivism.

METHODOLOGY

Based on Creswell (2012) a mixed method research approach that engaged aspects of phenomenology and survey research designs was utilized. Three data collection tools comprising questionnaires, interviews and focus group discussions were used in data collection. Validity and reliability of the research tools was assured through a pilot study at a rehabilitation institution that was not involved in the main study and prior to the actual study.

The study populations were children undergoing rehabilitation in the nine public juvenile rehabilitation institutions and their service providers. Out of the nine rehabilitation institutions, four (44.4%) institutions were sampled purposively based on their function and gender. A sample of ninety children and forty eight service providers were drawn from the four rehabilitation schools.

The study utilized a mix of stratified, purposive, and random sampling procedures. Children were drawn from the strata that were classes attended after which purposive sampling was employed to select children committed for being in conflict with the law, leaving out the children committed for care and protection. Managers were selected purposively. Other members of staff were randomly selected based on the officer on duty at the time of the study. In addition, policy documents were analyzed to find out the recommended methods of juvenile rehabilitation, The total distribution of respondents within the four rehabilitation institutions is presented in Figure 1.

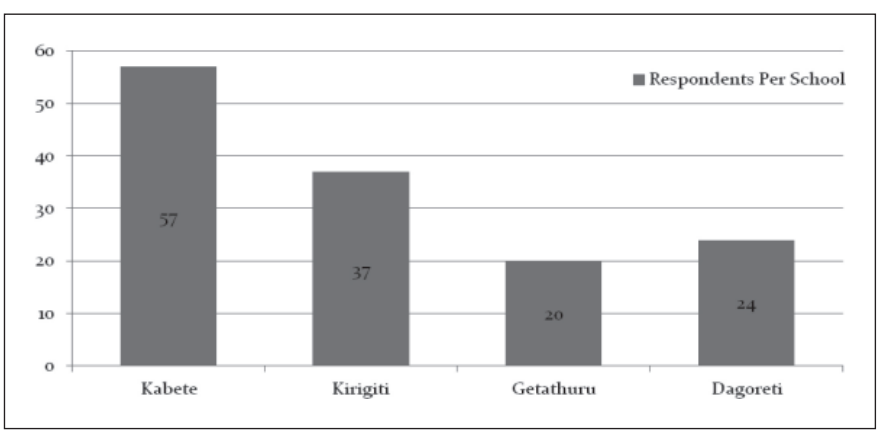

Figure 1. Total number of respondents per rehabilitation institution.

The total number of respondents varied in each institution because 20% sample of all children committed for juvenile delinquency were selected. Kabete boys' rehabilitation institution had the highest number 57 (41%), followed by Kirigiti girls' rehabilitation institution 37 (27%). Dagoreti girls' rehabilitation

institution ranked third with 24 (17%) respondents while Getathuru boys' had the least number of respondents at 20 (15%). Generally, all the rehabilitation institutions were well represented.

Capacity Levels of Personnel at Rehabilitation Institutions

Professional qualifications gauge the capacity levels of the personnel delivering services at rehabilitation institutions. This measure establishes whether the personnel have the relevant prerequisite skills, knowledge, and qualifications for assessing and rehabilitating children involved with ADA. The professional qualifications as reported by the rehabilitation personnel are presented in Figure 2.

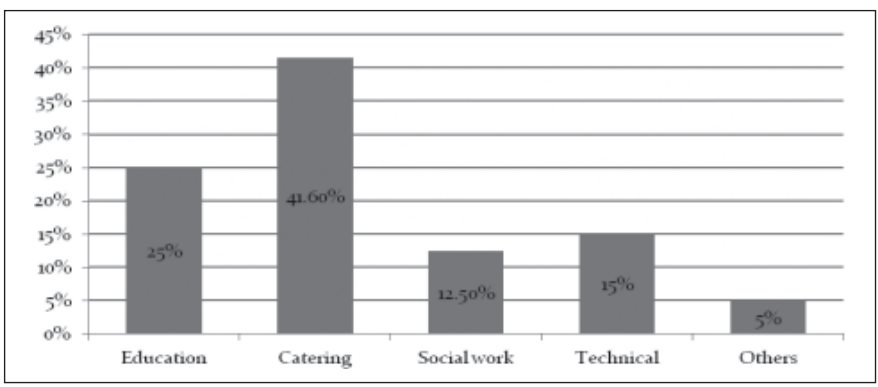

Figure 2. Distribution of staff members by profession.

The findings in the bar chart in Figure 2 indicate that the majority or 23 (47.9%) of the rehabilitation personnel were qualified in catering and 12 (25.0%) of the staff had qualifications in education. Another 6 (12.5%) were qualified in technical areas such as computer and hairdressing, while 5 (10.4%) of the staff had social work qualifications. Two (4.2%) of the staff had secondary education. These findings indicate that most of the rehabilitation personnel were professionals in hospitality and culinary work and therefore lack skills and qualifications in behavioural sciences, which are necessary for ADA rehabilitation.

RESULTS

One hundred and thirty eight respondents participated in the study. The following were the research findings presented based on the research objectives.

Children Committed to Rehabilitation Institutions Due to Alcohol and Drug Abuse

The children described how they found themselves at rehabilitation institutions during focus group discussions. Their responses were analyzed thematically and categories of the offences committed by children emerged. Application of descriptive statistics determined the frequencies of each category of offence. The findings are presented in Figure 3.

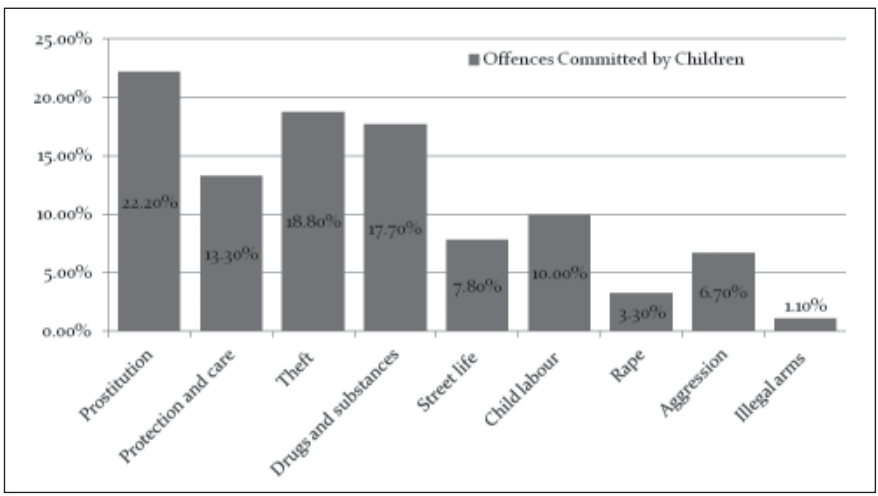

Figure 3. Offences committed by the children in rehabilitation schools.

The research established that although ADA was a lesser cause for committal of children to rehabilitation institutions, it was responsible for committal of 16 (17.7%) of the 90 sampled children. It rated third cause of committal after prostitution (22.2%) and theft (18.8%). This indicates that close to 20% of children in conflict with the law were involved with ADA. Furthermore, although the research did not investigate the connection, there are possibilities that some of the children committed for prostitution may have encountered ADA, and therefore ADA as a cause of committal would score higher. Moreover, the identified ADA cases were serious because they had caused a child to miss regular schooling. The study proceeded to find out the treatment given to the children.

Treatment of Children Involved in Alcohol and Drug Abuse at Rehabilitation Institutions

The research established that there is no curriculum for juvenile rehabilitation in Kenya. This implies absence of recommended method of treatment of children

involved in ADA. This is in spite of policy recommendations for development of curriculum for all categories of learners with special needs (GoK, 2003; National SNE policy framework, 2009). In particular, recommendation 7.10 of the GoK (2003) in part demanded that the Special Needs Education division at the Kenya Institute of Curriculum Development undertake the development of syllabuses for specialized areas of special needs for immediate implementation including for Emotional and Behavioral Disorders which comprise child offenders. The document review clarified that there is no curriculum of juvenile rehabilitation more than a decade since the call for curriculum development. In the absence of a curriculum, the researcher sought to establish the mode of ADA rehabilitation offered to child offenders.

During focus group discussions, children negotiating life at rehabilitation institutions volunteered the following content of rehabilitation analyzed and presented thematically. The first was attending primary school academic work, done by all children between 8.15am and 12.30pm, regardless of whether a child was in secondary school at the time of committal. The second type of content was working at farm, kitchen, splitting firewood, and any other assigned places at the rehabilitation institutions. The third content of juvenile rehabilitation mentioned by children was vocational training. Most children were enthusiastic as they boasted about the certificates they had acquired for completed vocational courses.

The fourth content of rehabilitation given by the children came under rehabilitation activities. This included dancing, livestock farming and counseling. The children appreciated the first two; they however complained that there was no counseling going on in the school. Some children were unhappy with the rehabilitation programs and complained that they were not offering skills for behavior change as presented in the following sentiments of a girl undergoing rehabilitation at Kirigiti School on 18th January 2012:

> "*They say that we have counseling services here, and it's even on our timetable. Yet, we spend all the counseling time singing in the Dining Hall, on our own. Can people really be counseled in a hall?*"

The information from children implies that the variety of vocational courses offered constitute rehabilitation content. The research findings further point to a lack of guidance and counseling programs at rehabilitation institutions. According to the rehabilitation managers and children's officers, rehabilitation programs occur in the afternoons. They said the recommended methods include guidance and counseling, pastoral, vocational skills training, farming activities, music and dance/drama, discussions, games and sports (on alternate days).

The managers and children's officers expounded their responses saying that the recommended methods rarely applied due to lack of qualified staff. This information corresponds with information of capacity levels of rehabilitation personnel (Figure 2), showing that none of the staff members was a qualified

counselor. Furthermore, the responses from other rehabilitation personnel gave a wide variety of methods, which may be an indicator of uncertainty on methods of rehabilitation used. The rehabilitation methods mentioned by the service providers are listed in Table 1.

Table 1
Methods of Rehabilitation Mentioned by Staff Members

Methods for Rehabilitation	Frequency of mention (x)	Percentage of mention (x/40 * 100) (%)
Guidance and counselling	14	35.0
Role modelling	3	7.5
Making follow-up strictly	7	17.5
Making decisions with children	4	10.0
Sports and games	10	25.0
Following the ITP	7	17.5
Establishing classroom norms	2	5.0
Punishment	4	10.0

The staff members mentioned a variety of recommended rehabilitation methods as shown in Table 1. The findings shows that 14 (35.0%) of the forty staff members mentioned guidance and counseling. Sports and games were mentioned 10 (25.0%) times, while making strict follow-up and following the individual treatment plan were mentioned by 7 (17.5%) each. Other methods for rehabilitation mentioned included involving children in decision making and punishment, which were mentioned by 4 (10.0%) each, role modelling 3 (7.5%), and establishing classroom norms which was mentioned by 2 (5.0%).

Success versus Recidivism among Graduates of Rehabilitation Treatment Programs

Information on levels of recidivism was gathered from children undergoing rehabilitation at the time of the study. The children were asked whether they had been committed to a rehabilitation institution before the current committal. This question was meant to generate information on the levels of repeat offenders in Kenya. The children's responses were collected through focus group discussions involving about 7 children each. Results are shown in Table 2.

Table 2
Levels of Recidivism among Children Undergoing Juvenile Rehabilitation

Rehabilitation School	Total (Children)	Recidivists	Percentage (%)
Kirigiti	24	8	
Dagoreti	12	5	
Total Girls	36	13	14.40
Kabete	44	13	
Getathuru	10	5	
Total Boys	54	18	20.00
Grand Total	90	31	34.40

The results in Table 2 show that both girls and boys rehabilitated through public institution had a high level of recidivism. The average level of recidivism was (34.4%) among rehabilitation graduates. This means that more than a third of the rehabilitation graduates became recidivists. The study concluded that although a large number (65.6%) of rehabilitation graduates were successful as shown in Figure 4, there was high level of recidivism. This is important because a few individuals abusing alcohol and drugs or otherwise can make a large region unsafe.

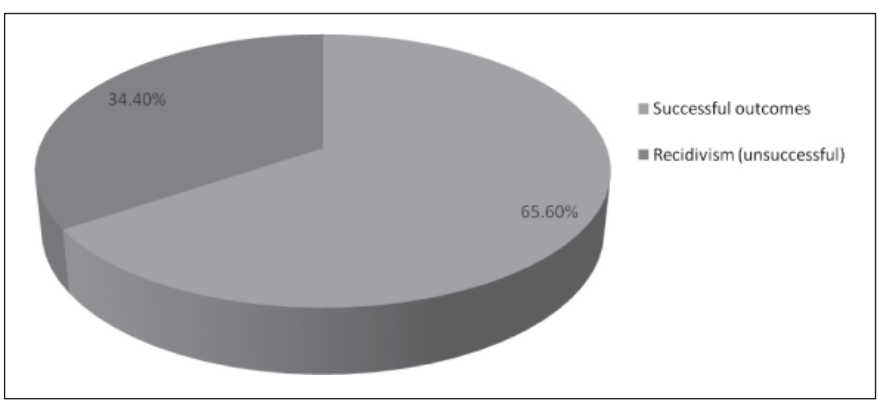

Figure 4. Success versus recidivism of juvenile rehabilitation outcomes.

Watt (2006) observed that the level of recidivism is a major factor that can be used in determining the success of a rehabilitation program and hence its efficiency. A level of recidivism that exceeds a third may be considered very high considering that only a small number of offenders are required to make a society unsafe and that these children are released into society to continue offending,

probably to eventually graduate to hardened criminals, and to ultimately find themselves committed to adult jails.

RECOMMENDATIONS FROM THE STUDY

Based on the findings, the study made the following recommendations to the relevant stakeholders:

The first recommendation goes to The National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA). In collaboration with the Department of Children, NACADA should provide or facilitate ADA in-services training to the service providers on methods of rehabilitation for ADA, to build capacities of service providers for rehabilitation of children involved with ADA.

Secondly, the Kenya Institute of Curriculum Development should develop a specific curriculum for the variety of children processed through rehabilitation institutions. It should be learner centered and enhance exit strategies.

Thirdly, the rehabilitation institutions should create exit strategies that offer support programs and follow-up to prevent recidivism and relapse of ADA. This would include skills for social competence that enable exit candidates to say NO to ADA. This will however depend on the first recommendation.

Fourthly, the ministry of youth should develop a policy on employment bureaus/agencies for youth. The rehabilitation institution can link its graduates to the employment bureaus/agencies to deter recidivism; this is applicable based on the age of the child exiting rehabilitation care.

RECOMMENDATIONS FOR FURTHER STUDIES

The study found that methods of ADA rehabilitation are lacking in rehabilitation institutions though they are mandated to change behavior of children committed for ADA. Today, there are many licensed ADA rehabilitation institutions in Kenya. The study recommends an audit of these ADA rehabilitation institutions to establish the programs they employ and the rates of success versus recidivism of their graduates. This will capture the best practices, which less successful institutions can employ.

This study found that the current juvenile rehabilitation programs leave a large window for recidivism to occur in post-institutional lives of their graduates. In particular, this study found that more than a third of rehabilitation graduates were recidivists. A tracer study is needed to establish the post-institutional life trajectories of rehabilitation institution graduates, previously committed for ADA, to establish the push factors for recidivism. This will be the basis for re-emphasis on follow-up strategies for juvenile rehabilitation graduates.

The study also recommends that further research be conducted to establish the number of convicts committed to adult correctional institutions for ADA

related crimes and how many had gone through the juvenile correction centres before.

CONCLUSIONS

Based on the research findings the following conclusions were made. Close to 20% of children committed to rehabilitation institutions are involved in ADA. The majority of the service providers at rehabilitation institutions lack capacities for ADA rehabilitation. There is no curriculum and syllabus of rehabilitation for children involved with ADA and committed to rehabilitation institutions in Kenya. Children receive vocational and academic education in place in rehabilitation programs, and on a few occasion they engage in dancing and farming activities. Guidance and counselling programs exist in the form of recommended methods of rehabilitation; however the methods are not applied due to lack of human capital. There is a high level (more than a third of all rehabilitees) of recidivism of juvenile rehabilitation graduates, which may indicate program ineffectiveness.

REFERENCES

American Heritage Dictionary. (2015). *Dictionary of the English language* (5th Ed.). Boston, MA: Houghton Mifflin.

Creswell, J. (2012). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research* (4th Ed.). Upper Saddle River, NJ: Pearson.

Gargiulo, M. R. (2012). *Special education in contemporary society: An introduction to exceptionality* (4th Ed.). London: Sage.

Government of Kenya. (2001). Kenya Gazette Supplement No. 95 (Act. No. 8). 'The Children Act, 2001'. Nairobi: Government Printers.

Government of Kenya. (2003). (Kochung Report, 2003). A Report of the Task Force on Special Needs Education: Appraisal Exercise. Nairobi: Ministry of Education.

Government of Kenya. (2009). The National Special Needs Education Policy Framework. Nairobi: Government Printers.

Hoge, R. D. (2009). Advances in the assessment and treatment of juvenile offenders. Retrieved from www.unafei.or.jp/english/pdf

Kaba, M. (2010). Offences and Incarceration among Girls and Young Women in Illinois and Chicago. Project NIA and Chicago Taskforce on Violence against Girls and Young Women. Retrieved from www.project-nia.org/doc/project

Kathungu, B. (2010). Relationship between Emotional Intelligence and juvenile offender performance among service providers in rehabilitation schools in Kenya. (Unpublished doctoral thesis, Kenyatta University, Nairobi).

Kathungu, B., Mwaura, L., & Wambugu, B. (2013). Alcohol and drug abuse among selected groups of persons with disabilities in Central, Nairobi, and Coastal Regions of Kenya. Nairobi: unpublished research, Funded by NACADA.

Kauffman, J., & Landrum, T. (2009). *Characteristics of children with emotional and behavioral disorders of children and youth* (9th ed.). Upper Saddle River, NJ: Pearson.

Kerr, M., & Nelson, C. (2010). *Strategies for managing behavior problems in the classroom* (6th Ed.). Upper Saddle River, NJ: Pearson.

Kinyua, P. (2004). A comparative analysis of pupils' self-esteem in selected rehabilitation schools. (Unpublished Master's thesis, Kenyatta University, Nairobi).

Mugo, K. J. (2004). *Juvenile rehabilitation of street children in Kenya: Approaches, quality and challenges*. Piscataway, NJ: Transaction.

United Nations. (1985). Standard Minimum Rules for the Administration of Juvenile Justice. (The Beijing Rules).

United Nations. (1989). Convention on the Rights of the Child (1989). UN General Assembly Document A/RES/44/25.

United States Department of Justice. (2015). *Criminal resource manual.* Retrieved from www.justice.gov.usam/criminal-resource-manual