Social intervention with families in a situation of chronicity in basic social care services

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Abstract

Families in situations of chronicity and dependency on social services constitute just one of the profiles professionals forming basic social care services deal with. The risk of dependence on the part of these families often stems from two aspects: firstly, the gradual delegation of basic functions onto institutional and professional structures; and, secondly, lack of knowledge or difficulties for professionals when it comes to determining the most suitable models and methods for intervention. In addition to these aspects there are contextual factors relating to financial vulnerability and inequality which trigger processes involving social exclusion and, furthermore, chronicity. This article sets out the foremost elements established in the research project "Social intervention with families in situations of chronicity in basic social care services", which was conducted on the context of the 8th edition of the Dolors Arteman Prize awarded by the Official Association of Social Work of Catalonia to the social workers team of Lleida City Council and the University of Lleida.

Keywords: Chronicity, dependence, social intervention, empowerment

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1. Contextualization

The motivation for conducting the research "Social intervention with families in a situation of chronicity in basic social care services" stemmed from the basic social care service (BSCS) professionals from the city of Lleida themselves. They reported on the worsening of family situations in which they intervened on a permanent basis wherein there was no development of the situation towards family autonomy, giving rise to discontentment among the professionals, aside from dependence on the part of said families.

Starting from this initial situation, we considered conducting a study from a participatory action/research approach in order to identify key aspects that would enable us to reflect on and understand the phenomenon in greater detail. These aspects focussed on elements such as the profile of chronic families served by BSCS, the type of intervention carried out by social workers over time, and the way the families perceived their situation of dependence. The aim of finding out this information would be to propose new intervention strategies enabling more positive outcomes to be achieved.

According to Ginesta, Civit, Rivera and Rodríguez (2017), individuals or families defined as being in a chronic situation require long-term intervention since their situations are highly complex. They are often individuals and families in a situation of social exclusion, with varying kinds of difficulties or needs and which, according to the authors, may be defined as follows:

– Lacking autonomy (i.e., social or functional dependence, health – mental or physical illnesses and addictions).
– Encountering difficulties in interacting (social integration or interaction, with an inadequate, insufficient or non-existent social support network).
– Having instrumental and material needs (subsistence).

The combination of various needs may give rise to complex situations that have a tendency to become chronic unless suitable treatment or a response is provided. As Rodríguez (2003) mentions, chronicity is one of the characteristics of these multi-problem families and the relationship formed between them and the services. Nevertheless, Rodrigo, Máiquez and Martín (2011) point out that systematically naming or labelling these families as multi-problem, multi-supported, dysfunctional or broken adversely affects their potential for recovery. Likewise, a shifting of family and parental responsibilities to professionals is brought about as a consequence of sustained multi-support over time and the gradual invasion in all aspects of family life.

It is necessary to bear in mind that the time factor ends up being a constraint. According to Escudero (2013), it is a component that nega-

tively heightens the final outcome because the chronic time factor of an imbalance makes it more serious. Conversely, shorter time in this state is linked with greater resilience and a better assurance of balance. The aforesaid author refers to two structures affecting chronicity: firstly, one formed by bio-psychosocial conditioning factors that prevent the family from progressing, solving or overcoming their situation; and secondly, the structure of bio-psychosocial resources that may be mobilized within the family environment in order to encourage change.

It is also essential to take into consideration elements relating to chronicity, aside from intra-family factors, which are a major conditioning factor to the chronification of vulnerable families. We are referring to ongoing financial vulnerability, which may trigger processes of social exclusion and dependence on BSCS professionals. The context of the recession over the past 10 years has given rise to situations of chronification in families that have been pushed into highly unstable employment situations, resulting in financial and residential problems, among others. These were not typically multi-problem families, nor were any risk indicators or prior trans-generational aspects present that would point to their initial relationship with and subsequent dependence on social services.

With regard to these "new families" tied to BSCS professionals, financial poverty has immersed them in a situation of social complexity with gradual impairment of their capacities and latent potential, leading them to end up developing problems that become worse and cause the cycle of chronicity to emerge and become cemented.

Difficulties in tackling these cases have harmful effects among BSCS professionals, such as burnout (Lázaro, 2004), fatigue due to compassion (Campos, Cardona and Cuartero, 2017) or anticipatory anxiety (Coletti and Linares, 1997), which are triggers that need to be taken into consideration in the work performed with these kinds of families. These feelings affecting professionals are linked to unsuccessful strategies that fail to produce positive effects for the families or the professionals themselves. This is added to the powerlessness of all parties in being able to secure a response to the context in order to beat the sustained situation of vulnerability in time.

If we change perspectives and shift the emphasis onto strengths, intervening in relation to them may balance specific aspects that cause complexity in interventions, such as asymmetry in power relationships. It is necessary to bear in mind that lack of power is inherent to the reason why families in a situation of chronicity seek help. If the approach centres solely on shortcomings, vulnerability is reinforced and the unequal relationship is highlighted. On the other hand, according to Paz, Rodríguez and Mercado (2014), if professional practice is conducted from the standpoint of highlighting strengths, without overlooking the actual problems, a different vision of the other may be portrayed. Accordingly, applied to social work, empowerment would be a cooperative process of mutuality through which the families and their members may individually and in conjunction with the social worker achieve awareness and heightened personal power

throughout a process in which certain goals are set and work is carried out in order to reach them.

Along these lines, Richmond (2005) states that individuals may become paralyzed if they are treated as beings who are to be instructed and when the professional is established as the benefactor. An attitude of compassion is a huge barrier to development because, in short, the positive perception is enhanced if wellbeing can be achieved on the basis of existing elements on which progress can be achieved rather than if others come up with said elements.

Placed in this complex situation, we rest on the words of Brugué (2016) suggesting that to combat poverty new responses are called for and innovation becomes necessary. The ideas and tools used thus far to combat poverty are proven to be insufficient in order to address the complexity of this new phenomenon, according to the author. He also states that the tools used have failed in the case of families in a situation of chronicity and conventional dependence. Consequently, we need to generate updated tools and ideas. Along these lines, any process of innovation must be embarked upon by taking on the problem and acknowledging the inability to solve it using the approach adopted hitherto. This entails a radical change of approach for both professionals and institutions.

2. Methodology

In order to conduct this research we ventured for a mixed methodology with a participatory action/research approach because, as indeed López de Ceballos (1998), Marchioni (1999) or Barbero and Cortés (2005) point out, we believe that in the social sphere a collective approach is required where all actors involved in the research are active subjects.

The techniques used were quantitative (statistical analysis) and qualitative (family talks, self-assessments and group discussions with professionals). With regard to the quantitative aspect, this has been performed by means of access to the database used by Lleida City Council to store information managed by BSCS professionals. This data has been processed statistically by the programme Statistical Package for the Social Sciences (SPSS). With respect to the qualitative aspect, below a more in-depth explanation has been given of two of the techniques applied. In relation to the third technique –group discussions–, a total of six were organised between October 2017 and May 2018, which were arranged in order to address the issues that arose in the various stages of the study with the BSCS professionals.[4]

4 For statistical processing, a process of anonymization of the personal information in the database has been conducted. With regard to participation in family talks, the informed consent procedure has been followed with the participants. Moreover, the research team has conducted this study adopting the guidelines of the code of ethics established by the Official Association of Social Work of Catalonia with regard to the need to ensure that the goals and outcomes of the research conducted may have a positive impact on the individuals studied.

The time factor in choosing the sample

The families considered to be in situation of chronicity were chosen based on the time factor. This decision stems from the consensus of the research team, based on criteria founded by Escudero (2013). It was deemed that regular contact over a period of 10 years or more was a suitable timeframe in order for it to be considered that a situation of severe chronicity and dependence on BSCS professionals applied. Nevertheless, other situations involving shorter timeframes could be taken into consideration if they exhibited a tendency towards severe chronicity.

On the basis of this premise, we performed our analysis based on three distinguished situations. Firstly, we worked with a total of 403 case files that have been worked on continuously over the 10 years prior to the start of this research. These individuals have been receiving some kind of intervention from social services over this period. We described this first group as the “high chronicity” group.

Secondly, we took into consideration a total of 453 case files comprised by individuals who had received intervention for between 6 and 9 years overall in the 10-year period prior to the study. We described this group as the “moderate chronicity” group. The final group, formed by 111 case files, is formed by beneficiaries who received assistance for between 2 and 5 years overall in the 10-year period prior to the study. This group has been described as comprising individuals receiving “occasional care over the past 10 years”. Overall, a total of 967 cases were included in the study.

The adoption of a comparative perspective was implemented in order to gain a broader vision of the phenomenon, which could provide us with more specific information about the development process that characterises individuals and families who are edging towards a situation of chronicity within social services.

Self-assessments from the professionals

One of the issues that interested us in particular in order to meet the goals set out in the participatory action/research approach was self-reflection on the part of professionals with regard to their task over time, understanding the message that goes with their assessments. This aspect was carried out by means of a self-assessment. It is a tool that helps us to think about our job as it provides us with perspective and, at the same time, reveals the narrative behind the reflection and analysis, whilst also being a tool with which the means of intervention is justified and given meaning. It becomes a self-exam in order to learn as it enables individuals to stop, think, and promote positive best practices or elements and build on what has worked. With regard to chronicity, this technique provides us with indicators in order to be able to identify our responsibility in the dependency and autonomy processes experienced by families.

Aside from establishing relationships with models, theories and the methodology specific to social work, as well as the ethical issues associated with the intervention, the self-assessment prepared incorporated elements and indicators that also seek to place the emphasis on a host of

aspects, such as: involvement in the case and with the family; expectations towards users; the rights perspective; encouragement of autonomy and participation; and the gender perspective, among others.

According to Julià and Pirla (2017), self-assessments must be carried out under the principles of honesty, ethics and objective, holistic, and critical vision, based on the methodological and theoretical reasoning of social work. Although some of the information compiled could be obtained using the existing database, the aim is for professionals to review, re-read and reflect on the data they gather in order to gain an awareness of the work they have been performing normally for several years, often without a critical perspective. In all, 71 self-assessments were conducted by social workers from the various BSCS areas of Lleida city.[5]

Family talks/appreciative dialogues

We have incorporated the technique of *family talks* raised by Marchioni (1987) in order to understand the way families view their reality from a more realistic standpoint, free of prejudice. According to Marchioni, "the social worker approaches individuals because they themselves exhibit problems and solutions, difficulties and potential, so that change is brought about from what they see, understand and want to change" (Marchioni, 1987, p. 92).

Marchioni reminds us that family talks prepare us for the intervention, for the action of change. We are adding other elements to this technique which complement it and stem from *appreciative inquiry* (Subirana and Cooperrider, 2013) and *appreciative dialogues* (Barranco, 2011). Appreciative inquiry changes a traditional view of research based on identification of shortcomings, and puts forward an opposing view based on the ecology of strengths. To begin, its name anticipates two components of its essence: inquiring about the search for strengths and appreciating what is relevant and significant. This technique brings to the fore the resources individuals have based on the recognition of existing success factors. At the same time, it encourages them to personally point out problems and solutions, difficulties and potential, so that change is brought about from what they see, understand and want to change.

With regard to appreciative dialogues, we associate ourselves with the following proposal put forward by Barranco (2011, p. 63), in which:

> [...] they provide us social workers with strategies in order to discover how to promote best practices of quality; to benefit from positive tools to engage in the actions of accompanying and encouraging the involvement of each participant –at individual and collective moments– fostering appreciative dialogue-based processes to encourage shared actions and visions and successful practices among groups, organizations and communities.

5 The self-assessments and the family talks have been carried out on families deemed as suffering high chronicity, i.e., those who have received continuous care from the BSCS over a period of 10 years or more.

Another element on which we base this qualitative technique is taken from Campanini (2016), who considers the need to empower families in solving their problems through the use of the dialogical assessment model. This technique is a tool that allows for direct participation by the family both in the information collection stage and in the definition of the areas on which the project goals will be focussed.

Throughout the research, 31 talks/appreciative dialogues were carried out. They were carried out at individuals' homes and all major members of the nuclear family were included. The goal was to obtain information of a trans-generational, gender-based, cultural, cognitive, and emotional nature relating to their family and personal circumstances over time. It was deemed to be highly significant to create and provide this new framework for joint work in conjunction with the family and define the future course of the intervention based on this meeting in the form of a talk. For this reason, it was incumbent on the professionals from the BSCS in contact with the families to engage in this technique.

3. Analysis of the family profile and significant variables

By means of a cluster analysis of the host of data linked to the 967 case files worked on, we have obtained three different profiles in relation to users in a situation of chronicity:

- Elderly women, with organic diseases, pensioners, who live alone, indigenous, and who have been receiving care for an average of 8 years, and which we have referred to as "tough senior women".
- Men who live alone, indigenous, with an average age of 56.8 years, who are unemployed or in receipt of the guaranteed minimum income, and who have been receiving care for an average of 8.9 years, referred to as "dependent men".
- Women with an average age of 46 years, indigenous, unemployed, not in receipt of any benefits, who have a nuclear family and who have been receiving care for an average of 8.4 years, referred to as "courageous mothers".

If we focus on the high chronicity clusters, two profiles emerge, one of which is replicated in the general analysis while the other incorporates a Roma ethnic factor from a specific neighbourhood in the city:

- Elderly women, with organic diseases, pensioners, who live alone, indigenous, most of whom live in the Antic Oest neighbourhood. We have referred to this profile as "tough senior women".
- Middle-aged women (50.5 years), unemployed, who have a nuclear family, do not suffer illnesses, are currently in receipt of the guaranteed minimum income and most of whom are Roma

and live in the Mariola-Blocs neighbourhood. We have referred to this profile as "courageous Roma mothers".

Statistically significant variables in relation to the type of chronicity are: the neighbourhood; the type of family (living in a couple in moderate chronicity and, in particular, the situation of the single mother in high chronicity); and the number of members in the family (families with more members are more commonly in high chronicity than in other situations). The presence of children in the nuclear family is also significant (we have noted that high chronicity is linked to there being more dependent children).

Origin or ethnic group also relates to chronicity, particularly in the case of Roma families in high chronicity situations, or Latin American families, in moderate chronicity situations. Education level is also an important factor in chronicity. Illiteracy is a major factor in high chronicity.

The employment situation is also important. Being a pensioner is noteworthy among those in moderate chronicity and many of those receiving occasional care are on a salary. Unemployment is a common trait among those in high chronicity. Illness is also related to the type of chronicity, where mental illness is a significant factor among those in high chronicity. Being in receipt of the guaranteed minimum income is also a major factor among those in high chronicity.

Along these lines, it can be stated that families in high chronicity in which situations of economic poverty, family responsibilities, health problems, low education level, long-term unemployment or reliance when it comes to benefits such as the guaranteed minimum income, urgently require differentiated, priority action from the BSCS.

4. Analysis of elements linked to professional intervention and chronicity

If we take into consideration the problems linked to high chronicity, we can state that they witness a gradual increase. High chronicity has led to the resources spent on intervention skyrocketing in recent years, particularly in terms of in kind material resources. The response to this is based on more interventions, more home visits, and, above all, the provision of more financial and in kind resources.

In parallel, it should be noted that the number of contact professionals that families have had increases substantially among the high chronicity group, accounting for an average of 6.6. This is an element that distorts the relationship of support and ties in view of the constant changes this rotation triggers.

Home visits are at an average of 5 (among those in the moderate group, the figure is 3.4), which is a very low number when compared to the use of other techniques. Accordingly, the number of interventions performed (primarily in-office interviews) comes to an average of 120 among the high chronicity group (equivalent to 10 interventions per year).

With regard to the strengths of families and individuals in a high chronicity situation, they have been undervalued inasmuch as, in most cases, interventions have not been targeted in order to strengthen them. On the other hand, weaknesses have been in the crosshairs, giving rise to low self-esteem and hindering the triggering of bio-psychosocial resources in order to cope and forge ahead.

Families end up shifting the locus of control onto external factors that do not enable them to progress autonomously. This entails lack of responsibility over their lives and their autonomy. It also affects the professionals, who are required to engage in multiple interventions in time that are sometimes handed down to new generations joining the BSCS for them to continue.

From this angle, families place the blame for their situation on aspects such as difficulty in finding or holding down a job, their health, or the recession, and this does not help them to overcome their situation. Accordingly, they place their expectations of "recovery" in the system, the professionals, or the public authorities. In addition, the trend among professionals is the same: they blame the system, the organisation or families for their dependence.

Another element to bear in mind is the fact that the professional interventions carried out reaped negative outcomes in terms of autonomy. It is clear that the strategies followed were futile in improving this aspect for the families and the individuals assisted. Nevertheless, positive areas may be gleaned, inasmuch as the bond has provided security for coping and moving forward, even though in itself and with the resources provided it has not brought about other improvements or major changes.

If autonomy is the goal of social work, the resources offered by BSCS fail to achieve this. A failure on the part of social services, and of welfare systems generally, is identified in this respect, giving rise to negative impacts on social work professionals and families. Another idea we arrive at is the fact that the organisational system and the institution itself have favoured the implementation of intervention models based on *benefits*. The heavy bureaucratization of social services means that the paternalism of professionals is highlighted as a result of the administrative rationale in which they are shrouded.

The risk is that the profession will largely opt to identify social work by means of "efficient and effective" management of social resources. Despite this, it is important not to forget that management of resources is tied in with social rights and their equitable distribution, an essential duty of a social state governed by the rule of law in which, owing to their circumstances, there are individuals who need this support throughout their lifetime. In these cases, it is important to understand that the system is not one of dependence generation; rather, it becomes an asset inasmuch as the supervision that can be carried out by social services is a key, positive element in helping individuals to survive and resist throughout their lives. In other words, being accompanied by professionals through care, protection, and security will help users benefit from a better quality of life.

It is vital to strike a balance between empowering professional intervention and the provision of material resources to meet needs. This provision should make it possible to alleviate the destabilizing effects of the current system. In this respect, we believe it is valuable to pick up on the approach of Cardona and Campos (2009) with regard to the suitability of distinguishing the contexts of intervention we may forge with families. According to the authors, a context of intervention is built by means of an explicit agreement between the system of support and the family. Consequently, depending on what stage the intervention is at, it may be placed within a context of care, information, counselling, clinical care, assessment or check-up. Based on this idea, we believe that it is necessary to define what family's needs are and the best way of meeting them in a participatory and consensus-based manner with said families, coming to arrangements in the medium-term to provide material security and enable us to progress with the intervention towards relational contexts of support that encourage autonomy.

Furthermore, the study set out professional concerns relating to a widespread perception of normalization surrounding instability affecting the group analysed in this study, as well as the implementation of certain social policies that drive away families and individuals from a social rights-based standpoint. It was deemed necessary for each institution to take on its responsibilities and to release the BSCS from the responsibility of acting beyond their limits. Upholding this trend only affords shortcomings and frustration due to wanting to achieve the impossible based on the respective responsibilities. Indeed, it is pointed out that it is necessary to venture for policies of employment, housing and guaranteed income that provide a response to families in a situation of instability from the standpoint of rights.

Another aspect stemming from the research which should be pointed out is the fact that women are the main contacts for chronic families and the BSCS. This situation should be borne in mind in particular as it is necessary to reassess intervention in terms of gender and, at the same time, try to involve men, if any, in the improvement of their family situation. By means of self-assessments and talks we have noted that the gender perspective is not well incorporated into intervention within social work, nor is the empowerment of women in a specific, proactive manner.

What is more, cultural diversity of immigrant families in a situation of chronicity is also lacking in terms of integration, and comprehensive models are not actively employed in the social intervention. Along these lines, if we focus on cultural diversity, the Roma group concerns professionals in particular. There is a feeling of despair with regard to their improvement and autonomy, resulting in trans-generational dependence on BSCS and institutions.

One other critical concern is the needs of children and teenagers in the more disadvantaged groups of those in a situation of poverty. At various points in the study we have seen that the generational legacy becomes obvious in many cases, not merely among the Roma group. On a

day-to-day basis, professionals see the generational transfer of chronicity and, despite expressing hope of a favourable change for their children, families do not see tangible prospects of overcoming this.

In this regard, if we want to reduce the chances of future dependence among children of chronic families on BSCS during their youth or adult stages, we must set up mechanisms for family support and specific intervention for the children. This must be carried out by means of access to training and education and, in parallel, by establishing the mechanisms needed to ensure the nuclear families themselves are endowed with the vital elements for upbringing, seeking to avoid delegating on third parties.

5. The perspective of families in a situation of chronicity

Through the family talks we have been able to establish what families in a situation of chronicity feel and think in relation to the professionals, the institutions, the support they receive and have received over the years, their future expectations, and the factors contributing to their dependence.

Firstly, families value the backing and support provided by social workers throughout their intervention. As we have mentioned, this support is primarily understood in terms of the provision of resources. They convey their respect for professionals and their social function and many value the support received aside from financial aid, acknowledging that the professionals are central pillars in their lives and their role is more on a par with that of the family than of a worker from the authorities. With regard to resources and financial aid they have received over the years, they consider it to be suitable but that it falls short when it comes to meeting all their needs.

Another aspect to point out is related to situations in which dependence on the BSCS takes place due to illness or any disability. Health problems are an aspect that is present within chronic families, and their deterioration compromises the rest of the nuclear family, particularly when it affects the leading family figure. Poorer health entails greater instability. Age and health are identified as elements that limit change and the future. Getting older inevitably brings with it a progressive physical decline. If health problems are added to this, the situation is viewed in a more negative light, as the individuals see themselves as old, ill, and alone.

We have noted that, as far as the professionals are concerned, chronicity is more easily integrated in cases where mental health, addictions or chronic organic diseases are present, as this type of profile is one where a dependence on third parties is assumed with a degree of clarity. Indeed, for the BSCS the task of support in handling their day-to-day affairs and help in meeting their basic needs is part and parcel of their duty. For this group, chronicity within social services could be considered a positive element that benefits individuals and families who will need support throughout their whole lives in all likelihood.

The families and individuals who took part in the talks state that they had never previously been asked about their strengths and, in general, they have difficulty identifying them. The families highlight the fact that they are tight-knit, like "bread and butter" in moving forward provided all members stay strong and stick together. Accordingly, the intra-family relational dimension comes first in terms of strengths.

With regard to the perspective of rights, although the professionals state that they worked in order to guarantee them, the families believe that they lack sufficient knowledge as to what they mean. On several occasions, this aspect is solely equated to claiming specific benefits or resources.

Moreover, in many cases they express that respect towards the professionals is a duty, acknowledging the need to follow any directions the professional hands to them, understanding that this is their obligation, particularly those instructions relating to care and schooling of children. We are once again faced with the need to intervene with caution and sensitivity to avoid slipping into an abuse of power, given that the individuals we work with see us as holding power. In this respect, Jiménez (2002) states that social work professionals may end up engaging in abuse, such as: discretion (service users' dependence on the decision-making capacity of the professional); lack of active participation from service users in organisations; and the consequences of bureaucracy (focussing on technical aspects and the administrative process of the service leads to lack of flexibility and dehumanization of care).

Absence of connections is another problem that arises in many cases. It often emerges in individuals in the nuclear family as a need to be closer to the family and at other times it is an aspect that relates more to the need for affection and a partner. Lack of relational support is another frequently observed weakness, and in this void of informal support the social worker emerges as a pillar for the family. Families downgrade their involvement in the social intervention process and state that they do not feel involved, while professionals rate this aspect as satisfactory in their self-assessments.

Moreover, families feel they are victims of their fate, of institutions and of the social context. They feel powerless to change their lives. Although most point to the need to receive benefits and resources to survive, others go beyond mentioning material resources and state that they need someone they can rely on, someone to support them, to listen to them, and make them feel respected and dignified.

Faith in being able to have a better future is depicted in a negative light and shows little hope in most cases. Some families associate a better life with a concept of normality within the framework of the traditional family: a couple with children, whose material needs are met, with employment and a home. Indeed, they place their hopes in their children's generation but not in themselves. By and large, the families want a better future for their children, who they see as having greater potential and they place their hopes in them benefitting from a dignified life, without depending on anyone, avoiding repeating certain patterns that they acknowledge

have not favoured themselves. Despite this, they are not entirely sure about these more favourable expectations, and it is not due to lack of capacity or skills, but rather owing to the current circumstances of the recession, which limits access to certain training and the labour market.

In this regard, a weak self-perception of families is observed along with poor willingness to change. They speak of wanting to be happy, to have peace of mind, but of also experiencing feelings of loneliness and lack of support, as well as not being able to envision the possibility of a future without help from the BSCS. The professionals have a similar perception of families, despite expressing higher expectations than those reported by the families with regard to their situation.

6. Final notes

In order to conclude the various aspects we have highlighted in this paper, which are covered in greater depth in the research published by the Official Association of Social Work of Catalonia, we wish to point to the suitability of focussing social interventions on the individuals in order to combat institutional dependence. We believe this lays the foundations on which any innovation in the public administration should be hinged when its goal is to prevent and ease situations of chronicity.

In addition, assuming chronicity in the diagnosis is vital in order to understand and re-focus interventions, and to adapt them to the specific characteristics of each case. It is appropriate to bear in mind that there will be especially complex cases where the social worker and other professionals from the social and healthcare fields will be present throughout the user's lifetime. We should understand this circumstance as being an asset that benefits these individuals, and make a distinction between this and other situations where professionals incite or maintain dependence on resources or services in view of the fulfilment of a praxis scarcely centred on autonomy, in which institutions hinder processes of change.

In short, it is once again relevant to promote the intervention and methodology inherent to social work: ensuring the building or rebuilding of ties and relationships; fostering the assurance of rights; and promoting accompaniment and support from the standpoint of individual work and a community-based approach. We believe that only with a critical approach to the current paradigm will it be possible to reintroduce genuine social work that can use the BSCS as a channel to generate different effects within families in a situation of chronicity. Indeed, we as the institutions and professionals forming part of this reality must rest on the criteria of organizational ethics in order to advocate this new rationale, providing our knowledge in order to create conditions conducive to this change.

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