INTERNATIONAL BEST PRACTICES IN THE INTERVENTION OF LIVES OF HOMELESS MOTHERS – A SYSTEMATIC REVIEW

Sunette Luther
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Prof. Dee Smythe

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See http://www.knowledgeco-op.uct.ac.za or
Contact us at know-op@uct.ac.za / 021 – 650 4415

1 Introduction

Home is a rich concept that embodies comfort, belonging, identity and security. Living on the streets of the Cape Town central business district (CBD) does not embody the concept of *home* and is under no circumstances in the best interests of a child.

There is an estimate of 14 357 homeless people in Cape Town.[1] Among these homeless people are homeless mothers and children.

Homeless mothers often struggle with mental health issues and substance abuse, and needless to say the environment is extremely unfavourable for children as they are often malnourished and exposed to substance abuse, gangs, and violence.

This research paper will consider international best practices for intervening in the lives of homeless mothers in order to provide the Cape Town Central City Improvement District (hereinafter referred to as the CCID) with a framework of the most effective intervention models worldwide.

The CCID is a public-private partnership established in November 2000, by local property owners with the vision of keeping the Cape Town CBD a safe, clean, and caring urban environment. A city improvement district (hereinafter referred to as a CID) refers to a specific geographical area, approved by the City Council in terms of section 22 of the Municipal Property Rates Act 6 of 2004 and the Special Rates Area Bylaw (hereinafter referred to as the SRA), in terms of which complementary top-up services are provided in addition to those rendered by the CID's primary partners. The primary partners of the CCID are the City of Cape Town (hereinafter referred to as the COCT) and the South African Police Services (hereinafter referred to as the SAPS). Together with the COCT and the SAPS the CCID offers top-up services in the following areas namely, Safety & Security, Urban Management, and Social

[1] Hopkins. J. Reaper, J. Vos, S. & Brough, G. *The Cost of Homelessness Cape Town* https://homeless.org.za/wp-content/uploads/2021/02/THE-COST-OF-HOMELESSNESS-CAPE-TOWN-_Full-Report_Web.pdf [accessed 2/6/2022].

Development. The CCID also has a Communications department. As a non-profit organisation[2] the CCID operates with its own board of directors and liaises across both the public and private sectors. The aim is to work together to develop, promote and manage the Cape Town Central City. As a result of these efforts, the Cape Town Central City is considered today to be South Africa's most vibrant and safest CBD. The CCID operates in the traditional downtown of the city across an area measuring 1.6km². It stretches from Buitensingel to FW de Klerk Boulevard, and from Buitengracht to Canterbury Street.

2 Method

This study has been conducted by way of a systematic review. Due to the substantial heterogeneity across the designs of the included studies, their populations, interventions, and outcomes, the statistical pooling of the results of the included studies was not attempted, instead, the outcomes of the included studies were synthesised narratively.

Alongside the systematic review, an interview was conducted with the Social Development Manager of the CCID in order to gain a better understanding of the CCID's approach to homelessness intervention for mothers and children.

Upon application, the University of Cape Town Research Ethics Committee granted a Certificate of Approval for Ethical Clearance to conduct the interview.

2.1 Search strategy

The electronic databases SCOPUS, ERIC, EBSCOHost, PsycInfo, and PubMed were used to search for literature on this topic. A grey area literature search was also done on Google and Google Scholar.

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[2] The CCID obtains funding by adding a CCID levy to the rates bill of the residents and business within the specific geographical in which it operates.

2.2 Study eligibility criteria and selection

Pilot intervention studies were included in this systematic review, provided that the studies were published in English, in peer-reviewed academic journals between 2000-2022. Moreover, the studies must have had a sample size between 10-400, must have related to the efficacy of intervention models specifically relating to homeless mothers, children and families (to include caregivers other than mothers) and importantly, I had to have institutional access to the studies through the University of Cape Town (UCT).

The definition of homelessness in the studies was not used as a criterion as there is no single definition for homelessness. (See 3 below).

2.3 Limitations

The limitations of this research paper are that most of the studies were done internationally in first-world countries, nevertheless, this highlights the lack of research on homeless mothers and children in not only third-world countries but Africa specifically. Furthermore, as an individual researcher, I had to review the methodological quality of the studies and extract the data singlehandedly. I did not have another independent reviewer and, as a consequence, I relied heavily on the fact that the studies included were all peer-reviewed and published in academic journals.

3 Homelessness defined

There are considerable variations in the definition of homelessness internationally as every society has different perceptions of individuals or families referred to as homeless.[3] Consequently, a very important starting point for this research paper is the definition of homelessness. Due to the fluidity and relativity of homelessness as a concept, there is no single accepted definition of what constitutes homelessness. The relativist conceptualisation

[3] Springer, S. *Homelessness: A proposal for a global definition and classification* 2000 Habitat International (24) 476.

of homelessness implies that it must be understood across situations, countries, societies, and contexts. The terms roofless, homeless, sleeping rough, houselessness, inadequate housing, shelterlessness, or pavement dwellers do not always cover the same people and sometimes these terms overlap.[4]

There has been much debate regarding the definition of homelessness and the need for a globally accepted definition.[5]

Among third-world countries, the criteria for homelessness vary widely because there appears to be a broad margin of housing inadequacy that cannot easily be assumed to constitute homelessness,[6] for example, slums.[7] The criteria include lifestyles, location, the permanence of occupation, security of tenure, quality, welfare entitlement, and homeless people deprived of welfare. These considerations tend to generate different perspectives on homelessness. For example, in South Africa, when defining homelessness officials of the Gauteng Provincial Housing Department and Greater Johannesburg Metropolitan Council, refer to people without adequate shelter, secure tenure, living in squatter settlements, living in backrooms in townships, and living in slum conditions.[8] They mention cardboard houses in the inner city, occupation of metropolitan open spaces, parks, vacant land with dirt-stained blankets on the corners of high-rise buildings, or occupation of unused buildings (street homelessness).[9] Furthermore, the South African Homeless People's Federation regards shack-dwellers and squatters as homeless people (homeless due to inadequate housing).[10] This wider definition

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[4] Tipple, G. & Speak, S. *Definitions of homelessness in developing countries* 2005 Habitat International (29) 338.

[5] Springer, S. *Homelessness: A proposal for a global definition and classification* 2000 Habitat International (24) 475.

[6] Tipple, G. & Speak, S. *Definitions of homelessness in developing countries* 2005 Habitat International (29) 341.

[7] A residential area with substandard housing that is poorly serviced and overcrowded. Consequently, the environment is unhealthy, unsafe, and socially undesirable.

[8] Tipple, G. & Speak, S. *Definitions of homelessness in developing countries* 2005 Habitat International (29) 343.

[9] Tipple, G. & Speak, S. *Definitions of homelessness in developing countries* 2005 Habitat International (29) 343.

[10] Tipple, G. & Speak, S. *Definitions of homelessness in developing countries* 2005 Habitat International (29) 346.

allows for support of persons living in conditions that in many other countries would not be considered homeless.[11] The quality of housing is an important consideration in Egypt's definition of homelessness.[12] In Ghana, the concept of homelessness sits uneasily within the context of extended family responsibility, but the Ghana Statistical Service accepts that anyone living in a structure with a roof is not homeless.[13] Zimbabwe establishes homelessness according to welfare entitlement. In Egypt people living in marginal housing, institutional housing, and unsuitable housing are regarded as homeless, and as a consequence, these homeless people are entitled to government-provided housing.[14]

There is no doubt that people living on the streets and under bridges are homeless, however, the margin between homeless and inadequately housed is very vague.[15] Consequently, because the CCID operates in the Cape Town Central City, for the purposes of this research paper, I define homelessness as individuals (specifically mothers and children) who for any reason use the outdoors as a place of abode for at least a year, that is to say chronically homeless mothers and children.

3.1 The consequences of homelessness

The inability to secure basic needs results in stress, low self-esteem, social isolation, a sense of failure and rejection, personal inadequacy, loneliness, and feeling helpless.[16] With that being so, it is no surprise that homelessness has various long-term damaging effects on health which include premature mortality, depression, anxiety, higher risk of infections.[17] Other

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[11] Tipple, G. & Speak, S. *Definitions of homelessness in developing countries* 2005 Habitat International (29) 347.

[12] Tipple, G. & Speak, S. *Definitions of homelessness in developing countries* 2005 Habitat International (29) 344.

[13] Tipple, G. & Speak, S. *Definitions of homelessness in developing countries* 2005 Habitat International (29) 344.

[14] Tipple, G. & Speak, S. *Definitions of homelessness in developing countries* 2005 Habitat International (29) 345.

[15] Tipple, G. & Speak, S. *Definitions of homelessness in developing countries* 2005 Habitat International (29) 350.

[16] Rokach, A. *The Lonely and Homeless: Causes and Consequences* 2004 Social Indicators Research (69) 45.

[17] Wickham, S. *Effective interventions for homeless populations: the evidence remains unclear* 2020 The Lancet Public Health (5) 304.

consequences of homelessness include substance abuse issues, violence, parenting stress, conflict, maltreatment, and neglect of children, and behavioural issues in children.[18]

3.3 The CCID's approach to homelessness

An interview was conducted with Ms. Pat Eddy, who has been the Manager of Social Development at the CCID for 14 years. A key part of her role involves developing strategies around homeless people; managing a team of outreach workers (a social worker, an auxiliary worker, and a community worker); establishing and managing partnerships with all three levels of Government, stakeholders as well as NGOs and the community-based partners of CCID.

Ms. Eddy defines homelessness within the context of the CCID as someone who for whatever reason finds themselves living on the streets of the Cape Town CBD. She defines chronic homelessness as being a person being homeless consistently anywhere from 6 months to a year, chronic homeless people (6 months to 25 years) are her biggest concern.

The longer a person lives on the street the more difficult it is to generally help that person off the street. – Ms. Pat Eddy.

According to Ms. Eddy when a homeless person arrives in Cape Town, the CCID is often alerted by SAPS (or one of their other community partners). A member of Ms. Eddy's team will make contact with the homeless person in order to get more information, and then together with the homeless person determine the help they need. In other words, through assessment of the circumstances, the member of Ms. Eddy's team will determine how best to support the person and refer them to one of the CCID's community-based partners. As specified by Ms. Eddy, if the homeless person needs medical assistance, they will be referred to a hospital. Moreover, if the person is unemployed and has lost their house they will be placed in a shelter and assisted in finding employment and earning an income; or if the person is homeless due

[18] Tipple, G. & Speak, S. *Definitions of homelessness in developing countries* 2005 Habitat International (29) 338.

to a specific reason such as abuse, trauma counselling will be arranged for the person by Ms. Eddy's team.

Ms. Eddy's explained that her team temporarily supports homeless persons until they are back on their feet, however, often complex issues such as mental health issues, substance abuse issues, severe trauma within communities such as the complete breakdown of families, violence, and gangs, keep people on the street.

When asked what she would change about the CCID's approach to homelessness Ms. Eddy mentioned the lack of psycho-social services because it is expensive. However, one of the CCID's community partners has secured funding (stipends for 500 homeless people) for an Expanded Public Works Programme (hereinafter referred to as an EPWP).[19] It is a short-term work-based rehabilitation programme (6 months), for chronic homeless people, that not only involves employment and stipends but also psycho-social support groups for substance abuse issues and mental health support. 13 NGOs are collaborating on this project and Ms. Eddy is hopeful that the EPWP will be extended for another two years.

Ms. Eddy's enthusiastically filled me in on a partnership between her team and the Artscape Theatre. 16 chronic homeless people, all of whom suffer from substance abuse and mental health issues were placed on a work-based rehabilitation programme. The homeless people clean the grounds of the Artscape Theatre. Since the programme started in January a large percentage of the 16 homeless people have moved off the streets by securing a place in a shelter or safe space. Their behaviour has improved, and even though they are still abusing substances they know that their substance abuse issues cannot influence their employment, as they only get paid for the hours they work.

Ms. Eddy also briefly touched on the lack of alternative safe spaces because shelters are not necessarily the best option for all homeless people. For example, POD Houses and

[19] One of the South African Government's key programmes aimed at providing poverty and income relief through temporary work for the unemployed.

accommodation in derelict buildings. Moreover, more specialised housing with facilities for homeless people with mental illnesses such as a psychiatric nurse that makes sure that the patients take their medication.

Ms. Eddy is retiring at the end of June 2022, and when I asked about the highlight of her career at the CCID, she referred to the countless partnerships and collaborations with community partners and NGOs throughout her career.

The ultimate success for the CCID is helping homeless people move off the streets. Sustainable solutions for homelessness not only significantly improve the lives of the formerly homeless people, but also improves the Cape Town CBD for residents and business.

4 Results

4.1 The studies selected for review

45 studies were identified for the systematic review through the electronic searches. The study eligibility criteria (2.2) were used to single out 15 studies that were included in this systematic review. One study was done in the United Kingdom (UK), eleven studies were done in the United States of America (USA), one study was done in Mexico, one study was done in Egypt and one study was done in Kenya.

4.2 The homeless interventions

The homeless interventions included mental health interventions,[20] summer school programs for children,[21] environmental behavioural modification programs,[22] evidence-based substance

[20] Tischler *et al Evaluation of a mental health outreach service for homeless families* 2002 Archive of Disease in Childhood (86) 158-163.

[21] Nabors *et al Evaluation of an Intervention for Children Experiencing Homelessness* 2003 Child & Youth Care Forum (32) 211-227.

[22] Hosny *et al Environmental behavioural modification program for street children in Alexandria, Egypt* 2007 La Revue de Santé de la Méditerranée orientale (13) 1438-1448.

abuse treatment programs,[23] housing interventions,[24] case management services,[25] Ecologically-Based Treatment (EBT),[26] supportive services,[27] Family Critical Time Intervention (FCTI),[28] collaborative care intervention,[29] Community Reinforcement Approach (CRA),[30] Motivational Enhancement Therapy (MET), Cognitive Behavioural Therapy (CBT),[31] evidence-based parenting programs[32] and adapted evidence-based Parenting for Lifelong Health (PLH) for Young Children programs.[33]

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[23] Smith *et al Eighteen-Month Follow-Up Data on a Treatment Program for Homeless Substance Abusing Mothers* 2008 Journal of Addictive Diseases (14) 57-72.

[24] Slesnick, N. & Erdem, G. *Intervention for Homeless, Substance Abusing Mothers: Findings from a Non-Randomised Pilot* 2012 Behavioral Medicine (38) 36-48.

[25] Slesnick, N. & Erdem, G. *Intervention for Homeless, Substance Abusing Mothers: Findings from a Non-Randomised Pilot* 2012 Behavioral Medicine (38) 36-48.

[26] Slesnick, N. & Erdem, G. *Efficacy of ecologically-based treatment with substance-abusing homeless mothers: Substance use and housing outcomes* 2013 Journal of Substance Abuse Treatment (45) 416-425 and Guo *et al Housing and Support Services with Homeless Mothers: Benefits to the Mother and Her Children* 2016 Community Mental Health Journal (52) 73-83.

[27] Portwood *et al Examining the impact of family services on homeless children* 2015 Child & Family Social Work (20) 480-493.

[28] Shinn *et al Longitudinal Impact of a Family Critical Time Intervention on Children in High-Risk Families Experiencing Homelessness: A Randomized Trial* 2015 American Journal of Community Psychology (56) 205-216.

[29] Weinreb *et al Managing Depression Among Homeless Mothers: Pilot Testing and Adapted Collaborative Care Intervention* 2016.

[30] Zhang, J. & Slesnick, N. *Substance Use and Social Stability of Homeless Youth: A Comparison of Three Interventions* 2018 Psychology of Addictive Behaviors (32) 873-884.

[31] Castaños-Cervantes, S. *Brief CBT group therapy for Mexican homeless girls* 2019 The Cognitive Behaviour Therapist (12) 1-21.

[32] Armstrong *et al Effects of Brief Parenting Intervention In Shelters for Mothers and Their Children Experiencing Homelessness* 2021 Journal of Child and Family Studies (30) 2097-2107.

[33] Murphy *et al "From analogical to digital": Feasibility, acceptability and preliminary outcomes of a positive parenting program for street-connected mothers in Kenya* 2021 Children and Youth Services Review (127) 1-10.

4.3 The outcomes of the studies

The outcomes of the studies were improved mental health of the homeless families,[34] improved classroom behaviour and school outcomes of the children,[35] improved behavioural and emotional functioning of the children,[36] a decrease in substance abuse,[37] increased housing stability[38] and employment,[39] economically self-sufficient families,[40] reduction in intimate partner violence,[41] improvement of parenting practices[42] and reduced child maltreatment.[43]

The included studies are summarised and set out in *Table 1*, below.

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[34] Tischler *et al Evaluation of a mental health outreach service for homeless families* 2002 Archive of Disease in Childhood (86) 158-163 and Castaños-Cervantes, S. *Brief CBT group therapy for Mexican homeless girls* 2019 The Cognitive Behaviour Therapist (12) 1-21 also Weinreb *et al Managing Depression Among Homeless Mothers: Pilot Testing and Adapted Collaborative Care Intervention* 2016.

[35] Nabors *et al Evaluation of an Intervention for Children Experiencing Homelessness* 2003 Child & Youth Care Forum (32) 211-227.

[36] Nabors *et al Evaluation of an Intervention for Children Experiencing Homelessness* 2003 Child & Youth Care Forum (32) 211-227.

[37] Smith *et al Eighteen-Month Follow-Up Data on a Treatment Program for Homeless Substance Abusing Mothers* 2008 Journal of Addictive Diseases (14) 57-72 and Zhang, J. & Slesnick, N. *Substance Use and Social Stability of Homeless Youth: A Comparison of Three Interventions* 2018 Psychology of Addictive Behaviors (32) 873-884.

[38] Smith *et al Eighteen-Month Follow-Up Data on a Treatment Program for Homeless Substance Abusing Mothers* 2008 Journal of Addictive Diseases (14) 57-72 and Slesnick, N. & Erdem, G. *Intervention for Homeless, Substance Abusing Mothers: Findings from a Non-Randomised Pilot* 2012 Behavioral Medicine (38) 36-48.

[39] Slesnick, N. & Erdem, G. *Intervention for Homeless, Substance Abusing Mothers: Findings from a Non-Randomised Pilot* 2012 Behavioral Medicine (38) 36-48.

[40] Portwood *et al Examining the impact of family services on homeless children* 2015 Child & Family Social Work (20) 480-493.

[41] Guo *et al Housing and Support Services with Homeless Mothers: Benefits to the Mother and Her Children* 2016 Community Mental Health Journal (52) 73-83.

[42] Murphy *et al "From analogical to digital": Feasibility, acceptability and preliminary outcomes of a positive parenting program for street-connected mothers in Kenya* 2021 Children and Youth Services Review (127) 1-10.

[43] Armstrong *et al Effects of Brief Parenting Intervention In Shelters for Mothers and Their Children Experiencing Homelessness* 2021 Journal of Child and Family Studies (30) 2097-2107.

Table 1

Study; Country	Population *n*	Intervention	Baseline	Comparison Follow up in months	Primary Outcome
Tischler (2002), UK.	*n* = 23 families 27 children (16 single mothers)	Mental health intervention. Mental Health Outreach Service (MHOS).	**Baseline** **Parental Mental Health** **Experimental Group** **GHQ Scores** 13.28 **Control Group** **GHQ Scores** 14.95	**6 months** **Parental Mental Health** **Experimental Group** **GHQ Scores** 7.23 **Control Group** **GHQ Scores** 8.85 **Social Dysfunction Subscales** **Experimental Group** Improved 61.1% **Control Group** Improved 52.6% **Children SDQ Scores** **Experimental Group** **Improved on:** **Conduct scores** 42% **Hyperactivity scores** 44% **Emotional scores** 56% **Relationship scores** 44% **Control Group** **Improved on:** **Conduct scores** 32% **Hyperactivity scores** 28% **Emotional scores** 44% **Relationship scores** 20%	Improved mental health of parents and children.

Nabors (2003), USA.	*n* = 122 homeless children 67 boys 55 girls	Summer Program: -Classroom Activities -Recreational Activities -Mental Health Promotion Activities Bracelets were awarded to reinforce positive classroom behaviour such as: -Helping other children -Following Directions Completing work and staying on task -Being a role model for other children -Using anger management skills	**Intervention Group** **Bracelets/week** **1** 7.72 **2** 8.49 **3** 7.52 **4** 8.40 **5** 8.90 **6** 8.62 **7** 8.54 Improved mother's and teacher's reports.	**Alternative Program Group** **Bracelets/week** **1** 6.45 **2** 7.53 **3** 6.41 **4** 7.30 **5** 8.50 **6** 7.16 **7** 7.25		Improved classroom behaviour of homeless children. Improved behavioural and emotional functioning.
Baer (2007), USA.	*n* = 117 homeless adolescents (13-19 years old)	Brief Motivational Intervention (BMI). A method of psychological outreach, a low-threshold, low-demand intervention.	**Baseline** **BMI** **Abstinence** 8.7 **Alcohol use** 5.8 **Marijuana use** 17.4 **Other drug use** 6.4 **Agency Reported Utilization** **Drop-in** 5.5 **Additional services** 0.5 **Youth Reported Utilization** **Other agencies** 11.8	**1 month** **BMI** **Abstinence** 12.4 **Alcohol use** 3.7 **Marijuana use** 13.7 **Other drug use** 4.1 **Agency Reported Utilization** **Drop-in** 6.4 **Additional services** 0.5 **Youth Reported Utilization** **Other agencies** 9.5	**3 months** **BMI** **Abstinence** 11.4 **Alcohol use** 4.5 **Marijuana use** 14.8 **Other drug use** 3.6 **Agency Reported Utilization** **Drop-in 4.4** **Additional services** 0.6 **Youth Reported Utilization** **Other agencies** 8.4	CBT shows no significant and enduring benefit for homeless adolescents.

			TAU **Abstinence** 9.2 **Alcohol use** 4.8 **Marijuana use** 19.1 **Other drug use** 5.6 **Agency Reported Utilization** **Drop-in 6.3** **Additional services** 0.5 **Youth Reported Utilization** **Other agencies** 16.5	**TAU** **Abstinence** 15.6 **Alcohol use** 3.5 **Marijuana use** 13.0 **Other drug use** 2.6 **Agency Reported Utilization** **Drop-in** 6.1 **Additional services** 0.5 **Youth Reported Utilization** **Other agencies 9.5**	**TAU** **Abstinence** 15.2 **Alcohol use** 2.9 **Marijuana use** 13.2 **Other drug use** 3.3 **Agency Reported Utilization** **Drop-in 5.3** **Additional services** 0.4 **Youth Reported Utilization** **Other agencies** 8.3	
Hosny (2007), Egypt.	*n* = 35 street children (7-15 years old)	Environmental Behavioural Modification Programme. 7 main units of education: -outdoors and recreational -heritage and museum -moral and religious -human rights and peace -economic and civic -future and sustainable Camping Fieldtrips Theatre Storytelling Gardening Life-skill activities Animal care	**Baseline** **Independent behaviour** 7.89 **Economic activities** 5.57 **Vocational activities** 3.89 **Responsible behaviour** 4.26 **Social relations** 5.23 **Destructive behaviour** 4.77 **Antisocial behaviour** 1.14 **Rebellious behaviour** 2.77 **Non-trustable behaviour** 1.45 **Withdrawal behaviour** 2.11 **Non-acceptable habits** 5.26 **Psychological and emotional disorders** 7.63	**After Environmental Behavioural Modification Programme.** **Independent behaviour 28.97** **Economic activities 11.46** **Vocational activities 9.23** **Responsible behaviour 12.23** **Social relations 15.09** **Destructive behaviour 16.94** **Antisocial behaviour 5.23** **Rebellious behaviour 9.91** **Non-trustable behaviour 5.23** **Withdrawal behaviour 8.29** **Non-acceptable habits 19.31** **Psychological and emotional disorders 24.09**		Improved behaviour.

Smith (2008), USA.	*n* = 149 homeless mothers	Substance abuse treatment program.		**Baseline**	**6 months**	**12 months**	**18 months**	
	Residential treatment group (living at the Family Centre) *n* = 67	-Grace Hill's settlement house philosophy of strengthening neighbours so that neighbours help each other.	**RTG**					Improvement in drug use and housing stability regardless of time spent in the program.
			Alcohol Use	0.13	0.12	0.16	0.18	
			Drug Use	0.17	0.10	0.09	0.07	
			Housing stability	0.11	0.20	0.39	0.20	
			Employment	0.92	0.89	0.85	0.84	
	Non-residential group (attended during the day but lived elsewhere, in precarious, temporary living spaces) *n* = 85	-Traditional recovery services drawing on the 12-step approach in the context of group therapy. -Yablonsky's theory of a therapeutic community in which addicts act as co-therapists.	**NRTG**					
			Alcohol Use	0.13	0.17	0.18	0.16	85% dropout rate.
			Drug Use	0.17	0.07	0.06	0.07	Dropout rate lower among RTG.
			Housing stability	0.11	0.25	0.34	0.29	RTG = Successful substance abuse treatment.
			Employment	0.85	0.85	0.81	0.79	Improve retention rates = additional gains.
Slensick (2012), USA.	*n* = 15 homeless mothers and their 2- to 6-year-old children	Housing, case management services, evidence-based substance abuse treatment.		**Baseline**	**3 months**	**6 months**		Housing stability, improved mental health, higher employment rates, less child behavioural problems.
			Housing (% days homeless past 3 months)	75.5%	20.9%	7.8%		
			Substance abuse (% days substance use past 3 months)	48.8%	18.9%	33.7%		
			Mental Health:					
			SF Mental Health Composite Score	36.6	43.8	45.5		
			BDI (Beck Depression Inventory) Depressive Symptoms	24.6	22.9	22.9		
			Employment (% workdays past 3 months)	10.5%	6.1%	6.1%		
			Child Behavioural Problems:					
			CBCL (Child Behaviour Checklist) Internalizing behaviour	10.8	9.5	6.5		
			CBCL Externalising behaviour	18.8	13.2	9.2		
			Interpersonal Stress:					
			PSI Parenting stress	90.8	92.4	91.8		
			WEB Total Battering	24.0	19.0	19.02		
			Women experiencing battering	8	5	4		

Study	Participants	Intervention	Outcome	Baseline		3 months		6 months		9 months		Findings
				EBT	**TAU**	**EBT**	**TAU**	**EBT**	**TAU**	**EBT**	**TAU**	
Slesnick & Erdem (2013), USA.	$n = 60$ homeless mothers with young children (2-6 years old) in their care EBT $n = 30$ TAU $n = 30$	Ecologically-Based Treatment: -rental and utility assistance -case management services -substance abuse counselling. Usual Care: -Housing and services through the family shelter and community housing programs.	**Resided in own apartments**	29	25	74	33	83	60	62	60	EBT showed a quicker decline in alcohol frequency and a quicker increase in housing stability. With supportive services, 2/3 of the women were successful in maintaining their apartment for 6 months after rental assistance ended. 100% of the participants completed the follow-up assessments.
			Alcohol use	22	38	6	15	7	20	8	5	
			Drug use	74	53	43	41	31	30	40	44	
			Consequences of substance use (Score by treatment condition)	12	11	7	8	5	6	5	6	

Study	Sample	Intervention	Measure	Baseline to 6 months: Time 1	Baseline to 6 months: Time 2	Baseline to 12 months: Time 1	Baseline to 12 months: Time 2	Baseline to 12 months: Time 3	Conclusions
Portwood (2015), USA.	*n* = 370 127 adults 244 children (0-18 years old) 109 families PSS: Perceptions of Social Support PSI: Parenting Stress Index	Housing and supportive services.	**Perceived family conflict**	50.19	49.77	51.14	50.63	50.75	Significant improvement in the economic self-sufficiency of families. Significant improvement in externalising and internalising behaviour. Reduction of the risk of homeless students falling further behind their peers academically.
			PSS-family	11.51	11.63	12.93	12.79	12.71	
			PSS-friends	12.23	12.60	11.32	11.36	11.68	
			PSI-Parental Distress	42.15	43.05	42.60	42.00	42.52	
			PSI-Parent Child Dysfunction	51.07	51.58	50.71	51.64	50.00	
			PSI-Difficult Child	47.86	46.81	46.58	46.08	44.31	

Study	Sample	Intervention	Measure	**Baseline** FCTI	**Baseline** CG	**3 months** FCTI	**3 months** CG	**9 months** FCTI	**9 months** CG	**15 months** FCTI	**15 months** CG	**24 months** FCTI	**24 months** CG	Conclusions
Shinn (2015), USA.	*n* = 200 newly homeless families (Mothers with diagnosable mental illness or substance abuse problems)	Family Critical Time Intervention (FCTI): housing and structured time-limited case management to connect shelter leaving families with community services.	**Externalizing behaviour**	**54**	**54**	**53**	**53**	**52**	**53**	**51**	**53**	**50**	**53**	Decline in self-reported school troubles children (6-10 &11-16 years old). Improved mental health and school outcomes for children experiencing homelessness.
			Probability of school trouble			**0.42**	**0.42**	**0.27**	**0.41**	**0.15**	**0.39**	**0.06**	**0.37**	

Guo (2016), USA.	*n* = 60 homeless mothers	Ecologically-Based Treatment (EBT): -independent housing and integrated support services. Treatment as usual (TAU): -community-based housing and support services.		**Baseline**		**3 months**		**6 months**		**9 months**		Reduction in children's behavioural problems. Reduction in mothers' mental health problems and intimate partner violence.
				EBT	**TAU**	**EBT**	**TAU**	**EBT**	**TAU**	**EBT**	**TAU**	
			BDI-*II* total (Beck Depression Inventory-*II*)	23.43	**23.23**	**15.03**	**13.63**	**14.63**	**14.91**	**13.21**	**13.37**	
			CBCL (Child Behaviour Checklist)									
			Internalising	14.97	**13.86**	**8.43**	**10.91**	**8.20**	**11.57**	**9.21**	**11.96**	
			Externalising	20.10	**19.34**	**14.48**	**15.92**	**12.60**	**15.78**	**13.31**	**15.83**	
			PSI/SF total (Parenting Stress Index-Short Form)	85.87	**88.00**	**78.14**	**75.33**	**74.43**	**84.39**	**71.03**	**78.46**	
			SES (general Self-Efficacy Scale)	62.10	**61.27**	**66.30**	**67.21**	**67.66**	**64.43**	**67.45**	**66.50**	
			SF-36 PCS (Physical Component Summary)	63.41	**61.94**	**64.12**	**62.10**	**66.52**	**62.63**	**68.08**	**61.99**	
			SF-36 MCS (Mental Component Summary)	39.50	**39.30**	**46.77**	**46.29**	**48.43**	**49.00**	**49.72**	**49.67**	
			WEB total (Women's Experience with Battering Scale)	27.17	**24.75**	**19.72**	**18.42**	**19.50**	**19.70**	**16.17**	**16.50**	
Weinreb (2016), USA.	*n* =123 of 328 women screened for depression. *n* = 67 women enrolled in the intervention. *n* = 56 usual care women.	Collaborative care intervention. -Leadership engagement -Proactive outreach by case managers -enhanced patient self-management -use of clinical decision-making tools	Intervention group women (67) **3 months** 40% (receiving depression treatment) 73.3% (anti-depressants) 74.3% (primary care physician) 91.4% (care manager visits) **6 months** 46.75% (primary care physician) 70% (care manager visits)			Usual care women (56) **3 months** 5.9% (receiving depression treatment) 5.9% (anti-depressants) 53.3% (primary care physician) 26.7% (care manager visits) **6 months** 23.5% (primary care physician) 17.7% (care manager visits) **Depression symptoms improved 50% or more:** Intervention group: 30% Usual-care group: 5.9%						Improved mental health of homeless mothers.

<table>
<tr>
<td>Zhang & Slesnick (2018), USA.</td>
<td>n = 270
(14-20 years old)

CRA n =93
MET n = 86
CM n = 91</td>
<td>Community Reinforcement Approach (CRA).
Motivational Enhancement Therapy (MET)
Case Management (CM).</td>
<td>Substance Use

Baseline 61.84
CRA 59.90
MET 68.16
CM 56.80</td>
<td>Social Stability

Baseline 46.61
CRA 42.76
MET 38.55
CM 58.15</td>
<td>Substance Use

3 months
CRA 53.60
MET 45.67
CM 49.38
6 months
CRA 39.10
MET 48.88
CM 42.64
12 months
CRA 39.59
MET 50.72
CM 45.76</td>
<td>Social Stability

3 months

CRA 65.80
MET 75.83
CM 76.67

6 months
CRA 81.88
MET 99.10
CM 100.98

12 months
CRA 103.53
MET 101.90
CM 101.60</td>
<td>Decreased substance use and increased social stability.</td>
</tr>
<tr>
<td>Castaños-Cervantes (2018) Mexico.</td>
<td>n = 84 homeless girls (9-17 years old)

CBT n = 42 (intervention group)
Treatment as usual (TAU) n = 42 (control group)</td>
<td>Cognitive behavioural intervention (CBT).

-Scientific principles that research has shown to be effective for a wide variety of psychological problems.</td>
<td colspan="2">TAU Group
Pre-Test

Anxiety symptoms 3.82
Depression symptoms 3.22
Assertiveness 3.36
Subject wellbeing 4.10
Functional emotional regulation strategies 3.42
Dysfunctional emotional regulation strategies 3.12

Post-Test

Anxiety symptoms 3.79
Depression symptoms 3.24
Assertiveness 3.43
Subject wellbeing 3.99
Functional emotional regulation strategies 3.43
Dysfunctional emotional regulation strategies 3.45</td>
<td colspan="2">CBT Group
Pre-Test

Anxiety symptoms 3.68
Depression symptoms 3.17
Assertiveness 3.51
Subject wellbeing 4.08
Functional emotional regulation strategies 3.71
Dysfunctional emotional regulation strategies 3.13

Post-Test

Anxiety symptoms 3.15
Depression symptoms 2.47
Assertiveness 4.36
Subject wellbeing 4.73
Functional emotional regulation strategies 4.38
Dysfunctional emotional regulation strategies 2.57</td>
<td>Decreased symptoms of anxiety and depression. Increased assertive skills, functional emotion regulation strategies, and subjective well-being.</td>
</tr>
</table>

				2 month follow up **Anxiety symptoms** 2.85 **Depression symptoms** 2.28 **Assertiveness** 4.32 **Subject wellbeing** 12.102 **Functional emotional regulation strategies** 4.49 **Dysfunctional emotional regulation strategies** 2.38			
Armstrong (2021), USA.	*n* = 39 homeless mothers residing in a shelter with children aged 2-6 years old	Evidence-based parenting program. Triple P: Positive Parenting Program. -Prevention services -Intensive parenting interventions for high-risk parents -Discussion groups -Training		**Time 1**	**Time 2**	**Time 3**	Significant improvement in mother-reported parenting practices and child behaviour. Decreased maltreatment of children.
			T1 (Pre-Intervention) ECBI (The Eyberg Child Behaviour Inventory) PS (Parenting Scale) BCAP (Brief Child Abuse Potential Inventory)	124.88 105.68 12.25	118.73 96.18 11.50		
			T2 (Post-Intervention) ECBI (The Eyberg Child Behaviour Inventory) PS (Parenting Scale) BCAP (Brief Child Abuse Potential Inventory)		121.68 96.04 11.38	112.76 90.19 10.79	
			T3 (Follow-up) ECBI (The Eyberg Child Behaviour Inventory) PS (Parenting Scale) BCAP (Brief Child Abuse Potential Inventory)	130.28 106.73 12.54		112.68 90.19 11.00	
Murphy (2018), Kenya.	*n* = 30 mothers	Adapted evidence-based Parenting for Lifelong Health (PLH) for Young Children program – participatory methods.	**Baseline** **PARYC** **Supporting Good Behaviour** 13.95 **Setting Limits** 12.25 **Parental inefficacy** **Physical Abuse** 4.88 **Parental Stress** 8.83	**Post-test** **PARYC** **Supporting Good Behaviour** 22.27 **Setting Limits** 21.89 **Parental inefficacy** **Physical Abuse** 2.00 **Parental Stress** 5.52			Reduced child maltreatment and parental stress and increased positive parenting.

5 Discussion

Overall, the outcomes of the included studies show that the intervention models meet the needs of homeless mothers, children, and families.

MHOS (Mental Health Outreach Services) provide assessment and treatment to homeless families, trains shelter staff, and has a positive impact on families with mental health problems.[44] Collaborative care intervention by a team of mental health professionals who work together on a diagnosis and treatment also improves the mental health of homeless mothers living in shelters.[45] Summer programs implementing behaviour management systems and mental health promotion services significantly improve child behaviour, emotional functioning, and mental health.[46] Family Critical Time Intervention (FCTI) provides housing and structured time-limited case management to connect shelter leaving families with community services and has proved to also be feasible in this regard. Moreover, Cognitive Behaviour Therapy (CBT) is a psycho-social intervention and it is useful in reducing symptoms of anxiety and depression in homeless children as it improves their assertive skills, functional emotion regulation, and subjective well-being.[47] In Egypt, an Environmental behavioural modification program that involves camping, field trips, recreational activities, games, role play, theatre, storytelling, and life skill activities proved to be successful in learning the children new skills and improving their self-esteem and behaviour.[48] With regards to substance abuse, treatment programs involving group therapy, addicts acting as co-therapists, [49] housing and case management had positive outcomes.[50] Furthermore, Ecologically-Based Treatment (EBT) is a home-based, family preservation model that focuses on families who are in crisis because a child has run away from home. EBT was successful in decreasing the frequency of alcohol

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[44] Tischler *et al Evaluation of a mental health outreach service for homeless families* 2002 Archive of Disease in Childhood (86) 158-163.

[45] Weinreb *et al Managing Depression Among Homeless Mothers: Pilot Testing and Adapted Collaborative Care Intervention* 2016.

[46] Nabors *et al Evaluation of an Intervention for Children Experiencing Homelessness* 2003 Child Youth Care Forum (32) 211-227.

[47] Castaños-Cervantes, S. *Brief CBT group therapy for Mexican homeless girls* 2019 The Cognitive Behaviour Therapist (12) 1-21.

[48] Hosny *et al Environmental behavioural modification program for street children in Alexandria, Egypt* 2007 La Revue de Santé de la Méditerranée orientale (13) 1438-1448.

[49] Slesnick, N. & Erdem, G. *Intervention for Homeless, Substance Abusing Mothers: Findings from a Non-Randomised Pilot* 2012 Behavioral Medicine (38) 36-48.

[50] Smith *et al Eighteen-Month Follow-Up Data on a Treatment Program for Homeless Substance Abusing Mothers* 2008 Journal of Addictive Diseases (14) 57-72.

use in homeless mothers, it resulted in increased housing stability amongst homeless mothers,[51] and it reduced behavioural problems in homeless children.[52]

Equally important is family services assisting and supporting homeless parents in their role as caregivers significantly improve the economic self-sufficiency of homeless families.[53] Additionally, Community Reinforcement Approach (CRA) is a comprehensive behavioural treatment approach for people with substance use disorders and is based on the theory of operant conditioning which means that behaviour is shaped by its consequences.

Motivational Enhancement Therapy (MET) is a counselling approach that helps individuals resolve their hesitance about engaging in treatment and stopping their substance use. Both CRA and MET are successful in decreasing substance use and increasing social stability.[54] Lastly, with regards to parenting practices[55] and maltreatment of children evidence-based parenting programs have proved to be advantageous.[56] However, BMI (Brief Motivational Intervention) shows no enduring benefit for homeless children.[57]

These intervention models (excluding BMI) equate to the international best practices in the intervention of the lives of homeless mothers, children and families.

6 Conclusion

This research paper considered the international best practices for intervening in the lives of homeless mothers to provide the CCID with a framework of the most effective intervention models worldwide. The ultimate success for the CCID is helping homeless people move off the streets by means of early intervention and referrals to community-based partners, work-based rehabilitation programmes, and behavioural change programmes. These programmes

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[51] Slesnick, N. & Erdem, G. *Efficacy of ecologically-based treatment with substance-abusing homeless mothers: Substance use and housing outcomes* 2013 Journal of Substance Abuse Treatment (45) 416-425.

[52] Guo *et al Housing and Support Services with Homeless Mothers: Benefits to the Mother and Her Children* 2016 Community Mental Health Journal (52) 73-83.

[53] Portwood *et al Examining the impact of family services on homeless children* 2015 Child & Family Social Work (20) 480-493.

[54] Zhang, J. & Slesnick, N. *Substance Use and Social Stability of Homeless Youth: A Comparison of Three Interventions* 2018 Psychology of Addictive Behaviors (32) 873-884.

[55] Armstrong *et al Effects of Brief Parenting Intervention In Shelters for Mothers and Their Children Experiencing Homelessness* 2021 Journal of Child and Family Studies (30) 2097-2107.

[56] Murphy *et al "From analogical to digital": Feasibility, acceptability and preliminary outcomes of a positive parenting program for street-connected mothers in Kenya* 2021 Children and Youth Services Review (127) 1-10.

[57] Baer *et al Brief Motivational Intervention with Homeless Adolescents: Evaluating Effects on Substance Use and Service Utilization* 2007 Psychology of Addictive Behaviours (21) 582-586.

are amongst the most effective intervention models for intervening in the lives of homeless mothers worldwide however, there are a few other international intervention models that might prove to also be useful for the CCID. Namely, Collaborative Care Intervention in shelters by a team of mental health professionals who work together on a diagnosis and treatment of mentally ill mothers. Moreover, Cognitive Behaviour Therapy (CBT), which is a psycho-social intervention that is useful in reducing symptoms of mental health issues in homeless mothers and it improves the assertive skills, functional emotion regulation, and subjective well-being of children. In addition to that, another practical intervention model is providing housing and structured time-limited case management to connect shelter leaving families with community services and the CCID's community-based partners (FCTI). The aforementioned can be combined with Ecologically-Based Treatment (EBT), a home-based treatment and preservation model, which is successful in decreasing the frequency of alcohol use in homeless mothers, increasing housing stability amongst homeless mothers, and reducing behavioural problems in homeless children. With regards to substance-abusing mothers, Comprehensive Behavioural Treatment (CBT)(behaviour is shaped by its consequences) together with Motivational Enhancement Treatment (MET)(a counselling approach aimed at resolving hesitance to engage in treatment and breaking bad habits) is a feasible option. Lastly, the importance of an intervention model designed specifically for homeless children cannot be over-emphasized. Through an Environmental Behavioural Modification Program homeless children can be taught invaluable new skills which in turn will significantly improve their self-esteem and behaviour. It is important to note that these international intervention models have proved to be feasible in mostly first world countries. They should be assessed from a third world country perspective, more specifically a South African perspective and adapted accordingly.

This systematic review not only highlights the international best practices in the intervention of the lives of homeless mothers, children and families but it also focuses attention on the lack of evidence on which to build intervention models to assist and end homelessness not only for mothers, children, and families but for all homeless persons in Africa. In order to gain ground on homelessness, evidence-based research must be done to develop effective interventions to assist homeless people in Africa. A good starting point is the implementation of international best practices through pilot-intervention studies, as it will determine the needs of the most vulnerable amongst us and allow us to design tailormade homeless interventions that meet the specific needs of homeless people within an African context.

The measure of any society is how the needs of the most vulnerable people are met. Consequently, human dignity must be ensured by providing adequate living conditions for the homeless.

Bibliography:

Books

1. Downer, RT. *Homelessness and Its Consequences: The Impact on Children's Psychological Well-being* 1st ed (2001) Routledge: New York.

Case Law

1. S v M 2008 3 232 (CC).

Electronic Resources

1. Damons, M. *Cape Town to give an additional R10-million to shelters* 4 April 2022 GroundUp https://www.groundup.org.za/article/lack-ablution-facilities-and-shelters-families-among-main-challenges-raised-report-homelessness-cape-town/ [accessed 5/4/2022].
2. Herron, B. *Cape Town's approach to homeless people is cruel and expensive* 1 September 2020 GroundUp https://www.groundup.org.za/article/cape-towns-cruel-and-expensive-approach-to-homeless-people/ [accessed 4/4/2022].
3. Hopkins. J. Reaper, J. Vos, S. & Brough, G. *The Cost of Homelessness Cape Town* https://homeless.org.za/wp-content/uploads/2021/02/THE-COST-OF-HOMELESSNESS-CAPE-TOWN-_Full-Report_Web.pdf [accessed 2/6/2022].
4. Western Cape Government *Homelessness* 2019 https://www.westerncape.gov.za/general-publication/homelessness-0 [accessed 2/6/2022].

Journal Articles

1. Armstrong *et al Effects of Brief Parenting Intervention In Shelters for Mothers and Their Children Experiencing Homelessness* 2021 Journal of Child and Family Studies (30) 2097-2107.
2. Baer *et al Brief Motivational Intervention with Homeless Adolescents: Evaluating Effects on Substance Use and Service Utilization* 2007 Psychology of Addictive Behaviors (21) 582-586.
3. Castaños-Cervantes, S. *Brief CBT group therapy for Mexican homeless girls* 2019 The Cognitive Behaviour Therapist (12) 1-21.
4. Chamberlain, C. & Johnson, G. *The Debate About Homelessness.* 2016 AJSI (36) 35-50.

5. Chamberlain, C. & Mackenzie, D. *Understanding Contemporary Homelessness: Issues of Definition and Meaning* 1992 Australian Journal of Social Issues (27) 274-297.
6. Glick, JE. *Mothers With Children and Mothers Alone: A Comparison of Homeless Families* 1996 Journal of Sociology and Social Welfare (23) 85-94.
7. Guo *et al Housing and Support Services with Homeless Mothers: Benefits to the Mother and Her Children* 2016 Community Mental Health Journal (52) 73-83.
8. Holtrop, K. & Holcomb, JE. *Adapting and Pilot Testing a Parenting Intervention for Homeless Families in Transitional Housing* 2018 Family Process (57) 884-900.
9. Hosny *et al Environmental behavioural modification program for street children in Alexandria, Egypt* 2007 La Revue de Santé de la Méditerranée orientale (13) 1438-1448.
10. Killander, M. *Criminalising Homelessness and Survival Strategies through Municipal By-Laws: Colonial Legacy and Constitutionality* 2019 South African Journal on Human Rights (35) 70-93.
11. Munthe-Kaas, H.M., Berg, R.C. and Blaasvær, N. *Effectiveness of interventions to reduce homelessness: a systematic review and meta-analysis* 2018 Campbell Systematic Reviews (14) 1-281.
12. Murphy *et al "From analogical to digital": Feasibility, acceptability and preliminary outcomes of a positive parenting program for street-connected mothers in Kenya* 2021 Children and Youth Services Review (127) 1-10.
13. Nabors *et al Evaluation of an Intervention for Children Experiencing Homelessness* 2003 Child & Youth Care Forum (32) 211-227.
14. Naidoo, V. *Government responses to street homelessness in South Africa* 2010 Development Southern Africa (27) 129-141.
15. Portwood *et al Examining the impact of family services on homeless children* 2015 Child & Family Social Work (20) 480-493.
16. Rokach, A. *The Lonely and Homeless: Causes and Consequences* 2004 Social Indicators Research (69) 37-50.
17. Shinn *et al Longitudinal Impact of a Family Critical Time Intervention on Children in High-Risk Families Experiencing Homelessness: A Randomized Trial* 2015 American Journal of Community Psychology (56) 205-216.
18. Slesnick, N. & Erdem, G. *Efficacy of ecologically-based treatment with substance-abusing homeless mothers: Substance use and housing outcomes* 2013 Journal of Substance Abuse Treatment (45) 416-425.
19. Slesnick, N. & Erdem, G. *Intervention for Homeless, Substance Abusing Mothers: Findings from a Non-Randomised Pilot* 2012 Behavioral Medicine (38) 36-48.

20. Smith *et al Eighteen-Month Follow-Up Data on a Treatment Program for Homeless Substance Abusing Mothers* 2008 Journal of Addictive Diseases (14) 57-72.
21. Springer, S. *Homelessness: A proposal for a global definition and classification* 2000 Habitat International (24) 475-484.
22. Tipple, G. & Speak, S. *Definitions of homelessness in developing countries* 2005 Habitat International (29) 337-352.
23. Tischler *et al Evaluation of a mental health outreach service for homeless families* 2002 Archive of Disease in Childhood (86) 158-163.
24. Weinreb *et al Managing Depression Among Homeless Mothers: Pilot Testing and Adapted Collaborative Care Intervention* 2016.
25. Wickham, S. *Effective interventions for homeless populations: the evidence remains unclear* 2020 The Lancet Public Health (5) 304-305.
26. Zhang, J. & Slesnick, N. *Substance Use and Social Stability of Homeless Youth: A Comparison of Three Interventions* 2018 Psychology of Addictive Behaviors (32) 873-884.

Legislation

1. The Children's Act 38 of 2005.
2. The Constitution of the Republic of South Africa, 1996.

International Instruments

1. African Charter on the Rights and Welfare of the Child (1999).
2. The United Nations Convention on the Rights of the Child (1990).