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The Amunt! Pilot: Integrated and comprehensive attention for sociolaboral inclusion

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The Amunt! Project (2022-2023) has been an experimental pilot initiative driven by the Barcelona City Council and the Ministry of Inclusion, Social Security, and Migrations. The project aims to test and evaluate a new socio-labour service that, through a more comprehensive and integrated approach, improves the inclusion of individuals in the city benefiting from the Minimum Living Income. Operating as a "one-stop-shop," the service establishes a single methodology for the entry and follow-up of individuals, providing access to a diverse set of actions. The model is based on three interconnected elements: comprehensive reception and diagnosis of the individual, their enrolment in one or more actions tailored to their profile, needs, and interests, and personalized support to help them navigate their journey. While impact evaluation results are pending, this document presents and analyses the project's experience and implementation.

1. Context and Background

The Minimum Living Income (IMV) holds a prominent place in the recent evolution of Spain's minimum income guarantee system (Arriba González de Duana and Aguilar Hendrickson, 2021b). Urgently introduced during the pandemic spring of 2020, it integrated a non-contributory benefit into Social Security, recognized as a subjective right for households with considered insufficient incomes. By the end of 2021, with the approval and implementation of Law 19/2021 establishing the IMV, this first nationwide minimum income program was solidified. It coexists today with regional minimum incomes and local emergency social aid, among others. The political and academic debate sparked by this change has been significant and adds to discussions on the need to review active employment policies, the role of social services, and the relationship between protection and activation.

Specifically regarding the IMV, the national government, through the Ministry of Inclusion, Social Security, and Migrations (MISSM), simultaneously launched a set of projects aimed at increasing its effectiveness. From the regulations governing them, it is evident that MISSM assumes that if the monetary benefit alone proves insufficient to reduce the vulnerability of its beneficiaries, it should be linked to active policies enabling their full social and labour inclusion. These interventions, in collaboration with autonomous communities, municipalities, or third-sector social action entities, have been deployed throughout 2022 and 2023, funded by the

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Recovery, Transformation, and Resilience Plan from the European Recovery Instrument (Next Generation EU). The projects are subject to external impact evaluations, conducted by CEMFI (Center for Monetary and Financial Studies) and J-PAL (Abdul Latif Jameel Poverty Action Lab), employing experimental RCT (randomized controlled trial) methodology, with results expected in 2024.

The Barcelona City Council, through the Area of Social Rights, Health, Cooperation, and Community, has been responsible for Amunt!, one of these projects. To launch it, valuable previous experience was drawn upon. Since 2014, the Làbora program, a public-social cooperation initiative aimed at the labour insertion of unemployed individuals using municipal social services, has been in place. Additionally, since 2008, Barcelona Activa, in collaboration with SOC, has implemented the Comprehensive Care Device in Priority Neighbourhoods (previously known as Work in the Neighbourhoods). Furthermore, between 2019 and 2022, Barcelona Activa executed the Bridges to Employment and Inclusion project, which included comprehensive socio-labour insertion pathways. Finally, Amunt! takes over from the B-MINCOME pilot (2017-2019), a comprehensive policy combining municipal emergency social aid with active socio-labour inclusion policies (educational, labour, and community-based), also evaluated with RCT methodology (Riutort, Laín, and Julià, 2023).

2. Experimental Design and Target Population

Fundamentally, the Amunt! project has been an active municipal policy that, for a year (from September 2022 to September 2023), offered various inclusive activities or services with a certain comprehensive –personalized– and integrated –intersectorial– vision. The target population for the intervention was 1,000 individuals from different households receiving the Minimum Income Vital (IMV) in the city of Barcelona. Few exclusion criteria were applied: only individuals over 65 years old were excluded, and, for technical and professional criteria, individuals from cohabiting units involved in studies or with child protection measures were excluded. Individuals with disabilities or those not using social services were not excluded.

The selection process for individuals had to meet the requirements of the impact assessment type to which the project was subjected. The Randomized Controlled Trial (RCT) experimental methodology is based on the comparative analysis of a group receiving the intervention (the treatment group) and another group not receiving it (the control group), both randomly selected from a defined universe of potential participants with similar characteristics. Randomization had to be carried out on a population adequately informed about the project and its evaluation, and prior signed consent had to be collected on paper. This involved a fairly complex contact process, requiring significant time and resources.

During June and July 2022, the Barcelona City Council contacted up to 5,472 potential participants who met the criteria identified from data provided by MISSM. They were contacted via letter and/or SMS and subsequently invited to one of the 60 informational sessions organized in different city facilities. 1,648 people attended, of whom 1,182 decided to participate in the project (21.6% of the contacted universe, 71.7% of attendees at the sessions), accepting the possibility of being part of the control group. Descriptively, these individuals were mostly women (63.9%) aged between 25 and 55 years (73.3%), although 24.3% were over 55 years old; 61.9% were of Spanish nationality, but there were more born outside Spain (65.9%); 18.4% had some recognized disability; 52.1% indicated a basic educational level, and 71.5% had not worked in the last six months.

Since, despite efforts, this number of individuals was smaller than planned, as the ideal goal was to have around 2,000 for two equally sized groups, evaluative teams determined that the treatment group would consist of 749 individuals and the control group of the remaining 433. Randomization balanced the two groups. However, to reach the target of 1,000 individuals served by the Amunt! service, a second recruitment of individuals with similar characteristics to

those already selected was conducted[1]. It was a different process, as those who agreed to participate would all receive the service and would not be part of the project's impact assessment for methodological reasons. An additional 80 people were successfully incorporated. Therefore, in summary, the total number of individuals targeted by the intervention was 829 people.

3. Description of the Intervention Model

3.1. Unique Reception and Support Process

One of the distinctive features of the Amunt! intervention is its reliance on a unique entry and follow-up process for individuals. The project's integration began with an initial reception conducted by professionals from a specific social services team to obtain a psychosocial diagnosis of the individual. Subsequently, and in coordination with the initial reception, a second reception was conducted by professionals from a job insertion team (orientation, training, and exploration). This second reception aimed to achieve a diagnosis in terms of employability and needs and interests, potentially linked to training activities. After sharing the results of the reception between the teams, which allowed for a comprehensive profiling of the individual, they worked with the individual to enrol them in one or several activities from the project's catalogue (linked to four areas: social, educational, employment, and community) that were not only aligned with their needs but also with their potential and interests. Additionally, to facilitate the activity, the individual received individual support, primarily from a professional from each of the two mentioned teams, who shared a common reference for the individual within the project framework.

The design of Amunt! is inspired by the basic logic of the one-stop shop (Askim et al., 2011; Minas, 2014). In other words, through a single entry point, access to services and activities that are usually offered—with varying degrees of coordination—separately or within specific sectors is provided. Behind Amunt! lies a multidimensional conception of inclusion. Therefore, the project is not oriented—solely—to formal labour market integration or improving employability but also aims to contribute to emotional well-being, social relationships, and community participation.

The diversity of activities—especially the emphasis on the development of social and community activities—and the plurality of actors executing them indicate this approach.

3.2. Catalogue of Inclusion Activities and Services

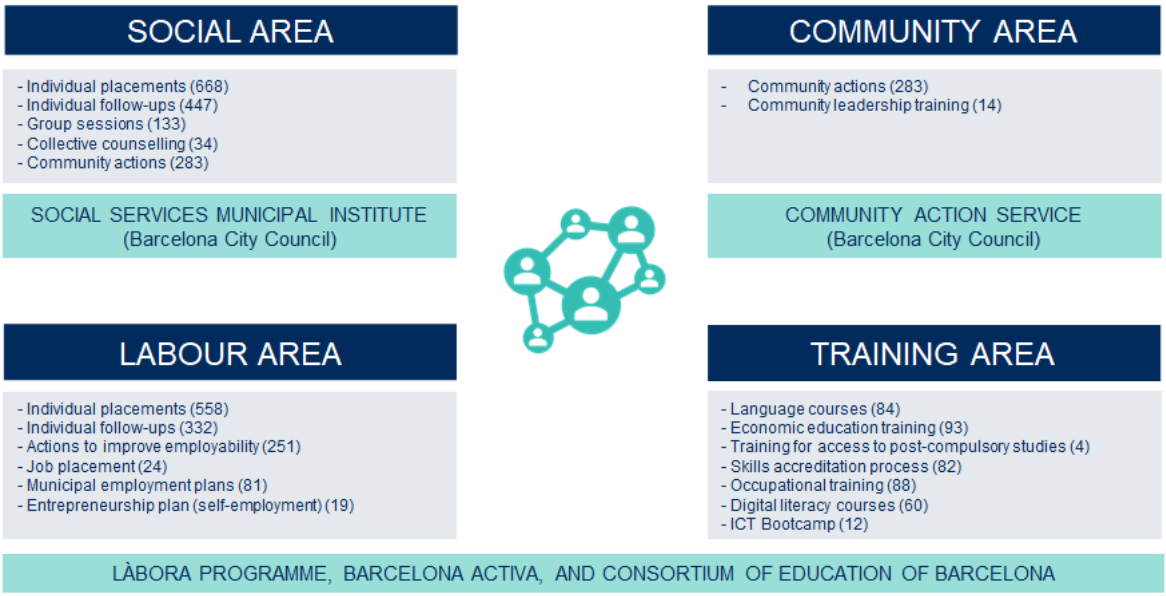
The actively participating actors in the intervention included the Municipal Institute of Social Services (IMSS), the Directorate of Community Action Services (SAC), Barcelona Activa, the Barcelona Education Consortium (CEB), and social entities from the Làbora program, represented by ECAS (Catalan Entities for Social Action).

At the governance level, a coordination and joint workspace was established for all these actors, led by the municipal area with the support of the Metropolis Institute. This working group or "core group" met regularly on a biweekly basis.

The catalogue of activities carried out within Amunt! was not created ad-hoc but was based on the actions typically offered by each of these actors, presented here in a framework of comprehensive and integrated perspective (Diagram 1).

1. In this second case, they were individuals benefiting from the Child Aid Supplement (CAPI), within the framework of the IMV benefit. None of these individuals had been contacted during the initial recruitment.

Diagram 1. Intervention scope, activities, participants, and actor



Source: Own elaboration.
Note: Based on project monitoring data, the number of participants for each activity is indicated in parentheses.

The social realm activities were carried out by the same team of social care professionals who had conducted the receptions (for 668 individuals, as the remaining declined to receive the service for various personal reasons or because they could not be contacted). During the project, the team performed orientation, support, and social and psychological accompaniment tasks—typical of social services professionals—in individual, group, and community sessions. The purpose of the care, beyond attempting to increase the autonomy of the individuals served, was also to facilitate their participation in project activities until completion. Additionally, the team carried out other actions such as coordinating collective advice sessions (34 attendees) on topics such as consumer rights, energy rights and habits, generic legal advice, or the municipal aid simulator. They also provided small-scale training and mentoring in basic economic education to help participants manage their individual and family finances[2].

Regarding community action, various activities were deployed by a team of three municipal social educators in close collaboration with the social care team. These actions included group dynamics, workshops, cultural outings in the city, and community leadership sessions aimed at working on people's social connections, relational skills, territorial roots, and their capacity for collective self-organization. The goal was for individuals to increase their social capital and knowledge about the socio-community fabric and local facilities, as well as to improve their emotional well-being by breaking situations of social isolation or unwanted loneliness. Up to 283 people participated in actions of this type at some point.

Activities directly related to the integration of individuals into the formal economy were carried out by social entities associated with the Làbora program and Barcelona Activa. Làbora professionals, in addition to leading the labour diagnosis of the reception process (for 558 people, as reception was not entirely relevant for those who were strongly removed from employability), also provided support and guidance in achieving activities and worked with individuals to enhance competencies for employment. They conducted sessions dedicated to improving employability (reviewing skills and interests, reinforcing skills and competencies, assisting in crafting resumes and preparing job interviews, etc.), benefiting 251 people. They also conducted research and selection of job offers (successfully placing 24 people). This team was distributed across nine service points throughout the city. In addition, Barcelona Activa implemented employment plans (six-month work experiences in municipal projects of collective

2. The specific professional practice of this team is analyzed in more detail in section 5 of this article.

interest) and a plan to support individuals interested in starting a business (self-employment) within the framework of the Social and Solidarity Economy. The participants in these activities were 81 and 19, respectively.

Finally, the catalogue included training activities. CEB was the main actor in implementing them, specifically: language courses in Catalan, Spanish, and English (84 participants); specific training for preparing for the entrance exam to post-compulsory studies (4 participants); support in the process of accrediting professional competencies acquired through previous work experiences (82 participants); and a series of occupational training courses at level 1, with no access requirements and associated with a professional auxiliary category (88 participants).

Regarding training activities, it is also worth mentioning that Barcelona Activa and Làbora developed technological training. The former conducted 40-hour courses on basic digital skills (digital literacy) that allowed for diagnosis, basic training (basic use of computers and smartphones, internet navigation, communication tools, document creation, etc.), and individualized technological support (60 participants). On the other hand, Làbora offered a TIC Bootcamp (12 participants), which was an intensive training (850 hours) in full-stack web development. Interestingly, this training was primarily aimed at women, with the intention of addressing the gender digital or technological gap and promoting their integration into the ICT industries.

4. Characterization of the Participant Population

One of the weaknesses of the Amunt! project design, as explained in more detail in section 5.4, is that there was not enough prior knowledge about the population that would be served. Being beneficiaries of the IMV suggested that they were likely not only in a situation of unemployment or lack of income. However, there were not enough descriptive elements available to assess their degree of vulnerability. As the project progressed, its leaders and intervention teams gradually understood the type of population they would be working with.

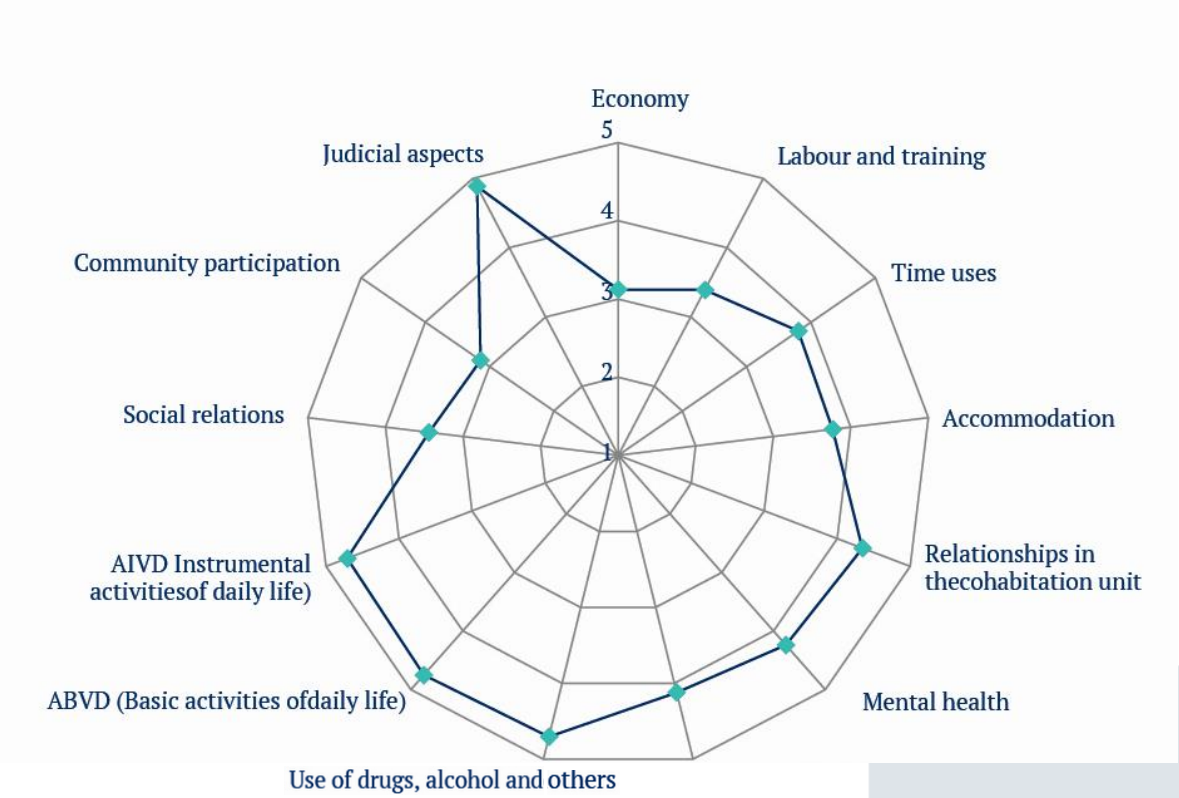
The initial lists sent by MISSM to the Barcelona City Council (April 2022) were cross-referenced with the Social Care Information System (SIAS), revealing that 26.8% of the people did not appear in it. This meant that they had never had contact with municipal social services. Furthermore, 62.8% of the registered individuals did not have open attention at that time.

Recruitment informational sessions were revealing, making it evident that the population being served often included individuals with communication difficulties, language barriers, physical and mental health issues, or cognitive limitations, among other situations. It seemed that the population to be attended to was in a more complex situation than expected, a diagnosis that the reception process confirmed.

In these initial individual interviews, the team used, to the extent possible, the SSM-Cat (*Self Sufficiency Matrix*), a diagnostic support tool. This tool allows professionals to measure a person's self-sufficiency or autonomy by analysing different categorized aspects of their daily life (13 domains or 17 in cases of individuals with dependents). Self-sufficiency is defined as a person's ability to achieve an acceptable level of functioning, taking into account the supports they have (from family or friends, but also professionals) to achieve or maintain this level. SSM-Cat includes five levels of self-sufficiency, with level 1 for situations of serious problems and/or unsustainable situations, and level 5 for maximum self-sufficiency. The tool, which IMSS has started to use, facilitates diagnosis and helps in professional decision-making by guiding intervention and follow-up. The clear representation of different dimensions makes it suitable for assessing the appropriateness of comprehensive approaches. The tool was considered not only for diagnostic purposes but also to measure the correlation between improvements observed in different domains and the itineraries undertaken in the project (as it was administered at the end of the project when possible).

The matrix below (Graph 1) aggregates the average scores in the 13 fundamental dimensions of self-sufficiency for 581 participants in Amunt! during the reception, as assessed by the tool. In very general terms, individuals showed low self-sufficiency in domains related to the economy, community participation, work and training, and social relations. These are the areas where the lowest levels of self-sufficiency were observed. It is also worth noting that the domains of time use and housing had scores below the level indicating significant self-sufficiency. This result primarily points to profiles of individuals facing economic, employment, and relational difficulties.

Graph 1. SSM-Cat Self-Sufficiency Matrix. Evaluations of the Amunt! Reception process.



Source: Own elaboration.

As the project progressed, the social care team began to identify more clearly the prevailing situations and profiles among the participating individuals, which can be summarized into three main categories. Firstly, there were the unemployed individuals (predominantly long-term unemployed), and although some were not actively seeking employment, they might have been part of active employment policies, whether or not linked to municipal social services. Secondly, individuals in situations of severe job precariousness were identified – referred to as "working poor" (Eurofound, 2017; Rodríguez Cabrero et al., 2019) – who held one or multiple jobs in the informal economy, the incomes from which served as a supplement to the shadow of the IMV[3].

Therefore, these were employable individuals, close to the job market – in fact, they were already part of it in some way – but lacking certain skills. In the third category, individuals clearly distant from the job market were identified, as they faced strong structural barriers (e.g., language ignorance, illiteracy, severe disabilities, or notable mental health issues, with or without a diagnosed disorder). For this third profile, employability would not be the priority dimension in their improvement process. The team also identified emotional distress as one of the common aspects among most individuals served.

3. Spain has one of the highest rates of occupational poverty in Europe: it affects 16% of households and continues to rise (Lanau and Lozano, 2022).

Their narratives often included elements such as hopelessness, disarray in daily life, insecurity, or suffering related to difficulties in future planning and, in some cases, linked to diagnoses of anxiety and depression (Benach et al., 2010).

5. Implementation of the Project: Professional Practice and Limitations

The implementation of Amunt! has involved putting into practice a different model of action than usual, resulting in a social intervention that distances itself from the attention provided by municipal social services and a specific coordination among various sector actors involved in the project. The following sub-sections address these issues and discuss the main limitations that have hindered or complicated the project's implementation.

5.1. The Purpose of Amunt! From the Current Model to a New Proposal

The ordinary model of socio-labour inclusion of the social services of the Barcelona City Council is implemented according to the following procedure: when a person approaches or is already attended to by social services for the first time, their demands related to the job market are considered and recorded within the SIAS. The problematic or needs regarding job search and/or demand are identified, and the response is assessed based on the weight that employability has in their improvement plan.

Primarily, the professional attention of social services focuses on offering resources according to the available catalogue, where the Làbora program, carried out in collaboration with social action entities, is the most prominent. This public-social collaboration aims to promote employment among users of social services through reception actions, professional orientation, training in basic and technical-professional skills, and the management of a protected labour market for individuals facing more significant challenges in entering the regular job market. However, access to the Làbora program is usually reserved for individuals who explicitly express a job search demand, live in the city, have knowledge of Catalan and/or Spanish, and do not present significant barriers to entering the job market (e.g., individuals with a disability level exceeding 33%). Aware of the intensive care that some profiles would require and the shortcomings of the current model to support it, social service professionals often prioritize the difficulties of individuals and, in practice, end up limiting referrals to the service.

On the other hand, and less frequently, some social service users are referred to the comprehensive care devices managed by Barcelona Activa. However, such resources or others that are directly accessible to the public, such as local entities serving specific groups, are not included in the predefined catalogue of social services. Therefore, individuals are referred to them only if the professional is aware of them and deems it professionally appropriate.

The fact that the use of available resources, whether considering referral to the Làbora program or another catalogue or neighbourhood resource, is primarily based on discretionary criteria (i.e., the final decision is made by the professional based on the case assessment) results in highly heterogeneous professional practice. The outcome is the implementation of a socio-labour inclusion model characterized by a lack of uniformity in both referrals and the application of criteria regarding coordination with other services and resources. In fact, these tend to become isolated without a more defined and articulated network collaboration.

Furthermore, the current model is limited in offering personalized and comprehensive care. Firstly, although theoretically, the receiving resources develop individual socio-labour itineraries, diagnostics usually give little weight to the person's interests and specific context. In many cases, the itineraries proposed to individuals are predefined in advance. For example, the assigned activity is linked to the systematic categorization of the person based on their employability level (whether they are further away or closer to the job market), as in the Làbora program, or based on their belonging to a specific sociodemographic group. This can be critical, as the lack of participation by the person being served in defining their work plan hinders the

identification of both their potentials and specific needs (Martínez Sordoni, 2022; Laparra Navarro and Martínez, 2021; Carrión Molina, 2020; Lara Montero et al., 2016).
Secondly, even though it is increasingly problematic to assume that employment automatically guarantees inclusion – according to Lanau and Lozano (2022), in Spain, more than half of the poor households in which one or more members enter the job market continue to be in poverty – today, the diagnosis of needs continues to be governed by an overly labour-centric vision of inclusion (Carrión Molina, 2020; Zalakain, 2017). Many individuals who seek social services and are referred to this socio-labour inclusion circuit not only have a problem related to the sphere of work but also present other personal circumstances that need to be addressed. In fact, there is ample evidence that inclusion programs exclusively based on the labour dimension are insufficient to improve the situation of households or individuals with multiple issues (Laparra Navarro and Martínez, 2021). In this sense, the limited coordination between municipal social services and available socio-labour inclusion resources is an obstacle to implementing a comprehensive approach, as is the fact that within the process of exploring needs, the assessment of their relational and community network lacks centrality. Beyond influencing their well-being, relationships are strategic for work activation or improvement (Granovetter, 1983; Ibáñez, 1999; Requena, 1991).

5.2. A Different Social Care Approach

The social care teams of the Amunt! project have implemented a model with multiple innovative elements compared to the ordinary care provided by municipal social services. Firstly, the functions performed by the team have been reconsidered, leading to changes in its configuration and the methodology of care used.

On one hand, the team adopted a "case manager" model in which each participating individual had a designated professional responsible for their care process[4]. What has been innovative in Amunt! is that in assigning this reference, a professional role not usually considered was incorporated: that of a psychologist (Carmona Barrales and Fernández Trujillo, 2020). From the initial reception, the psychologist took on the reference for all those individuals who were currently being served or had previously been served by specific services for women (PIAD), male violence (SARA), or homelessness. Subsequently, the psychologist also took on the reference or co-reference for those individuals who, because of reception and the start of the intervention, were identified as requiring more intensive attention regarding certain aspects related to emotional distress.

The main function of the psychologist has been focused on facilitating the adaptation of these individuals to the activities planned in their itineraries, providing attention aimed at balancing their abilities, possibilities, and expectations. The various professional teams involved in the project have noted that this professional figure has been crucial for setting and achieving satisfactory goals among the individuals she served. The psychologist offered them specific emotional support and served as a lever or bridge for referral or coordination with specialized mental health services. The inclusion of a psychologist in the social care team responds to a greater emphasis on integrity and acknowledges that, in the case of some individuals, addressing emotional or psychic discomfort is a necessary condition to initiate any improvement process that increases the chances of social inclusion.

On the other hand, the decision was made to provide care in spaces different from the usual ones. This decision aimed to avoid the stigmatization that typically falls on social services centres and choose spaces that facilitate the establishment of trust and the use of alternative methodologies. Following a territorialisation logic and from a community approach, proximity facilities in different neighbourhoods were chosen to hold both individual appointments and collective care. Additionally, there was a commitment to expand the range of types of spaces,

4. However, for those individuals who were being assisted by municipal social services, the reference social professional was maintained, and the professionals from the social care team at Amunt! coordinated with them.

and individuals were served in various contexts different from the classic professional office (e.g., workplaces or training centres, homes, or public spaces).
The social care model of Amunt! has placed the transformation of the bond between the professional and the individual served at its core, along with other changes in the methodological field. Beyond the figure of the psychologist, all professionals have provided closer attention, generating a more horizontal bond, a more accurate and proactive case follow-up, direct and agile communication (use of WhatsApp, calls, the possibility of unscheduled appointments, etc.), and a sensitive approach to the emotional distress and needs of individuals. To make this possible, it was necessary for the team to collectively address strategies to regulate the bond and establish limits, and, on the other hand, for professionals to have lower ratios than those usual in social services.

Furthermore, in Amunt!, there has been a desire to break with the logic and dynamics of social care based on the prescription of resources, giving a much more active role to the individual in defining their process. This is based not only on a more comprehensive co-diagnosis of their needs but also on basing the intervention on their interests and potentials. In this way, not only the paradigm in the conception of individuals' changes – they shift from being passive demanders of resources to active subjects with opportunities and decision-making capacity – but also the role of the professionals. The latter have had to incorporate a high level of flexibility into their role and base their intervention much more on accompanying and supporting individuals to achieve agreed-upon objectives than on the allocation and control of resources.

This process has led professionals to take a step forward and evolve from a person-centred care (PCC) model to a self-directed support model, which refers to the process where the professional's intervention is based on personalized accompaniment and support to the individual according to the informed decisions they make based on the guidance they receive, the available resources, and the rhythms they set themselves (Manthorpe et al., 2011). For example, to assess if a person was ready to be referred to job orientation resources, their willingness and preferences were taken into account, which also determined the employability diagnosis and the proposed itinerary. That is, through a co-production or joint construction between the individual and the professional to agree on the intervention objectives, resources are presented and mobilized based on the circumstances and determinations of the participant. This way of proceeding facilitates that the person being served has control and the final decision on the process by which their support needs are met.

5.3. Intersectoral Collaboration: Mechanism for Service Integration in the Amunt! Project

The Amunt! project has aimed to implement a type of single-window service integration (Askim et al., 2011; Minas, 2014). The integration in Amunt! has not occurred through the fusion or structural reassignment of competencies – in fact, the different involved parts have not lost their autonomy – but it has been fostered through a particular intersectorial collaboration. In this section, we delve into some aspects of this integration to determine its intensity. The effectiveness of the service integration in Amunt! is related, on the one hand, to how collaboration occurs between professionals from different fields (social, labour, educational, and community) and, on the other hand, to how it benefits the individual being served.

At the beginning of the project, collaborative work made it possible for the diagnostic tool to collect items of interest from all involved parties, thereby facilitating the identification of a greater number of needs and potentials of the individual that might not have surfaced otherwise. The goal was to have a more comprehensive view of the person. Furthermore, the multidisciplinary teamwork aimed to jointly assess the participating individuals – especially cases with particular or complex circumstances – and mutually support each other in making decisions about the most suitable inclusion activity for the person or what supports or adaptations were necessary for them to carry it out. The "motor group" meetings and bilateral relationships between actors facilitated this shared decision-making. However, at times, this dynamic of combining different expertise has not been efficient enough. For example, the digital monitoring tool that teams

could use and consult did not fulfil all expected functionality. Additionally, communication between teams lacked some fluidity and systematization. Moreover, a more formalized approach would have been helpful for decision-making and review to gain agility and avoid possible misunderstandings. Nevertheless, collaboration has been effective because, despite obstacles, it has contributed to maximizing the fit between the participating individual and the inclusion activity carried out.

Conducting an intervention without losing sight of the holistic situation of the person and, therefore, providing the most personalized care possible, necessarily required teams to practice close collaboration and adapt – reducing access requirements, providing support for reconciliation as much as possible, adapting methodologies, offering half-day work, etc. Teams had to be flexible in the execution of their activities and admit exceptions; otherwise, many individuals with strong structural barriers would not have been able to carry them out. This was especially the case for training and employment activities, which were more demanding. This flexibility was achieved thanks to the ability of responsible actors to adopt an even more inclusive perspective than they usually profess, taking more into account the personal circumstances (health, relational, etc.) of each individual. It was also thanks to mutual support between actors. For example, the creation of a technical unit (qualified by professionals as an "observatory") integrated by the psychologist from the social care team, a trainer from the Làbora team, the technical referents of the employment plans, and the program coordinator from Barcelona Activa. Its main objective was to ensure that people participating in an employment plan succeeded, facilitating the coordinated resolution of incidents and the adaptation of action lines.

Despite these achievements, the intersectorial collaboration in Amunt! has not been sufficiently balanced between the social care teams, job guidance (Làbora), community action, Barcelona Activa, and the CEB. The strongest and most stable collaborations occurred between social care and job guidance as a reflection of the shared referentiality produced after the chain of two receptions (see section 3.1). The close collaboration between professionals, who worked as a tandem, is perhaps the most evident embodiment of the integration of social and occupational services. Another notable collaboration has been that established between social care and community action, which jointly led community activities. Here, integration is almost total and exemplifies what community social services would be (Aguilar Hendrickson, 2020; Ajuntament de Barcelona, 2018; Cortés Izquierdo and Llobet Estany, 2006).

The Barcelona Activa and CEB teams, faced administrative difficulties that delayed their full integration into the intervention, placing them at a secondary level in the overall interactions of the project. Barcelona Activa, experiencing fewer delays, was able to interact more with the other actors, especially with the Làbora teams and, to a lesser extent, with the CEB. This fact illustrates the usual integration or collaboration that occurs between the educational and activation fields in employment insertion policies. On the other hand, the CEB team had a less active role in the collaborative dynamics of case assessment, and calendar demands forced them to focus on execution. Due to these circumstantial reasons, it was a poorly interconnected team. This qualifier also applies to the community action team, which, in addition to the union with the social care team, did not have the connectivity expected with the rest of the professional teams because the project, in its conceptualization, emphasized a vision of inclusion that gave significant weight to the relational dimension. The peripheral location of this team can be explained by the lack of previous relationships between this area and policies linked to economic promotion and employment (Rebollo and Morales, 2013: 313), as well as the limited time available in Amunt! to attempt this, given the shortened execution schedule experienced by Barcelona Activa and the CEB.

5.4. Limitations and Challenges of the Project

The implementation of the Amunt! project has not been without difficulties. In addition to the usual uncertainties that surround innovation pilot projects, there have been complications

arising from the legal and normative framework governing the project's development. The legal and management context has been particularly complex since the project was framed within a call subject to a subsidy granted by another administration (MISSM) and external funding. Specifically for Amunt!, funds had to be allocated using different legal-administrative formulas according to the diversity of participating agents. This challenging management resulted in a significant delay in the start of some project activities, leading to the main consequence of a shortened intervention period. Although the project end date was extended by three months, it was insufficient to cover the gap. Furthermore, changes in project leadership during its course presented a challenge in terms of governance and leadership.

The calendar misalignment has been the transversal cause of most deviations from the initial design. On one hand, the delay in commencing work and educational activities until the first and second quarters of 2023, respectively, made it impossible for individuals to overlap or sequence more than one activity. Consequently, some key elements of the project, such as the realization of a sequential inclusion activity itinerary tailored to each person's profile and interests, or the intended central role of community action, were distorted and lost their planned centrality. This delay also resulted in dissociation between the initial reception phase's diagnosis or profiling and the needs, interests, or circumstances of individuals at the actual activation moment of certain resources or actions.

On the other hand, some activities could not be executed. In some cases, the reason was the lack of interested participants or an eligible situation for activity implementation, such as the "second chance school" service for young people aged 16 to 25 from participating households who dropped out of education, level 2 occupational training, or community entrepreneurship activities. In other cases, the rejection was related to the execution difficulties of certain activities within the project's limited schedule, either because it was impossible to complete their certification (dual-mode vocational training or other certifiable reskilling programs) or because there was not enough time to carry them out within the deadlines of public procurement (such as the development of a mobile app or the implementation of the OECD test of basic skills for adults).

Another challenging aspect of the implementation had to do with the fact that the finally participating individuals were in situations that made some of the resources and activities included in the initial design inadequate. The result of this deviation was the cancellation of certain actions or the need to adapt others (for example, enabling part-time work in employment plans or the need to offer more support and follow-up). That is, the lack of more information at the beginning about individuals and the subsequent inability to introduce substantial changes to the activity catalogue due to the mentioned calendar problems resulted in some of the included activities being irrelevant, and others that could be relevant for some profiles (for example, more pre-employment activities) were not available to the project.

Finally, another type of difficulty encountered was achieving the adherence and continuity of project participants. Behind this limitation are issues related to both the project's design and the adversities of scheduling. On one hand, the fact that participation was entirely voluntary and did not involve any kind of economic incentive or conditionality - as was the case with B-MINCOME - posed a challenge in terms of generating initial interest in the project and maintaining it over the months. Moreover, this challenge is even greater when situations of life complexity are accentuated, as has been the case. On the other hand, project continuity was also threatened by the delay in starting activities, as this translated into demotivation in some cases and ultimately led to abandonment by some participants.

6. Concluding Remarks: Preliminary Results and Pending Challenges

Although the impact assessment of the project will not be available until 2024, it is possible to highlight some achievements and results identified during its implementation, both among participants and among professionals and organizations involved.

On one hand, many participants have expressed that the attention received within the framework of Amunt! has been significantly different from their experiences in other instances or previous projects, especially concerning municipal social services. The shift in focus and methodology driven by Amunt! has allowed individuals who claimed to have felt invisible to public administration, in their own words, to experience a different approach through their participation in a project that has given more prominence to their voice, situation, or specific needs. The project has not emphasized the conditionality of financial aid but rather respected their decisions and the voluntariness of their participation. In general, participants have felt more accompanied, listened to, and respected, enabling them to make better decisions and use resources more meaningfully.

Thus, according to the evidence gathered with the project, it seems possible to affirm that unconditional policies and methodologies aligned with person-centred care and/or self-directed support generate more satisfying experiences among individuals in their use of resources. This, in turn, contributes to their empowerment and improves their perception of services, both in terms of their effectiveness and usefulness, as well as the treatment received from professional teams.

The multiple changes in perspectives and methodologies implemented in this project have helped deploy an innovative care model capable of generating, on one hand, closer and more horizontal participant-professional relationships and, on the other hand, a more personalized and empowering approach. This has been possible mainly by articulating care and itineraries not only based on people's needs but on their potentialities and interests, giving more central importance to addressing emotional well-being, including community policy, intervening with people in different facilities and spaces than usual, or establishing more agile and accessible communication channels. This innovative model was also possible due to the exceptional nature of the project itself, as a pilot, which could adapt and flexibilize resources.

On the other hand, it is worth noting some achievements among the organizations involved and their teams. The Amunt! project has managed to, at least: shift the role of the social care team towards a more supportive and accompanying role rather than prescriptive of resources (a change that has generally increased satisfaction among professionals); provide psychosocial care to IMV beneficiaries who had no previous contact with social services; expand the coverage of labour and training activation services to more complex profiles by flexibilizing and adapting access and use of resources; test a tandem of social care and career guidance as shared referentiality for the person, based on intense coordination and a territorial proximity perspective; promote intersectorial governance dynamics among professionals from different services.

However, there are still pending challenges. One significant challenge from the integrated perspective of the project is that intersectorial collaboration should have been more symmetrical. It is true that limitations associated with the reduction of the implementation calendar have made this difficult. It is also worth noting that the challenge was enormous considering that, with very little time, teams from three areas of municipal policy (social, economic, and community), social entities (Làbora program), and a consortium (CEB) between the Barcelona City Council and the Catalan Government had to leave their sectoral perspective behind and work together with an integral and integrated vision as shared as possible to positively impact the people served. Moreover, having to do it with shared diagnostic and monitoring tools that have not worked satisfactorily and in a framework of integration that maintains the autonomy of the parts in the execution of their own activities implies that it has been a complex process not without conflicts. For example, teams have often been pushed by lack of time toward intersectorial collaboration more marked by the needs of participants than by the achievement of more strategic organizational objectives for the modeling of service integration. However, both the fact that some of the people who made up the teams already knew each other and had participated in the B-MINCOME project – with some degree of

intersectorial collaboration – and everyone's professional commitment seem to have been key to tackling the challenge and overcoming the multiple difficulties that have arisen throughout the process.

In conclusion, the experience of the Amunt! project contributes to the idea that to improve the social inclusion of individuals, it is necessary to pay higher attention to their personal and family realities, as well as their interests and needs, giving them a more active role in establishing their work plan. To make this possible, it is necessary to expand social diagnosis, promote alternative care methodologies, and advance in the integrated execution of services (especially labour and social services), as doing it in a segmented way has limited effectiveness, especially in the case of more complex or challenging profiles (Martínez Sordoni, 2022). In this regard, the transfer of learnings and impacts from the Amunt! project, and subsequent pilot interventions, is crucial, as is the ability of administrations to use them instrumentally to transform their services and structural active policies.

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