Inclusion Policy Lab: Evaluation results

Madrid City Council: Social accompaniment project for promoting autonomy among RMI/MIS beneficiaries with children

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Index

The General Secretariat of Inclusion of the Ministry of Inclusion, Social Security, and Migration has prepared this report within the framework of the Inclusion Policy Lab, as part of the Recovery, Transformation, and Resilience Plan (RTRP). It has been funded by the Next Generation EU funds. As the agency in charge of carrying out the project, the Government Area of Social Policies, Family and Equality of the Madrid City Council has participated in the writing of this report. This collaborating entity is one of the implementers of the pilot projects and has collaborated with the General Secretariat of Inclusion in the design of the RCT methodology, actively participating in the provision of the necessary information for the design, monitoring, and evaluation of the social inclusion itinerary. Furthermore, their collaboration has been essential to gathering informed consents, ensuring that participants in the itinerary were adequately informed and that their participation was voluntary.

The partnership with J-PAL Europe has been a vital role in the efforts of the General Secretariat of Inclusion to improve social inclusion in Spain. Their team has provided technical support and shared international experience, assisting the General Secretariat in the comprehensive evaluation of pilot programs. Throughout this partnership, J-PAL Europe consistently demonstrated a commitment to promoting the adoption of evidence-based policy and facilitating the integration of empirical data into strategies that promote inclusion and progress within our society.

This evaluation report has been produced using the data available at the time of its writing and it is based on the knowledge acquired about the project up to that date. The SGI reserves the right to clarify, modify, or delve into the results presented in this report in future publications. These potential variations could be based on the availability of additional data, advances in evaluation methodologies, or the emergence of new information related to the project that may affect the interpretation of the results.

Executive Summary

- The **Minimum Income Scheme,** established in May 2020, is a minimum income policy that aims to guarantee a minimum income to vulnerable groups and provide ways to promote their social and labor integration.
- Within the framework of this policy, the Ministry of Inclusion, Social Security, and Migration (MISSM) fosters a strategy to promote inclusion through pilot projects of social innovation, which are conducted in the **Inclusion Policy Lab**. These projects are evaluated according to the standards of scientific rigor and using the methodology of Randomized Controlled Trials.
- This document presents the evaluation results and main findings of the "Social accompaniment project for promoting autonomy among RMI/MIS beneficiaries with children" which has been performed in **cooperation between the Ministry of Inclusion, Social Security and Migration (MISSM) and the Government Area of Social Policies, Family, and Equality of the Madrid City Council**.
- This study evaluates the impact of **two treatments** on the work-life balance of the families benefiting from the project. The two treatment groups and the control group receive the "Socio-Labor Program", aimed at improving the employability of families. Treatment group 1 receives, in addition to the "Socio-Labor Program", the "Respira" Program, which consists of a bundle of hours of childcare. Treatment group 2 receives, in addition to the "Socio-Labor Program", the "Crecer Felices en Familia II" Program, which consists of a psychosocial and educational intervention that seeks to improve the effective autonomy of families by promoting an increase in employability.
- The project took place in **Madrid**, with the target of 1,525 families in a situation of social vulnerability residing in the municipality, with at least one child under 8 years of age in their care.
- On average, participating families have an average of 2.11 children, 43% of which are single parents. 70% of families live in the south of Madrid. In addition, 41% have been in the Madrid City Council's register of social services since before 2018. On the other hand, 11% of these families are at high psychosocial risk.
- The percentage of participation in the "Socio-Labor Program" has been 21%, the "Respira" Program has registered 20% participation, and the "Crecer Felices en Familia" Program has had 48% and 27% participation for group and home sessions, respectively.
- The main results of the evaluation are:
    - **Increase in social networks of family support**: Treatment 2, which receives the "Socio-Labor Program" and the "Crecer Felices en Familia II" Program, shows a significant increase of 0.24 points in the assessment of informal support. In addition, this study estimates an increase of 0.23 points in the assessment of formal support, although it is no longer significant if baseline data are included.

- **Increase in the quality of childcare and education attitudes and practices and a sense of competence as parents**: Treatment group 2 shows a significant increase of 0.01 points in the quality of parental attitudes.
- The results indicate that the proposed treatments do not generate a statistically significant improvement in the reduction of parental stress, nor in work-life balance, resilience in the face of adversity or in the improvement of the child's behavior.

1 Introduction

General Regulatory Framework

The Minimum Income Scheme (MIS), regulated by Law 19/2021[1], is an economic benefit whose main objective is to prevent the risk of poverty and social exclusion of people in situations of economic vulnerability. Thus, it is part of the protective action of the Social Security system in its non-contributory modality and responds to the recommendations of various international organizations to address the problem of inequality and poverty in Spain.

The provision of the MIS has a double objective: to provide economic support to those who need it most and to promote social inclusion and employability in the labor market. This is one of the social inclusion policies designed by the General State Administration, together with the support of Autonomous Communities, the Third Sector of Social Action and local corporations[2]. It is a central policy of the Welfare State that aims to provide minimum economic resources to all individuals in Spain, regardless of where they live.

Within the framework of the National Recovery, Transformation, and Resilience Plan (RTRP),[3] the General Secretariat of Inclusion (onward SGI by its acronyms in Spanish) of the Ministry of Inclusion, Social Security, and Migration (MISSM) participates significantly in Component 23 "New public policies for a dynamic, resilient, and inclusive labor market", framed in Policy Area VIII: "New care economy and employment policies".

Investment 7: "Promotion of Inclusive Growth by linking socio-labor inclusion policies to the Minimum Income Scheme" is among the reforms and investments proposed in this Component 23. Investment 7 promotes the implementation of a new model of inclusion based on the MIS which reduces income inequality and poverty rates. Therefore, the MIS goes beyond being a mere economic benefit and supports the development of a series of complementary programs that promote socio-labor inclusion. However, the range of possible inclusion programs is very wide, and the government decides to pilot different programs and interventions to evaluate them and generate knowledge that allows prioritizing certain actions. With the support of investment 7 under component 23, the MISSM establishes a new framework for pilot inclusion projects constituted in two phases through two royal decrees covering a set of pilot projects based on experimentation and evaluation:

[1] Law 19/2021, dated December 20, establishing the Minimum Income Scheme (BOE-A-2021-21007).

[2] Article 31.1 of Law 19/2021, of December 20, 2021, establishing the Minimum Income Scheme.

[3] The Recovery, Transformation, and Resilience Plan refers to the Recovery Plan for Europe, which was designed by the European Union in response to the economic and social crisis triggered by the COVID-19 pandemic. This plan, also known as Next Generation EU, sets out a framework for the allocation of recovery funds and for boosting the transformation and resilience of member countries' economies.

- **Phase I: Royal Decree 938/2021**[4], through which the MISSM grants subsidies for the execution of 16 pilot projects of inclusion pathways corresponding to autonomous communities, local organizations, and the Third Sector of Social Action organizations. This royal decree contributed to the fulfillment of milestone number 350[5] and monitoring indicator 351.1[6] of the RTRP.
- **Phase II: Royal Decree 378/2022**[7], which grants subsidies for a total of 18 pilot projects of inclusion pathways executed by autonomous communities, local organizations, and the Third Sector of Social Action organizations. Along with the preceding Royal Decree, this one helped the RTRP's monitoring indicator number 351.1 to be fulfilled.

To support the implementation of evidence-based public and social policies, the Government of Spain decided to evaluate the social inclusion pilot projects using the Randomized Controlled Trial (RCT) methodology. This methodology, which has gained relevance in recent years, represents one of the most rigorous tools to measure the causal impact of a public policy intervention or a social program on indicators of interest, such as social and labor insertion or the well-being of beneficiaries.

Specifically, RCT is an experimental method of impact evaluation in which a representative sample of the population potentially benefiting from a public program or policy is randomly assigned either to a group receiving the intervention or to a comparison group that does not receive the intervention for the duration of the evaluation. Thanks to the randomization in the allocation of the program, this methodology can statistically identify the causal impact of an intervention on a series of variables of interest. This methodology enables us to analyze the effect of this measure, which helps determine whether the policy is adequate to achieve the planned public policy objectives. Experimental evaluations enable us to obtain rigorous results of the intervention effect, i.e., what changes the participants have experienced in their lives due to the intervention. In addition, these evaluations provide an exhaustive analysis of the program and its effects, providing insights into why the program was effective, who has benefited most from the interventions, whether there were indirect or unexpected effects, and which components of the intervention worked, and which did not.

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[4] Royal Decree 938/2021, of October 26, 2021, which regulates the direct granting of subsidies from the Ministry of Inclusion, Social Security, and Migration in the field of social inclusion, for an amount of €109,787,404, within the framework of the Recovery, Transformation, and Resilience Plan (BOE-A-2021-17464).

[5] Milestone 350 of the RTRP: "Improve the rate of access to the Minimum Income Scheme and increase the effectiveness of the MIS through inclusion policies, which, according to its description, will translate into supporting the socio-economic inclusion of the beneficiaries of the MIS through itineraries: eight collaboration agreements signed with subnational public administrations, social partners and social action entities of the third sector to conduct the itineraries. The objectives of these partnership agreements are: (i) to improve the MVI access rate; ii) increase the effectiveness of the MVI through inclusion policies."

[6] Monitoring indicator 351.1 of the RTRP: "at least 10 additional collaboration agreements signed with subnational public administrations, social partners and social action entities of the third sector to conduct pilot projects to support the socio-economic inclusion of MVI beneficiaries through itineraries".

[7] Royal Decree 378/2022, dated May 17, regulating the direct granting of subsidies from the Ministry of Inclusion, Social Security and Migration in the field of social inclusion, for an amount of €102,036,066, within the framework of the Recovery, Transformation and Resilience Plan (BOE-A-2022-8124).

These evaluations have focused on the promotion of social and labor inclusion among MIS beneficiaries, recipients of regional minimum incomes, and other vulnerable groups. In this way, the MISSM establishes a design and impact evaluation of results-oriented inclusion policies, which offers evidence for decision-making and its potential application in the rest of the territories. The promotion and coordination of 32 pilot projects by the Government of Spain has led to the establishment of a laboratory for innovation in public policies of global reference named the Inclusion Policy Lab.

For the implementation and development of the Inclusion Policy Lab, the General Secretariat of Inclusion has established a governance framework that has made it possible to establish a clear and potentially scalable methodology for the design of future evaluations and promoting decision-making based on empirical evidence. The General State Administration has had a triple role as promoter, evaluator and executive of the different programs. Different regional and local administrations and the Third Sector of Social Action organizations have implemented the programs, collaborating closely in all their facets, including evaluation and monitoring. In addition, the Ministry has had the academic and scientific support of the Abdul Latif Jameel Poverty Action Lab (J-PAL) Europe and the Centre for Monetary and Financial Studies (CEMFI), as strategic partners to ensure scientific rigor in the assessments. Likewise, the Inclusion Policy Lab has an Ethics Committee[8], which has ensured the strictest compliance with the protection of the rights of the people participating in the social inclusion itineraries.

This report refers to "Social accompaniment project for promoting autonomy among RMI/MIS beneficiaries with children", executed within the framework of Royal Decree 938/2021[9] by the Government Area of Social Policies, Family and Equality of the Madrid City Council. This report contributes to the fulfillment of milestone 351 of the RTRP: "Following the completion of at least 18 pilot projects, the publication of an evaluation on the coverage, effectiveness and success of the MIS, including recommendations to increase the level of application and improve the effectiveness of social inclusion policies".

Context of the project

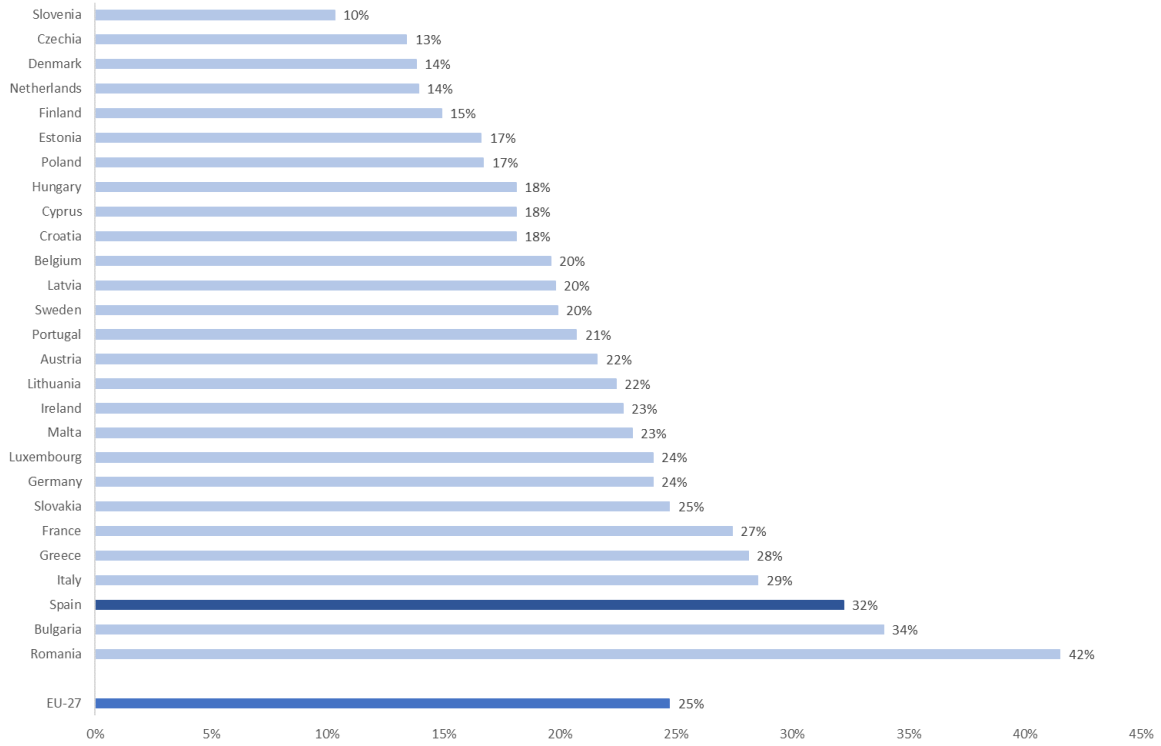
Analyzing the most recent data from Eurostat it reveals that Spain ranks among the top three countries with the highest percentage of children and adolescents under the age of 18 at risk of poverty or social

[8] Regulated by Order ISM/208/2022, dated March 10, which creates the Ethics Committee linked to social inclusion itineraries, on 20/05/2022 it issued a favorable report for the realization of the project that is the subject of the report.

[9] On December 23, 2021, an agreement was signed between the General State Administration, through the SGOPIPS, and the Madrid City Council for the implementation of a project for social inclusion within the framework of the Recovery, Transformation, and Resilience Plan, which was published in the "Official State Gazette" on February 1, 2022 (BOE no. 27).

exclusion[10]. It follows only Bulgaria and Romania, with a rate 7 percentage points above the European Union average.

Figure 1: Share of children aged less than 18 years at risk of poverty or social exclusion (2022)



Fuente: Living conditions in Europe (Eurostat)

Based on Save the Children's calculations using data from the 2023 Living Conditions Survey (LCS) of the National Institute of Statistics (INE)[11], the estimate suggests that more than 2.3 million children in Spain live in poverty.

[10] Population at risk of poverty or social exclusion is defined according to criteria established by Eurostat. It is the population that is in at least one of these three situations: (1) At risk of poverty (equivalent income below 60% of the median income per unit of consumption). (2) Severe material and social deprivation (if you declare a deficiency in at least 7 items out of 13 on a list that includes, for example, not being able to afford a meal of meat, poultry or fish at least every other day, keeping the house at an adequate temperature, having two pairs of shoes in good condition or replacing damaged clothes with new ones). (3) In households that are unemployed or low in employment intensity (i.e., households in which less than 20% of their total work potential did so during the year preceding the interview).

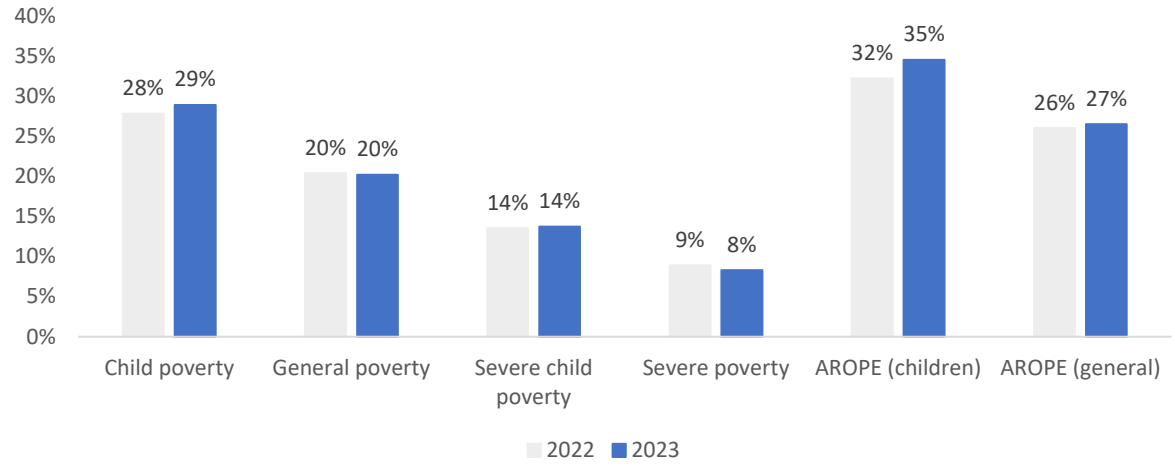
[11] https://www.savethechildren.es/notasprensa/encuesta-de-condiciones-de-vida-la-pobreza-infantil-sube-en-espana-de-la-mano-del

Figure 2 shows that 28.9% of children under the age of 18 in Spain were living in poverty in 2023[12], which is 1.1 percentage points higher than in 2022, when the child poverty rate was 27.8%. Thus, child poverty continues to exceed general poverty, which remains stable at around 20%.

On the other hand, **Figure 2** exhibits that the rate of severe child poverty[13] remains high (13.7%, two tenths higher than in 2022): 1.1 million children and adolescents are in this situation.

If the AROPE rate is considered[14], the impact of child poverty rises to 34.5%, from 32.2% in 2022. The gap between severe poverty among children and adolescents compared to that of the population maintains significant differences (the AROPE rate of child poverty in 2023 is 8 percentage points higher than the general AROPE rate).

Figure 2: Indicators of poverty and social exclusion



Source: Save the Children and Living Conditions Survey (INE)

In the specific context of the municipality of Madrid, subject of this project, the data highlight a very unequal situation between districts[15]. For example, districts such as Puente de Vallecas, Usera, or Villaverde have child poverty rates of 45.8%, 43.7% or 41.8%, respectively, compared to 22.8% in the autonomous community.

[12] In the Living Conditions Survey, the income used in the calculation of the at-risk-of-poverty rate always corresponds to the year prior to the interview. Therefore, the data from the 2023 Living Conditions Survey corresponds to the income for the year 2022.

[13] The severe poverty line is 25% of the median equivalent income.

[14] Percentage of population at risk of poverty or social exclusion.

[15] Data from the High Commissioner against Child Poverty calculated based on tax data from the State Tax Administration Agency (AEAT) for the year 2021: https://www.comisionadopobrezainfantil.gob.es/es/datos-e-indicadores/mapa-tasa-de-riesgo-de-pobreza-infantil-por-distritos. Due to the different nature of the data sources, both the poverty line and the indicator of the child poverty risk rate calculated from it are not comparable to those of the Living Conditions Survey of the National Institute of Statistics (INE).

Regulatory framework associated with the project and the governance structure

This pilot aligns with the framework established in the 2030 Agenda and with the Sustainable Development Goals (SDGs), specifically contributing to SDGs numbered 1, 8 and 10.

Regarding international organizations, the Convention on the Rights of the Child stands out in this area, about the recognition of the right of every child to an adequate standard of living for his or her physical, mental, spiritual, moral, and social development, as well as the right to education.

On the other hand, at the European level, there are several instruments relating to childhood and adolescence, including:

- **European Pillar of Social Rights (EPSR).** It contains, within its chapter on social protection and inclusion (in relation to childcare and support to children), the right to enjoy affordable and good quality education and childcare, as well as the right to protection from poverty. It states that "children from disadvantaged backgrounds have the right to specific measures to enhance equal opportunities".
- **EU Strategy on the Rights of the Child.** It states that all children should enjoy the same rights and live free from discrimination of any kind. In this document, the European Commission proposes concrete actions to protect and promote children's rights.
- **European Parliament resolution dated March 11, 2021,** on children's rights in view of the EU Strategy on the rights of the child**.**
- **Council Recommendation (EU) 2021/1004 dated June 14, 2021, establishing a European Child Guarantee.** It aims to ensure that all children and adolescents at risk of poverty or social exclusion in the European Union have access to six basic rights: education and childcare, education and extracurricular activities, at least one healthy meal per school day, healthcare, adequate housing and healthy eating.

Finally, it should be noted that Spain has both normative and strategic documents and public policies related to children and adolescents. Specifically:

- **State Action Plan for the Implementation of the European Child Guarantee (2022-2030).** It is the main programmatic instrument for implementing the European Child Guarantee in Spain. It includes the objectives, goals and actions that Spain undertakes to develop to achieve its recommendations.
- **State Strategy for the Rights of Children and Adolescents (2023-2030).** It includes actions in eight strategic areas, including ending poverty and social exclusion in childhood and adolescence, as well as strengthening the comprehensive development of children and adolescents in the fields of education and culture.

The scientific objective of the project is to evaluate, through the randomized controlled trial (RCT) methodology, whether families in situations of vulnerability with dependent children could increase their well-being and regain their autonomy more easily/quickly when they are provided with family support in childcare and education for their children during a period.

The governance framework established for the proper execution and evaluation of the project includes the following actors:

- The **Madrid City Council** is responsible for the project execution through the Government Area of Social Policies, Family, and Equality. Other relevant agents for the project are the Employment Agency of the Madrid City Council in the development of the Socio-Labor Program and the Universities of La Laguna and Las Palmas de Gran Canaria, authors of the "Crecer Felices en Familia II" Program and the scientific results report elaborated within the framework of the research contract.
- The **Ministry of Inclusion, Social Security and Migration** (MISSM) is the funding source of the project, and the main responsible for the RCT evaluation process. For this reason, the **General Secretariat of Inclusion** (SGI) assumes the following commitments with the Madrid City Council:
    - Provide the beneficiary organization with support for the design of the actions to be conducted, for the execution and monitoring of the object of the subsidy, as well as for the profiling of the potential participants of the pilot project.
    - Design the randomized controlled trial (RCT) methodology of the pilot project in coordination with the beneficiary organization and scientific partners. Also, conduct the evaluation of the project.
    - Ensure strict compliance with ethical considerations by obtaining the approval of the Ethics Committee.
- **J-PAL Europe** are scientific and academic institutions that support MISSM in the design and RCT evaluation of the project.

In view of the above, this report follows the following structure: s**ection 2** provides a project description, detailing the issues to address, the target audience for the intervention, and the specific interventions associated with improving levels of social inclusion. Next, **section 3** contains information related to the evaluation design, defining the Theory of Change linked to the project, hypotheses, sources of information, and indicators used. **Section 4** describes the implementation of the intervention, the analysis of the sample, the results of random allocation, the level of participation, and attrition in the intervention. This section is followed by **section 5**, where the results of the evaluation are presented, along with a detailed analysis of the econometric analysis conducted and the results for each of the indicators used. Finally, the conclusions of the project evaluation are described in **section 6**. Besides, the appendix **Economic Management and Regulatory** additional information is provided on the management tools and governance of the pilot project.

Ethics Committee linked to Social Inclusion Itineraries

During research involving human subjects in the field of biology or the social sciences, researchers and workers associated with the program often face ethical or moral dilemmas in the development of the project or its implementation. For this reason, in many countries it is common practice to create ethics committees that verify the ethical viability of a project as well as its compliance with current legislation on research involving human beings. The Belmont Report (1979) and its three fundamental ethical principles – respect for individuals, profit and justice – constitute the most common frame of reference in which ethics committees operate, in addition to the corresponding legislation in each country.

With the aim of protecting the rights of participants in the development of social inclusion itineraries and ensuring that their dignity and respect for their autonomy and privacy are guaranteed, Order ISM/208/2022 dated March 10 creates the Ethics Committee linked to the Social Inclusion Itineraries. The Ethics Committee, attached to the General Secretariat of Inclusion and Social Welfare Objectives and Policies, is composed of a president – with an outstanding professional career in defense of ethical values, a social scientific profile of recognized prestige and experience in evaluation processes – and two experts appointed as members.

The Ethics Committee has conducted analysis and advice on the ethical issues that have arisen in the execution, development, and evaluation of the itineraries, formulated proposals in those cases that present conflicts of values and approved the evaluation plans of all the itineraries. In particular, the Ethics Committee issued its approval for the development of this evaluation on April 27, 2023.

2 Description of the program and its context

This section describes the program that the Madrid City Council, through the Government Area of Social Policies, Family, and Equality, implemented in the framework of the pilot project. Furthermore, it describes the target population and the territorial scope and provides a detailed description of the intervention.

2.1 Introduction

The main objectives of the project are to promote the development and strengthening of the emotional, educational, and parenting competence of the families benefiting from the project (psychosocial and educational well-being), to promote work-life balance of households benefiting from the MIS and/or minimum insertion income, and to contribute to the improvement of the employability of the families benefiting from the project.

The pilot proposes an innovative project that aims to test the effectiveness of specific tools to promote the recovery of the autonomy of the most vulnerable households in which children live in the municipality of Madrid. Among these people, there are many of the recipients of the MIS and minimum insertion income, as well as beneficiaries of the economic benefit to cover basic food, cleaning, and hygiene needs from the Madrid City Council, such as the "Family Card" (Tarjeta Familias). The difficulties that these families experience are undoubtedly many and generate an added vulnerability for children who grow up in more depressed environments.

The conceptual framework for improving the social inclusion of families with children in vulnerable situations is based on understanding social exclusion as a multidimensional phenomenon (Alguacil Gómez, 2012). This implies recognizing many unfavorable circumstances, such as lack of access to economic, educational, and health resources, adequate housing, or community support networks, which are closely related to each other (Subirats et al., 2005). Addressing this problem therefore requires an approach that combines policies that promote integration with individualized and versatile assistance.

Given the number of issues addressed in relation to child poverty and social inclusion, the empirical evidence on the use of RCT ranges from purely economic interventions to those aimed at the labor and social insertion of families. From an economic point of view, interventions that provide unconditional economic support to families with children excel, obtaining important benefits for children's physical and mental health in Canada (Milligan and Stabile, 2011), and Finland (Määttä et al., 2015). Other interventions associated with paying for school lunches also found, in addition to reducing food insecurity, improvements in the emotional well-being of children from low-income families (Feely et al., 2020).

From a labor point of view, the RCTs conducted in Colombia (Attanasio et al., 2008) and in the Dominican Republic (Ibarraran et al., 2014; Card et al., 2007) are noticeable, which demonstrate the importance of job training in improving employment, income and job stability, especially in families with a low level of education. At society level, the study by Negrão et al. (2014) in Portugal focused on teaching parenting skills in families living in poverty, with very positive results on family well-being thanks to improvements in parenting and communication skills between parents and children. Noble et al. (2021) evaluate the effects of an intervention that includes, in addition to economic transfers, parenting support services and access to community resources, also with very positive results in reducing poverty and improving financial stability, child development, and family well-being.

There is literature documenting the effectiveness of social (Singla, Kumbakumba, & Aboud, 2015), educational (Guryan et al. 2023), and employment (Altmann et al. 2018) interventions that help improve the well-being of families. The project is fully aligned with innovative advances and values positively the evolution towards professional practices that support quality family support and is considered as a basic right of children and adolescents (Dolan, Žegarac & Arsić, 2020).

There is also evidence of the impact of home visiting programs on children. Thus, for example, Peacock et al. (2013) through a systematic review of the RCT literature in the USA, find significant improvements in certain areas, such as cognitive development, weight or the prevention of child

abuse; Gaylor and Spiker (2012) emphasize the need for a comprehensive approach that addresses the multiple needs of families; and Heckman and Zhou (2020) analyzes a specific program implemented in rural China, which achieves substantial improvements in language, cognitive, motor, and socio-emotional skills.

Finally, there is evidence of the effect of positive parenting programs. In this sense, Rodrigo (2016) presents an introduction to the analysis of this type of program; Rodrigo, Almeida and Richle (2016) provide an overview of its design, implementation and evaluation; Rodrigo, Byrne and Álvarez (2017) limit the analysis to Spain; and Álvarez, Byrne and Rodrigo (2021) present the results of the evaluation on a sample of 256 parents in three autonomous communities, with significant effects on empathy, parenting satisfaction, or the perception of the child.

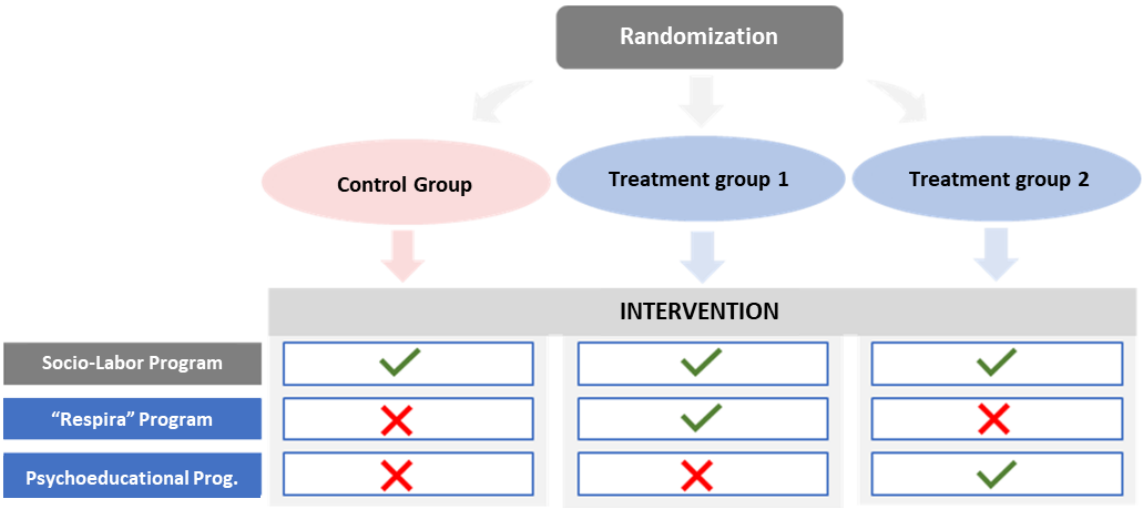
2.2 Target population and territorial scope

The main areas of intervention are work, care, and social accompaniment. The target population of the project are families in a situation of social vulnerability residing in the municipality of Madrid, with at least one child under 8 years of age.

2.3 Description of the intervention

To rigorously evaluate the impact of the proposed interventions, participants were equally distributed into three groups: two treatment groups and a control group. All experimental groups receive the "Socio-Labor Program", aimed at improving the employability of the participating families. Treatment group 1 (T1) receives, in addition to the "Socio-Labor Program", the "Respira" Program, which consists of a bundle of hours of childcare. Treatment group 2 (T2) receives, in addition to the "Socio-Labor Program", the "Psychoeducational Program 'Crecer Felices en Familia II'", which consists of a psychosocial and educational intervention that aims to improve the effective autonomy of families by promoting an increase in employability. In this way, the participants of the control group (CG) receive only the "Socio-Labor Program" (as do the treatment participants). **Figure 3** provides a summary in a schematic way the interventions received by the participants of the different groups.

Figure 3: Intervention scheme



Each program is described below:

Socio-Labor Program

Offered to all experimental groups, the "Socio-Labor Program" consists of a basic intervention aimed at improving the employability of the participating families. This program follows the most conventional channel of policies that seek to recover the autonomy of the most vulnerable population due to a lack of income through the training-increase of skills-employability/occupation scheme. The entity in charge of implementing this program is the Employment Agency of the Madrid City Council.

This Socio-Labor Program encompasses skills and digital training, with the objective of reducing barriers, so that they know the labor market and can acquire new skills that allow them to access a paid work activity according to the circumstances of each person, in addition to obtaining digital knowledge to be able to opt for job offers on the Internet, among other factors.

The procedure implemented has implied the assignment of an Employment Technician to each participating family, who performed an analysis and knowledge of the situation of each member of the participating family, identifying their degree of interest and commitment, in addition to carrying out a competency diagnosis and employability assessment before and after the implementation of the program. The training program consisted of 100 teaching hours of "Emplea+" and "Viaje web", programs developed by the Employment Agency of the Madrid City Council.

Respira Program

The "Respira" Program, which is aimed only at treatment group 1, seeks to alleviate the performance of family responsibilities that reduce the possibilities of work-life balance in these households.

This program aims to provide parents with scheduled time off, offering a designated period to address their own needs. Specifically, families are offered 40 hours of supervised childcare, enabling them to allocate caregiving time to other activities. These hours will be available to household parents over a

span of four and a half months. The service can be provided either at the family residence or elsewhere, depending on the service's delivery mode and tasks involved.

This service was conducted on a voluntary basis by the families, who could choose the time, volume of hours, and periodicity that suited their needs. The service has great flexibility of schedules from Monday to Friday from 8 to 22h and from 8 to 15h on Saturdays, Sundays, and holidays.

Psychoeducational Program 'Crecer Felices en Familia II'

Aimed at treatment group 2, the "Psychoeducational Program 'Crecer Felices en Familia II'" aims to strengthen the capacities of parental figures so that they contribute to the integral development of their children, family well-being, increased autonomy of family functioning, and social inclusion.

This program consists of providing psychoeducational support aimed at promoting the parenting skills of parents in situations of social vulnerability. The program combines group intervention (20 sessions, planned weekly) with home-based intervention (7 sessions, planned weekly). The program uses an experiential methodology, already validated in other parenting education programs, created by the Developmental and Educational Psychology team of the University of La Laguna and the University of Las Palmas de Gran Canaria. The purpose is to strengthen the relationship and interaction with the children, establish educational guidelines and organization of daily life, favor protective factors, and minimize risk factors, and improve the coexistence in the home of the people participating in the program.

The family support program "Crecer Felices en Familia II" relies on evidence and is grounded in a theoretical framework. It features a manual detailing its content and activities, designed to foster mindful parenting through collaborative engagement with families, ensuring adherence to high-quality standards. All this, under the scientific framework of an ecological-systemic approach to child development, in addition to the positive parenting approach as detailed in the Scientific Report of Results of the Universities of Las Palmas de Gran Canaria and the University of La Laguna.

3 Evaluation design

This section describes the design of the impact assessment of the project outlined in the preceding section. The section describes the Theory of Change, which identifies the mechanisms and aspects to measure, the hypotheses to test in the evaluation, the sources of information to build the indicators, and the design of the experiment.

3.1 Theory of Change

This report, with the aim of designing an evaluation that enables us to understand the causal relationship between the intervention and its final objective, develops a Theory of Change. The Theory of Change schematizes the relationship between the needs identified in the target population, the benefits, or services that the intervention provides, and the immediate and medium-long term results

sought by the intervention. It explains the relationships between these elements, the assumptions underlying them, and outlines measures or outcome indicators.

Theory of Change

A Theory of Change begins with the correct identification of the needs or problems to be addressed and their underlying causes. This situational analysis should guide the design of the intervention, i.e., the activities or products that are provided to alleviate or resolve the needs, as well as the processes necessary to properly implement the treatment. Next, we identify the expected effect(s) based on the initial hypothesis, i.e., what changes – in behavior, expectations, or knowledge – are expected to be obtained in the short term with the actions conducted. Finally, the process concludes with the definition of the medium- to long-term results that the intervention aims to achieve. Sometimes, the effects directly obtained with the actions are identified as intermediate results and one identifies the indirect effects in the final results.

The development of a Theory of Change is a fundamental element of impact evaluation. At the design stage, the Theory of Change helps to formulate hypotheses and identify the indicators needed for the measurement of results. Once the results are achive, the Theory of Change makes it easier, if results are not as expected, to detect which part of the hypothetical causal chain failed, as well as to identify, in case of positive results, the mechanisms through which the program works. Likewise, the identification of the mechanisms that made the expected change possible allows a greater understanding of the possible generalization or not of the results to different contexts.

The theory of change of this project is based on the identification, by the Madrid City Council, of the obstacles and difficulties for the social and labor inclusion of the most vulnerable families derived from parenting and childcare. The situation of vulnerability of families with dependent children in Madrid makes the recovery of the autonomy of the adults who are part of these families very complicated or even impossible. These families need resources that allow them to improve their predisposition or preparation to be autonomous, as well as time and tools to manage the upbringing of their children. This need or problem defines the different areas of action of the project and the activities associated with each of the programs that make up the two treatments indicated in the previous section.

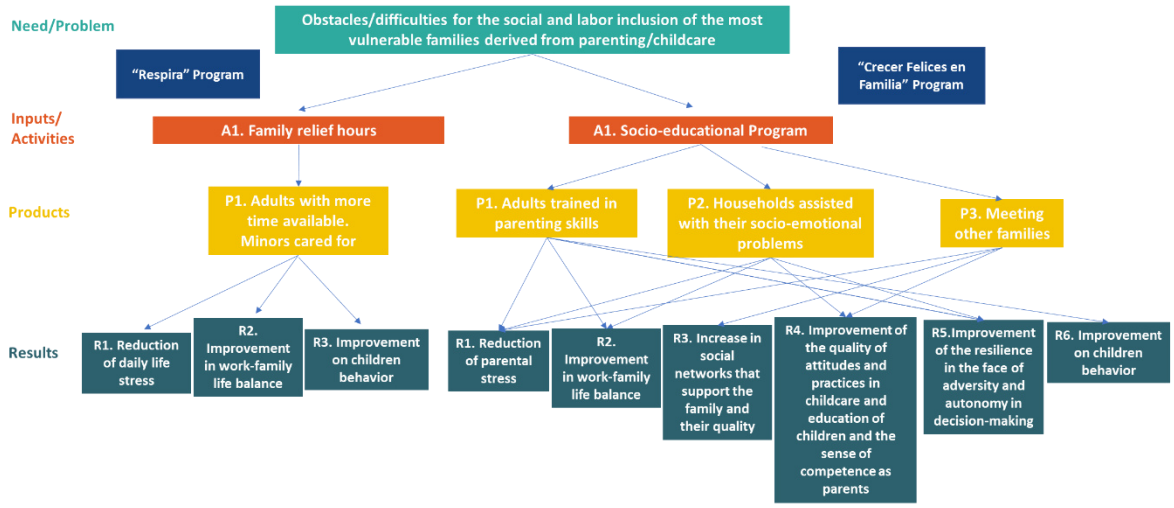
To address this situation, the project proposes a series of actions (inputs or activities), which constitute the resources and actions required to generate the program's outputs. Within the framework of the "Respira" Program, a bundle of hours of family discharge; in the "Psychoeducational Program 'Crecer Felices en Familia II'", socio-emotional support activities (cohabitation at home) and positive parenting strategies.

As a result of the actions described above, the project expects to obtain a series of products. That is, as a direct result of the activities programmed in treatment 1, adults are expected to have more free time and children are expected to be cared for. As a product of the "Psychoeducational Program 'Crecer Felices en Familia II'", it is expected that adults will be trained in parenting skills, that homes will be attended to in their socio-emotional problems and, in addition, that they will get to know other families.

The project's development leads to distinct outcomes for each program[16] (final changes). In the first case, it results in reduced daily life stress, enhanced work-life balance, and improved child behavior. In the second, it enhances the quality of caregiving attitudes and practices, parental sense of competence, resilience in adversity, autonomy in decision-making, and children's behavior. Additionally, it reduces parental stress related to caregiving and increases social support networks that enhance family quality of life.

Figure 4 illustrates both causal sequences of actions. In each case, the scheme is initiated by the activities and resources necessary to be able to obtain the expected changes in the participants. To this end, each phase encompasses a series of components that make these changes possible and that are determined by the actions carried out in the previous phase.

Figure 4: Theory of Change



3.2 Hypotheses

The starting hypothesis of this project is that families in vulnerable situations with dependent children could increase their level of well-being and regain their autonomy more easily and/or quickly when they are provided with family support (childcare and child education) for a period.

The project tests the following hypotheses:

Reduction of parental stress

The main hypothesis to test in this area is whether either of the two treatments reduces self-perceived parental stress, compared to the traditional socio-labor program. Also, as a secondary hypothesis, this report proposes whether the treatment reduces the level of self-perceived economic precariousness.

[16] This project does not propose what, in the general approach of a Theory of Change, are called "intermediate results", considering all results as final.

Improvement of work-life balance

In relation to work-life balance, the main hypothesis is that either of the two treatments reduces the level of conflict in work-life balance. As a secondary hypothesis, this study tests whether either of the two interventions improves the family climate.

Improvement of the child's behavior

In relation to the improvement of the child's behavior, the main hypothesis is that the treatments improve the child's behavior.

Increase in social networks to support the family and their quality

The main hypothesis to test in this area is whether psychoeducational treatment increases the social support received. On the other hand, the secondary hypothesis considers that the treatment, compared to the traditional socio-labor program, reduces the obstacles self-perceived by the family in relation to the search for social and personal support.

Improvement in the quality of childcare, education attitudes and practices, and improvement in the sense of competence as parents

In this case, this report postulates two main hypotheses: whether psychoeducational treatment improves the quality of parents' parenting attitudes, and whether it improves parenting skills.

Improvement of resilience in the face of adversity and autonomy in decision-making

The main hypothesis postulates that the treatment, as opposed to the traditional socio-labor program and the treatment that provides hours of family relief, increases the resilience of the household.

3.3 Sources of information

This project gathers data for the primary indicators from a variety of questionnaires. Specifically, this study employs a quantitative methodology based on data collected through participant surveys. The surveys are conducted at various time points: July-August and September 2022 (sociodemographic profile questionnaire), before the start of the project (the rest of the questionnaires), and after the end of the intervention programs. The psychosocial risk questionnaires and part of the evaluation questionnaires are completed after the end of the intervention programs, and those of economic precariousness, socio-labor balance, and part of the evaluation questionnaires are collected two months after the end of the intervention.

The Madrid City Council is responsible for collecting all the information. The project uses the following ad-hoc evaluation questionnaires for data collection:

- **Sociodemographic profile questionnaire.** This questionnaire collects information on the main adult (head of the family), the cohabiting adult (partner of the main adult, if applicable) and

the children living with the main adult[17]. For the main adult and the cohabitant, it requests information on gender, country of origin, year of birth, educational level, marital status, employment status, type of housing, whether social services have been sought and (if applicable) the type, and whether they live with the partner. Regarding cohabiting children, it asks about the number of children, the age of the child who was going to participate in the program, the number of children by age group, the number of children by gender, and who lived in the family unit with the children.

- **Psychosocial risk questionnaire (biparental).** This questionnaire is based on the Psychosocial Risk Assessment Protocol of Rodríguez et al. (2006)[18]. It consists of a series of items, grouped by themes: family organization, personal history and characteristics of the father or caregiver, personal history and characteristics of the mother or caregiver, characteristics of the family microsystem, educational risk guidelines, support networks, and adaptation of the child.
- **Psychosocial Risk questionnaire (single parent).** Like the two-parent questionnaire, but for single-parent families.
- **Questionnaire on economic precariousness.** It is a questionnaire based on the *Economic Hardship Questionnaire* by Lempers et al. (1989)[19]. It asks how often individuals or families have taken certain actions (reducing leisure or free time expenses, postponing large purchases for the house or going shopping for clothes, changing transport habits, the way they buy food or eating habits to save money, etc.) in the last two years. It also asks about the change in family income over the last two years and about the assessment of the family's economic situation at the time of the interview.
- **Questionnaire on socio-labor balance.** This is an abbreviated version of *The Spanish Work-Family Conflict Scale (SP-WFCS)*[20]. It asks about the degree of agreement with a series of statements about conflicts in work-life balance (time pressure, emotional pressure, and behavioral pressure), both from work to family and from family to work.
- **Evaluation questionnaires.** This questionnaire collects information on diverse topics: development of the child according to his/her age (degree to which he/she has managed to perform certain actions and adaptation of development to his/her age, depending on this,

[17] Reference is made to children who live with the primary adult (with full or joint custody). Grandchildren and other persons are included when there is custody of them and children residing abroad are not included.

[18] Rodríguez, G., Camacho, J., Rodrigo, M. J., Martín Quintana, J. C., & Máiquez, M. L. (2006). Evaluación del riesgo psicosocial en familias usuarias de servicios sociales municipales. Psychothema, 18(2), 200-206.

[19] Lempers. J.D., Clark-Lempers, D., y Simone, R.L. (1989). Economic hardship, parenting and distress in adolescence. *Child Development*, 60, 25-39. Spanish version: Ayala-Nunes, L., Jiménez, L., Jesus, S. et al. Social Support, Economic Hardship and Psychological Distress in Spanish and Portuguese At-Risk Families. *J Child Fam Stud* 27, 176–186 (2018).

[20] Original version: Carlson, D. S., Kacmar, K. M., y Williams, L. J. (2000). Construction and initial validation of a multidimensional measure of work–family conflict. *Journal of Vocational Behavior*, 56(2), 249–276. Abridged version: Matthews, R. A., Kath, L. M., y Barnes-Farrell, J. L. (2010). A short, valid, predictive measure of work–family conflict: Item selection and scale validation. *Journal of occupational health psychology*, 15(1), 75. Spanish version: Pujol-Cols, L. (2021). Development and validation of the Spanish work-family conflict scale (SP-WFCS): evidence from two independent samples in Argentina. *Current Psychology*, 40(9), 4189-4204.

from 2 months to 8 years), assessment of the capacity to be a father or mother (collected at the end of the intervention), attitudes about children's education (collected at the end of the intervention), personal and social support for problem solving (both with one of the children and personally, as well as reasons for not asking for help, collected at the end of the intervention), frequency with which different types of support are available when needed (collected at the end of the intervention), stress related to paternity or motherhood (collected at the end of the intervention), family relationships (collected 2 months after the end of the intervention), and resistance to problems (collected 2 months after the end of the intervention).

3.4 Indicators

This section describes the indicators that this study uses to evaluate the impact of the itinerary, divided into themes related to the hypotheses described in **section 3.2.**

Reduction of parental stress

Self-perceived parental stress level. Synthetic indicator based on the level of self-perceived parental stress, calculated using the 36 variables that correspond to all the items of the Parental Stress Index, as the normalized mean of the variables involved. It takes values between 0 (maximum stress level) and 1 (minimum stress level).

Self-perceived level of economic precariousness. Synthetic indicator based on the level of economic precariousness perceived by the family, calculated as the normalized average of the variables involved. It takes values between 0 (maximum economic precariousness) and 1 (minimum economic precariousness). This information is collected in POST2.

Improvement of work-life balance

Two indicators obtained in POST2:

Level of conflict in work-life balance. Synthetic indicator based on the self-perceived level of conflict between family and work life, calculated using the 6 variables that are recorded through the Spanish Work-Family Conflict Scale (SP-WFCS) as the normalized mean of the variables involved. It takes values between 0 (minimum reconciliation level) and 1 (maximum reconciliation level).

Level of cohesion and adaptability. Synthetic indicator based on the family's description of the family climate, calculated as the normalized average of the variables involved. It takes values between 0 (minimum cohesion level) and 1 (maximum cohesion level).

Improvement of the child's behavior

The child's level of behavior. Synthetic indicator based on the perception of improvement in the child's behavior, calculated as the average of the 12 variables involved. It takes values between 0 (minimum level of behavioral improvement) and 1 (maximum level).

Increase in social networks to support the family and their quality

Quality of the self-perceived social network. Synthetic indicator based on perceived social support, calculated as the normalized mean of the variables involved. It takes values between 0 (minimum level of quality of support) and 1 (maximum level).

Number of informal supports. Synthetic indicator based on the number of informal supports that the family report, calculated as the sum of the variables involved.

Assessment of their informal support. Synthetic indicator based on the family's assessment of their informal support, calculated as the average of the variables involved. This indicator has the particularity that it will only be calculated for those participants who receive certain support, specifically from a series of relatives and acquaintances, so the number of observations may be significantly lower than in other indicators. It takes values between 1 (minimum rating) and 5 (maximum rating).

Number of formal supports. Synthetic indicator based on the number of formal supports that the family report, calculated as the sum of the variables involved.

Assessment of their formal support. Synthetic indicator based on the family's assessment of its formal support, calculated as the average of the variables involved. This indicator has the same particularity as the assessment of informal support indicator, since in this case the indicator is calculated for those participants who receive certain specific support from a series of institutions, so the number of observations may be significantly lower than in the rest of the indicators. It takes values between 1 (minimum rating) and 5 (maximum rating).

Number of reasons not to seek support. Synthetic indicator based on the number of reasons given by families for not seeking help from both formal and informal networks, calculated as the sum of the variables involved. Take values between 1 and 14.

Improvement of the quality of childcare, education attitudes and practices, and improvement of the sense of competence as parents

Quality of parental attitudes. Synthetic indicator based on parents' parenting attitudes, calculated using the 40 variables of educational practices obtained from the Adult-Adolescent Parenting Inventory (AAPI 2) as the normalized mean of the variables involved. It takes values between 0 (minimum quality score) and 1 (maximum score).

Level of parental competence. Synthetic indicator based on the level of parental competence perceived by the family, calculated as the normalized average of the 16 variables involved. It takes values between 0 (minimum level of parental competence) and 1 (maximum level).

Improved resilience in the face of adversity and autonomy in decision-making

One indicator included in POST2:

Level of resilience. Synthetic indicator based on the level of self-perceived resilience, calculated using the 10 variables that come from the questions formulated from the Connor-Davidson Resilience Scale (CD-RISC 10) as the normalized mean of the variables involved. It takes values between 0 (minimum level of resilience) and 1 (maximum level).

3.5 Design of the experiment

To assess the effect of the treatment on each of the previously mentioned indicators, this study uses an experimental evaluation (RCT), in which participants are randomly assigned to either the treatment or the control group. In this project, the control group is not pure, insofar as the three experimental groups receive a baseline intervention aimed at improving their levels of employability[21].

The following section details the recruitment and selection process of the beneficiary families for the intervention, as well as the random allocation and the temporal framework of the experiment.

Recruitment of intervention beneficiaries

The population of families potentially benefiting from the project is composed of cohabitation units living in the municipality of Madrid, with at least one child under 8 years of age (as of September 1, 2022) and in a situation of vulnerability[22].

The Madrid City Council is in charge of contacting the participants. Initially, it sends a letter to the families selected to participate. In addition, and from a certain point in the recruitment process this is the first step in the contact, municipal technicians (social workers, psychologists or social educators) make a telephone call with basic information about the project, offering an appointment to explain the procedures of the project, its benefits, and the characteristics of all the interventions. Appointments always take place at one of the municipal social services centers of the Madrid City Council.

A second meeting is held with the families to collect information through standardized questionnaires, the result of which provides information on the characteristics of the sample, variables that will not be affected due to the intervention: the Sociodemographic Profile Questionnaire and the Psychosocial Risk Assessment Questionnaire.

Once the candidates have been contacted and the project has been explained in detail, the family units that provide their informed consent to participate in the pilot project define the study sample.

[21] For the control group, this will be the only intervention.

[22] To obtain this population, the project starts with the families registered in the Social Services database of the Madrid City Council (CIVIS) in May 2022 and who have received some type of aid-action in the last two years. Within these families, some of them have accessed the Family Card service. This information has been cross-referenced with families who meet the entry requirements for the program and who as of April 2022 are beneficiaries of the Minimum Income Scheme.

Informed Consent

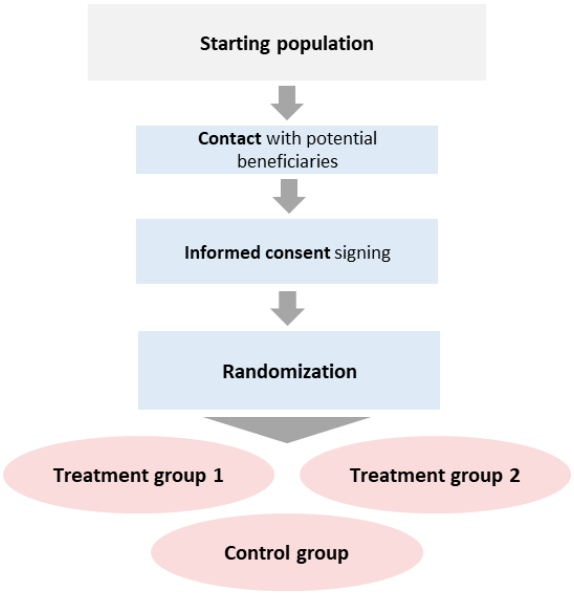
One of the fundamental ethical principles of research involving human beings (respect for people) requires study participants to be informed about the research and consent to be included in the study. Informed consent is usually part of the initial interview and has two essential parts: the explanation of the experiment to the person, and the request and registration of their consent to participate. Consent should begin with a comprehensible presentation of key information that will help the person make an informed decision, i.e., understand the research, what is expected of it, and the potential risks and benefits. Documentation is required as a record that the process has taken place and as proof of informed consent, if so.

Informed consent is required in most research and may be oral or written, depending on different factors such as the literacy of the population or the risks posed by consent. Only under very specific circumstances, such as when the potential risks to participants are minimal and the informed consent is very complex to obtain or would harm the validity of the experiment, informed consent may be avoided, or partial information may be given to participants with the approval of the ethics committee.

Random assignment of participants

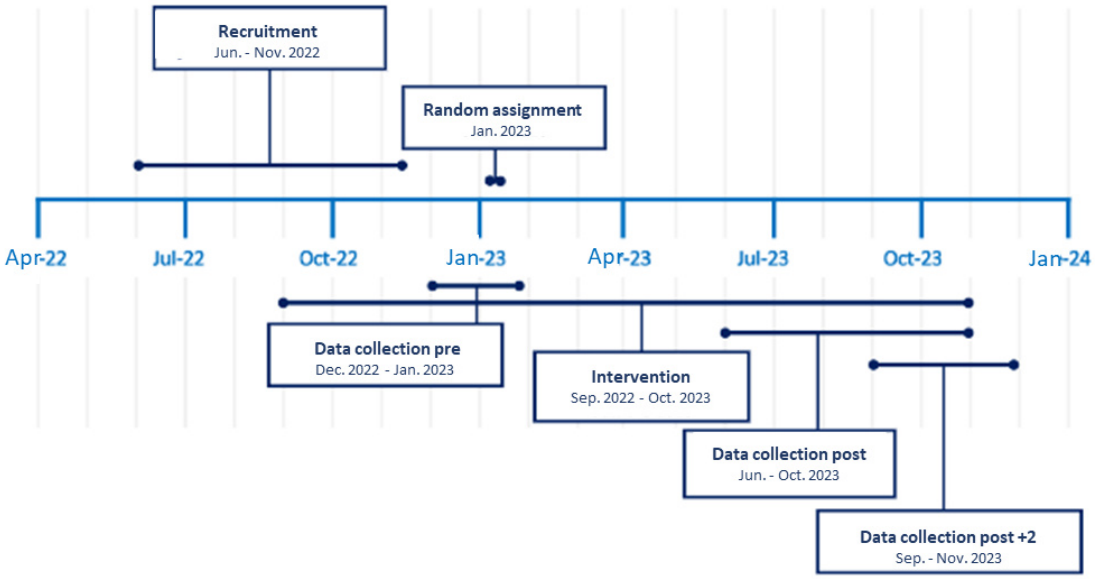
After concluding the recruitment process, participants are randomly assigned to either the treatment or control groups from families who provided informed consent. Stratification by household characteristics related to their interaction with social services ensures sufficient balance among the three groups. Impact indicators are measured before the experiment begins. Specifically, these variables are type of household (single-parent/non-single-parent), seniority in the register of social services of the Madrid City Council (prior to 2018 and 2018 or later), area of residence (in districts of the northern or southern zone of Madrid), and level of psychosocial risk (low, medium and high). This process produces 24 strata.

Figure 5: Sample Design



Finally, **Figure 6** illustrates the timeline for the implementation and evaluation of the itinerary. The participant recruitment process occurs between June and November 2022. Participants complete baseline surveys between November and January 2023. In January 2023, participants who meet the criteria and who have signed the informed consent and are interested in participating are randomly assigned. The itinerary's or intervention's development occurs from September 2022 to October 2023. Finally, the final survey for participants takes place between June and October 2023, depending on the intervention group. Data collection two months after the intervention takes place between September and November 2023, also depending on the intervention groups.

Figure 6: Evaluation timeline



4 Description of the implementation of the intervention

This section describes the practical aspects of how the intervention was implemented as part of the evaluation design. It describes the results of the participant recruitment process and other relevant logistical aspects to contextualize the results of the evaluation.

4.1 Sample Description

Due to the larger number of potential beneficiary families compared to program capacity, a sample has been selected using stratified sampling with proportional allocation based on household type (single-parent and other families with children) from the total population of potential beneficiaries. A part of the households are registered in the database of the Social Services of the Madrid City Council (CIVIS) and receive the MIS, another part receives the MIS and does not appear in CIVIS and the rest

appear in CIVIS-Family Card and do not receive the MIS, so that a very high percentage of beneficiaries of both systems (MIS and Social Services of the City Council) is reached, but also having representation from the two other groups.

The initial group consisted of 2,871 families, which expanded to 6,911 families due to factors like inability to contact or refusal to participate in the program. **Table 1** illustrates the recruitment process from the total sample to the number of signed consents (excluding withdrawals after signing).

Table 1: Recruitment process

	Number of families
Total sample	6,911
Contacted by telephone	5,473
Booked appointments	3,876
Come to appointment	2,343
Signed consents	1,846
Withdrawals after signing	295
Final signed consents	1,525[23]

Characteristics of the final evaluation sample

Table 2 shows the descriptive statistics of the different variables taken at baseline. It shows the stratification variables listed above, the type of household as a function of what is collected in the baseline surveys that is slightly different from that collected in the records, the number of children, and the outcome indicators. For each of the variables, it shows the mean, standard deviation, minimum and maximum values, and the number of observations.

As can be seen in the first panel of **Table 2**, 70% of the families live in the south of Madrid, 43% are single-parent households and 41% have been in the register of social services of the Madrid City Council since before 2018. On the other hand, 72% of the families in the sample have a low psychosocial risk, compared to 11% who have a high psychosocial risk. On average, families have 2.11 children, with a minimum of 1 and a maximum of 6.

Regarding the outcome indicators, the average number of informal supports is higher than that of formal support (3.43 and 2.29, respectively), and their assessment is somewhat higher in the informal ones (3.78 and 3.41 respectively). In addition, on average, families give 2.95 reasons for not asking for help. Finally, the table presents descriptive data of the rest of the impact indicators that have been normalized and take values between 0 and 1: stress level (0.32 on average), level of economic precariousness (0.59 on average), level of conflict in the work-life balance (0.46 on average), level of cohesion and adaptability (0.74 on average), quality of the perceived social network (0.5 on average),

[23] 26 of these families did not belong to any of the groups envisaged as the population of potential beneficiaries, so they are not assigned to any treatment group.

quality of parental attitudes (0.6 on average), level of parental competence (0.59 on average), level of resilience (0.72 on average), and level of behavior of the child (0.31 on average).

Table 2: Descriptive statistics of the sample

Variable	Mean	Std. Dev.	Min.	Max.	Observations
Stratification variables					
North area	0.30	0.46	0	1	1,525
South area	0.70	0.46	0	1	1,525
Type of household - single-parent (record)	0.43	0.50	0	1	1,525
Type of household - non-single-parent (record)	0.57	0.50	0	1	1,525
Type of household - single-parent (survey)	0.45	0.50	0	1	1,525
Type of household - non-single-parent (survey)	0.55	0.50	0	1	1,525
Time in social services (before 2018)	0.41	0.49	0	1	1,525
Time in social services (2018 and after)	0.59	0.49	0	1	1,525
Low psychosocial risk	0.72	0.45	0	1	1,525
Medium psychosocial risk	0.17	0.37	0	1	1,525
High psychosocial risk	0.11	0.32	0	1	1,525
Sociodemographic variables					
Number of children	2.11	1.02	1	6	1,171
Indicators (results)					
Level of support seeking (number of informal supports)	3.43	3.09	0	18	1,173
Level of support seeking (assessment of informal supports)	3.78	0.82	1	5	975
Level of support seeking (number of formal supports)	2.29	2.25	0	15	1,173
Level of support seeking (assessment of formal supports)	3.41	0.92	1	5	879
Level of support seeking (reasons not to ask for help)	2.95	2.58	0	14	1,173
Level of stress	0.32	0.15	0	1	1,173
Level of economic scarcity	0.59	0.19	0.06	1	1,173
Level of conflict on work-life balance	0.46	0.23	0	1	1,026
Level of cohesion and adaptability	0.74	0.17	0	1	1,173
Quality of the perceived social network	0.50	0.27	0	1	1,173
Quality of parental attitudes	0.60	0.11	0.15	0.91	1,173
Level of parental competence	0.59	0.12	0.17	1	1,173
Level of resilience	0.72	0.19	0	1	1,173

Level of child's behavior	0.31	0.17	0	1	1,173

4.2 Random Assignment Results

After defining the sample, participants are randomly assigned. As mentioned, the allocation process includes the stratification method according to the variables of type of family, time in the register of social services of the Madrid City Council, residence, and level of psychosocial risk, creating a total of 24 strata.

Table 3 shows the results of the random assignment, detailing the number of participants assigned to each group and dividing this information according to the different stratification variables[24].

Table 3: Results of random assignment

	North area	South area	Total
Treatment 1	166	334	**500**
Treatment 2	145	355	**500**
Control group	154	371	**525**
Total	**465**	**1,060**	**1,525**

Since there were 25 additional families in addition to the 1,500 planned, 500 families were assigned to each of the treatment groups and 525 to the control group. There were 25 families within this group randomly ordered to serve, if necessary, as substitutes for possible withdrawals from the psychoeducational treatment group.

Once the sample is defined, participants are randomly assigned to either the treatment group or the control group, as explained in **Section 3.5**, and a balance test is conducted to ensure that, on average, the observable characteristics of the participants in both groups are equal. Balance between experimental groups is crucial for inferring the causal effect of the program by comparing their outcomes.

Figure 7[25] shows the balance tests results between the different experimental groups. All data presented in this figure refer to the survey conducted prior to the intervention (baseline). For each observable variable, the difference between the mean of that variable in the treatment and control group is represented by a dot and focused on it, the 95% confidence interval of that difference. A confidence interval containing zero, i.e., the vertical axis, will indicate that the mean difference between groups is not statistically significant or, in other words, is not statistically different from zero, meaning that the intervention groups are balanced. In case the confidence interval of the mean

[24] The full table is shown in the Appendix. The assignment considers T1 as the psychoeducational program and T2 as the discharge hours program, however, they were finally used in reverse. Since the assignment was random and the change occurred at the start of the intervention, it does not affect the intended design of the experiment.

[25] Please refer to **Table 21** in the Appendix on **Balance between Experimental Groups** for details of the results of the equilibrium tests.

difference does not contain zero, the difference is statistically significant meaning the groups are unbalanced in this characteristic.

Figure 7 shows that all the variables included in the evaluation scheme as possible control variables are balanced at baseline by treatment groups (treatment 1 vs. control group, treatment 2 vs. control group, and treatment 2 vs. treatment 1).

Figure 7: Difference between standardized means between treatment and control group (confidence interval at 95%)

Note: in red, the variables used for sample stratification are displayed; in blue, the remaining sociodemographic variables, and in orange, the specific indicators used for project evaluation.

4.3 Degree of participation and attrition by groups

The group that signs the informed consent form constitutes the experimental sample randomly assigned to the control and treatment groups. However, both participation in the program and responses to the initial and final surveys are voluntary. On the one hand, it is convenient to analyze the degree of participation in the program since the estimation of results will refer to the average effects of offering it given the degree of participation. For example, if participation in treatment activities is low, the treatment and control groups will be very similar, and it will be more difficult to find an effect. On the other hand, this section tests whether the non-completion of the final survey by some of the participants reduces the comparability of the treatment and control groups after the intervention, if the response rate is different between groups or according to the demographic characteristics of the participants in each group.

Degree of participation

The indicators of participation in the socio-labor program show that the total participation rate among families in this program was 21%. Participation in the "Emplea+" program or the "*Viaje Web*" program (in one of the 2 programs, which is indicated in the table as low intensity) was 3%, while 18% of families have participated in both (high intensity). In other words, there has been a reduced participation in the socio-labor program; however, for the families that have participated, intensity has been high.

Table 4: Share of participating families in the Socio-Labor Program

Treatment group	Null intensity	Low intensity (Emplea+ or *Viaje Web*)	High intensity (Emplea+ and *Viaje Web*)
Control group	77%	3%	20%
Treatment 1	79%	3%	19%
Treatment 2	83%	3%	14%
Total	79%	3%	18%

Note: Participation in one of the two programs ("Emplea+" or "*Viaje Web*") is considered "low intensity"; Participation in both programs is considered "high intensity".

Regarding the programs implemented within the treatment groups ("Respira Program" and "Psychoeducational Program 'Crecer Felices en Familia II'", with group and home sessions), participation rates were 20%, 48% and 27%, respectively. On the other hand, 11%, 12% and 23% of the families have had a high intensity in each of the programs. In other words, there has been little participation in general terms, although this has been of high intensity in the case of home sessions.

Table 5: Share of participating families in the treatment groups

Treatment group	Treatment	Null intensity	Low intensity	Medium intensity	High intensity
Treatment 1	Programa Respira	80%	5%	3%	11%
Treatment 2	*Crecer Felices en Familia* (group sessions)	52%	20%	16%	12%

Treatment group	Treatment	Null intensity	Low intensity	Medium intensity	High intensity
	Crecer Felices en Familia (home sessions)	73%	3%	2%	23%

Note: in the "Respira" Program the use of less than 15 hours is considered "low intensity", the use of between 15 and 30 hours is considered "medium intensity", and the use of between 30 and 40 hours is considered "high intensity"; in the "Psychoeducational Program 'Growing Up Happy in the Family'" (group sessions), attendance at less than 7 sessions, between 7 and 14 sessions and between 14 and 21 sessions, respectively; regarding home sessions, 1 or 2 visits, 3 to 5 visits and 6 or 7 visits, respectively.

Attrition by groups

Table 6 presents, in detail, the number of families that have dropped out of the program according to assignment group, time of cancellation, and reason. In total, 560 families (37% of the total) have left at some point in the project. 352 families (23%) dropped out at the baseline, before completing the baseline survey, while 66 (4%) did so in the group compliance phase, and 142 (9%) in the intervention phase. On the other hand, an analysis by allocation groups shows that the percentage of withdrawals was relatively similar between the three experimental groups (24% in the control group versus 23% in both treatment groups).

Table 6: Families that have dropped out, by assignment group, time of leave, and reason

Dropout	Time of leave	Reason	Control Group	Treatment 1	Treatment 2	Total
YES	PRE	Lack of interest	12	7	10	29
		Untraceable	39	23	25	87
		Other	41	38	35	114
		Vital situation	33	46	43	122
		Total	**125**	**114**	**113**	**352**
	Group conformity	Lack of interest	0	0	1	1
		Disagreement with assigned group	6	1	5	12
		Untraceable	19	10	7	36
		Other	2	0	2	4
		Vital situation	2	3	8	13
		Total	**29**	**14**	**23**	**66**
	Intervention	Lack of interest	1	0	1	2
		Disagreement with assigned group	0	0	55	55
		Untraceable	0	2	7	9
		Other	1	2	47	50
		Vital situation	0	0	26	26
		Total	**2**	**4**	**136**	**142**
NO			369	368	228	965
TOTAL			**525**	**500**	**500**	**1,525**

Regarding the assignment groups and the groups finally treated, as planned, when there were any dropouts in treatment group 2 during the first two weeks after the start of the intervention, 11 families assigned to the control group were used as possible substitutes.

All the families who participated in the interventions did so in the corresponding group. With respect to data availability, 1,173 households have baseline data.

Finally, it should be noted that 707 families have completed the final line survey (46% of the total number of families) and for 528 (35%) the survey was carried out 2 months after the end of the intervention.

Table 7: Families according to treatment group and data availability (PRE = Baseline; POST = First Endline Survey; POST2 = Second Endline Survey)

Treatment group	PRE Data		POST Data		POST2 Data		Total
	No	Yes	No	Yes	No	Yes	
Control group	125	389	257	257	343	171	**514**
Treatment 1	114	386	216	284	306	194	**500**
Treatment 2	113	398	345	166	348	163	**511**
Total	**352**	**1.173**	**818**	**707**	**997**	**528**	**1,525**

There are important differences among groups: in treatment group 2, 32% of families responded, compared to a response of 57% in treatment group 1 or 50% in the control group. These levels of attrition are quite high, which will have to be considered when interpreting the results for treatment group 2. This is related to the dropouts that occurred in the treatments, with a higher incidence in treatment group 2.

To assess whether this difference in sample attrition rate between experimental groups is statistically significant, this study estimates a simple regression of the non-survey binary variables for endline surveys on the assignment to each of the treatments.

Regarding treatment attrition rates, column 1 of **Table 8** shows that the coefficient of treatment variable 1 is -0.07, statistically significant at 5%, while that of treatment 2 is 0.18, significant at 1%. This indicates that attrition in treatment group 1 is 7 percentage points lower than in the control group and in treatment group 2 is 18 percentage points higher than in the control group, both differences being significant. In the second endline survey, attrition is lower by 6 percentage points in treatment group 1 versus the control group and the difference is significant at 10%. The attrition rate in POST2 is not significantly different in treatment group 2 versus the control group.

Table 8: Attrition rates by experimental groups

	First Baseline Survey (POST)	Second Baseline Survey (POST2)
Treatment group 1	-0.07**	-0.06*
	(0.03)	(0.03)
Treatment group 2	0.18***	0.01
	(0.03)	(0.03)
Observations	1,525	1,525

Note: ***=.01, **=.05, *=.1. Robust standard errors.

Focusing on the first endline survey, **Table 9** shows attrition as a function of sociodemographic variables and outcome indicators. Columns 1 and 2 show the coefficients of the interaction between the treatment variables and each control variable obtained in the same regression where the dependent variable is attrition in the survey collected in POST. Columns 3 and 4 show the same information on attrition in the POST2 survey.

In general terms, there is an uneven attrition by groups, with a significant difference, especially in treatment group 2 compared to the others. However, when analyzed for each of the control variables at baseline, there is no significant and differential relationship between intervention groups between attrition and most of the characteristics of the participants. There is a relationship between attrition in treatment group 2 and psychosocial risk at baseline, so that those who answered the least had a low or medium risk.

In the second endline survey (columns 3 and 4 of **Table 9**), attrition in the different intervention groups is also not significantly different with respect to most of the variables analyzed. However, as in the previous case, families are more likely to respond when they are at high psychosocial risk and receive treatment 2, compared to control families. There is a negative relationship between attrition in treatment group 2 and the level of stress (households with a higher level of stress are less likely to respond) and a positive relationship with the level of cohesion and the level of resilience (they are less likely to respond when they have higher levels of cohesion and resilience)[26].

Table 9: Selective attrition by observables

	First Baseline Survey (POST)		**Second Baseline Survey (POST2)**	
Control Variable	**(1) Treatment group 1**	**(2) Treatment group 2**	**(3) Treatment group 1**	**(4) Treatment group 2**
Treatment x North area	0.05	-0.08	0.09	-0.02

[26] The study performs a Lee-Bounds analysis for all indicators. However, given the high percentage of attrition, the results are inconclusive and are not included in this report.

	First Baseline Survey (POST)		Second Baseline Survey (POST2)	
Control Variable	**(1) Treatment group 1**	**(2) Treatment group 2**	**(3) Treatment group 1**	**(4) Treatment group 2**
	(0.07)	(0.07)	(0.07)	(0.07)
Treatment x Type of household - single-parent	-0.03	0.11*	-0.05	0.04
	(0.06)	(0.06)	(0.06)	(0.06)
Treatment x Time in social services (before 2018)	-0.06	0.05	-0.05	0.06
	(0.06)	(0.06)	(0.06)	(0.06)
Treatment x Low psychosocial risk	0.16*	0.27***	0.05	0.19**
	(0.10)	(0.10)	(0.10)	(0.09)
Treatment x Medium psychosocial risk	0.19	0.39***	0.15	0.35***
	(0.12)	(0.12)	(0.12)	(0.11)
Treatment x Number of children	0.03	0.06*	0.03	0.04
	(0.03)	(0.03)	(0.04)	(0.03)
Treatment x Level of stress	-0.03	-0.24	-0.09	-0.42*
	(0.23)	(0.24)	(0.25)	(0.24)
Treatment x Level of economic scarcity	0.17	0.22	0.26	0.15
	(0.17)	(0.18)	(0.19)	(0.19)
Treatment x Level of conflict on work-life balance	-0.14	0.12	-0.18	0.20
	(0.16)	(0.16)	(0.17)	(0.17)
Treatment x Level of cohesion and adaptability	-0.04	0.20	0.23	0.54**
	(0.20)	(0.21)	(0.21)	(0.21)
Treatment x Quality of the perceived social network	-0.11	-0.02	-0.25*	-0.03
	(0.12)	(0.13)	(0.13)	(0.13)
Treatment x Level of support seeking (number of informal supports)	0.00	0.00	0.00	0.01
	(0.01)	(0.01)	(0.01)	(0.01)
Treatment x Level of support seeking (assessment of informal supports)	-0.01	-0.00	-0.01	0.01
	(0.04)	(0.05)	(0.05)	(0.05)
Treatment x Level of support seeking (number of formal supports)	0.02	0.00	0.01	-0.01
	(0.01)	(0.02)	(0.02)	(0.02)

	First Baseline Survey (POST)		Second Baseline Survey (POST2)	
Control Variable	**(1) Treatment group 1**	**(2) Treatment group 2**	**(3) Treatment group 1**	**(4) Treatment group 2**
Treatment x Level of support seeking (assessment of formal supports)	0.03	-0.02	-0.04	-0.06
	(0.04)	(0.04)	(0.04)	(0.04)
Treatment x Level of support seeking (reasons not to ask for help)	0.00	0.01	0.01	0.01
	(0.01)	(0.01)	(0.01)	(0.01)
Treatment x Quality of parental attitudes	-0.01	0.40	0.06	0.46
	(0.29)	(0.31)	(0.31)	(0.31)
Treatment x Level of parental competence	-0.21	-0.07	-0.14	0.23
	(0.28)	(0.29)	(0.30)	(0.29)
Treatment x Level of resilience	0.13	0.26	0.30*	0.41**
	(0.17)	(0.18)	(0.18)	(0.18)
Treatment x Level of child's behavior	0.09	-0.24	-0.12	-0.33
	(0.20)	(0.20)	(0.22)	(0.21)

Note: In order to simplify the table, it only shows the coefficients associated with the interactions between treatment and each control variable in the columns for all the regressions performed (identified by a separation line). =.01, **=.05, *=.1. Robust standard errors.

5 Results of the evaluation

Random assignment of the experimental sample to the control and treatment groups ensures that, a sufficiently large sample given, the groups are statistically comparable and therefore any differences observed after the intervention can be causally associated with the treatment. Econometric analysis provides, in essence, this comparison. However, it has the advantages of allowing other variables to be included to gain precision in estimates and of providing confidence intervals for estimates. This section presents the econometric analysis accomplished and the estimated regressions, as well as the analysis of the results obtained.

5.1 Description of the econometric analysis: estimated regressions

The regression model specified to estimate the causal effect in a randomized experiment is typically just the difference in the variable of interest between the treatment group and the control group, since these groups are statistically comparable thanks to randomization. Given the results shown in the balance tables (**Figure 6**), the analysis presents regressions that include the treatment variable (or

both treatments, if applicable) and, on the other hand, regressions that include the baseline value of the dependent variable. Therefore, it does not include additional control variables[27].

Specifically, the main specification of regressions is as follows[28]:

$$y_{i(post)} = \beta_0 + \beta_1 T_{1i} + \beta_2 T_{2i} + \beta_3 y_{i(pre)} + \epsilon_i$$

Where $y_{i(post)}$ is the dependent variable of interest observed after completion of the intervention for family i; T_{1i} indicates whether family I has been assigned to treatment group 1; T_{2i} indicates whether family i has been assigned to treatment group 2; $y_{i(pre)}$ is the value of the variable of interest captured during the baseline; and ϵ_i it's the error term.

For those indicators in which impact is only expected for treatment group 2, the estimate only includes the binary variable that indicates whether the family has been assigned to this treatment group, not the one corresponding to treatment 1. This analysis does not include observations from treatment group 1. Therefore, the results will be interpreted for treatment group 2 versus the control group.

5.2 Analysis of the results

5.2.1 Main and secondary results

This section presents the results of analyzing the hypotheses presented above, following the structure of the evaluation framework. For each variable, the tables present two specifications: (i) without the variable of interest in the baseline, (ii) with the variable of interest in the baseline.

Reduction of parental stress

Table 10 presents the analysis of the main and secondary indicators intended to measure the reduction of parental stress. The specification without the baseline data (columns 1 and 3) shows no significant effect, and the results persist after adding this data (columns 2 and 4). Although the model yields a reduction of 0.02 points in the level of economic precariousness in both specifications, and although the sign goes against what is specified in the hypotheses, this estimate is not significant. In addition, there are no differences between the two treatments in the reduction of parental stress (p-value of the test of difference in effect between the two treatments in the last row of the table).

[27] As an additional specification, the analysis obtains the results by incorporating the variables of characteristics (type of household, area of residence, time in social services, and psychosocial risk) as controls in all regressions. The analysis of these data coincides with what was obtained without controls for all indicators, so they are not included in the report as they do not provide additional information.

[28] The specification is equivalent for the results obtained in POST2.

Table 10: Effects on parental stress indicators

	Level of stress		Level of economic scarcity	
	(1)	(2)	(3)	(4)
Treatment 1	0.00	0.00	-0.02	-0.02
	(0.01)	(0.01)	(0.02)	(0.02)
Treatment 2	0.00	-0.00	-0.02	-0.02
	(0.01)	(0.01)	(0.02)	(0.02)
Observations	707	707	528	528
R^2	0.00	0.31	0.00	0.09
Control group average on PRE	0.30	0.30	0.59	0.59
p-value difference T1-T2	0.81	0.68	0.97	1.00
Dependent variable initial value	No	Yes	No	Yes

Note: Robust standard errors in parentheses. Levels of significance: *p<0.1, **p<0.05 and ***p<0.01.

Improvement of work-life balance

Table 11 presents the analysis of the main and secondary indicators aimed to measure the improvement of the work-life balance. The specification without baseline data shows a significant reduction of 0.03 points, significant at 10% level, in the cohesion and adaptability level for treatment 2 (column 3), which in principle goes against the baseline hypothesis. However, this impact loses significance after adding the variable measured at baseline (column 4). In this case, there are no differences between the two treatments.

Table 11: Effects on work-life balance indicators

	Level of conflict on work-life balance		Level of cohesion and adaptability	
	(1)	(2)	(3)	(4)
Treatment 1	-0.01	-0.02	-0.01	-0.00
	(0.02)	(0.02)	(0.02)	(0.01)
Treatment 2	0.01	0.01	-0.03*	-0.02
	(0.02)	(0.02)	(0.02)	(0.01)
Observations	471	471	528	528
R^2	0.00	0.02	0.01	0.23
Control group average on PRE	0.52	0.52	0.78	0.78
p-value difference T1-T2	0.34	0.21	0.18	0.40
Dependent variable initial value	No	Yes	No	Yes

Note: Robust standard errors in parentheses. Levels of significance: *p<0.1, **p<0.05 and ***p<0.01.

Increase in social networks to support the family and their quality

Table 12 shows the analysis of the quality indicator of the self-perceived social network, used to contrast the main hypothesis related to the social networks of family support and their quality. Both specifications (without and with baseline data) show a null effect of treatment 2 versus the control group on this indicator.

Table 12: Effects on the quality of the perceived social network

	(1)	(2)
Treatment 2	-0.00	0.00
	(0.03)	(0.02)
Observations	423	423
R^2	0.00	0.31
Control group average on PRE	0.53	0.53
Dependent variable initial value	No	Yes

Note: Robust standard errors in parentheses. Levels of significance: *p<0.1, **p<0.05 and ***p<0.01.

On the other hand, **Table 13** presents the analysis of secondary indicators in this area. The specification without baseline data (column 3) shows an increase of 0.25 points, representing a significant improvement of 6.8%, significant at 1% level, in the assessment of informal supports for treatment 2, which is 6.4% when adding baseline data (column 4), with a significance level of 5%. On the other hand, there is a significant increase of 0.23 points (significant at to 5% level) in the assessment of formal support, which represents an improvement of 6.6%, and which loses significance when including baseline data (column 8).

Table 13: Effects on the level of support seeking

	Number of informal supports		Assessment of informal supports		Number of formal supports		Assessment of formal supports		Reasons not to ask for help	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
Treatment 2	0.38	0.41	0.25***	0.24**	0.21	0.20	0.23**	0.18	0.23	0.27
	(0.36)	(0.32)	(0.09)	(0.09)	(0.22)	(0.20)	(0.11)	(0.11)	(0.26)	(0.25)
Observations	423	423	335	298	423	423	305	263	423	423
R^2	0.00	0.23	0.02	0.09	0.00	0.20	0.01	0.11	0.00	0.08
CG average on PRE	3.63	3.63	3.69	3.75	2.09	2.09	3.47	3.48	2.53	2.53
Dep. Var. Initial value	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes

Note: Robust standard errors in parentheses. Levels of significance: *p<0.1, **p<0.05 and ***p<0.01.

Improvement in the quality of childcare, education attitudes and practices, and improvement in the sense of competence as parents

Table 14 reports the analysis of key indicators measuring improvements in the quality of caregiving attitudes and practices for child education, along with enhancements in parental competence. The specification without baseline data shows a non-significant improvement of 0.01 points compared to the control group, which represents a 1.5% improvement in the quality of parental attitudes for treatment 2 (column 1), which becomes significant at 10% after adding the variable measured at baseline (column 2). No significant effects were found on the level of parental competence.

Table 14: Effects on the indicators of quality of childcare and education attitudes and practices and improvement of the sense of competence as parents

	Quality of parental attitudes		Level of parental competence	
	(1)	(2)	(3)	(4)
Treatment 2	0.01	0.01*	-0.02	-0.01
	(0.01)	(0.01)	(0.01)	(0.01)
Observations	423	423	423	423
R^2	0.00	0.33	0.01	0.36
Control group average on PRE	0.66	0.66	0.61	0.61
Dependent variable initial value	No	Yes	No	Yes

Note: Robust standard errors in parentheses. Levels of significance: *p<0.1, **p<0.05 and ***p<0.01.

Improvement of resilience in the face of adversity and autonomy in decision-making

Table 15 shows the analysis of the level of resilience indicator, used to test the main hypothesis in this area. Both specifications (without and with baseline data) show a null effect of treatment 2 on this indicator.

Table 15: Effects on the level of resilience

	(1)	(2)
Treatment 2	0.00	0.02
	(0.02)	(0.02)
Observations	334	334
R^2	0.00	0.10
Control group average on PRE	0.77	0.77
Dependent variable initial value	No	Yes

Note: Robust standard errors in parentheses. Levels of significance: *p<0.1, **p<0.05 and ***p<0.01.

Improvement of the child's behavior

Finally, **Table 16** presents the analysis of the main indicator, which seeks to measure the improvement of the child's behavior. Both specifications (without and with baseline data) show a null effect of both

treatments on this indicator compared to the control group. There was also no statistically significant difference between the two treatments: the p-value of the difference test between the two treatments is 0.26 without baseline data and 0.59 without baseline data, which is, in both cases, higher than 0.10.

Table 16: Effects on the level of child's behavior

	(1)	(2)
Treatment 1	-0.01	-0.00
	(0.01)	(0.01)
Treatment 2	0.01	0.00
	(0.02)	(0.01)
Observations	707	707
R^2	0.00	0.25
Control group average on PRE	0.30	0.30
p-value difference T1-T2	0.26	0.59
Dependent variable initial value	No	Yes

Note: Robust standard errors in parentheses. Levels of significance: *p<0.1, **p<0.05 and ***p<0.01.

5.2.2 Heterogeneity analysis

This section presents analyses of heterogeneity of treatment effects according to household type (single-parent or non-single-parent) for treatment 2 versus the control group. Thus, the analysis runs regressions like those in the previous section, adding the interaction between the type of household and the treatment variable. In the following tables, the odd-numbered columns show the results of the regressions without controls, while the even-numbered columns show the results of the regressions that include as a control the value of each of the respective indicators in the baseline.

Table 17 shows the results for the indicators of parental stress and work-life balance. The coefficient of interest corresponds to the interaction between the treatment and the binary variable that indicates that the household is single-parent. In none of the cases is the coefficient significantly non-zero. Therefore, there are no heterogeneous effects by type of household.

Table 17: Heterogeneous effects by household type (1)

	Level of stress		Level of economic scarcity		Level of conflict on work-life balance		Level of cohesion and adaptability	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Treatment 2	-0.00	0.00	-0.02	-0.01	0.03	0.03	-0.01	0.00
	(0.02)	(0.02)	(0.03)	(0.03)	(0.03)	(0.03)	(0.02)	(0.02)
Single-parent household	-0.02	0.01	-0.01	0.00	0.03	0.02	0.06***	0.04**
	(0.02)	(0.01)	(0.03)	(0.03)	(0.03)	(0.03)	(0.02)	(0.02)

Treatment 2 x Single-parent household	0.01	-0.02	-0.01	-0.02	-0.04	-0.02	-0.05	-0.04
	(0.03)	(0.02)	(0.04)	(0.04)	(0.05)	(0.05)	(0.03)	(0.03)
Observations	423	423	334	334	305	305	334	334
R^2	0.00	0.34	0.00	0.12	0.00	0.03	0.03	0.23
Control group average on PRE	0.30	0.30	0.59	0.59	0.52	0.52	0.78	0.78
Dep. Var. Initial value	No	Yes	No	Yes	No	Yes	No	Yes

Note: Robust standard errors in parentheses. Levels of significance: *p<0.1, **p<0.05 and ***p<0.01.

Table 18 shows the results for indicators of child behavior, quality of attitudes and practices for childcare and education, and improvement of the sense of competence as parents and resilience. Again, there are no significant heterogeneous effects by household type for these indicators.

Table 18: Heterogeneous effects by household type (2)

	Level of child's behavior		Quality of parental attitudes		Level of parental competence		Level of resilience	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Treatment 2	0.01	0.01	0.01	0.01	-0.01	-0.02	0.01	0.02
	(0.02)	(0.02)	(0.01)	(0.01)	(0.02)	(0.01)	(0.02)	(0.02)
Single-parent household	0.01	0.03	-0.00	-0.01	0.01	-0.01	0.02	0.01
	(0.02)	(0.02)	(0.01)	(0.01)	(0.01)	(0.01)	(0.03)	(0.02)
Treatment 2 x Single-parent household	0.01	-0.02	0.01	0.01	-0.02	0.01	-0.02	-0.02
	(0.03)	(0.03)	(0.02)	(0.01)	(0.02)	(0.02)	(0.04)	(0.03)
Observations	423	423	423	423	423	423	334	334
R^2	0.00	0.27	0.00	0.33	0.01	0.36	0.00	0.10
Control group average on PRE	0.30	0.30	0.66	0.66	0.61	0.61	0.77	0.77
Dep. Var. Initial value	No	Yes	No	Yes	No	Yes	No	Yes

Note: Robust standard errors in parentheses. Levels of significance: *p<0.1, **p<0.05 and ***p<0.01.

Table 19 shows the results for some of the indicators related to social networks of support for the family and their quality: in particular, the quality of the perceived social network and the level of search for support (number and assessment of informal support). Again, there are no heterogeneous effects by household type for these indicators.

Table 19: Heterogeneous effects by household type (3)

	Quality of the perceived social network		Level of support seeking (number of informal supports)		Level of support seeking (assessment of informal supports)	
	(1)	(2)	(3)	(4)	(5)	(6)
Treatment 2	0.01	0.01	0.74*	0.77**	0.24*	0.18
	(0.03)	(0.03)	(0.41)	(0.38)	(0.13)	(0.13)
Single-parent household	0.15***	0.08***	1.68***	1.06***	0.23*	0.12
	(0.03)	(0.03)	(0.44)	(0.40)	(0.13)	(0.13)
Treatment 2 x Single-parent household	-0.03	-0.01	-0.85	-0.87	0.07	0.16
	(0.05)	(0.04)	(0.75)	(0.66)	(0.18)	(0.18)
Observations	423	423	423	423	335	298
R^2	0.07	0.33	0.04	0.24	0.04	0.11
Control group average on PRE	0.53	0.53	3.63	3.63	3.69	3.75
Dep. Var. Initial value	No	Yes	No	Yes	No	Yes

Note: Robust standard errors in parentheses. Levels of significance: *p<0.1, **p<0.05 and ***p<0.01.

Finally, **Table 20** shows the results for the rest of the indicators related to social networks of family support and their quality: in particular, the level of seeking support (number and assessment of formal support) and the reasons for not asking for help. In this case, there is a significant negative impact of treatment in single-parent households.

Table 20: Heterogeneous effects by household type (4)

	Level of support seeking (number of formal supports)		Level of support seeking (assessment of formal supports)		Level of support seeking (reasons not to ask for help)	
	(1)	(2)	(3)	(4)	(5)	(6)
Treatment 2	0.23	0.29	0.41***	0.28*	0.44	0.52
	(0.28)	(0.25)	(0.14)	(0.15)	(0.35)	(0.34)
Single-parent household	-0.09	0.07	0.26*	0.23	-0.03	0.13
	(0.27)	(0.24)	(0.14)	(0.14)	(0.33)	(0.31)

	Level of support seeking (number of formal supports)		Level of support seeking (assessment of formal supports)		Level of support seeking (reasons not to ask for help)	
	(1)	(2)	(3)	(4)	(5)	(6)
Treatment 2 x Single-parent household	-0.06	-0.23	-0.47**	-0.28	-0.50	-0.60
	(0.45)	(0.40)	(0.22)	(0.23)	(0.53)	(0.51)
Observations	423	423	305	263	423	423
R^2	0.00	0.20	0.03	0.12	0.01	0.08
Control group average on PRE	2.09	2.09	3.47	3.48	2.53	2.53
Dep. Var. Initial value	No	Yes	No	Yes	No	Yes

Note: Robust standard errors in parentheses. Levels of significance: *p<0.1, **p<0.05 and ***p<0.01.

6 Conclusions of the evaluation

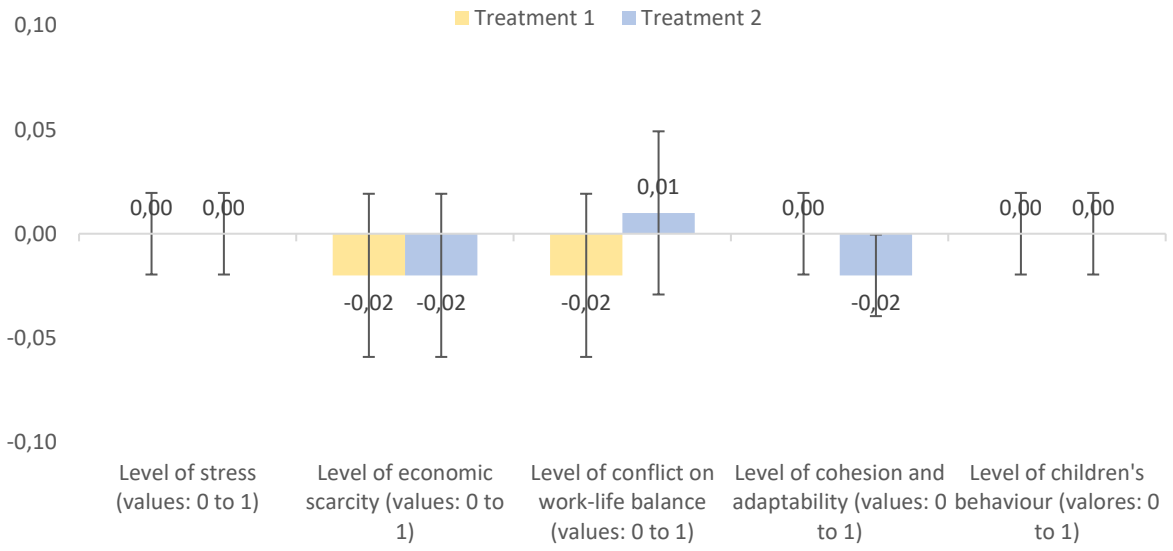
The aim of this study is to obtain causal evidence on the effect on the development and strengthening of emotional, educational and parental competence, work-life balance and the employability of the families benefiting from two innovative projects: the "Respira" Program, consisting of a bundle of hours of family discharge, and the "Psycho-educational Program 'Crecer Felices en Familia II'", with socio-emotional support activities and positive parenting strategies for parenting. Both interventions aim to test the effectiveness of specific tools to promote the recovery of the autonomy of the most vulnerable households in the municipality of Madrid in which children live, compared to a base intervention aimed at improving the employability of participating families (the "Socio-Labor Program"). This project follows the more conventional channel that seeks to recover the autonomy of the most vulnerable population due to a lack of income through the training-increase of skills-employability/occupation scheme.

One of the experimental treatments studied (the "Psychoeducational Program 'Crecer Felices en Familia II'", treatment 2) has a significant and positive impact with respect to the control group on the indicators of the level of search for support (assessment of informal support) and the quality of parental attitudes. It also has a significant and positive impact on the assessment of formal supports, although only on the specification that does not control for the value of the variable at baseline.

In the other indicators of the level of search for support, although the results are not statistically significant, the model yields positive coefficients for treatment 2 compared to the control group. In the rest of the indicators, there are no differences between groups, neither between those who received the different treatments, nor when comparing them with the control group.

Figure 8 shows the effect of the intervention on those outcome indicators that have been analyzed for both treatments. All the indicators show a non-significant causal impact effect of the intervention.

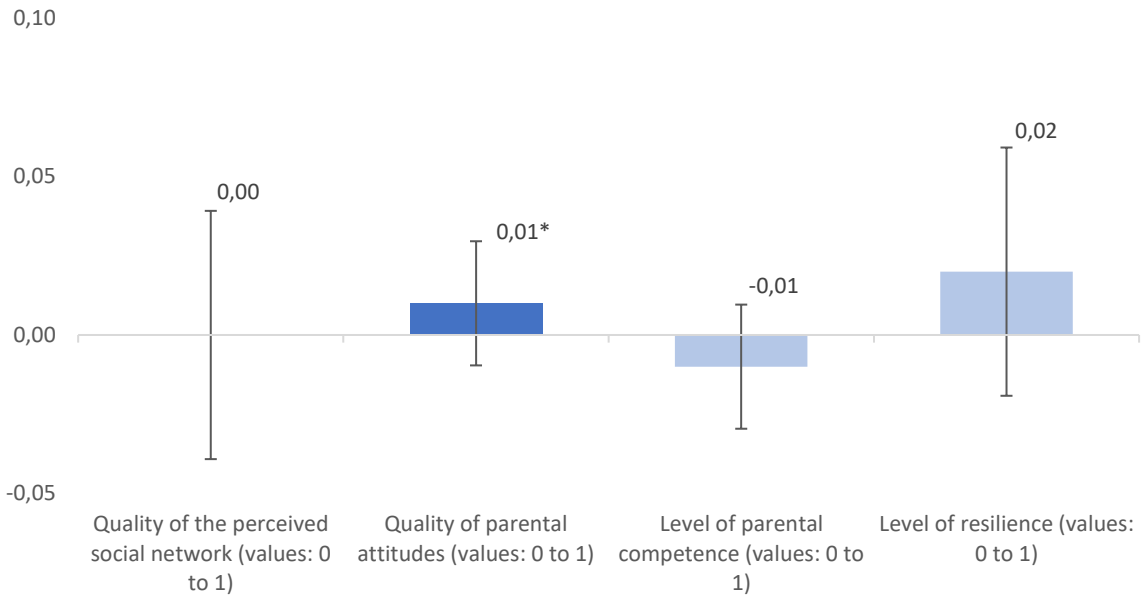
Figure 8: Effect of the intervention on outcome indicators (both treatments)



Note: Indicators whose treatment effect is not significant are presented in light color. The effects included in the graphs refer to regressions controlling for the value of the variable at the baseline.

Figure 9 shows the effect of the intervention on outcome indicators that aim to validate the main hypotheses measured for treatment 2. The effect on the quality of parental attitudes is positive and statistically significant at 10%, with an impact of 0.01 points.

Figure 9: Effect of the intervention on key outcome indicators (treatment 2)



Note: Indicators whose treatment effect is significant at 10% are presented in dark color; and in light color those whose treatment effect is not significant. The effects included in the graphs refer to regressions controlling for the value of the variable at the baseline.

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Appendix

Economic and regulatory management

1. Introduction

Within the framework of the Recovery, Transformation, and Resilience Plan, the General Secretariat for Inclusion (SGI) of the Ministry of Inclusion, Social Security, and Migration is significantly involved in Component 23 "New public policies for a dynamic, resilient, and inclusive labor market," framed in policy area VIII "New care economy and employment policies."

Investment 7 "Promotion of Inclusive Growth by linking socio-labor inclusion policies to the Minimum Income Scheme" is one of the reforms and investments proposed in this Component 23. Investment 7 promotes the implementation of a new inclusion model based on the Minimum Income Scheme (MIS), which reduces income inequality and poverty rates. To achieve this objective, the development of pilot projects has been proposed, among others, for the implementation of social inclusion pathways with autonomous communities, local entities, and Third Sector of Social Action organizations, as well as with the different social agents.

Royal Decree 938/2021, dated October 26, which regulates the direct granting of subsidies from the Ministry of Inclusion, Social Security, and Migrations in the field of social inclusion, for an amount of €109,787,404, within the framework of the Recovery, Transformation, and Resilience Plan[29], contributed to meeting milestone 350 for the first quarter of 2022 as outlined in the Council's Implementing Decision: "Improve the rate of access to the Minimum Income Scheme, and increase the effectiveness of the MIS through inclusion policies, which, according to its description, will translate into supporting the socio-economic inclusion of the beneficiaries of the MIS through itineraries: eight collaboration agreements signed with subnational public administrations, social partners and entities of the Third Sector of Social Action to conduct the pathways. The objectives of these partnership agreements are: (i) improve the MIS access rate; ii) increase the effectiveness of the MIS through inclusion policies". Likewise, along with Royal Decree 378/2022, of May 17[30], "at least 10 additional collaboration agreements signed with subnational public administrations, social partners and entities of the Third Sector of Social Action to implement pilot projects to support the socio-economic inclusion of the beneficiaries of MIS through itineraries" contributed to compliance with

[29]Royal Decree 938/2021, of October 26, regulating the direct granting of subsidies from the Ministry of Inclusion, Social Security, and Migrations in the field of social inclusion, for an amount of 109,787,404 euros, within the framework of the Recovery, Transformation, and Resilience Plan (BOE-A-2021-17464). It can be consulted at the following link: https://www.boe.es/diario_boe/txt.php?id=BOE-A-2021-17464.

[30] Royal Decree 378/2022, of May 17, 2022, regulating the direct granting of subsidies from the Ministry of Inclusion, Social Security and Migration in the field of social inclusion, for an amount of 102,036,066 euros, within the framework of the Recovery, Transformation and Resilience Plan (BOE-A-2022-8124). It can be consulted at the following link: https://www.boe.es/diario_boe/txt.php?id=BOE-A-2022-8124.

monitoring indicator number 351.1 in the first quarter of 2023, linked to the Operational Arrangements document[31].

In addition, after the implementation and evaluation of each of the subsidized pilot projects, an assessment will be conducted to evaluate the coverage, effectiveness, and success of the minimum income schemes. The publication of this evaluation, which will include specific recommendations to improve the access rate to the benefit and enhance the effectiveness of social inclusion policies, contributes to the achievement of milestone 351 of the Recovery, Transformation, and Resilience Plan scheduled for the first quarter of 2024.

In accordance with Article 3 of Royal Decree 938/2021, dated October 26, subsidies will be granted through a resolution accompanied by an agreement of the head of the Ministry of Inclusion, Social Security and Migration as the competent authority for granting them, without prejudice to the existing delegations of competence in the matter, upon request of the beneficiary organizations.

On **December 13, 2021**, the Madrid City Council was notified of the Resolution from the General Secretariat of Objectives and Policies for Inclusion and Social Welfare, granting a subsidy of **€10,523,291.80**. Subsequently, on **December 23, 2021**, a Convention was signed between the General Administration of the State, represented by the General Secretariat of Objectives and Policies for Inclusion and Social Welfare, and the Madrid City Council, for the implementation of a Social Inclusion Project within the framework of the Recovery, Transformation, and Resilience Plan. This Convention was published in the "Boletín Oficial del Estado" on February 1, 2022 (BOE No. 27)[32].

2. Time frame of the intervention

Article 16(1) of Royal Decree 938/2021, dated October 26, established that the execution period for the pilot projects of social inclusion itineraries subject to the subsidies provided for in this text shall not exceed the deadline of June 30, 2023, while their evaluation, shall not extend beyond March 31, 2024, in order to meet the milestones, set by the Recovery, Transformation, and Resilience Plan regarding social inclusion policy.

However, in accordance with Section 2 of the first final provision of Royal Decree 378/2022, of May 17, Article 6(4) and Article 16(1) are redrafted to extend the maximum term of the pilot projects of social inclusion itineraries subject to the subsidy until **October 31, 2023**, maintaining the deadline of **March 31, 2024,** for their evaluation.

[31] Decision of the European Commission approving the document 'Operational Provisions of the Recovery, Transformation and Resilience Plan', which can be consulted at the following link: https://www.lamoncloa.gob.es/serviciosdeprensa/notasprensa/hacienda/Documents/2021/101121-CountersignedESFirstCopy.pdf.

[32]Resolution of January 21, 2022, of the General Secretariat for Objectives and Policies of Inclusion and Social Provision, publishing the Agreement with the Madrid City Council for the implementation of a project for social inclusion within the framework of the Recovery, Transformation, and Resilience Plan. It can be consulted at the following link: https://www.boe.es/diario_boe/txt.php?id=BOE-A-2022-1640.

On October 31, 2022, the Madrid City Council requested an extension of the execution period until **October 31, 2023**. This extension was authorized by resolution of the General Secretariat of Objectives and Policies for Social Inclusion (SGOPIPS) dated November 14, 2022.

Within this generic time frame, the execution begins on **September 1, 2022**, with the start of the intervention itinerary, continuing the execution tasks until **October 31, 2023**, and subsequently, only tasks related to project dissemination and evaluation are conducted until **March 31, 2024**.

3. Relevant agents

Among the relevant agents for the implementation of the project are:

- The **Madrid City Council**, the beneficiary entity, is responsible for project implementation and project coordination through the Government Area of Social Policies, Family and Equality and the Employment Agency.
- The **Ministry of Inclusion, Social Security and Migration (MISSM)** as the sponsor of the project, and the main responsible entity for the RCT evaluation process. The General Secretariat of Inclusion (SGI) assumes the following commitments:
    a) Assist the beneficiary entity in the design of the activities to be carried out for the implementation and monitoring of the object of the grant, as well as for the profiling potential participants in the pilot project.
    b) Design the randomized controlled trial (RCT) methodology of the pilot project in coordination with the beneficiary entity.
    c) Evaluate the pilot project in coordination with the beneficiary entity.
- **EULEN Servicios Sociosanitarios S.A.,** subcontracted for the management of the work-life balance and support service for families with children.
- The **Universities of La Laguna and Las Palmas de Gran Canaria** contracted for the adaptation and training in the application of the positive parenting program "Crecer Felices en Familia" and for the measurement of its impact.
- **CEMFI and J-PAL Europe,** as scientific and academic institutions supporting MISSM in the design and RCT evaluation of the project.

Full Random Assignment Table[33]

Type of household	Time in Social Services	Area of residence	Psychosocial risk	Control Group	Treatment 1	Treatment 2	Total
Single parent	<2018	North	High	21	24	20	**65**
			Medium	5	5	5	**15**
			Low	4	3	3	**10**
		South	High	51	45	47	**143**
			Medium	12	10	11	**33**
			Low	5	4	5	**14**
	2018 and more	North	High	30	31	28	**89**
			Medium	10	10	8	**28**
			Low	3	4	3	**10**
		South	High	71	64	69	**204**
			Medium	14	14	14	**42**
			Low	4	3	3	**10**
Non-single parent	<2018	North	High	20	22	19	**61**
			Medium	3	5	4	**12**
			Low	5	5	5	**15**
		South	High	59	53	57	**169**
			Medium	17	16	17	**50**
			Low	13	11	11	**35**
	2018 and more	North	High	36	40	34	**110**
			Medium	6	7	7	**20**
			Low	11	10	9	**30**
		South	High	88	82	87	**257**
			Medium	19	17	18	**54**
			Low	18	15	16	**49**
Total				**525**	**500**	**500**	**1,525**

[33] The assignment was made considering T1 as the psychoeducational program and T2 as the discharge hours program. However, they were eventually used in reverse. Since the assignment was random and the change occurred at the start of the intervention, it is not estimated to affect the intended design of the experiment.

Balance between experimental groups

The following table reports balance tests between the experimental groups. Data shown in this table refer to the survey conducted before the intervention. The mean value of each variable is reported for both groups, as well as the number of observations in each group, and the p-value resulting from a test of mean differences (using the student's t-statistic). The lower the p-value, the more confidently the hypothesis that the variable means in both groups are equal can be rejected. For example, if the p-value is less than 0.05, the hypothesis of equal means can be rejected with 95% confidence.

Table 21: Balance tests between experimental groups

		(1)		(2)		(3)		Equilibrium F-Test among groups		(1)-(2)		(1)-(3)		(2)-(3)
	N	CG	N	T1	N	T2	N		N	Test t	N	Test t	N	Test t
Variable		Mean/ (Var)		Mean/ (Var)		Mean/ (Var)		F stat/p-value		p-value		p-value		p-value
North area	525	0.29	500	0.33	500	0.29	1,525	1.29	1025	0.18	1025	0.91	1000	0.15
		(0.21)		(0.22)		(0.21)		0.27						
South area	525	0.71	500	0.67	500	0.71	1,525	1.29	1025	0.18	1025	0.91	1000	0.15
		(0.21)		(0.22)		(0.21)		0.27						
Type of household - single-parent	525	0.44	500	0.43	500	0.43	1,525	0.02	1025	0.89	1025	0.84	1000	0.95
		(0.25)		(0.25)		(0.25)		0.98						
Type of household - non-single-parent	525	0.56	500	0.57	500	0.57	1,525	0.02	1025	0.89	1025	0.84	1000	0.95
		(0.25)		(0.25)		(0.25)		0.98						
Type of household - single-parent (survey)	525	0.47	500	0.46	500	0.42	1,525	1.23	1025	0.73	1025	0.13	1000	0.25
		(0.25)		(0.25)		(0.24)		0.29						
Type of household - non-single-parent (survey)	525	0.53	500	0.54	500	0.58	1,525	1.23	1025	0.73	1025	0.13	1000	0.25
		(0.25)		(0.25)		(0.24)		0.29						
Time in social services (before 2018)	525	0.41	500	0.41	500	0.41	1,525	0.01	1025	0.91	1025	0.96	1000	0.95
		(0.24)		(0.24)		(0.24)		0.99						
Time in social services (2018 and after)	525	0.59	500	0.59	500	0.59	1,525	0.01	1025	0.91	1025	0.96	1000	0.95
		(0.24)		(0.24)		(0.24)		0.99						
Low psychosocial risk	525	0.72	500	0.72	500	0.72	1,525	0.03	1025	0.84	1025	0.84	1000	1.00

Variable	N	(1) CG Mean/ (Var)	N	(2) T1 Mean/ (Var)	N	(3) T2 Mean/ (Var)	N	Equilibrium F-Test among groups F stat/p-value	N	(1)-(2) Test t p-value	N	(1)-(3) Test t p-value	N	(2)-(3) Test t p-value
		(0.20)		(0.20)		(0.20)		0.97						
Medium psychosocial risk	525	0.16	500	0.17	500	0.17	1,525	0.02	1025	0.86	1025	0.86	1000	1.00
		(0.14)		(0.14)		(0.14)		0.98						
High psychosocial risk	525	0.12	500	0.11	500	0.11	1,525	0.17	1025	0.62	1025	0.62	1000	1.00
		(0.11)		(0.10)		(0.10)		0.84						
Number of children	399	2.10	385	2.13	387	2.12	1,171	0.09	784	0.68	786	0.78	772	0.91
		(1.08)		(0.91)		(1.13)		0.92						
Level of stress	400	0.32	386	0.32	387	0.32	1,173	0.05	786	0.91	787	0.84	773	0.75
		(0.02)		(0.02)		(0.02)		0.95						
Level of economic scarcity	400	0.58	386	0.59	387	0.59	1,173	0.88	786	0.20	787	0.34	773	0.75
		(0.04)		(0.04)		(0.04)		0.42						
Level of conflict on work-life balance	354	0.47	330	0.47	342	0.46	1,026	0.38	684	0.88	696	0.40	672	0.52
		(0.05)		(0.06)		(0.05)		0.69						
Level of cohesion and adaptability	400	0.73	386	0.74	387	0.74	1,173	0.53	786	0.36	787	0.39	773	0.93
		(0.03)		(0.03)		(0.03)		0.59						
Quality of the perceived social network	400	0.50	386	0.50	387	0.51	1,173	0.10	786	0.95	787	0.67	773	0.73
		(0.07)		(0.07)		(0.07)		0.91						
Level of support seeking (number of informal supports)	400	3.51	386	3.29	387	3.49	1,173	0.61	786	0.32	787	0.91	773	0.36
		(10.70)		(8.96)		(9.04)		0.55						
Level of support seeking (assessment of informal supports)	326	3.76	317	3.80	332	3.78	975	0.24	643	0.49	658	0.76	649	0.68
		(0.76)		(0.63)		(0.66)		0.78						
Level of support seeking (number of formal supports)	400	2.33	386	2.22	387	2.31	1,173	0.29	786	0.48	787	0.88	773	0.56
		(5.67)		(5.28)		(4.30)		0.75						

Variable	N	(1) CG Mean/ (Var)	N	(2) T1 Mean/ (Var)	N	(3) T2 Mean/ (Var)	N	Equilibrium F-Test among groups F stat/p-value	N	(1)-(2) Test t p-value	N	(1)-(3) Test t p-value	N	(2)-(3) Test t p-value
Level of support seeking (assessment of formal supports)	298	3.40	283	3.38	298	3.45	879	0.46	581	0.80	596	0.50	581	0.35
		(0.88)		(0.84)		(0.80)		0.63						
Level of support seeking (reasons not to ask for help)	400	2.98	386	2.88	387	2.98	1,173	0.19	786	0.61	787	0.97	773	0.59
		(6.13)		(7.19)		(6.68)		0.83						
Quality of parental attitudes	400	0.60	386	0.60	387	0.60	1,173	0.41	786	0.62	787	0.67	773	0.38
		(0.01)		(0.01)		(0.01)		0.67						
Level of parental competence	400	0.59	386	0.60	387	0.58	1,173	1.12	786	0.31	787	0.64	773	0.14
		(0.01)		(0.01)		(0.01)		0.33						
Level of resilience	400	0.73	386	0.72	387	0.72	1,173	0.43	786	0.70	787	0.35	773	0.60
		(0.04)		(0.04)		(0.04)		0.65						
Level of children's behavior	400	0.31	386	0.30	387	0.30	1,173	0.54	786	0.31	787	0.45	773	0.83
		(0,03)		(0,03)		(0,03)		0,58						