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Serviço de Intervenção nos Comportamentos Aditivos e nas Dependências

Executive Summary

Reintegration of People with Addictive Behaviours and Dependencies: processes and results of the application of the social and community mediation model.

Credits

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Planning and Intervention Department

Therapeutic Intervention Division

November 2023

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Introduction

The reintegration intervention that is developed with citizens with addictive behaviours and dependencies (ABD) is aimed above all at developing autonomy and promoting full citizenship. It aims to promote change in order to reverse processes of exclusion and maximise the potential of individuals in a participatory and collaborative process. To this end, we advocate an approach both centred on the person and their environment and based on establishing a relationship of trust between the person and the social worker. In this process, the political-strategic dimension of the intervention model is not a passive variable but is configured in opportunities where the state and civil society play important roles in terms of structuring the socio-political framework and initiative of innovative proposals and projects at national, local and community level.

The aim of this intervention is the development of skills in various areas of life and (re)connecting citizens with ABD with their primary and secondary networks. It is part of a non-linear continuum of care, based on a social diagnosis and planning, linking various stakeholders, from the citizen himself to his family and partner organisations involved. In this process, the intervention is not limited to acting with the person, but goes beyond the individual, encompassing the most relevant social systems, such as the family, companies, and the community, among others.

After the publication of the document *Guidelines for Social and Community Mediation in the Reintegration of People with Addictive Behaviours and Dependencies*[1] , drawn up under the protocol between the General-Directorate for Intervention on Addictive Behaviours and Dependencies, the Faculty of Psychology and Educational Sciences of the University of Coimbra and the five Regional Health Administrations, questions about the applicability of the model became a source of interest. The working group therefore took on the challenge of developing a study that would allow the understanding of the Social and Community Mediation Model (SCM) by cross-referencing the views of the actors involved in the reintegration process.

This working group, experienced in direct action and in coordinating teams and services, became a research team motivated by the desire to build knowledge in an area where there is a gap in scientific production, based on a comprehensive reading of the practice developed in the field. In addition to describing and understanding the conceptual and operational model of social and community mediation constructed by the group, their biggest challenge was to integrate and produce an evaluative reading of the changes at a personal, interpersonal, family and community level that would enable them to present recommendations on social reintegration.

This executive summary presents the main features of the research process and the most significant results but does not exempt the reading of the full report[2] for more detailed analysis of the expression of the various analytical categories and extracts from the interviews.

[1] Almeida, H. e Carvalho, S., et al (2014). Linhas Orientadoras para a Mediação Social e Comunitária no âmbito da Reinserção de Pessoas com Comportamentos Aditivos e Dependências, Lisboa, SICAD. https://www.sicad.pt/BK/Intervencao/ReinsercaoMais/Documentos%20Partilhados/LinhasOrientadorasPara_a_MediacaoSocial_e_ComunitariaNo_ambitoDaReinsercaoDePessoasComComportamentosAditivos_e_Dependencias.pdf

[2] Almeida, H. et al (2020). A Intervenção em Reinserção de Pessoas com Comportamentos Aditivos e dependências: processos e resultados da aplicação do modelo de mediação social e comunitária. Relatório final, Lisboa, SICAD. https://www.sicad.pt/BK/Intervencao/ReinsercaoMais/Documentos%20Partilhados/2021/RelatorioFinal_IntervencaoReinsercaoPessoasComCAD.pdf

1. Brief description of the research project

This research is centred on understanding the applicability of the Guidelines and takes as its central reference facts and perceptions about the contexts, processes, strategies, and results of the social intervention developed in different Local Intervention Units of Regional Health Administrations (ARS) spread across different territorial areas. Insofar as it integrates the knowledge and expertise implicit in professional and personal practices and experiences, from the perspective of both social workers and the different stakeholders involved in the reintegration process, it is a comprehensive study of the specificity of intervention processes and strategies, the particularity of subjects and life contexts, and the diversity of knowledge and results of intervention in the reintegration of people with ABD.

Developed under the prism of qualitative methodologies that centre on the search for links of meaning, and the specification of the comprehensive detail of the facts, this research opted for a mixed case study plan (multi-case and multi-perspective), which combines the descriptive component with the analytical and reflective component. It is based on the study of 18 cases, using documentary research and semi-structured interviews with social workers, citizens with ABD and families (a total of 51 interviews), as well as a survey for partner organisations (a total of 21). This process began in September 2015 with training in scientific methodology, which preceded the preparation of the project, and lasted until the end of 2020, given the complexity of the research design and the large scale of the information collected and analysed.

1.1. Research problem, objectives and methodology

The **research problem**, formulated in the form of starting and guiding questions, is specified as follows:

Guiding Research Question: What are the processes and results of applying the SCM model in professional day-to-day work in the field of reintegration of people with ABD?

Subsidiary questions (for further specification and development of the project):

1. What procedures and results (changes) are associated with the process of reintegrating people with ABD?
2. What limits and potentialities are identified in the intervention developed within the logic of Social and Community Mediation?
3. How are they perceived by the different actors involved in the process?

OBJECTIVES

The **objectives** defined for this research are as follows:

- Identify the factors that make up the diversity of social intervention processes;
- Gain an in-depth understanding of the design and development of social intervention in the reintegration of people with ABD from the perspective of the various actors (subject, family, technicians and partners);
- Identify the social intervention procedures that form part of the SCM model;
- Evaluate the effectiveness of the interventions carried out (changes, limits and potential), from the viewpoint of the perceptions of the various stakeholders.

METHODOLOGY

As far as **methodology** is concerned, this research is essentially qualitative and was developed according to a mixed case study plan (Multi-case Study). It combines statistical and descriptive data on intervention contexts and processes with detailed analyses of intervention in specific situations. The multi-case study therefore includes the descriptive analysis of situations monitored by professionals (anamnesis) based on the collection and processing of data from the Multidisciplinary Information System platform and paper files, and the content of semi-structured interviews carried out with social workers, subjects and families or significant others, as well as surveys of partners involved in monitoring citizens and families. This research strategy proved suitable for analysing the intervention processes linking the pillars and the objectives of the SCM model, as well as the changes (expected and existing), the constraints and the potentialities of the developed action.

SAMPLE

With regard to the **sample**, criteria were defined for selecting the Local Intervention Units (LIUs), the social workers and the subjects to be included in the study. After applying these requirements, the sample consisted of 18 cases, spread across 5 regions (Regional Health Administrations) and 18 LIUs, including Centres of Integrated Response (CIR), Alcohology Units (AU) and Therapeutic Communities (TC).

The research protocol called for three interviews to be carried out for each case: with the social worker who accompanied the process (18)), with the citizen with ABD, who was the target of the intervention (18) and with their family member or significant other (in this case it was only possible to carry out 15 interviews out of the 18 planned). Fifty-one interviews were thus carried out, which content was analysed.

The perspective of the partner organisations was gathered through a survey. It was based on the 18 cases and was applied to various partner organisations that took part of the reintegration process. Twenty-one questionnaires were received from public and private organisations.

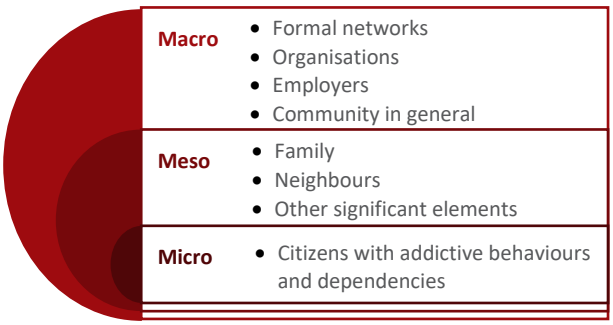
1.2. The Analysis Model

1.2.1. Conceptual model

In order to achieve the objectives of this research, all the information collected was analysed according to the model's intervention levels (micro, meso and macro) and the five pillars of intervention. These two structuring axes were fundamental for organising the information and for understanding the procedures and results observed.

According to the Guidelines for Social and Community Mediation in the Field of Reintegration of People with Addictive Behaviours and Dependencies (Almeida e Carvalho et al., 2014, pg. 22-25), intervention takes place at three levels: micro, meso and macro.

Figure 1. Levels of intervention in the Social and Community Mediation Model



At the **MICRO** level, the intervention focuses on the person with ABD and involves personal mobilisation,

empowerment and the creation of conditions for the exercise of citizenship and participation.

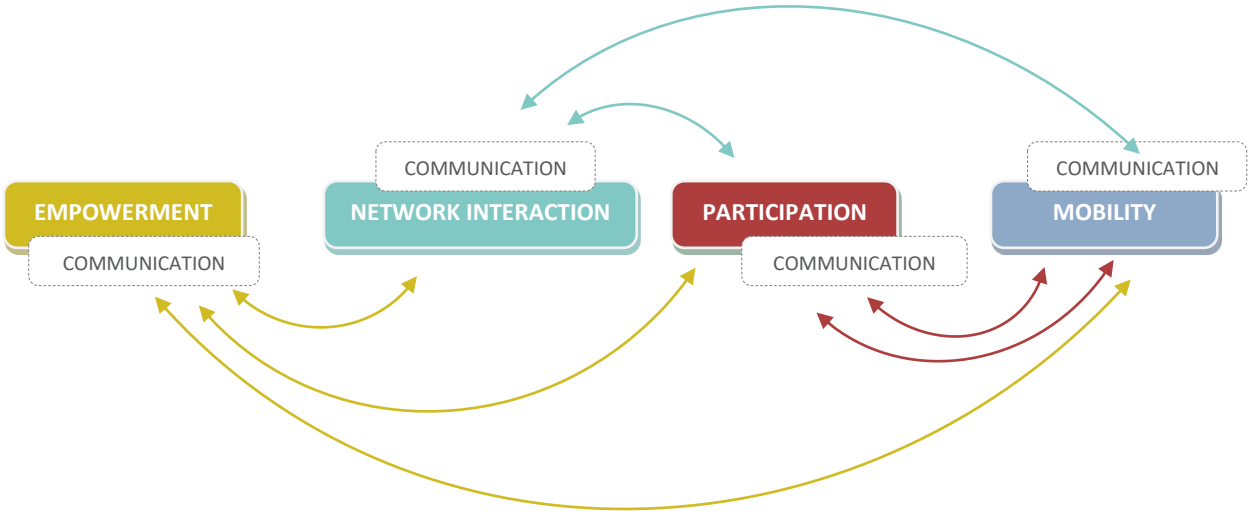
At the **MESO** level, intervention takes place essentially with the family and other significant elements of the immediate environment, as well as at the level of friendships, belonging and reference groups. The aim is for these closer relationships to facilitate the person's integration process.

Intervention at the **MACRO** level involves establishing communication channels and partnerships with different support structures in order to facilitate access to available responses and meet needs.

It is about building a support network for the process of integration of people with ABD, so that, at first, the most pressing needs can be met and, at a later stage, an integration programme defined with the person and the partners involved can be implemented.

Considering that intervention takes place at these three levels (micro, meso and macro) and that each one has different but complementary objectives, common points can be identified in the daily practice of professionals that cut across the various levels: the five fundamental pillars of social and community mediation in the context of reintegration of people with ABD.

Figure 2. Pillars of intervention in the Social and Community Mediation Model



According to the Guidelines for Social and Community Mediation within the Field of Reintegration of People with Addictive Behaviours and Dependencies (Almeida e Carvalho et al., 2014, pg. 27-28), the first pillar is **COMMUNICATION**, understood as a process of sharing and participation in a message in order to make it common to all the actors involved. At the same time, it is an instrument that facilitates the establishment of relationships with others. In the intervention scheme, it is the connecting element between everyone, underpinning all processes and enabling relationships to be regulated.

Individual and collective EMPOWERMENT implies preparation for the acquisition of skills that enable problems to be recognised and solved. In the area of ABD, this is a fundamental concept in the intervention with citizens, their families and social systems, in which awareness-raising, training and information are always present and take on a strategic character in promoting change. It is about developing personal and social skills, aimed at individuals and their families, in order to help change attitudes and behaviours at micro, meso and macro level.

NETWORK INTERACTION of systems takes us back to the concept of networking, which is essential for achieving the objectives established for reintegration. It is a process that fosters a dynamic exchange between different social actors in order to generate synergies that allow for the creation of social alternatives, i.e. new paths to

reintegration. It is based on the need to create and maintain social ties, which are mirrored in the family and the community, by mobilising social and health resources that enable a network of partners with an integrated work culture.

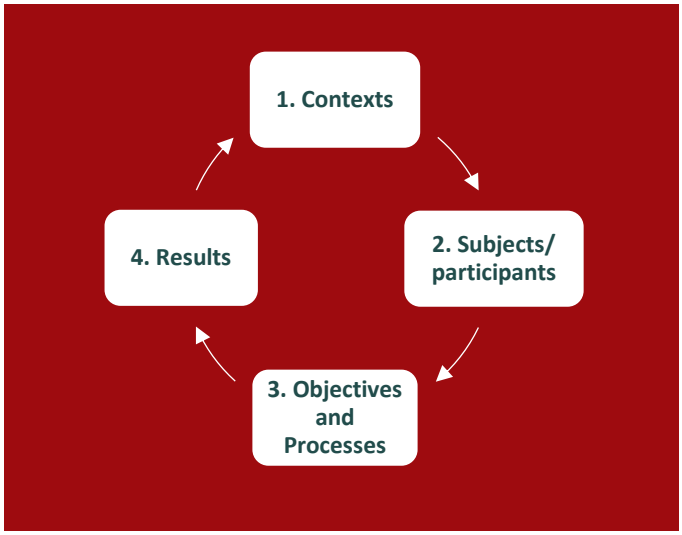
PARTICIPATION, which promotes cooperation and the co-construction of social alternatives is the action based on establishing and implementing commitments in the field of citizenship, which implies the involvement and the responsability of all the actors. It is about co-construction, in which the person with ABD and the surrounding systems mobilises each other. At the individual level, it is the process of co-construction that allows citizenship to be exercised. At the macro level, the mobilisation of the political and economic actors involved makes it possible to manage social risks and make joint decisions.

The main goal of intervention is to achieve **MOBILITY - change of social systems**. This concept, in this context, is based on a transitional movement between individual and collective change aiming to alter the representations associated with ABD. Prejudices and taboos regarding the phenomenon of addiction to psychoactive substances, particularly illicit ones, are a major obstacle to the emergence of opportunities and integration possibilities.

1.2.2. Analytical model

The study focuses on facts and perceptions, is centred on intervention processes and products (results) and takes into account the intersection of 4 analytical dimensions in the context of the reintegration of people with ABD, at micro, meso and macro level (Fig. 3).

Figure 3.Analysis model: Analytical dimensions



1. Contexts	Macro/Political/Community Meso (family) Micro (concrete situations)
2.Participants	Professionals (social workers) Citizens with ABD Family members/significant others Institutional/professional stakeholders
3. Social Intervention objectives and processes	Levels of Intervention Pillars of the SCM Model Objectives of the SCM Model Social Diagnosis Intervention processes and strategies
4. SCM Model Results	Changes that have taken place (individual, social and community) Limits Potentialities

1. The contexts of the research are understood at a macro (political/community context), meso (services that are responsible for social reintegration intervention) and micro level (concrete situations/cases).

2. The subjects participating in the Intervention, namely: ABD social workers, citizens, family members/significant

others and Stakeholders (institutional partners/external professionals)

3. The Objectives and Intervention Processes, considering:

- **Levels of intervention**: Micro Individual level (people with ABD), Meso (primary solidarity networks) and Macro (formal networks, public or private institutions, organisations, employers and the community in general);
- **The Pillars of the SCM Model:** 1 - Communication; 2 - Individual and collective empowerment; 3 - Network Interaction of systems; 4 - Participation that promotes cooperation and the co-construction of social alternatives; 5 - Mobility of social systems.
- **The objectives outlined for each pillar of the MSC model** in the field of the reintegration of people with ABD (at micro, meso and macro level), focussing on the processes and products associated with the development of the practice;
- **The diagnosis with the identification of the factors associated with ABD** presented to the social worker, using the SCM model;
- **The intervention processes and strategies** developed during the intervention process, by pillar of the SCM model.

4. The Results of the Intervention: Changes, limits and potentialities of the SCM model.

1.3 Description of cases: subjects of intervention and object of research in ABD

The cases illustrate situations with unique and complex social contexts, life circumstances and subjective experiences, but where, at the same time, the diversity and specificity of social relationships, ways of life, attitudes and ways of acting intersect and are the mainstay of the intervention of ABD social workers in the Centres of Integrated Responses, Therapeutic Communities and Alcohology Units included in this study.

When the intervention began, the subjects involved in the study had the following characteristics:

- They were mainly men (83 per cent), single (44 per cent), aged between 45 and 54 (67 per cent). Regarding educational qualifications, the majority had a 2nd or 3rd cycle education (67 per cent), and only 39 per cent had some kind of vocational training.
- With regard to their housing situation, 33 per cent lived in a relative's house, cohabiting with their parents and 33 per cent lived alone.
- The vast majority of cases had a history of substance abuse (alcohol or illicit substances) in the family (72 per cent). An equal percentage also had a high prevalence of other associated illnesses, whether mental, physical or both, and only 28 per cent had no comorbidities.
- In terms of sources of income, 44 per cent had no income and 39 per cent lived on social support. Only 17 per cent had a fixed income from work or retirement.
- A large proportion of cases had no legal problems (61 per cent).
- The main substance of consumption was alcohol (61 per cent) and a third of the cases had heroin as the most relevant substance.
- The majority started using substances between the ages of 15 and 24 (61 per cent), with 83 per cent having started consuming before the age of 24.
- Sixty-one per cent had tried more than once to stop using substances without success.

- With regard to the most recent treatment process, its duration is very varied and 28 per cent had been followed up for between 2 and 4 years. However, a third of cases had been followed up for at least 10 years and 17 per cent for 20 years or more, i.e. more than 50 per cent of cases had been followed up for more than 10 years.
- The initiative to seek help and start a treatment process came mainly from the person him/herself (61 per cent).
- In the 30 days prior to the interview, 72 per cent of subjects were abstinent.

The profile of the people who took part in this research shows relevant factors of individual and social vulnerability, with financial dependence, low levels of education, lack of autonomy, comorbidities, long duration of follow-up processes and the existence of other cases of ABD within the family being noteworthy.

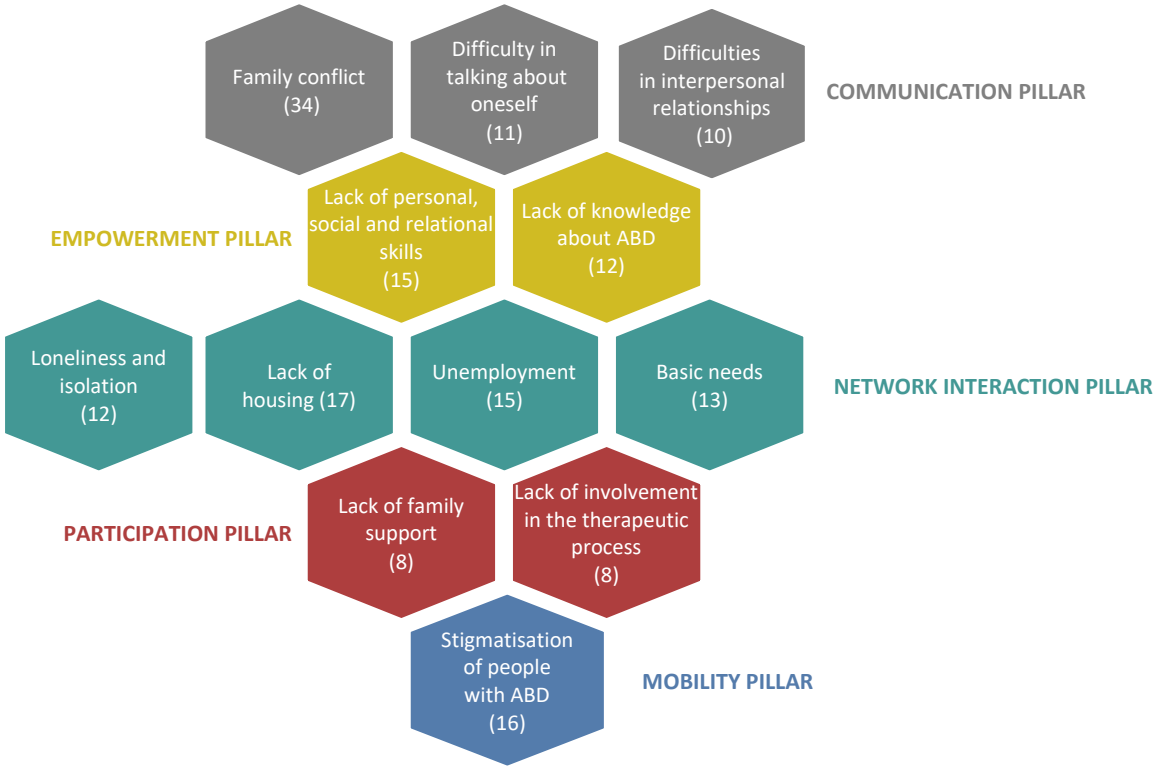
2. Search results

In the final research report, the results obtained by the content analysis of the 51 interviews are presented in an exhaustive and detailed manner, both descriptively and analytically. The description focuses on identifying the categories resulting from the content analysis performed on the interviews with social workers, citizens with ABD and family members or significant others, a total of 728 analytical categories, spread over 11 dimensions and 32.107 references (text extracts). The analysis was guided by the intervention levels (micro, meso and macro) and the pillars of the MSC model, and highlights the contexts, the subjects, the intervention processes, and strategies, as well as the evaluation of the changes that have taken place, translated into the impact of the intervention. Multiple extracts were used as evidence of the main categories and to give voice to the interviewees, the main actors in the studied reintegration processes. In this Executive Summary we have chosen to include a small number of extracts from the interviews, so as not to overload the reading.

The main results of the analysis are presented below, based on three components: the **social diagnosis**, which characterises the situation prior to the intervention and highlights the vulnerability factors of this population; the **intervention**, translated into intervention strategies and processes that were delivered; and finally, the main results achieved, considered to be the **impact** of the intervention. The results obtained led to the formulation of recommendations, which are explained in the conclusion of this document.

1.3. Social diagnosis

Figure 4. Main categories identified in the social diagnosis
(most referenced categories in each pillar of intervention)



Analysing the social diagnosis that was performed on the 18 subjects, the main problems identified are:

- **family conflict** is the most significant category with 92 excerpts in 34 interviews, this being a problem relating to the communication pillar;

"I'm living with my mum. And my sister doesn't agree. What she says is that I should drink water. Do something with my life. My mum always tells her that I need help and that's when she repeats: she should drink water. Jealousy!" (Subject, CIR, C 01)

- the **difficulty in talking about oneself** and the existence of **difficulties in interpersonal relationships** are also problems identified in the communication pillar;

"The subject is a very insecure person, avoidant, he wouldn't talk about himself and didn't want to talk about himself, he avoided talking about himself at all costs, it gave him nightmares, it made him worse." (Social worker, CIR, C 03)

"My mum spoke aggressively to me and as I felt responsible for "correcting her'" I also tried to impose my place and to show her what is best for her." (Family member, TC, C 04)

- a **lack of personal, social and relational skills** of citizens with ABD translates into difficulties in the area of empowerment;

"The subject herself finds it very difficult to restrain, to contain, to tolerate, to be flexible and quickly responds, reacts and this brings her a lot of conflict in her relationship with her neighbours." (Social worker, TC, C 04)

- the **lack of knowledge about ABD**, identified above all among family members and technicians from partner organisations, is the second category with the most references in the empowerment pillar;

"There was a difficulty in dealing with this situation and even understanding it - even with my psychologist's explanations trying to explain what this addiction thing is, what this problem is, that it's a disease, my parents can't understand that it really is a disease. What they think is the person who consumes - does it because they want to and doesn't leave it because they don't want to and that it's a question of willpower." (Subject, TC, C 14)

- **unemployment, lack of housing**, difficulties in accessing **basic and subsistence needs** and **loneliness and isolation** are needs that call for the mobilisation and network interaction;

"I had a situation, which is now two years old. Unfortunately, I became homeless. I spent almost a year living on the streets." (Subject, CIR, C 02)

"There is now extreme difficulty in finding housing here in the area. Especially for people who can't even afford it. And there's no way round it." (Social worker, CIR, C 03)

"I have my addiction problem, I'm as old as I am and things are getting complicated and the labour market is very difficult. I tried working in a restaurant for twelve hours straight and I couldn't take it." (Subject, AU, C 05)

"I've always been a bit of a loner. I stopped going to the cafés I used to go to, so as not to be tempted, so to speak. Most of the time I spend alone, otherwise I don't have any other ties." (Subject, CIR, C 03)

- the **lack of support from the family** and the low involvement of the person in his/her therapeutic process are difficulties expressed in the participation pillar;

"He doesn't have any family ties, so he's a gypsy, he has quite a large family, but doesn't have any ties with his parents. At the moment, has no ties with his children, and his family life is very precarious." (Social worker, CIR, C 08)

"Because I get really tired, I missed a lot of work to come here with him to his appointments, sometimes he was here, sometimes he wasn't, I couldn't do anything without him, I often went back." (Family member, CIR, C 18)

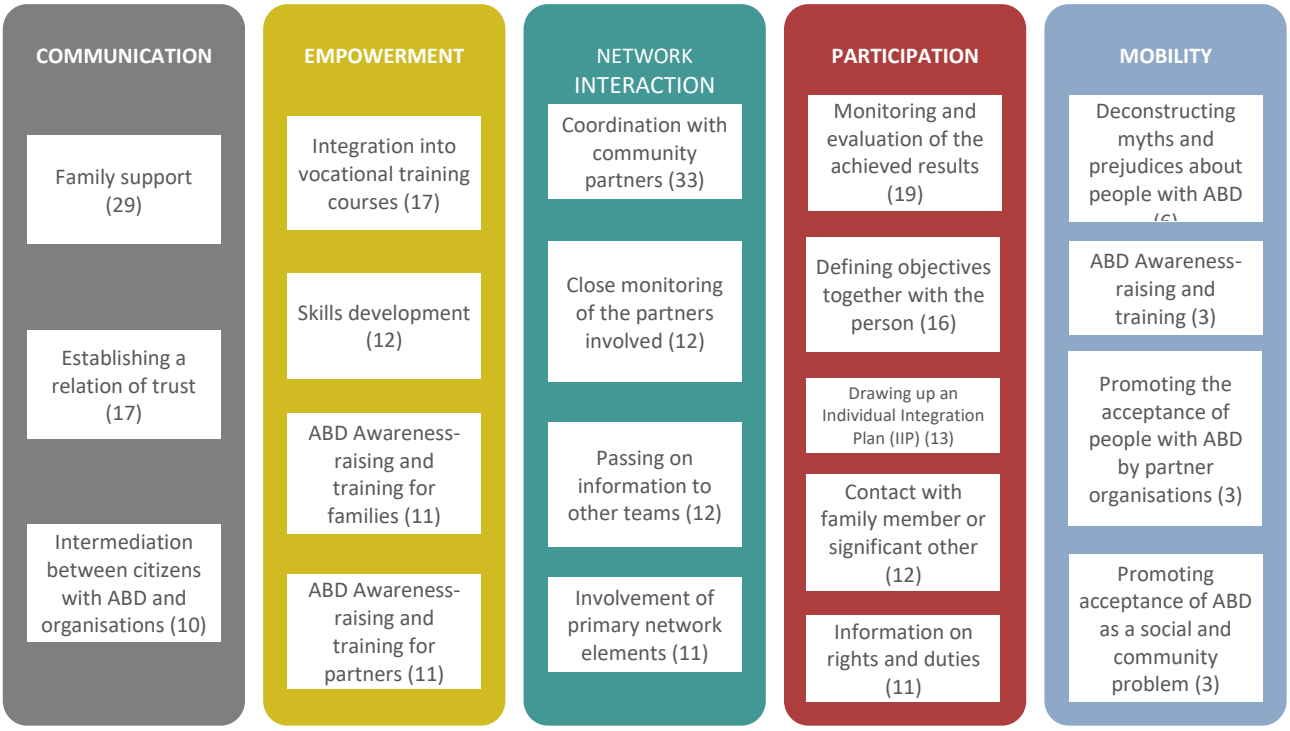
- the **stigmatisation of people with ABD in the local community** is the main problem experienced within the mobility pillar.

"Yes. For example, going to the supermarket to buy a packet of wine and them not wanting to sell it to me. That sort of thing. And in the street, feeling the taunt: look at the drunks! Those kinds of issues, like that." (Subject, CIR, C 03

1.4. Processes and intervention strategies

In the interviews, the influence of each of the pillars interconnected with the different levels of intervention (micro, meso and macro) stands out, making it possible to identify points in the day-to-day practice of professionals that cut across the various levels.

Figure 5. Main categories relating to intervention processes and strategies
(most referenced categories in each pillar of intervention)



- the **communication** pillar was the most frequently mentioned in the 51 interviews and is seen as an instrument that facilitates establishing a relationship with the other, the link between all the pillars, which underpins all the processes and allows relationships to be regulated.

- In terms of communication, **accompanying the family** and **establishing a relation of trust** are the most mentioned strategies in the interviews. In this context, communication proves to be a vital pillar for professionals to develop their work.

"You can't work without the family. It's just not possible. In fact, this is the case for all the families here, for all the residents. That's our principle. We always have to have the family, with us and with them." (Social worker, TC, C 04)

"This construction is done through a relationship of empathy. It's obvious! Because if you can't create an empathetic relationship with the person, in which he feels that he is being cared for and that he is not being managed, that he is not my property because I'm not here managing a provision, I'm not here managing a meal, I'm not here managing just the issue of rights and duties. (...) (Social worker, CIR, C 03)

- The second most highlighted pillar in the interviews is **empowerment**, which involves preparing for the acquisition and recognition of skills and contributes to the change in attitudes and behaviour. In the interviews, the sphere of **vocational training** and **development of skills** of citizens with ABD were the strategies that stood out the most, and which take place at the micro level.

"He always loved this part, this area of IT and at the time he was referred. We contacted the Employment Centre, and he did a training, because he had only completed the 11th year and so he completed a training in the IT area, which then gave him the 12th year certificate." (Social worker, CIR, C 17)

"In terms of relational skills, many of these skills were worked on here, (...) his being in the relationship, what issues he could question about himself or not, what decisions he could make or not. We talked a lot about his attitude of isolation when he was at these family leisure activities, suggesting alternatives so that he could actually get round this kind of isolation." (Social worker, AU, C 10)

- At the meso level, the application of strategies to **raise awareness of ABD**, in order to prepare families, was the most perceived dimension. Within the scope of empowerment, but at a macro level, **awareness-raising and training strategies on ABD** were also developed for **partners**.

"I think it was the deconstruction of some myths and predefined ideas about the world of drugs, the world of drug treatment. It was this deconstruction and the construction of a discourse of hope and participation. It was he who was at the centre of this ability to reconvert reality that was achieved by the family." (Social worker, CIR, C 06)

"For example, when we asked for help to house the subject, we had to meet with our colleagues and explain what we wanted, explain what addictive behaviours and dependencies were. This whole process always has to be worked out very well before referring the person because if the institutions aren't receptive, they won't welcome the person either." (Social worker, CIR, C 08)

- The network interaction pillar is centred on the interactions of the systems, namely the **coordination with community partners**, a strategy that was mentioned in 33 interviews.

"Unfortunately, I became homeless. I spent almost a year living on the streets. At the time, the social worker helped me and showed me places to eat and to clean myself. He also helped me at that time, I remember we were dealing with a request for funding for a room, which was successful, it was well handled " (Subject, CIR, C 02)

- The **close monitoring of the partners involved** and **passing on information to other teams** are very common categories that reflect the collaborative work carried out by the social worker.

"Well, I always start by identifying the needs and all the institutions are chosen for that person. The way I work is always a personal contact, by telephone with the institution and always putting everything in writing, with Social Security the referral form, with the Employment Institute an e-mail to the coordinator and getting back to the job offer technician always explaining who that person is and what we want so that there is a clear understanding of the entire process." (Social worker, CIR, C 08)

- As part of this work to mobilise resources, the social workers also sought to **involve members of the primary network** (direct or more distant family members, neighbours and/or other close people), who can contribute to achieving the objectives set out in each IIP.

"In the beginning and at a certain point, the person of reference was the daughter. However, her daughter went through some professional changes and some instability, so we had to ask another family member to collaborate, who quickly joined in." (Social worker, TC, C 04)

- The high incidence of these categories associated with the **network** interaction pillar may indicate that the social workers have worked to improve the relationship between individuals, families and the entities with which they interact, which reflects the importance of networking in meeting the needs and building the life projects of people with ABD.

- **Participation** is identified in all the interviews and is reflected in the categories of **monitoring and evaluating the results achieved, defining objectives together with the person and drawing up an Individual Integration Plan**. These are strategies that maximise the person's involvement in their own process and ensure that strategies can be adapted at any time, depending on the progress made.

"I think it was also very important to always point out the positive things he was achieving, emphasising in some way these gains that were emerging." (Social worker, CIR, C 12)

"At around three months, which is the phase of reintegration, we thus start to define a life project, with objectives. [...] I make a plan every time the residents leave. We make an occupational plan for the week. This plan is detailed. It's important to break it down by task, by time of the day." (Social worker, TC, C 04)

- The concept of participation refers to the promotion and co-construction of social alternatives and commitments in the context of citizenship, and so **information on rights and duties** is an essential strategy in this area.

"Yes, she informs me about everything because we don't know everything, because there's always a law, isn't there, now I know that when I'm about to be assessed to be given a pension, that law [...]. And the social worker is always telling me when I come for my appointments, "oh, sir, look, this or that has been published"'." (Subject, CIR, C 08)

- Also with regard to the participation pillar, it is important to emphasise **contact with family members or a significant other** as a strategy for involving these actors, who are so important to the reintegration process.

"His partner is a person with many cognitive difficulties, always very appealing, quite ill but always trying to support her husband and she realises that there have been many improvements over the years. I think that

despite difficulties in understanding some situations, we always tried to reach her using a discourse that facilitated her understanding and promoted her participation" (Social worker, CIR, C 12)

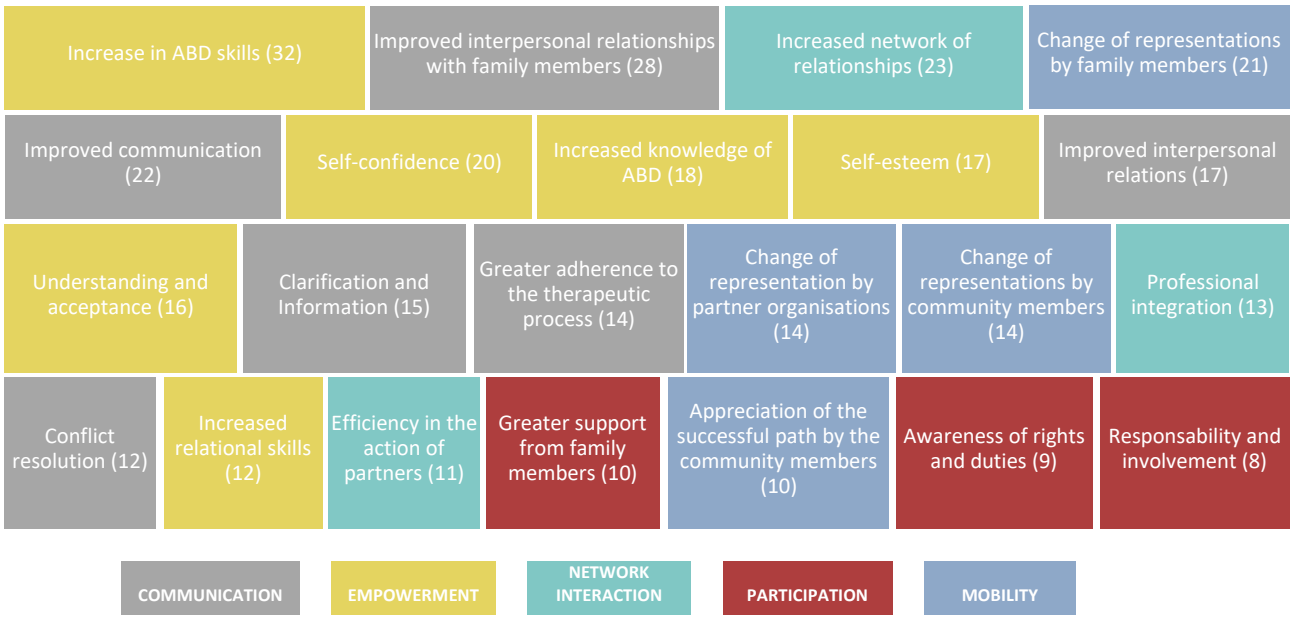
- **Mobility** is the least identified pillar in terms of the work processes and strategies developed. As already mentioned, it involves the dynamics of social systems, where obstacles arise to the process of creating opportunities and possibilities for integration, often motivated by the stigma surrounding ABD. The intervention aimed at **deconstructing myths and prejudices about people with ABD** is fundamental and needs to be reinforced within the scope of the intervention of social workers.

"Anyway, these were the strategies we developed, above all to establish communication with these organisations that would allow them to accept us and to break down some myths and beliefs, false beliefs and prejudices that are always an obstacle. [...] I wanted the community and the institution in question to somehow be able to look at this person as they look at any of the other employees. Basically, it was to dedramatize this stigma that often occurs, which is of course an obstacle." (Social worker, CIR, C 06)

1.5. Perceived results / Impact of the intervention

With regard to the results achieved through the intervention carried out by the social worker, translated in this context as the impact of the intervention, we can see that the pillars of communication and empowerment are the most frequently mentioned in the 51 interviews. Furthermore, it is within these two pillars that more categories of impact are actually found.

Figure 6. Main categories relating to the impacts of the intervention
(most referenced categories in each pillar of intervention)



- Since the social worker is an agent who manages communication and intervenes through certain strategies, we can say that, according to the interviewees, there have been significant **improvements** in **interpersonal relationships with family members** and significant others, as well as in

terms of **interpersonal relationships with other elements** of the wider network.

"Yes, it has increased. I had cases that, due to consumption, were left behind and once they learnt that I had started treatment, they approached me. More family members, who only said hello over the phone, but when they heard I'd taken the step, they bothered to ask how I was. Friends too." (Subject, TC, C 04)

"It was being calmer, I'd get angry at anything. Maybe it was because I felt lonely and I'd flare up at the slightest thing and reply rudely to people. There was no way I would accept being told anything." (Subject, CIR, C 11)

- We also noticed **significant** improvements in the **ability to communicate** of citizens who were being followed up.

"For example, up until now I was a bit afraid to talk to the mayor or a doctor or something, a lawyer or something. A person now speaks more openly, more freely, if one has any doubts or difficulties, one speaks without a hitch, without any problems, and up to now it was a bit more, they used to say "but that guy is talking to me and he's... just his breath, it's only morning and he's already like that. No, that boy is of no interest to human society." (Subject, CIR, C 07)

- In terms of the **communication** pillar, there was also **clarification and information**, **greater adherence to the therapeutic process** and in some cases references to **conflict resolution**.

"Whichever situation I found myself in during treatment, the Doctor listened to/attended me very well. Useful advice for my life, for my day-to-day life, practical advice." (Subject, TC, C 04)

"Realising that it was important to maintain a closer relationship with the technicians who can support me in my treatment." (Subject, AU, C 15)

"We were talking about a person who lived in a house with other people with similar problems but at different stages and there was a lot of conflict in fact, and the institution not being able to take sides with A, B or C, in certain circumstances there was this situation of referring them to the social worker because [...] she was someone we knew the subject held in high regard and that a word from her at that moment could make all the difference for him to see the situation in a different light." (Reference Person, CIR, C 08)

- As part of the process of **empowering** the people accompanied by the social workers, significant impacts were identified, translated into an increase in personal and social skills, such as: **self-confidence, self-esteem, understanding and acceptance, increased relational skills.** These impacts result from intervention at the micro level, with the citizen with ABD.

"They've changed for the better. Before, anything I had to solve, I made a problematic situation. I was already saying it was a problem, without knowing what the issue was first. So to speak, a storm in a tea cup. And now I approach things more calmly, more easily, I find my way, I feel useful. I can. Not as quickly as I'd like, but I'm getting there. And I'm slowly improving my self-worth. Which is something I couldn't do." (Subject, TC, C 04)

"He's been teaching me that I shouldn't keep things inside. And I have to be assertive with people. When it's no, it's no, and when it's yes, it's yes. And I couldn't do it. And I want to work on it even more. Because I know I need it." (Subject, CIR, C 01)

"Yes, very much so! I've changed, I've grown a lot as a person. Because this is a disease related to feelings. With the difficulty of dealing with our emotions, our incapacity, so, I've grown a lot as a person. It also made me very sensitive to others. Understanding other people, not judging, tolerating and being much more assertive. Being able to deal with sometimes very stressful situations, with a lot of pressure, very difficult moments, I'm once again the positive person I used to be." (Subject, TC, C 14)

"Knowing how to listen, responding only after listening to what the other person has to say. Talking about feelings. Listening to the other person's problem and then responding. Being true to ourselves. And sharing and communication. Yes, that was fundamental for me and for putting it into practice out there today. And to get on with people, right? (Subject, TC, C 09)

- But results were also felt at the meso and macro level, in terms of an **increase in knowledge about ABD** and an **increase in skills for dealing with people with ABD** identified in family members and partner organisations involved in the reintegration processes.

"Now I know how to deal better with this problem. I thought it was really because she didn't want to give up alcohol, but I realised that this really is a problem and it's not just because she doesn't want to. Even though she didn't want to consume, there were a lot of things involved." (Family member, TC, C 04)

"This time I have a different way of looking at things. I'll explain why. I've been a bit guilty that my son didn't complete a full programme both times he was in treatment. When he asks me to come home, I let him come home. It shouldn't be like that. I should say no. He should get to the end of the process. And the attitude I'm going to have this time is to get my son through to the end." (Family member, CIR, C 02)

- In the **empowerment** pillar, many other categories were identified, of less significance, which reflect effective work on acquiring and recognising skills, which have certainly contributed to changing attitudes and behaviours. Aspects such as being **responsible in complying with rules**, **creating work routines**, showing commitment in **carrying out tasks** and **ability to solve problems** are key skills identified as having been acquired by citizens.

"Without a doubt, they helped me to understand my rights and duties, they helped me to think and to realise that you have to be on time for work, you have to have certain rules." (Subject, CIR, C 12)

"Our work was also on impulse control, he was and still is quite impulsive, so we had to work with him on this need and it was from there that I think he was able, as he is now, for example, to fulfil the hours of community work (from nine to five in the afternoon) in an absolutely responsible and straightforward way until today." (Social worker, CIR, C 06)

- With regard to the results perceived in the **network interaction** pillar, it can be inferred that the teamwork and inter-institutional and inter-sectoral coordination that was developed in a coordinated and coherent manner may have contributed to an **increase in the network of relationships**, to the **professional integration** of citizens and to **greater efficiency in partners' work**, which translates into meeting the needs of people with ABD.

"A lot of things. Experience, as I've already told you, knowledge and socialising with people, people we didn't

know and socialising, I've always socialised with everyone, there's never been any problems, I leave the training sessions, everyone hugs me when I leave, "don't leave, mate," we have to go our separate ways, when I see people in the street, most of whom are from the area, everyone talks to me, sometimes I'm even distracted and they call out to me, "oh mate and stuff". [...] I've reconnected a lot, I'm telling you, with people I never even dreamed of. Never even dreamed of. Who also helped me." (Subject, CIR, C 08)

"So much so that after he finished three years of "Life-Employment", the subject was never abandoned by the municipality itself. Not only did the municipality then support him in Insertion and Employment Contracts, because he was receiving unemployment benefits, but then in the employment contract, they opened a tender and the subject entered immediately." (Social worker, CIR, C 17)

"The result was that we managed to stabilise the person, get him off the street and wean him off drugs, which was our main goal. Stop consumption, give the person a home and that was also achieved. So it was a joint effort." (Social worker, CIR, C 06)

- The intervention carried out by the social workers has also led to significant impacts associated with the participation pillar: **greater support from family members** or significant others, a clearer response to issues related to citizenship, with **greater awareness of duties and rights**, as well as greater **responsibility** and **involvement** in their own reintegration process.

"It's increased, since my mum got ill and my brother-in-law has been very supportive and willing to help me, as well as my son and nephew." (Subject, CIR, C 13)

"They taught me to have an active voice in what my rights were, to speak out, to contest, this made me a more enlightened human being." (Subject, CIR, C 12)

"I've been trying to fulfil the agreement with the social worker, because I have total confidence in her work and I know she wants to support me. I've always been present at the appointments, I always go to the interviews that the social worker schedules, I know that it has to be a joint effort, I also have to want to change my situation." (Subject, CIR, C 13)

- The mobility pillar refers to the need to change the representations that people in the neighbourhood, in the community, have of ABD and of people who use drugs. Prejudices and taboos regarding the phenomenon of addiction to psychoactive substances, particularly illicit ones, are a strong barrier to the emergence of opportunities and possibilities for integration (Almeida e Carvalho et al, 2018:53). The resistance of institutions, families and the community to the integration of people with ABD, often based on myths and beliefs, prejudice and stigma, often prove to be obstacles to full social integration. However, in the context of the impact of the social worker's intervention, we found that **changes** were mentioned **in the representations of family members, partner organisations and other members of the community**, and the **success** story that some of the interviewees had experienced during the follow up process was **valued**.

"I thought that drugs weren't a disease, that they were an addiction that they could control, say no to. It was enough to say no, I don't want any. It's doing me harm, I don't want any. I've learnt over the years that drugs are a vice, an addiction, which becomes a disease, and that it's important to treat them like any other disease, isn't it? This is also a serious disease." (Family member, CIR, C 06)

"Yes, it has changed. I see it in my neighbours once again. With my example. The fact that I was in treatment here and to get there and see that my life is completely different." (Subject, TC, C 04)

"It's not even the people closest to me, but in general everyone knows that I work, that I am contributing to the well-being of society. There's a valuing, not only by those closest to us, but more generally." (Subject, CIR, C 17)

"Yes, I think there was, in fact, a realisation that at certain times the work carried out, the knowledge and skills acquired helped the institutions to have a more assertive attitude towards the subject. [...] through communication and the skills that the organisation has been developing, they have been integrated in a non-judgemental way and in a way have been decontaminated from a certain mistrust of this type of population." (Social worker, CIR, C 06)

2. Perspectives of the different interviewees

The different interviewees' perspective on the **DIAGNOSED PROBLEMS** differs when comparing the problems mentioned in the interviews in each of the pillars.

Figure 7. Interviewees' perspective regarding the value of diagnosed problems, by pillar

Diagnosed problems	+	-
Social workers	Communication Empowerment Network Interaction	Mobility
Citizens with ABD	Mobility Communication	Participation
Family members	Communication	Participation

- With regard to the interviewed social workers, there were references to problems in the Communication, Empowerment and Network interaction pillars in all 18 interviews (which represents all of the interviewed social workers). The problems least mentioned by the social workers are those related to the Mobility pillar.
- The situation is reversed when we look at the problems from the citizens' with ABD viewpoint. The problems of the Mobility pillar are the most mentioned (17). Communication problems were also mentioned in 15 interviews with citizens with ABD (out of a total of 18).
- From the perspective of the family members interviewed, what is most valued are the problems in the Communication pillar (13 out of 15 interviews). Mobility issues are also strongly emphasised (12).

Also from the point of view of the **DEVELOPED INTERVENTION** there are different perspectives according to the interviewees.

Figure 8. interviewees' perspective regarding the value of the developed intervention , by pillar

developed Intervention	+	-
Social workers	Communication Empowerment Network interaction	Mobility
Citizens with ABD	Participation	Mobility
Family members	Empowerment	Mobility

- The most valued interventions are those related to the Empowerment pillar (50 out of 51 interviews). It is the pillar that gets the most visibility from all those involved in the reintegration process.
- The strategies developed in Communication and Network interaction are emphasised above all by the social workers.
- The intervention of the Mobility pillar is mentioned exclusively by the social workers, which may mean that this work has little visibility for citizens with ABD and their families.

Finally, also regarding references to the **IMPACT OF THE DEVELOPED INTERVENTIONS** on the various pillars, we found different opinions according to the type of interviewee.

Figure 9. Interviewees' perspective regarding the value of the impact of the developed intervention, by pillar

Impact of the intervention		+	-
Social workers		Communication Empowerment	Participation
Citizens with ABD		Communication Empowerment Network interaction	Participation
Family members		Communication	Participation

It is the citizens with ABD who refer the greatest number of impacts, even more so than the social workers themselves, who were responsible for the developed intervention.

The pillars of Communication, Empowerment and Network interaction are highly valued by both social workers and citizens with ABD.

For family members, the greatest number of references to impacts is concentrated in the Empowerment pillar.

The area of Participation seems to be the least referenced when it comes to recognising the impacts of the intervention, and from the viewpoint of the different interviewees it is also the least valued pillar.

The Mobility pillar, which made references to intervention exclusively by social workers, had an impact recognised by all those involved and above all valued by citizens with ABD (17 out of 18 interviews).

3. Partners' perspective

As part of this study, the perspective of the partners involved was also considered, reflected in the perceptions of the professionals from partner organisations who participated in the reintegration processes of the 18 cases. These perceptions were gathered by filling in a questionnaire, and 21 responses were obtained. The analysis of the 21 questionnaires provides relevant information to better understand the processes of integrating people with ABD into partner institutions and its impact.

From the viewpoint of **characterising the sample**, it consists of 21 questionnaires relating to 14 cases (9 Integrated Response Centres, 2 Therapeutic Communities and 3 Alcohology Units). The organisations involved in the reintegration processes in these cases were both public and private, with a slightly higher representation of private organisations (57,1 per cent). The public organisations belong mainly to local government (55,6 per cent), while the majority of the private ones are social solidarity institutions (IPSS) (75 per cent). The public organisations that responded to the questionnaire are larger in terms of dimension than the private ones, if we consider number of employees. About those responsible for following citizens with ABD, almost all of them have a degree in the social sciences and humanities.

Considering the **five pillars of intervention defined in the Social and Community Mediation Model**, it is possible to analyse the results obtained from the viewpoint of the operationalization of each one. The most important aspects are highlighted below:

COMMUNICATION PILLAR

It was possible to see that the start of the follow-up process by the partner organisations was triggered by the Integrated Response Centres, Therapeutic Communities or Alcohology Units social workers (47,6 per cent), by means of a referral. However, in some cases the follow-up was initiated by the person him/herself (14,3 per cent) or at the request of a third party (17 per cent).

The majority of these follow-ups were carried out daily (38,1 per cent) and occasionally (33,3 per cent). In this respect, it was possible to see differences between public and private organisations: 58,3 per cent of the visits to private organisations were daily, while 44,4 per cent of the visits to public organisations were occasional, which seems to point to closer monitoring by private organisations. This proximity is crucial to the success of the monitoring, as it allows for greater communication between all the elements of the process and consequently facilitates the relationship between them.

Regarding the occurrence of conflicts during the person's follow-up and the way in which the social worker may have participated in them, it can be concluded that there were no conflicts in the majority of cases (81 per cent); however, in the cases where they did occur, there was an intervention by the social worker to resolve them (75 per cent), which was assessed as very positive and relevant (the maximum score was given in 66,7 per cent of the cases).

As far as the organisation's communication with the Integrated Response Centres, Therapeutic Communities or Alcohology Units social worker is concerned, telephone contact is the most commonly used means of communication, and this contact is made on a monthly or fortnightly basis in most situations. Almost all of the respondents consider the frequency of this contact to be adequate for their needs and, when it comes to assessing the relationship with the social worker, all of the organisations' replies consider this relationship to be indispensable for the success of the process.

Also, with regard to the evaluation of joint work, the responses obtained reveal very positive assessments on the part of the organisations, with the majority considering this work to be very important.

These results show that communication was present frequently and regularly between organisations and citizens with ABD, as well as between organisations and Integrated Response Centres, Therapeutic Communities or Alcohology Units social workers, and was perceived as effective and with a frequency appropriate to needs.

EMPOWERMENT PILLAR

Considering the complexity associated with the reintegration processes of people with ABD, the preparation and the empowerment of those involved is one of the interventions that can be seen as facilitator of the processes. In this context, the empowerment of partner organisations to better understand and deal with this problematic enables them to recognise and resolve problems, as well as helping to change attitudes towards them.

- The need to acquire competences in the field of ABD was not found among the majority of respondents (57,1 per cent), which could be explained by the high level of education and the fact that the people in charge of these partner organisations are mostly graduates in the social sciences and humanities.
- The majority of respondents who expressed a need for more information on ABD were able to acquire the necessary knowledge during the follow-up process (66,7 per cent). This updating of knowledge was considered *important* and *very important* for the reintegration process of the citizen with ABD.
- This result demonstrates the importance of investing in empowerment initiatives aimed at partner organisations, since increasing knowledge about ABD has a positive impact on integration paths.

NETWORK INTERACTION **PILLAR**

A reintegration process involves intervention in various aspects and areas of the citizen's life, according to the diagnosed needs. Valuing a support network that enables the mobilisation of the various social resources that promote autonomy is essential.

- With regard to the partner organisations that responded to this questionnaire, it can be seen that the scope of participation is very varied and multifaceted, with the same organisation being able to intervene in several areas simultaneously. The most frequently areas intervened in are social support, support for food, clothing and/or hygiene, employment and housing or accommodation.
- On the other hand, these organisations also promote access to other resources, in addition to those they are already providing. In 43 per cent of situations, the partner organisation made referrals or coordinated with other organisations or structures, with the aim of obtaining appropriate responses to the person's needs. The main areas of intervention of the organisations contacted focus on health and ABD, employment, vocational training and social support.

When asked about the importance of the organisation's contribution to the person's reintegration process, the respondents considered it *important* and *very important* (90,5 per cent). This indicates that the partner organisations recognise the positive impact their intervention has had on the reintegration processes of people with ABD.

PARTICIPATION PILLAR

The participation and involvement of all the players in the reintegration process is fundamental to its success and sustainability. The participation of citizens with ABD, in particular, is of the utmost importance and is essential for building commitment and responsability in the full exercise of their rights and duties as citizens.

- Respondents believe that the vast majority of citizens were actively involved in the decisions taken (85,7 per cent), and that this participation was developed through collaboration in the proposed actions and the fulfilment of objectives.
- The degree of participation of the partner organisation was also demonstrated by the high frequency of the person's follow-up, as well as the regular contact with the social worker of Integrated Response Centres, Therapeutic Communities or Alcohology Units .

MOBILITY PILLAR

Considering the need to demystify and deconstruct the negative representations and meanings associated with ABD, it is very important to understand the influence that these follow-ups have on changing the perceptions of organisations and the community, in order to reduce prejudices and change attitudes towards people with ABD. The aim was to find out whether the involvement of the partner organisation in the reintegration process had changed their opinion of people with ABD.

- Half of the respondents felt that there had been no change in their perception of people with ABD (52,4 per cent). The respondents who justified this response said that no generalisations can be made on the basis of this experience. Each case is different. For those respondents who believe they have changed their opinion, the reason given is that their understanding of the issue has improved as a result of the additional training obtained during the process.
- Regarding the existence of situations of discrimination within the organisation towards people with ABD, the majority of respondents say that no situation of discrimination or protection has occurred or that they are not aware of it (80,7 per cent).
- With regard to the existence of situations in which the person has been discriminated in the community, the majority of respondents say they are not aware of any (42,9 per cent), but a significant percentage acknowledge that there have been situations of discrimination (33,2 per cent), either because the person has shown inappropriate and violent behaviour towards society, because they have been stigmatised, or because they had no access to opportunities for professional integration.

Finally, it should be noted that most of the **follow-up processes at these partner organisations were evaluated as positive**. When asked about how the monitoring took place, the respondents referred to close monitoring processes that went well and without incident. Only in three situations were incidents, ups and downs or relapses mentioned, only one of which resulted in support being interrupted.

On the other hand, when asked about **the reach of the objectives** they had set themselves with this intervention, the majority of respondents considered that the objectives had been achieved and fully achieved. On a scale of 1 to 5, where 1 means that the objectives have not been achieved and 5 that they have been fully achieved, the average response was 4.05, which certainly reflects the success of the reintegration processes for people with ABD. When this average is compared by type of organisation, it can be seen that the average attributed by private organisations (4.16) is slightly higher than that attributed by public organisations (3.88).

4. Analytical diagram of results

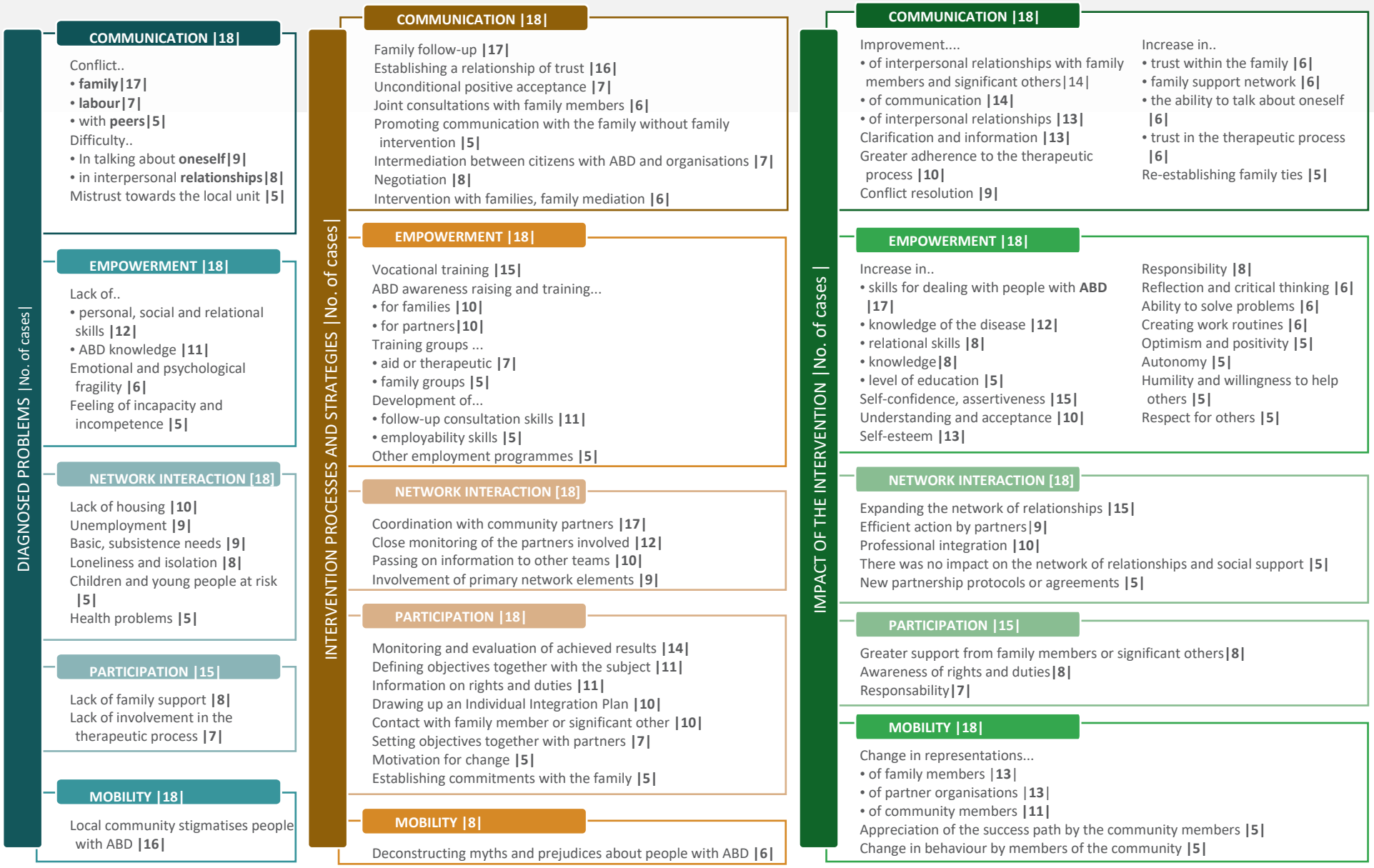
The content analysis carried out on the 51 interviews made it possible to compile a complex set of categories based on the perceptions of social workers, citizens with ABD and family members, which reflect the three main components explained in this report:

- The social diagnosis that results from the analysis of the cases carried out by the social workers;
- The intervention processes and strategies that have been developed with the aim of acting on the conditions of vulnerability diagnosed, facilitating changes at micro, meso and macro level, and promoting the reintegration of people with ABD;
- The evaluation of this intervention, reflected in the perceived impact and/or results achieved.

This analysis is based on the five pillars of intervention set out in the social and community mediation model, which allowed organizing and giving meaning to information.

In order to provide a more summarised view of the categories and their interactions, an analytical diagram was drawn up showing the main categories found in all the pillars. To facilitate the analysis, a cut-off point was set as to address only categories occurring in no less than 5 of the 18 cases under study. Figure 9 therefore shows the main categories, considering the number of cases where they were referenced and not the number of interviews, as presented throughout this report. This option results from the attempt to identify a pattern, a profile of meaning and significance of relationship among the categories, taking all the cases into consideration.

Figure 10. Analytical Diagram of Results



- **RELATIONSHIP BETWEEN THE DIAGNOSIS, THE INTERVENTION PROCESSES / STRATEGIES AND THE IMPACT OF THE SCM MODEL AT A PERSONAL, SOCIAL AND COMMUNITY LEVEL**

Social diagnosis is the initial stage of the intervention process for the reintegration of people with ABD and involves identifying and assessing the main problems and experiences of subjects and support structures. The results show that problems were identified in all cases and in the five pillars of intervention, albeit at different levels. Only in the Pillar of Participation is the number of cases with problems lower (15) than its total (18).

In order of the relevance of the **problems**, assessed on the basis of the number of cases identified in each pillar, the following should be noted:

1. Communication problems are the most prevalent, with family conflict being the most significant problem (17 of the 18 cases), followed by conflict at work (7) and between peers (5); people having difficulty talking about themselves (9) and establishing interpersonal relationships (8) is a diagnostic pattern in a large number of the cases studied;

2. This is followed by the identification of problems in the mobility pillar, related to the existence of prejudices associated with ABD and people who use drugs, especially problems associated with the perceived stigmatisation of people with ABD by the community (16);

3. In the empowerment pillar, a lack of personal, social and relational skills (12) as well as a lack of knowledge about ABD (11) are also present in the majority of cases; the population studied also shows emotional fragility and feelings of incompetence and incapacity in the face of challenges;

4. All the cases present needs and shortcomings that minimise the condition of citizenship, in particular the lack of housing (10), unemployment (9) and basic subsistence needs (9); loneliness and isolation (8), the existence of children and young people at risk (5) and health problems (5) are also diagnosed in a significant number of cases;

5. Deficits in subject and family participation were diagnosed in 15 cases, both in the reintegration process (8) and in the therapeutic process (7).

In what concerns the **intervention processes and strategies**, the results indicate that social workers acted in all pillars, with a correspondence between the number of cases in which problems were diagnosed and the number of cases in which intervention was registered. Only in the mobility pillar did the intervention carried out not correspond to all the cases with diagnosed problems (18 with problems associated with stigmatisation), with intervention only in 8 cases, through the deconstruction of myths and prejudices and other strategies. In other words, there was no intervention in 1 out of every 2 cases.

To deal with communication problems, strategies were used to accompany the family (17), either individually or in joint consultation with citizens with ABD (6), and to establish a relationship of trust (16). Another relevant strategy for communication intervention is unconditional positive acceptance (7), which strengthens the relationship of trust between the person and the social worker, an essential condition for developing a relationship of relational proximity that is effective in the field of diagnosis and intervention. Intermediation between citizens with ABDs and organisations (7) and negotiation (8) are strategies that are also used. Considering that family conflict is a dominant and cross-cutting element in almost the entire population studied, that communication difficulties both about oneself and in interpersonal relationships are present in almost half of the population and that work and peer conflict is present in more than a quarter of the population, **this evidence points to an adequate consistency between strategies and problems**.

But the reintegration process is continuous. And if the evidence shows the **centrality of communication in the reintegration process according to the SCM model**, the diagram also shows that the number of strategies is greater than the number of diagnoses, since **strategies are mediators in the relationship between mobilised means and expected ends**. In this way, the diagram highlights the **permeability between strategies**, only segmented here by pillar for the purposes of analysis.

Empowerment processes involve strategies that valorise the skills of the subjects, appropriate to the nature of the problems diagnosed and the characteristics of the intervention subjects (professionals, citizens with ABD, families and partners involved in the reintegration process). Thus, the **empowerment strategies identified and expressed in this diagram are appropriate to the problems diagnosed in this pillar, but revert to other pillars**, namely mobility (for example, the strategy of raising awareness and training families and partners in ABD in 10 cases). Integration into training courses (in 15 cases) and the development of employability skills are strategies for developing skills, but at the same time they are a response to the problem of unemployment identified in the network interaction pillar in half of the population studied; intervention through skill training groups (therapeutic or family groups) and the development of skills in consultation (11) also contribute to increasing the skills whose deficit was diagnosed in the empowerment pillar, and at the same time favour the involvement of the subjects and their families in the therapeutic process (whose lack was also diagnosed), thus valorising participation.

As far as network interaction strategies are concerned, coordination with community partners (17) and close monitoring of the partners involved (12) are important strategies in building a response to the diagnosed demand, a complex web of problems identified in this pillar (housing, unemployment, basic needs, health, children at risk, loneliness and isolation), but they are also an important strategy for intervening, together with the strategy of deconstructing myths and prejudices about people with ABD (6), in the problem of the stigmatisation of people with ABD by the local community, diagnosed in the mobility pillar. Passing on information to other teams (10) and involving elements of the primary network (9) are also relevant strategies used in the network interaction pillar, but they are also important at other levels, namely in the participation pillar (involving the family in the therapeutic process and in reintegration).

Although the participation pillar has the lowest number of cases diagnosed with problems in this area, the diagram identifies several relevant strategies that show the **participatory and collaborative intervention process** regardless of the diagnosis made. Participation strategies are used in all cases, from monitoring and evaluating results (14); setting goals together with the person (11); information on rights and duties (11) and motivation for change (5), which are equally important in the process of empowering subjects and families through social advocacy processes; drawing up individual integration plans (10); contacts with family members and significant others (10); setting common goals with partners (7), in conjunction with strategies in the network interaction pillar (close monitoring of the partners involved) are useful for responding to the complex web of problems diagnosed in that pillar.

As for the effects of the intervention, identified in this model as impacts analysed from the perspective of the results achieved, they are felt in all the pillars of the SCM model. What are the main impacts? **Given the permeability of the intervention processes and strategies and the strong link between the diagnosis and the strategies used, the data shows that the model is highly efficient and effective** at different levels, namely:

1. **Improving communication** in more than 70 per cent of cases in terms of interpersonal relationships, and communication (14) with family members or other significant people (14), and in the provision of

clarifications and information (13), greater adherence to the therapeutic process (10), and in conflict resolution (9), increased confidence, greater ability to communicate about oneself and the re-establishment of family ties;

2. The model also proves to be effective in terms of its **ability to increase the empowering skills of the people with whom the social workers interact.** In this area, social workers favour an increase in skills for dealing with ABD (17), knowledge about the disease (12), relational skills (8), improved self-esteem, reflection and critical thinking (6), the ability to solve problems (6), the creation of work routines (6), optimism, positivity, autonomy, willingness to help others and respect for others in more than a quarter of cases.
3. Also in the field of Network interaction, promoting participation and mobility, the **results show high effectiveness**: in more than 80 per cent of cases there is an increase in the network of relationships, in more than 70 per cent (13) of cases there is an increase in social support and a change in representations about ABD in family members and partner organisations and professional integration; network interaction in the field of housing and changing representations about ABD in members of the community also shows effectiveness in more than 60 per cent of cases.
4. The participation pillar is the one with the lowest number of problems, but with an impact on all the cases where they were diagnosed, namely through greater support from family or significant others, awareness of rights and duties and greater responsibility in the reintegration process.

5. Potentialities and limits of the social and community mediation model

In the context of this research, the SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis methodology was used to highlight the potential and limits of the SCM model. The application of this methodology aims to reduce the areas of uncertainty related to the implementation of intervention in ABD reintegration processes and aims to highlight the dominant factors that influence the intervention, both internally and externally, and to produce relevant strategic guidelines, linking the intervention process to its specific context. On the other hand, the SWOT analysis is used here to examine the validity of the SCM model analysed and recommend changes if deemed relevant.

In the **INTERNAL ENVIRONMENT**, evidence was sought on the intervention of human resources (social workers), intervention processes and strategies and internal objective conditions associated with the development of the intervention in the cases under study (organisational and training conditions).

As **EXTERNAL ENVIRONMENT** we considered the entire surrounding context, at micro, meso and macro level, such as current support policies, citizens with ABD, families, local communities, partner organisations and their responses.

Figure 11. SWOT Analysis of the Social and Community Mediation Model in ABD

INTERNAL ENVIRONMENT	**STRENGTHS**	**WEAKNESSES**
	- Interviewees' positive perception of the developed intervention. - Quality and professionalism of the social workers. - Effectiveness of the developed intervention. - Multiple effects and impacts generated by the developed intervention.	- The need for ongoing training for social workers to intervene with families from a conflict resolution or family therapy perspective. - Interviewees' lack of perception of the changes and impacts resulting from the intervention. - Little intervention in terms of changing the representations associated with ABD, in relation to the diagnosis made. - Intervention that promotes the participation of the actors (citizens with ABD and family) has little positive impact. - Long follow-up processes.
EXTERNAL ENVIRONMENT	**OPPORTUNITIES**	**THREATS**
	- Achieved results are opportunities to guarantee the success of reintegration. - Changes in representations about ABD produced by the intervention. - Positive perception of the participation of family members in the reintegration process. - Positive assessment of inter-institutional coordination. - Inter-institutional coordination that fosters the creation of new partnerships.	- A diagnosis that shows the presence of multiple and multidimensional problems, reflecting the individual and social fragility of the subjects monitored by the **social workers**. - High incidence of problems associated with the existence of prejudices about ABD and people who use drugs. - Difficulty in measuring the change in representations about ABD and people who use drugs. - Difficulty on the part of some family members in closely monitoring the reintegration process. - Difficulties in inter-institutional coordination threaten the implementation of integration itineraries.

The central aim of this analysis is to reflect on the limits and the potentialities of the social and community mediation intervention model, in order to highlight the risks to be considered and the problems to be solved, as well as the advantages and opportunities to be exploited. The SWOT analysis is shown in figure 4 and was built based on the results obtained from the content analysis carried out.

Considering the internal environment, which relates above all to the intervention developed and the conditions for that intervention, the following positive aspects or **STRENGTHS** were identified:

- The **interviewees' positive perception of the intervention.** Citizens with ABD and their families have mostly expressed positive opinions about the follow up process. On the other hand, it is the citizens with ABD who report the most positive impacts from the developed intervention, which emphasises the importance of the results achieved and the recognition that the intervention deserved from the subjects.

- **Quality and professionalism of the social workers**. Most of the interviewees' evaluations of the follow-up process refer to the high performance of the technicians, whether in terms of the results obtained, their availability for follow-up or the quality of the relationship established.

- **Effectiveness of the intervention developed**. Analysing the evaluations of the follow-up process shows that the intervention had a significant impact on the well-being of citizens with ABD and their families. "Improving all aspects of one's life", a category mentioned in 10 interviews, demonstrates an intervention whose effectiveness goes beyond changes in ABD and which has an effect on the various areas of the person's life. On the other hand, the developed intervention generated impacts that were perceived by the interviewees as positive and that made possible to change the fragile conditions identified in the diagnosis. In all cases where problems were diagnosed, strategies were developed to resolve them, finding appropriate responses to needs. This intervention made it possible to identify a positive impact in all the cases and in all the intervention pillars.

- **Multiple effects and impacts generated by the intervention**, which translate into changes at an individual and interpersonal level, but also into results at a family and institutional level. Communication and empowerment were very much developed at an individual and family level, but the intervention also made it possible to reach partner organisations and the community itself in some cases.

Also with regard to the internal environment, the following **WEAKNESSES** were identified:

- **The need for ongoing training for technicians to intervene with families from a conflict resolution or family therapy perspective**. This issue was verbalised by some technicians as a conditioning factor for the intervention. Considering that the most frequently reported problem is conflict, especially at family level, it is essential that the intervention allows for conflict resolution. The data shows that the intervention developed to resolve conflicts did not correspond to all the cases where they occurred and did not always enable the conflict to be resolved.

- **Interviewees' lack of perception of the changes and impacts resulting from the intervention.** There are residual situations in which the impacts of the intervention are perceived as negative, despite the frankly positive trend of the evaluation carried out. There are also situations in which the effect of the intervention was not noticeable. The low occurrence of these situations does not detract from the importance of developing strategies to increase awareness of the changes that have taken place.

- The problems associated with discrimination against people with ABD are the ones least mentioned by the

social workers in the diagnosis and highly valued and referred to by citizens with ABD. Thus, there was **little intervention in terms of changing representations about ABD, compared to the diagnosis made**. From the viewpoint of the cases under study, all of them present problems associated with this issue, but only in 8 cases was there an intervention specifically aimed at deconstructing myths and prejudices about ABD or increasing the community's knowledge of this issue. On the other hand, this intervention is totally invisible or not very relevant to the subjects and family members interviewed, as they make no mention of its existence during the interviews.

- Intervention to promote participation of the actors (citizens with ABD and family) with little positive impact. When an individual integration plan is not drawn up jointly, for example, the involvement of subjects can decrease and is an obstacle to evaluating the reintegration process. In 12 out of 51 interviews, this, and other limitations in promoting participation were mentioned. Regular monitoring of the results achieved, together with the person and family member, is essential to increase awareness of the steps taken, reinforcing motivation and the whole process of change.

-Long follow-up processes. The cases studied were followed up over long periods, as one third of the subjects were followed up for at least 10 years and 17 per cent for 20 years or more, i.e. more than 50 per cent of the subjects were followed up for more than 10 years.

Regarding the external environment, which refers to the entire context surrounding the intervention, the following **OPPORTUNITIES** can be identified:

- Achieved results are opportunities to guarantee the success of reintegration. Increased communication and interpersonal skills, skills for dealing with people with ABD, personal and social skills, a network of relationships and greater support from family members or other significant people indicate consistency in the reintegration process and sustainability in the changes produced.

- Changes in representations about ABD produced by the intervention. The intervention made it possible to reduce the stigma associated with ABD and to change behaviour towards people who use drugs. These changes occurred in all the cases under study and affected the family, the community and partner organisations. The significance of these results is even greater if we consider that only 8 cases mentioned strategies specifically aimed at promoting changes in representations about ABD. Despite this, the effect of the other strategies developed in communication, empowerment and network interaction contributed to changing perceptions about ABD, by providing more information and understanding about the problem.

- Positive perception of participation of family members in the reintegration process. The interviewees perceive family support as extremely important for the success of the process, and as a therapeutic agent. This aspect is reinforced when analysing the effect of the intervention, which shows greater support from family members or significant others.

- Positive assessment of inter-institutional coordination. References were made to the importance of coordinating with partner organisations, which was seen as fundamental to the implementation of integration plans. On the other hand, by analysing the impact of the intervention, it is possible to conclude that the contribution of partners made it possible to mobilise therapeutic, social, employment, family support and legal support resources.

- Inter-institutional coordination that fosters the creation of new partnerships and innovative forms of support to meet the needs of citizens with ABD. These partnerships have the potential to continue over time and benefit other people, contributing to the creation of social innovation.

Finally, with regard to the external environment, the following **THREATS** were identified:

- **The diagnosis shows that there are multiple and multidimensional problems present, reflecting the individual and social fragility of the people followed by the social workers.** The profile of the subjects shows very relevant vulnerability factors at the start of the intervention, including financial dependence, low schooling, comorbidities and the existence of ABD in the family. These weaknesses are reinforced by the diagnosis made: the problems present are multiple and multidimensional, concern the individual but also the family, and reflect problems of communication, interpersonal relationships, conflict, skills deficits, subsistence needs, unemployment, lack of housing, loneliness and isolation associated with a very poor support network. This multi-problem diagnosis, where each case presents more than five problems on average, calls for multi- and interdisciplinary intervention and work to activate the network of partners.

- **High incidence of problems associated with the existence of prejudices about ABD and people who use drugs**. Situations of discrimination were mentioned, mainly related to the stigmatisation of people with ABD by the local community. On the other hand, when analysing perceptions of ABD, the data shows that there are perceptions that are inadequate to understand the problem. These perceptions are mainly associated with members of the community and neighbourhood networks, as well as partner organisations. Although there has been a strong increase in skills to deal with the problematic, this is still a problem when it comes to evaluating inter-institutional coordination. These results reinforce the need for action to change perceptions of ABD in order to help reduce stigma and discrimination.

- **Difficulty in measuring the change in representations about ABD and people who use drugs**, so the changes that may occur are not always perceived. This difficult measurement may justify the fact that some of the interviewees said that there had been no changes or that they did not know if there had been changes in the representations of other actors. This indicates the need to value the perception of these representations during the intervention process.

- **Difficulty on the part of some family members in closely monitoring the reintegration process**, due to the combined factors of advanced age, mobility difficulties and geographical isolation. This reality calls for the development of local strategies of greater proximity and inter-institutional coordination in providing support and overcoming difficulties.

- **Difficulties in inter-institutional coordination threaten the implementation of integration itineraries.** Difficulties in communicating with partner organisations, bureaucracy and lengthy processes are the main factors perceived as negative in the assessment of inter-institutional coordination. These difficulties threaten the implementation of the integration programmes resulting from the plans adjusted to each person's profile and can generate demotivation, as well as feelings of injustice towards the institutions and the way in which support is provided.

An analysis of the potentialities of the social and community mediation model concludes that it is characterised by the effectiveness of the intervention developed, that achieves the expected results and that has a multidimensional impact, going beyond the individual sphere. By promoting the involvement of family members in the reintegration process, it makes the changes achieved more sustainable and makes it possible to mobilise the resources needed to implement the integration itineraries, through the valuing of a very important network of partners.

From the viewpoint of the limits of the intervention advocated by the model, we can say that it is necessary to strengthen skills for intervention in the field of conflict, especially conflict in the family, and it is also important to value strategies that promote the participation of citizens with ABD and their family members. Changing perceptions about ABD and people who use drugs should be a priority in reintegration intervention, both in inter-institutional coordination and in working with families and the community.

Conclusion and Recommendations

One of the guiding concerns of this research was to identify the factors that interfere in differentiating the procedures and results during and after follow-up. As part of a multi-case, multi-perspective approach, which crosses different contexts and stakeholders, the aim was to gain an in-depth and detailed understanding of the intervention processes and strategies developed. The combination of a quantitative and qualitative approach made it possible to associate description with the analysis of the particularity and uniqueness of professional processes and practices, integrating the meanings attributed by the subjects participating in the research with the characteristics of the problems and the analysed intervention.

Constructed from a perspective of analysis that starts from general and contextual data to delve deeper into them, aided by statistical data, graphs, tables and excerpts from the interviews, the results presented in the final report are designed to identify the main conclusions from analysing the interviews and the cases, as well as explaining the dynamics of the intervention process.

In this way, both the balance of results included here, the diagram constructed and the SWOT analysis, make it possible to identify the main components of the intervention process and also to reflect on its impact from the perspective of the effects of the intervention model at an individual, social and community level. The potentialities and the limits of the model are also explored through the content analysis of the interviews, which gives the results validity from a conceptual viewpoint and from the viewpoint of the evidence identified. In fact, because this study invests in the in-depth and comprehensive detail of the intervention process, it makes it possible to map out the problems, the intervention processes and the strategies, as well as the applicability of the model. This mapping extends to the results and impacts of the intervention, which are reflected in changes perceived by the interviewees in various areas (individual, interpersonal, therapeutic, social, family, institutional, labour, ...), giving visibility to the objective and perceived importance of the social and community mediation implemented in the reintegration process of people with ABD.

As this is essentially a qualitative study, the results cannot be generalised. However, delving into the details of the different stakeholders' perspectives adds valuable information for understanding the subjectivity (experiences, perceptions) associated with each case analysed and reinforces the proximity dimension of social intervention. The intersubjectivity resulting from the comparison of the data lends objectivity and validates the results, making them essential information for understanding both the phenomena of addictive behaviours and dependencies, and the intervention process developed around reintegration.

The results presented here highlight the potentialities and the limits of the social and community mediation intervention model at micro, meso and macro level and call for reflection in the form of recommendations. Specifically:

Recommendation 1. Support for training in conflict intervention

Considering that the problem most often referred is conflict, especially at family level, it is essential that the intervention allows for the exploration, construction and development of ways of resolving conflicts, from conciliation to negotiation and mediation. In this context, ongoing training for social workers in areas such as conflict management, conflict mediation, family therapy and family intervention, etc., should be a priority. Social workers need to have a more comprehensive analysis of the origin and nature of conflicts, of how the representations of the litigants underlie the construction of conflicts and interfere in the aggravation of a disagreement, which creates ruptures at an individual and social level. Conflicts are part of reality and are the result of social interaction; they do not necessarily have to be detrimental to life in society. When disagreements are soluble and do not constitute problems, with implications for the fragmentation of social ties, their existence doesn't require any kind of intervention.

In order to intervene in conflict management, it is essential to invest in training at different levels:

- Knowledge of concepts and alternative ways of resolving conflicts;
- Increased capacity to understand the origin, nature of the conflict and conflict dynamics;
- Deepening communication skills and personalising the relationship, to achieve effective communication, based on active listening, respect for the "other" and their arguments and points of view, with the logic that there are no winners or losers and that in building alternatives to conflict one does not "lose face". We gain in dignity and citizen participation. Communication is a fundamental structure of intervention and is particularly important in conflict management and resolution. It is not possible to intervene in conflicts without the ability to communicate.
- Development of collaborative intervention strategies to combat the escalation of conflicts and their repercussions on social relations.

Recommendation 2. Increased visibility of the results of the intervention.

Interviews with people with ABD and their families revealed difficulties in recognising the effects of the intervention and the results that had been achieved. It is therefore important to develop strategies that increase awareness of the changes that have taken place. In order to do this, it is necessary to manage the time set aside to evaluate progress and the changes achieved during follow-up. It is up to the social workers to make the changes that have taken place and the progress that has been made more visible, and to pass this perception on to the person's and their families. Small changes are valuable achievements that should be valorised on a regular basis. It is important to give subjects and their families the ability to understand the micro-changes that are being made and their strategic nature in terms of achieving reintegration objectives. The presence of an obstacle should not be seen as an insurmountable mountain, it is just one part of the continuous, non-linear process of building the life project of people with ABD.

Thus, regular monitoring of the results achieved, together with the person and their family, is fundamental to increasing the perception of the changes that have taken place, reinforcing motivation, involvement, and the whole process of change.

Recommendation 3. Redimensioning proximity monitoring strategies

The results of this study show the importance of family involvement in the reintegration processes of people with ABD. Albeit with little significance, situations were identified in which the participation of family members was conditioned by a combination of factors, such as: advanced age, mobility difficulties and geographical isolation. This reality calls for the development of local strategies of proximity, such as home visits, decentralised consultations held at partner facilities (which are more accessible and closer to home) and mobile care, which can help overcome these difficulties and increase participation in reintegration processes. To this end, it is imperative to allocate human and material resources to the services, taking advantage of community synergies.

Recommendation 4. Implementation of public policies to promote employability.

Given the predominance of the empowerment pillar in this study, the importance of this area for the reintegration process is clear. Investing in programmes to develop personal and social skills, which prepare citizens for greater empowerment in communication and interpersonal relationships, is a fundamental strategy for successful reintegration and the promotion of autonomy. Investing in ongoing training for social workers in this area will make it possible to implement and monitor skills development in a more systematic way in all LIUs, in order to guarantee a more equitable response for citizens at the level of the different LIUs.

Public strategies such as sheltered employment, which are valuable resources for the professional integration of citizens with ABD, based on analysed cases, should continue to merit investment from policymakers, as they are opportunities to train personal, social and professional skills, which allow the foundations to be laid for more ambitious professional integration processes. On the other hand, the support provided by social workers in this type of programmes helps to increase employers' knowledge of ABD and contributes to changing beliefs and attitudes about this problem. The Life-Employment Programme, for example, continues to be referred to by social workers as a fundamental resource, a good practice that has made it possible to promote employability and reduce the prejudice that exists in the community about ABD.

Recommendation 5. Promoting interventions to change preconceptions about ABD

The diagnosis carried out in the mobility pillar shows significant problems regarding the stigmatisation of this population by the community. And the intervention developed does not correspond to all the cases where such problems were found. There are also inadequate perceptions of this problem, especially in the community, but also in partner organisations and the family.

While this work is being carried out effectively with regard to the immediate family and the partner organisations involved in the reintegration processes, it is more difficult to intervene in the community and requires resources that are not always available in the LIUs. It is therefore essential to articulate the individual and collective dimensions of the intervention, strengthening community work and networking. Raising awareness among key players in the community can be a favourable strategy for reducing prejudice about ABD, by increasing knowledge about the problem.

On the other hand, it is important to develop local intervention that involves the beneficiaries in decision-making and promotes active participation aimed at their autonomy. Involving the various stakeholders in a logic of dialogue and participation, through collaborative

methodologies, allows for bottom-up intervention that provides individual and community empowerment.

Intervention aimed at institutions and the community itself helps to increase the opportunities and resources available to fulfil individual and social rights and promotes the viability of individual integration itineraries.

Recommendation 6. Creation of a "Community Care Network"

The results achieved in the 18 reintegration processes studied are the result of the intervention of the social workers, but also of other professionals and stakeholders. The impacts produced are the result of the combined efforts of the multidisciplinary team of each LIU, the person with ABD, their family or significant others, as well as several partner organisations in each territory. The integration of all these contributions, with articulated and common objectives, made it possible to build interdependence between the different interventions, in a logic of integrated work.

However, the operating model of social organisations has been characterised by excessive institutionalisation and a highly bureaucratised organisational structure that has encouraged the excessively administrative management of social problems. This has led to social intervention practices that run the risk of blaming individuals for their problems and focus essentially on individual (micro) and family (meso) work, abandoning the community dimension or reducing it to the articulation of institutional resources under the guise of inter-institutional work, with an overload of effort for professionals (social workers and others).

The configuration of social services based on standardised demand (framed by the pre-defined target public and the functions they perform) and the development of a fragmented and sectorised social services system by area (education, health, social protection, justice...) are two factors that add to those presented (institutionalisation of resources and bureaucracy). These factors have greatly contributed both to the devaluation of community work of building, repairing and transforming networks, where the formal dimension (social responses) and the informal dimension (family and neighbourhood) come together, and to the development of residual community practices.

Considering the multiplicity of problems that are present and associated with ABD - the diagnosis made revealed numerous weaknesses that call for multi- and interdisciplinary intervention - intervention in this area must be based on integrated networking, of a community nature, since the problems are not only multiple, but also extend beyond the health area. It is essential to promote the creation of a "Community Care Network" made up of a network of human resources of a technical and supportive nature that will also enable a holistic response to the needs of citizens with ABD in their reintegration process.

This network, built on a territorial and community logic, must be "fed" regularly and communication between its members promoted. Smooth communication channels and flows facilitate the provision of care, reducing noise and response times. Other strategies that can be useful for building an effective network are training initiatives aimed at members of the "Community Care Network". In this context, training sessions or the creation of Communities of Practice can be initiatives to increase the knowledge of each actor about the intervention of the others, highlighting how they should complement each other, thus contributing to the growth of this network.

Recommendation 7. Integration of the area of social intervention in ABD into interdisciplinary research concerns.

The research process is never closed. It provides answers to the questions that guided the research and creates opportunities for new questions to emerge from the results obtained. The mapping of problems, intervention processes and results, which involves a comprehensive and detailed look at the model of social and community mediation, such as the one presented here, opens up new avenues for the construction of other research objects directly connected to reintegration intervention. These include: collaborative methodologies and participation dynamics in reintegration processes; community intervention and the construction of solidarity networks; the dimensions of conflict in ABD and conflict management processes; and the potential of community intervention to change representations about ABD, among others.

In order to enable the development of future research and validate the knowledge produced with scientific rigour, it is recommended that the area of reintegration in the context of ABD is integrated into the interdisciplinary research concerns of SICAD and the Regional Health Administrations.

The diversity and depth of the information gathered in this study allows for the development of new readings and complementary analyses by cross-referencing variables and provides the basis for new research and reflections on the reintegration of people with ABD.

This work has highlighted the comprehensive arguments of the ABD phenomenon, the complexity of the intervention processes and the multidimensionality of the effects of intervention, which reflects the efficiency and effectiveness of the conceptual and operational model analysed here.

Bibliography of the Research Final Report[3]

Alarcão, M e Sousa, L. (2007). Rede Social Pessoal: Do conceito à avaliação. *Psychologica,* 44, 353-376.

Almeida, H. e Carvalho, S., et al (2014). *Linhas Orientadoras para a Mediação Social e Comunitária no âmbito da Reinserção de Pessoas com Comportamentos Aditivos e Dependências*, Lisboa, SICAD.

Almeida, H. e Carvalho, S., et al (2018). *Linhas Orientadoras para a Mediação Social e Comunitária no âmbito da Reinserção de Pessoas com Comportamentos Aditivos e Dependências*, 2ª Edição, Lisboa, SICAD.

Amit, V. (2000). *Constructing the Field*, Londres: Routledge.

Baggio, M.A., e A.L. Erdmann. (2011) "Teoria fundamentada nos dados ou Grounded Theory e o uso na investigação em Enfermagem no Brasil." *Revista de Enfermagem* III Série, n. 3: 177-185.

Bardin, L. (1979). *Análise de conteúdo*. Lisboa: Edições 70.

Barrón, A. (1996). *Apoyo Social: aspetos teóricos y aplicaciones*. Madrid: Siglo Veintiuno Espana Editores.

Berelson, B. (1971). *Content Analysis*, Chicago: Univ. of Chicago Press.

Carvalho, S. (2007). *Manual de Boas Práticas em Reinserção (1º caderno). Enquadramento Teórico*, Lisboa, Instituto da Droga e da Toxicodependência.

Charmaz, K. (2001). "Qualitative Interviewing and Grounded Theory Analysis", in Jaber Gubrium e James Holstein (ed.), *Handbook of Interview Research – Context & Method*, Thousand Oaks/London/New Delhi, Sage Publ., 675-694.

Coutinho, C.P. (2013). *Metodologias de investigação em ciências sociais e humanas: teoria e prática*. Edições Almedina.

Coutinho, C. e Chaves, J. H. (2002). "O estudo de caso na investigação da tecnologia educativa em Portugal" in *Revista Portuguesa de Educação*, 15 (1), Universidade do Minho, pp. 221-243.

Creswell, J. (2014). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*, Sage, 273 pp.

Dantas, C.C., J.L. Leite, S.B.S. Lima, e M.A.C. Stipp. (2009). "Teoria fundamentada nos dados ou Grounded Theory e o uso na investigação em Enfermagem no Brasil." *Revista Latino Americana de Enfermagem* 17, n. 4.

Fernandes, E.M., e A. Maia (2001). "Grounded Theory." In: *Métodos e técnicas de avaliação: contributos para a prática e investigação pscicológicas*, por Eugénia M. Fernandes e Leandro S. Almeida, 49-76. Braga: Universidade do Minho. Centro de Estudos em Educação e Psicologia.

[3] Almeida, H. et al (2020). *A Intervenção em Reinserção de Pessoas com Comportamentos Aditivos e dependências: processos e resultados da aplicação do modelo de mediação social e comunitária. Relatório final*, Lisboa, SICAD

Ferreira, D.A. (2013). "Discussões sobre a natureza paradigmática da Grounded Theory", XXXVII Encontro da ANPAD, Rio de Janeiro.

Flick, U. (2009). *Introdução à Pesquisa Qualitativa*, Porto Alegre, Artmed/Bookman, 3ª Ed.

Gerson, R. & McGoldrick, M. (1993). *Genogramas en la evaluación familiar*. Barcelona: Gedisa.

Guadalupe. S. (2009). *Intervenção em Rede. Serviço Social, Sistémica e Redes de Suporte Social*. Coimbra: Imprensa da Universidade de Coimbra.

Guerra, I. (2000) *Fundamentos e Processos de uma Sociologia de Acção – O Planeamento em Ciências Sociais*, Principia, Cascais.

Guerra, I. (2006). *Pesquisa Qualitativa e Análise de Conteúdo*. *Sentidos e Formas de Uso*, Estoril: Principia.

Hastrup, K e Hervik, P. (1994). *Social Experience*, Londres: Routledge.

Instituto da Droga e da Toxicodependência (2009). *Linhas Orientadoras para a Intervenção Social. Modelo de Intervenção em Reinserção*, Lisboa.

Instituto da Droga e da Toxicodependência (2004). *Novas perspectivas, Novos Horizontes. Coletânea de textos do Workshop de Reinserção*, Porto.

Krippendorf, K. (1980). *Contents Analysis: an Introduction to its Methodology*, Beverly Hills, CA: Sage.

Krüger, L.L; Werlang, B.S.G (2008). "O genograma como recurso no espaço conversacional terapeutico". In *Avaliação Psicológica*, 7 (3), pp. 415-426.

Ló, A. (2007). *Contextos de Trabalho e Processos de Integração de Toxicodependentes*. Coleção Estudos, Instituto da Droga e da Toxicodependência: 3, Lisboa.

Ló, A. (2011). "Integração Social e Estratégias de Mediação" in *Toxicodependências*, Vol. 17 n.º 1, Instituto da Droga e da Toxicodependência, pp. 53-60, Lisboa.

Lessard-Hebert, M., Goyette, G. Boutin, G. (2010). *Investigação qualitativa: Fundamentos e práticas*, 4ª Edição, Lisboa: Instituto Piaget.

Moreira, C. D. (2007). *Teoria e Prática da Investigação Social*, Lisboa: ISCSP, UTL.

Panagiotou, G. (2003). *Melhores práticas Upfront: Trazer Swot em foco. Estratégia de Negócios Review*, 14 (2), 8-10.

Poirier, J. e Valadon, C. (1995). *Histórias de Vida – Teoria e prática*, Oeiras: Celta Ed.

PORI – Programa Operacional de Respostas Integradas (2008). *Eixos de Intervenção: Componente Técnica e Financeira*, Instituto da Droga e da Toxicodependência, p. 88, acedido em 20/12/2020: http://www.sicad.pt/PT/Intervencao/ReinsercaoMais/SitePages/Home%20Page.aspx

Quivy, R.; Campenhoudt, L.V. (2003). *Manual de Investigação em Ciências Sociais*, 3ª edição. Lisboa: Gradiva.

Sluzki, C. (1996) *La Red Social: Frontera de la Practica Sistémica*, Coleção Terapia Familiar, Barcelona: Editorial Gedisa.

Sousa, P. e D'Almeida, J. (2016). *Avaliação Diagnóstica na prática do Serviço Social*, Viseu: Psicossoma.

Stake, R. (2012). *A Arte da Investigação com Estudos de Caso*, Lisboa, Fundação Calouste Gulbenkian (3.ª ed.)

Strathern (1987). *Dealing with Inequality: Analysing Relations in Metanesta and Beyond.* Cambridge: Cambridge University Press.

Turner, S. (2010). *Ferramentas de Apoio à Gestão – guia essencial para o gestor de sucesso*. Monitor – Projectos e Edições.

Vala, J. (1986). "A análise de Conteúdo", in Silva, A.S. e Pinto, J. Madureira (org). *Metodologia das Ciências Sociais.* Porto: Edições Afrontamento.

Valentim, R.K. (2001). "SWOT Analisis Frame Resource – Based View", *Journal of Marketing Theory and Practice*, (9): 54-68.

Wenger, E., McDermott, R. and Snyder, W. (2002). *A Guide to Managing Knowledge - Cultivating Communities of Practice*. Boston: Harvard Business School Press.

Yin, R. (2001). *Estudo de Caso: Planeamento e Métodos*, 2ª Edição, Porto Alegre: Bookman.

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