Inclusion Policy Lab: Evaluation Results

Murcia: Community Social Activation Project "Experience Box".

May 2024

Financiado por la Unión Europea NextGenerationEU
MINISTERIO DE INCLUSIÓN, SEGURIDAD SOCIAL Y MIGRACIONES
Plan de Recuperación, Transformación y Resiliencia
Región de Murcia
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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 Murcia Institute of Social Action has collaborated in the preparation 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. Likewise, their collaboration has been essential to gathering informed consent, ensuring that participants in the itinerary were adequately informed and that their participation was voluntary.

A research team coordinated by CEMFI (Centre for Monetary and Financial Studies) has substantially contributed to this study. Specifically, Antonio Cabrales, professor at Carlos III University of Madrid; Warn N. Lekfuangfu, professor at Carlos III University of Madrid; and Sergio Blanco, professor at University of Barcelona, have participated under the coordination of Mónica Martínez-Bravo (until January 8, 2024) and Samuel Bentolila, professors at CEMFI. The researchers have actively participated in all phases of the project, including the adaptation of the initial proposal to the needs of the evaluation through randomized experiments, the design of the evaluation, the design of measurement instruments, the processing of the data, and the realization of the econometric estimates that result in the quantitative results.

The partnership with J-PAL Europe has played a vital role in the efforts of the General Secretariat of Inclusion to improve social inclusion in Spain. Their team provided technical support and shared international experience, assisting the General Secretariat in comprehensively evaluating pilot programs. Throughout this partnership, J-PAL Europe consistently demonstrated a commitment to fostering evidence-based policy adoption and integrating 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 is based on the knowledge acquired about the project up to that date. The researchers reserve 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. The researcher is committed to continuing exploring and providing more accurate and updated results for the benefit of the scientific community and society in general.

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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 standards of scientific rigor and using the methodology of **Randomized Controlled Trials**.
- This document presents the evaluation results and main findings of the "Community Social Activation project for MIS and RBI beneficiaries, and other individuals in social vulnerability", which has been performed in **cooperation between the MISSM and the Murcian Institute of Social Action** (in Spanish, IMAS) attached to the Ministry of Social Policy, Families, and Equality of the Autonomous Community of the Region of Murcia.
- This study evaluates the incidence of **a treatment** based on the development of social activation itineraries. The **treatment group** received a personalized individual activation itinerary that was specifically adapted to their circumstances and needs, with individualized reinforcement care, a training agenda for group social activation and community participation called "Experience Box". The **control group** did not receive any treatment.
- The project took place in the **Murcian towns** of **Alcantarilla, Cartagena, and Murcia**. A total of 487 people participated (258 in the treatment group and 229 in the control group).
- On average, participants were 42 years old. Approximately 34% of the participants were men, and only 5% were actively working. More than half of the participants have an educational level below secondary school, and most have Spanish as their mother tongue.
- The level of attendance at the activities included in the "Experience Fund" stood at 75.5%. In addition, participation in the modules of personal autonomy, basic, digital, work and participation, and personal skills was 75%. In general terms, the attendance of participants in the activities offered was 78.2%.
- The main results of the evaluation are as follows:
    - **Increased well-being**: treatment increases life satisfaction by 0.30 standard deviations and perception of health status by 0.14 standard deviations.
    - **Greater digital accessibility**: treatment increases the rate of the digital services use by 0.16 standard deviations.
    - The results indicate that the proposed treatment does not generate a statistically significant improvement in employability.

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 the 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 (SGI) 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

[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, 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, within the framework of the Recovery, Transformation and Resilience Plan (BOE-A-2022-8124).

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.

These evaluations have focused on the promotion of social and labor inclusion among MIS beneficiaries, recipients of regional minimum income 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 pathways.

This report refers to "Community social activation project for MIS and RBI beneficiaries, and other individuals in social vulnerability", executed within the framework of Royal Decree 378/2022[9] by the Autonomous Community of the Region of Murcia through the Murcian Institute of Social Action (in Spanish, IMAS) attached to the Ministry of Social Policy, Families, and Equality.

Context of the project

Social exclusion represents a significant challenge in contemporary societies, manifesting itself in various forms that go beyond the lack of economic resources. The European Anti-Poverty Network (EAPN) identifies five main dimensions that contribute to social marginalization: economic, social, political, cultural, and residential. These dimensions interact with each other, configuring the situation of vulnerability or social exclusion.

[8] Regulated by Order ISM/208/2022, dated March 10, 2022, 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 19, 2022, an ~~A~~agreement was signed between the General State Administration, through the General Secretariat of Objectives and Policies of Inclusion and Social Welfare and the Autonomous Community of the Region of Murcia through the Murcian Institute of Social Action (IMAS) attached to the Ministry of Women, Equality, LGTBI, Families, Social Policy, and Transparency 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 December 31, 2022 (BOE no. 314).

On the other hand, the "*Report on the World Social Situation 2016: Leaving no one behind: the imperative of inclusive development*", prepared by the UN Department of Social and Economic Affairs (DESA), highlights the multidimensional nature of the problem, identifying several causes. These include poverty and inequality, scarcity of job opportunities, discrimination and prejudice, as well as social, cultural, and political regulations. In addition, it is necessary to consider that people at risk of social exclusion often lack basic personal and digital skills, which exacerbates their vulnerability by limiting their access to government services, educational resources, job opportunities, and healthcare services.

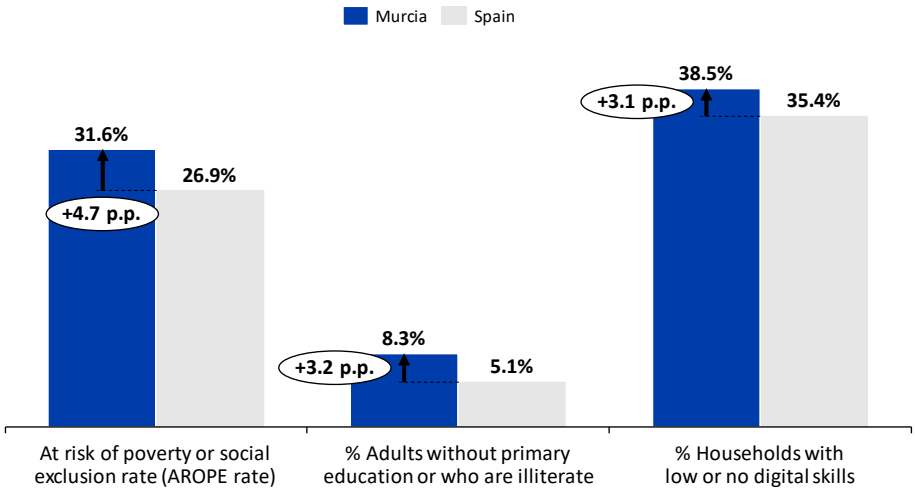
The INE's 2023 Living Conditions Survey (ECV)[10] offers a worrying view of Spain's social reality. In 2023, the at risk of poverty or social exclusion rate, measured by the AROPE indicator[11], reached 26.9%, which is equivalent to more than 12 million people in vulnerable situations. These data show a constant trend over the last decade, indicating that it is a structural problem.

In the specific context of the Region of Murcia, the data highlight a situation of greater urgency. From a socioeconomic perspective, INE statistics indicate that Murcia has a rate of risk of poverty or social exclusion of 31.6%, 4.7 percentage points above the national average. In addition, in terms of educational level, the Region of Murcia shows a higher proportion of adults with illiteracy or incomplete primary education, with 8.3% compared to 5.1% for Spain as a whole. Regarding digital skills, which are increasingly crucial for inclusion, 39.1% of residents in the Community lack these skills or have very limited them, a percentage higher than the national average (35.4%).

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

[11] The population at-risk-of-poverty or social exclusion is defined according to criteria established by Eurostat. This 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) In severe material and social deprivation (if you declare that you are deficient in at least seven of the 13 items 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 home at an adequate temperature, having two pairs of shoes in good condition or replacing damaged clothes with new ones). (3) In households with no employment or low employment intensity (households in which their working-age members did less than 20% of their total work potential during the year prior to the interview).

Figure 1: Comparison between the Region of Murcia and Spain in different areas



Source: Living Conditions Survey, INE. Active Population Survey, INE. Survey on Equipment and Use of Information and Communication Technologies in Homes, INE. Education and training outcomes, Eurostat.

Regulatory framework associated with the project and governance structure

This pilot project is in line with the framework established in the 2030 Agenda and with the Sustainable Development Goals (SDGs), contributing specifically to SDGs 1, 3, 4, 5, 8, 10, and 11.

In relation to the acquis of international organizations, the United Nations, within the framework of SDG 1 ("No Poverty"), has among its goals "by 2030, to reduce by at least half the proportion of men, women, and children of all ages who live in poverty in all its dimensions according to national definitions". In particular, it sets goals to "implement appropriate social protection systems and measures for all at the national level and, by 2030, achieve broad coverage of the poor and most vulnerable" and "create sound policy frameworks at the national, regional and international levels, based on gender-sensitive pro-poor development strategies, to support accelerated investment in measures to eradicate poverty."

On the other hand, at the European level, the fight against poverty and social exclusion has its legal basis in Articles 145 to 161 of the Treaty on the Functioning of the European Union (TFEU), relating to employment and social policy.

In particular, the fight against poverty and social exclusion is one of the specific objectives of the European Union and its Member States in the field of social policy. To this end, there are several instruments relating to the social activation of people in situations of social vulnerability, including:

- **European Pillar of Social Rights (EPSR).** In addition to the relevance of the rights set out in Chapter I (relating to equal opportunities and access to the labor market), it highlights in Chapter III ("Social protection and inclusion"), that "everyone who lacks sufficient resources has the right to adequate minimum income benefits that guarantee a dignified life throughout all stages of life as well as access to training goods and services." In particular, it is noted that,

"for people who are able to work, minimum income benefits should be combined with incentives for (re)integration into the labor market".

- **Council recommendation on an adequate minimum income that seeks active inclusion.** It aims to combat poverty and social exclusion by promoting adequate income support, including a minimum income. It also seeks effective access for people who lack sufficient resources to essential services and training and the promotion of the labor insertion of those who can work.

Finally, Spain has regulatory and strategic documents and public policies related to the social activation of people in situations of social vulnerability. Specifically, it excels the National Strategy for the Prevention and Fight against Poverty and Social Exclusion 2019 - 2023, which aims to combat poverty, especially child poverty, and reduce inequality and disparity in income levels. This National Strategy is developed through annual Operational Plans.

In any case, the prevention and fight against poverty and social exclusion is an objective associated with multiple measures and actions of a transversal or specific nature, given the multifactorial and complex nature of these phenomena.

The scientific objective of the project is, on the one hand, to design and test a support model for people with multiple care needs who are not at the time of accessing active inclusion processes towards employment and, on the other hand, to evaluate the results of the pilot projects through a randomized controlled trial (RCT) methodology to obtain recommendations and conclusions on innovative interventions that can work on the road to social inclusion.

The governance framework set up for the proper implementation and evaluation of the project includes the following actors:

- The **Autonomous Community of the Region of Murcia, through the Murcian Institute of Social Action (IMAS), attached to the Ministry of Social Policy, Families, and Equality,** as the main responsible for the execution of the project.

  The **Ministry of Social Policy, Families, and Equality** is the Department of the Autonomous Community of the Region of Murcia in charge of proposing, developing, and implementing the general guidelines of the Governing Council in matters of social assistance and welfare community development, and in general, the protection of people in situations of emergency, risk, or social exclusion.

  For its part, the IMAS is constituted with the purpose of executing the powers of administration and management of services, benefits and social programs. Its areas of action include, specifically, people in a situation or at risk of social exclusion, as well as any other group in need of social protection that is identified.

  In particular, the IMAS, through the Inclusion and Social Responsibility Programs Service of the General Directorate of Pensions, Evaluation, and Inclusion Programs, is responsible for the overall management and coordination of the project; the dialogue with the MISSM in all the

aspects necessary for the management, monitoring, and justification of the project; and the formalization of the legal instruments for contracting or commissioning the execution of the different actions with third parties. Within the operation of the project, the IMAS also assumes the task of recruiting the participants.

The **local entities** oversee the implementation of the actions in each of the municipalities, especially through their Primary Care Social Services. They collaborate with the IMAS in the recruitment of participants once the Social Activation teams have been constituted. In addition, they assume the provision of the activation itineraries in coordination with other agents and the dialogue with the IMAS in the coordination and monitoring of the project. Local entities participate through direct subsidies from the IMAS.

The **entities of the Third Sector of Social Action** and the **Mental Health Centers** participate in the referral process for potential participants.

- The **Ministry of Inclusion, Social Security, and Migration** (MISSM) as project sponsor and responsible for RCT evaluation. For this reason, the General Secretariat of Inclusion assumes a series of commitments to the Autonomous Community of the Region of Murcia:
    - Provide the beneficiary entity with support for the design of the actions to be carried out, for the execution and monitoring of the object of the subsidy, as well as for the profiling of the potential participants in the pilot project.
    - Design the randomized controlled trial (RCT) methodology of the pilot project in coordination with the beneficiary entity and with the scientific collaborators. Likewise, carry out the evaluation of the project.
    - Ensure strict compliance with ethical considerations by obtaining the approval of the Ethics Committee.
- **CEMFI and J-PAL Europe** are scientific and academic institutions that support MISSM in the design and RCT evaluation.

Considering all the above, the present report follows the following structure: **Section 2** provides a **description of the project**, detailing the problems to address, the interventions, and the target audience to which the intervention is directed. Next, **section 3** contains information related to the **design of the evaluation**, defining the Theory of Change linked to the project and the hypotheses, sources of information, and indicators used. **Section 4** describes the **implementation of the intervention**, the analysis of the sample, the results of randomization, and the degree of participation and attrition of the intervention. This section is followed by **section 5** which presents the results of the evaluation, with a detailed analysis of the econometric analysis performed and the results for each of the indicators used. **Section 6** outlines the general **conclusions** of the project evaluation. Finally, additional information on the management tools and governance of the pilot project is provided **in the Economic and Regulatory Management** appendix.

Ethics Committee linked to the 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 ~~a~~ 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 July 10, 2023.

2 Project description

This section describes the program that IMAS implemented in the framework of the pilot project. Furthermore, it describes the target population, the territorial scope, and provides a detailed description of the intervention.

2.1 Introduction

The project aims to inclusively activate adult beneficiaries of the MIS, RBI, or those facing accredited social vulnerability. These individuals are currently inactive or unemployed and are not yet ready to be incorporated into employment activation resources. Inclusive activation is understood as the process by which people access the resources and services of the environment, have the appropriate support and skills to develop their life projects, and actively participate in the community.

The operational objectives of the project are, on the one hand, to design and experiment with a support model for people with multiple care needs who are not at the time of accessing active inclusion processes towards employment and, on the other hand, to reduce the degree of vulnerability

and exclusion of these people, improving their skills for daily life. their social training and their active participation in the community.

There are few studies that focus on mentoring to promote social inclusion. For example, García-Ramírez et al. (2005) examine psychosocial interventions for immigrants in Andalusia, but do not use RCT methodology. Additionally, Papadaki et al. (2021) explore the effects of brief interventions with long-term unemployed people in Crete, without using a randomized controlled trial.

Another branch of literature focuses on the psychosocial impacts of job training for the unemployed. For example, Brooks et al. (2001) evaluate job search actions for beneficiaries of *Temporary Assistance for Needy Families*, including measures related to self-esteem, assertive job-seeking behavior, and perceived barriers to employment. Whelan et al. (2018) analyze the impact of a career guidance intervention in areas of well-being, perceived employability and improving professional sustainability.

Various studies insist on the relationship between personal skills and the improvement of employability, such as the doctoral thesis by Nieto Flores (2018). Furthermore, the research performed by Rebollo-Sanz and Pérez (2021) presents an evaluation of the impact of active employment policies on groups with difficult labor insertion. In general terms, improvements are observed in employment rates and in the job satisfaction of the participants.

Regarding the effects of specialized training in the digital field, Sanz et al. (2016) conducted an RCT study on Barcelona Activa's "Mobilitza't Mobile" program. This program offered training in digital skills and encouraged entrepreneurship. The study showed a positive impact on the employability of the participants. In addition, Choudhary and Bansal (2022) performed a comprehensive review of digital training programs, highlighting a diversity of impacts that are closely linked to the quality of services and the structure of the program.

2.2 Target population and territorial scope

The project targets individuals aged 18 and 64 who are beneficiaries of the MIS, RBI, or face accredited social vulnerability. These individuals are currently inactive or unemployed and not yet ready to engage with employment activation resources.

The profile of the participants fits the following characteristics:

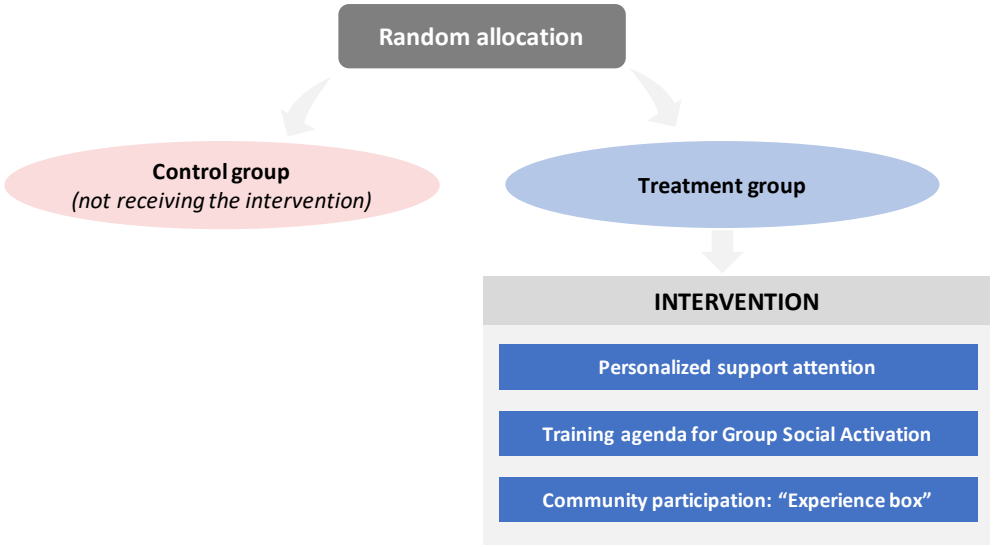
- Resident in Alcantarilla, Cartagena, or Murcia.
- Between 18 and 64 years of age.
- Primarily beneficiaries of the MIS or RBI; and other people in a situation or at risk of social exclusion who, although they meet the conditions, are not beneficiaries of the MIS or RBI.
- They have multiple care needs and are not carrying out activation itineraries towards employment.
- They are not participating in other experimental projects of C23 I 7 in the Region of Murcia.
- They are in a situation of inactivity at work.
- They voluntarily accept their participation in the project.

The project took place in the Murcian towns of Alcantarilla, Cartagena, and Murcia.

2.3 Description of interventions

To rigorously evaluate the impact of the proposed interventions, this project performed an equitable distribution of the participants in two groups: a treatment group, which participates in the designed interventions, and a control group, which does not receive any services from the program. **Figure 2** schematically summarizes the interventions received by the participants in the different groups.

Figure 2: Intervention scheme by experimental group



The treatment group engages in an intervention focused on the development of social activation pathways conducted by the Primary Care Social Services (SSAP) of participating local entities. This intervention is performed through Social Activation Teams (SATs) comprised of professionals in psychology, social work, and social education, along with a technical figure for coordination and support from a technical-administrative unit. This unit consists of an administrative management technician and an administrative assistant.

These itineraries are structured based on a sequential relationship of professional support actions in the process of promotion and personal autonomy. This delves into the life trajectory of the participant, identifying their strengths and recovering their motivation.

Each participant follows a personalized individual activation itinerary, specifically tailored to their circumstances and needs. To this end, the technical team elaborates an initial diagnosis to address four main dimensions: material resources, capacities and competencies, social relationships and psychosocial factors. Based on this initial diagnosis, the case manager prepares with the participants their individual activation itinerary, selecting the activities in which to participate according to their needs and their willingness to participate.

This project classifies the available activities into three blocks:

Individualized reinforcement care activities

Through individualized reinforcement care actions, the case manager offers professional support to empower personal autonomy. These activities consist of individual sessions in which, depending on the identified needs, psychological, social, or personal autonomy support is provided for a maximum of 12 hours in total per participant.

Group social activation training agenda

The social activation training agenda focuses on the development of personal competencies through practical and participatory methodologies, adapted to individual needs. This training consists of five group training modules that cover areas such as personal autonomy, personal skills, basic skills such as reading, writing, mathematics, and digital skills, as well as work and social skills. It has a maximum duration of 120 hours of training. This study uses innovative methodologies to ensure the effectiveness of learning, and the practical application of the knowledge acquired.

Community participation activities "Experience Box"

Community participation activities aim to foster participants' understanding and utilization of local resources, thereby enhancing their autonomy within the community. This involves visits to essential services such as sports centers, local police stations, and health centers, as well as participation in cultural, artistic, sports, and environmental activities. These experiences allow participants to interact with their natural, social, and cultural environment, fostering greater integration and participation in the community. These activities have a maximum duration of 35 hours.

Each participant, in collaboration with the case manager, will select activities based on their needs and their willingness to participate. They are required to attend 100% of the scheduled tutorial care services and community participation activities, as well as 80% of the training agenda.

Participants in the treatment group have access to a scholarship of €9 per day to attend the activities of the Training Agenda and the Experience Fund, fulfilling a minimum of 3 hours a day, as well as scholarships and transport vouchers of up to €4 per day. They also receive an incentive of €300 for completing the social itinerary, an aid for work-life balance, an incentive of €50 after completing the pre-intervention evaluation survey, and another incentive of €75, when taking the evaluation survey after the intervention. The control group does not receive services from the program, but they are incentivized to participate in the evaluation with the same amounts as the treatment group, i.e., an incentive of €50 in the first survey and €75 in the second one.

Considering the intervention scheme indicated above, the phases of treatment are broadly the following:

Figure 3: Treatment phases

- At the **Entry**, the treatment group participants attend group reception sessions in batches of 20 to 25 individuals in each municipality of implementation. These sessions provide detailed explanations about the service, its operation, the support available within the activation pathway framework, and the evaluation criteria. This stage ends with an initial diagnosis and the formulation of individual activation pathways.
- During the **Intervention** phase, participants must follow the personalized itinerary defined in the previous phase. These itineraries have a maximum duration of 167 hours and a minimum of 143 hours. During this period, the social activation teams of the SSAP are in charge of coordinating the different resources provided and monitoring the participation of people in the different activities.
- In the **Exit** phase, once the activation itinerary has been completed approximately five months, and after verifying the activities carried out, a final diagnostic report of their situation is prepared together with the participant.

3 Evaluation design

This section describes the design of the impact assessment of the projects 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 understanding 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, understanding the relationships between them, the assumptions on which they rest, and outlining measures or outcome indicators.

Theory of Change

A Theory of Change begins with the correct identification of the needs or problems to address 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 for the treatment to be properly implemented. Next, this theory identifies what effect(s) are expected to happen, depending 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 from the actions are identified as intermediate results, while the indirect effects in the 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 have been obtained, 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.

Identifying the need to reduce the sizable population facing social and economic vulnerability and lacking access to resources and services. Access to services and resources in the environment is closely related to active participation in the community, together with the support and skills necessary to adequately develop a life project. In addition, the high rate of inactivity in this region generates a wide gap in inequality and extreme situations of social exclusion.

This need or problem defines the different areas of action of the project and the activities associated with each of them. This project defines three main blocks of action. Firstly, the intervention offers a series of individualized reinforcement and support care activities, depending on the psychological, social, and personal autonomy needs of the participants. Furthermore, the intervention also contemplates personal and social training activities and covers areas such as personal autonomy, personal skills, and basic skills in reading, mathematics, writing, and digital skills. The last package of actions includes a series of community participation activities called "Experience Box", to publicize and promote the use of local resources.

All these resources and activities produce a series of products. By measuring the products obtained, it is identified whether the beneficiaries have received the activities or inputs and with what intensity. Properly receiving the resources and activities performed is essential for the program to achieve the expected intermediate and final results, since if the beneficiaries do not effectively receive the program, it is difficult to observe improvements in the indicators of poverty reduction and social inclusion. In this project, products are defined as the number of participants with knowledge of personal and social habits, as well as those who receive personalized support and guidance to pursue their work plan. On the other hand, a series of products are generated by the number of participants

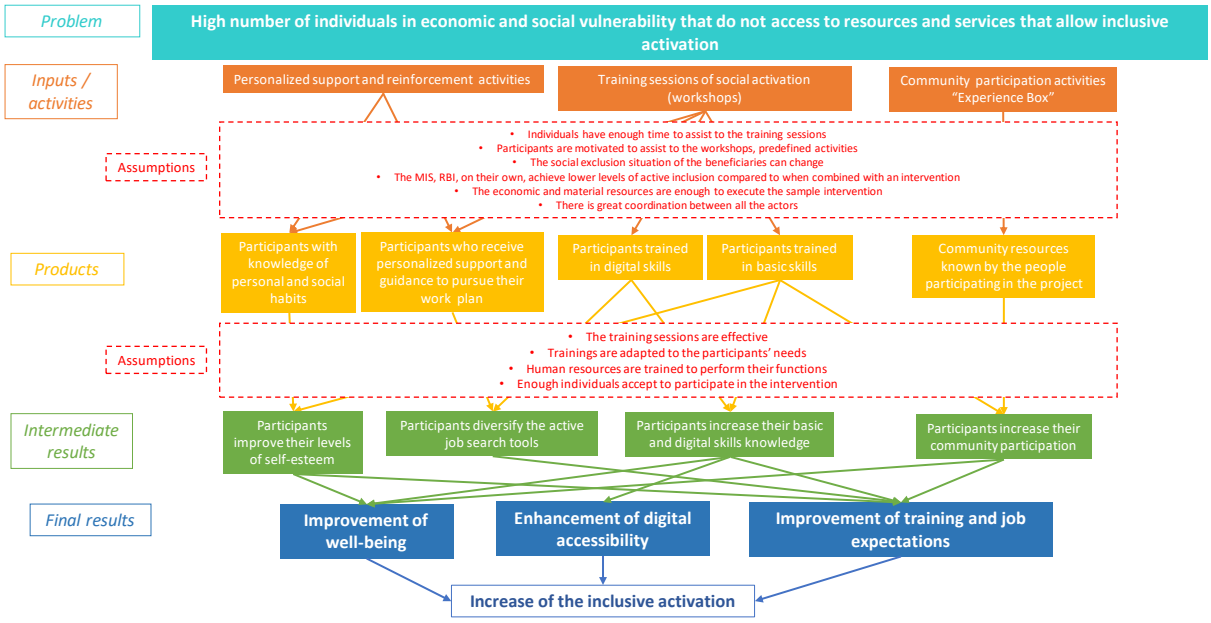
trained in digital skills and basic skills. In addition, the activities contemplated in the "Experience Box" define a network of community resources known to the people participating in the project.

As direct results of the intervention, the personalized intervention expects that the participants will improve their level of self-esteem and diversify the tools for active job search. In addition, the treatment also expects that participants will increase their basic and digital skills and knowledge and increase community participation.

Indirectly, the improvement of the intermediate indicators should result in an increase in well-being, improved digital accessibility, and improved expectations towards training and employment. Likewise, all these improvements estimate a greater inclusive activation of the participants.

The following figure illustrates this causal sequence of actions, initiated by the identified needs or problems, activities, and resources necessary to obtain the expected changes in the participants.

Figure 4: Theory of Change



3.2 Hypothesis

The main objective of the itinerary is to improve the inclusive activation of the beneficiaries of the IMV and RBI, as well as individuals in vulnerable situations. The project assumes that social inclusion, or the activation of processes that culminate in that inclusion, is directly related to active participation in the community and to having the appropriate support and capacities.

Inclusive activation is understood as the process by which people access the resources and services of the environment, have the appropriate support and capacities to develop their life projects, and actively participate in the community.

As detailed in the Theory of Change, this project includes a multitude of areas: psychosocial; pre-employment; job search; basic and digital skills; healthy habits; and the community environment. Consequently, when evaluating the model, various hypotheses are formulated that compare the results of the treatment with those of the control group in each of the aforementioned areas, using specific indicators for each of them. This multidimensional approach allows for a comprehensive assessment of the impact of the intervention on the lives of beneficiaries and enables a more complete understanding of its effectiveness in different dimensions.

Next, this section presents the hypotheses to test in each of the major areas:

1. Improved well-being

The first main hypothesis postulates that, thanks to the treatment, the participants improve their socio-emotional health, as determined by an improvement in self-esteem and self-control. In addition, the treatment also estimates an improvement in the healthy habits of the participants with a greater self-perception of state of health. All this has an impact on an improvement in life satisfaction in general and on the economic situation of the participants.

In a complementary way, the second main hypothesis regarding the improvement of well-being focuses on greater community participation using environmental resources and the strengthening of affective bonds. Thus, it is expected that the participants in the treatment group will learn to manage conflicts, improving attitudes of respect and tolerance towards the community.

2. Improving digital accessibility

The main hypothesis postulates how the participants in the treatment group acquire basic knowledge and skills in the digital field, which allows them to properly use Information and Communication Technologies (ICT).

3. Improved expectations for training and employment

This hypothesis postulates that, thanks to the treatment, the participants diversify their active job search, improving their job search habits. In addition, an improvement in the level of employability (self-perceived and effective) is expected.

3.3 Sources of information

To gather the necessary information to construct the outcome indicators, this project conducted surveys with participants. Specifically, they answered a survey **before the intervention** (baseline) and **after the intervention** (endline).

These surveys allow us to know certain aspects of the participants in the two moments of analysis and constitute the main source of information about the project. It is proposed that an external entity be in charge of collecting data from the participants in this survey, as well as conducting interviews

(telephone, face-to-face, online, or mixed), focus groups, workshops, and non-participant observation[12].

Participants in the control and treatment groups completed each survey which consists of the following sections:

- **Sociodemographic characteristics:** the questions aim to analyze the generic situation of the household, nationality, knowledge of Spanish, the components that make it up, and the income and shortcomings of the families.
- **Personal well-being, autonomy, and self-perception**: this group of questions presents aspects related to the level of emotional health and self-perception of the participants. A series of questions related to healthy habits, personal autonomy, and self-perceived physical health are also included.
- **Community participation**: this section includes aspects related to the home, studying personal and community relationships with the aim of measuring the degree of inclusion in the environment and their level of knowledge regarding local resources or institutions.
- **Accessibility, basic digital and basic skills:** study the provision of resources in terms of digital skills and the level of skills and use of these. The main objective is to determine the frequency of internet use and what types of activities are carried out. This section also includes questions related to reading comprehension, language use, mathematics, and household chores.
- **Competences in work habits**: it asks about the employment situation of the participants, the frequency of job searches, actions taken aimed at finding a job, the number of selection processes carried out recently, a series of questions related to employability skills and the reasons for not looking for a job.
- **Economic resources**: the stability of the household's monthly income was asked, as well as the source of this income and an approximation of the amount.
- **Satisfaction**: this block of questions is only conducted in the end-line survey of the participants in the treatment group. It covers a series of questions related to the satisfaction concluded with the individualized reinforcement sessions, the training modules and the activities of the "Experience Box", from the topics covered, the attention of the professionals, the materials used to the schedules, and organization of the activities. They are also asked about their level of overall satisfaction with the program and with the different issues that make it up (organization, grant, professionals, work-life balance aids, economic incentive, and duration of the project).

On the other hand, this project also contemplates the use of administrative records, relating to the beneficiaries of the MIS and the RBI, from the administrative sources available in the Autonomous Community of the Region of Murcia and the MISSM, as well as from the departments of local Social

[12] 21 interviews, 3 focus groups, 3 workshops, and 3 observation sessions were conducted.

Services and Third Sector entities. However, as of the date of completion of this report, these sources of information have not been incorporated.

3.4 Indicators

This section describes the indicators that this study uses to evaluate the impact of the itinerary, used for the impact assessment of the pathway, divided by themes related to the hypotheses described above.

1. Welfare

This study uses the following indicators to assess the socio-emotional health of the participants:

Level of emotional health: synthetic indicator calculated as the sum of the scores of the nine items presented below. Each of the items is normalized to establish a minimum value of 0 (the minimum level of emotional health) and a maximum value of 1 (the maximum level of emotional health).

- Felt useful
- Has felt relaxed
- Has had plenty of energy
- It has faced the problems with satisfaction
- Has felt satisfied with themselves
- Has felt safe (with confidence)
- Has felt joyful
- Have had difficulty sleeping
- Has felt capable of making decisions

Level of self-perceived self-esteem: measured through a synthetic indicator calculated as the sum of the scores of the eight items presented below. Each of the items is normalized to establish a minimum value of 0 (minimum level of self-perceived self-esteem) and a maximum value of 1 (maximum level of self-perceived self-esteem).

- Putting into words what I mean
- Understanding what other people mean
- Collaborating with others in social activities
- Controlling my emotions in difficult or stressful situations + Maintaining a positive or constructive attitude
- Resolving conflicts
- Reflecting on important issues
- Developing creative ideas
- Identifying my own mistakes

Level of healthy habits: measured through a synthetic indicator calculated as the sum of the scores of the ten items presented below. Each of the items is normalized to establish a minimum value of 0 (minimum level of healthy habits) and a maximum value of 1 (maximum level of healthy habits).

- Eat at least three meals a day
- Eat fruit and vegetables+ Do not drink alcohol
- No smoking
- Maintain a schedule routine
- Brush your teeth every day
- Shower or bathe every day
- Maintaining cleanliness and order in the home
- Managing household waste
- Walk for a while every day
- Exercise at least once a week

Perceived health index: measured through a synthetic indicator calculated as the sum of the scores of the three items presented below. Each of the items is normalized to establish a minimum value of 0 (minimum level of perceived health) and a maximum value of 1 (maximum level of perceived health).

- Assessment of the state of your physical health
- Assessment of the state of their mental health
- Satisfaction with current health status

Satisfaction index: measured through a synthetic indicator calculated as the sum of the scores of the two items presented below. Each of the items is normalized to establish a minimum value of 0 (minimum level of satisfaction) and a maximum value of 1 (maximum level of satisfaction).

- Overall satisfaction with your personal life
- Satisfaction with your financial situation

Within the well-being of the participants, the following indicators related to social participation stand out:

Level of social participation: measured through a synthetic indicator calculated as the sum of the scores of the ten items presented below. Each of the items is normalized to establish a minimum value of 0 (minimum level of social participation) and a maximum value of 1 (maximum level of social participation).

- I get visitors from my friends and family
- I get help with matters related to my home
- I get praise and recognition when I do my job well
- I have people who care about what happens to me
- I receive love and affection
- I have the possibility to talk to someone about my problems at work or at home
- I have the possibility of talking to someone about my personal and family problems
- I have the possibility of talking to someone about my financial problems
- I get invitations to distract myself and hang out with other people
- I get helpful advice when an important event happens to me in my life

Index of belonging to community entities: measured through a synthetic indicator calculated as the sum of the number of community activities or organizations (e.g., neighborhood organization, political party, cultural organization, school...) in which they participate and their frequency. Each of the items is normalized to set a minimum value of 0 (minimum level of community membership) and a maximum value of 1 (maximum level of community membership).

Community resource knowledge index: measured through a synthetic indicator calculated as the sum of known community resources, organized into the following five areas: health, administrative, educational, culture-leisure and free time, and citizen security and transportation. Each affirmative answer is equivalent to a summed point, where a normalization is then carried out to establish a minimum value of 0 (minimum level of knowledge of community resources) and a maximum value of 1 (maximum level of knowledge of community resources).

2. Greater digital accessibility

Three indicators measure the digital accessibility of the participants:

Digital services index: measured through a synthetic indicator calculated as the sum of those devices (computer or laptop, tablet and mobile phone) on which you have access to the internet. Normalization is performed to establish a minimum value of 0 (minimum level of digital services) and a maximum value of 1 (maximum level of digital services).

Digital services use index: measured through a synthetic indicator calculated as the sum of those services used in the last 3 months through digital services. Normalization is executed to set a minimum value of 0 (minimum use of digital services) and a maximum value of 1 (maximum use of digital services).

Basic skills index: measured through a synthetic indicator calculated as the sum of the scores regarding the level of knowledge and comprehension of a series of items regarding reading comprehension; use of language; mathematical skills, and organization of household chores. Each of the items is normalized to establish a minimum value of 0 (minimum level of basic skills) and a maximum value of 1 (maximum level of basic skills).

3. Improved expectations for training and employment

This project uses the following three indicators to assess expectations towards training and employment:

Job search habits index: it is measured through a synthetic indicator calculated as the sum of the scores of the nine items presented below. Each of the items is normalized to set a minimum value of 0 (minimum level of job search habits) and a maximum value of 1 (maximum level of job search habits).

- Contacting the Public Employment Office
- Contacting a private employment office or signing up for a job bank
- By requesting it from the employer directly or by submitting your CV
- Through friends, parents

- Through job advertisements or offers, including the Internet (Infojobs; JobToday; Laboris; Indeed, etc.)
- Planning to create your own business
- Conducting exams or interviews
- You have been waiting for the results of a job application or a competition
- You've been waiting for a call from a Public Employment Office

Index of perception of one's own employability: it is measured through a synthetic indicator calculated as the sum of the inverses of the assessments of the six items presented below. Each of the items is normalized to establish a minimum value of 0 (minimum level of perception index in employability) and a maximum value of 1 (maximum level of perception index in employability itself).

- I don't look for a job because I find that my self-image makes it difficult for me to find a job
- I don't look for a job because I don't know how to do it
- I don't look for a job because I have trouble expressing what I think and relating to other people
- I don't look for a job because I lack self-confidence
- I don't look for a job because I must be more consistent when I look for it and not get discouraged
- I am not looking for a job because I am not up to date with my profession, and I am not competent

Days actually worked: is the number of days the person is registered in any job, measured through the administrative source of employment history document. This information is not yet provided at the time of this report.

3.5 Experiment design

To assess the effect of personalized versus traditional treatment on each of the above indicators, this study uses an experimental assessment (RCT). In this assessment participants are randomly assigned between the treatment group and the control group. The section below details the process of recruitment and selection of the beneficiary families of the intervention, as well as the random assignment and the timeline of the experiment.

Recruitment of the intervention beneficiaries

The starting population are vulnerable individuals at risk of social exclusion in the municipalities of Alcantarilla, Cartagena and Murcia, between 18 and 64 years of age.

To obtain information on potential beneficiaries, the project performed an identification of the beneficiaries of the MIS and RBI in the municipalities of intervention (Alcantarilla, Cartagena, and Murcia) through the databases provided by the MISSM in the case of MIS recipients, and the IMAS, for RBI beneficiaries.

From these lists, the project identified three potential recruitment channels:

- **Direct referral from Primary Care Social Services**: people who have regular contact with SSAPs; beneficiaries or not of MIS and RBI, who meet the access requirements according to professional criteria.
- **Direct referral from social entities or other agents**: people who meet the access requirements and can be referred to from other entities such as health centers, specialized mental health centers or care centers for victims of gender violence.
- ***Triage* and direct referral from the project team:** contacting MIS and RBI beneficiaries who have not been contacted by other means.

In this way, the professional teams in the area directly select the potential participants, based on compliance with the requirements at the time of selection. Priority was given to those people for whom data were available in the IMAS-SUSI databases[13], since it is the database usually handled by SSAPs, facilitating the identification of people. After the selection of potential participants, the project generated two groups:

- People referred to by local entities, social entities and mental health centers, whether they are on the lists, and for whom there is confirmation of compliance with requirements, identifying whether they belong to the same cohabitation unit.
- People on the lists who have not been referred and for whom there is no confirmation of compliance with requirements, identifying if they belong to the same cohabitation unit.

After selecting the potential participants, the team of IMAS professionals contacted each of the identified people, through two types of phone calls:

- Calls for the call for an information session for all people who have been referred by local or social entities and who have had the profile validation of their reference professionals.
- Calls for *triage*, profile verification, and an information session for people registered on the lists.

Contact with all the people at the disposal of the IMAS was accomplished between the months of May and July 2023, proceeding to planning in different areas of each municipality and, especially, in those with a greater number of beneficiary population. These briefings could accommodate approximately 70 people. In this way, the project made an in-depth explanation, detailing the support participants could receive within the framework of the activation itinerary, the implications of being part of the treatment group and control group, and the characteristics of the evaluation.

At the end of each of these sessions, interested individuals could proceed to sign the informed consent with which they approve their participation in the program. Thus, the signatory group goes on to define the sample of the study.

[13] Unified system with IMAS SIUSS.

Informed Consent

One of the fundamental ethical principles of research involving human beings (respect for persons) 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 signing the informed consent form, the participants in the experiment are randomly assigned to either the treatment group or the control group. Random assignment is the fundamental pillar of RCTs for the identification of a causal relationship between treatment and outcomes. When executed properly, this process ensures that the treatment and control groups are statistically comparable, encompassing both observable and unobservable variables. This homogeneity provides the structure required to accurately measure the potential effects of the intervention.

The unit of randomization is the person. This process was accomplished by the MISSM to assign the participants to the treatment and control groups for each of the locations. In this way, two lists were presented: a first list of potential beneficiaries for the treatment group, and a list of people for the control group. The only stratification variable used is the municipality: Alcantarilla, Cartagena and Murcia.

Figure 5: Sample design

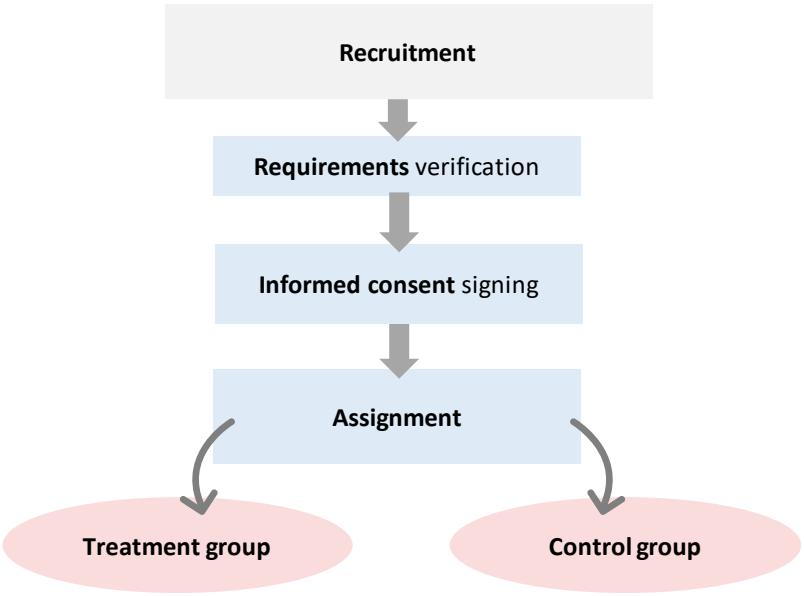
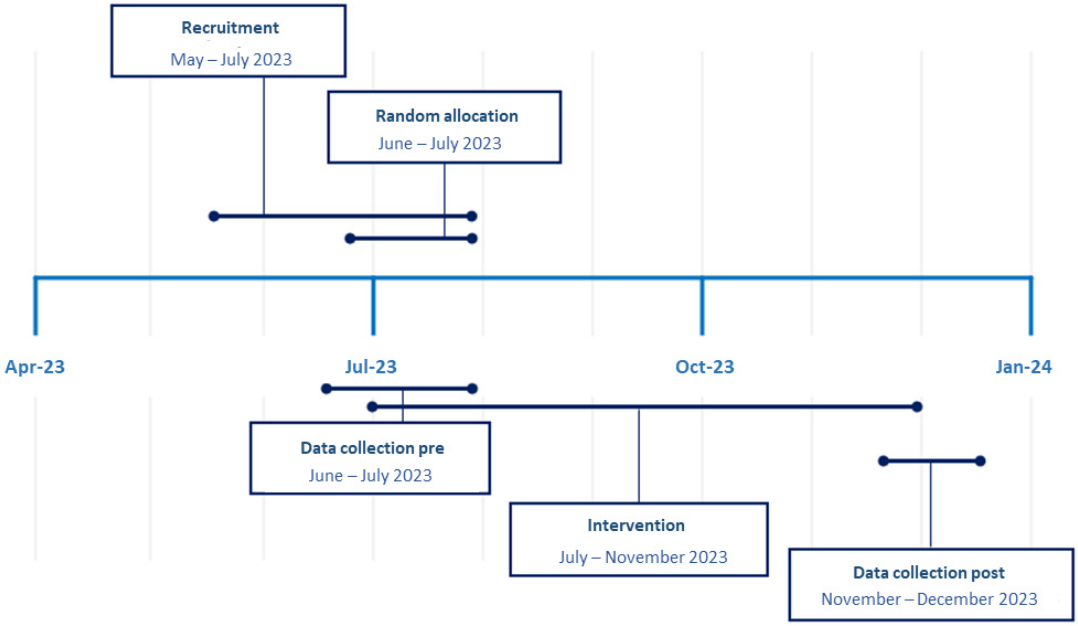


Figure 6 illustrates the timeline for the implementation and evaluation of the itinerary. After completing the experimental evaluation design, IMAS will begin recruiting participants. This recruitment process, taking place between May and July 2023, involves identifying potential beneficiaries and assessing whether they meet the participation criteria. Thus, during recruitment, participants who meet the criteria and are interested in participating will sign the informed consent and then undergo random assignment. Participants answered the baseline survey after the collection of informed consent and prior to the intervention in any case. Depending on the planned schedule and to avoid declines in the sample, this task was prioritized, so the first surveys were carried out prior to randomization by the MISSM. The development of the intervention took place for each participant from the moment of entry, July 2023, until the end date of the intervention was reached, at the end of November 2023. Finally, participants completed the final survey once the intervention was completed.

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

Initially, the project expected a first contact with around 2,352 people, with an initial estimate of compliance with requirements of 1,764 people. Therefore, a theoretical objective was set regarding obtaining the informed consent of a total of 1,100 people.

However, the recruitment process resulted in an initial sample of 487 participants, with 221 in the control group and 242 in the treatment group, implementing a group of substitutes (24) in Alcantarilla, which finally resulted in a composition of the treatment group of 258 people and a control group of 229.

Subsequently, a total of 41 individuals did not take the initial survey, being left out of the project, due to the following reasons: the impossibility of contacting them (43.9%); health problems (19.5%); refusal to participate (14.6%), work (9.8%), family reconciliation (4.9%), and 7.3% attributable to other reasons. This situation represents a sample loss of 8.4% of the total number of randomized

participants, resulting in an analysis sample of 446 individuals, 210 in the control group and 236 in the treatment group.

Therefore, the initial sample comprises a total of 446 individuals, with 210 people in the control group and 236 in the treatment group.

Table 1 describes the most relevant socioeconomic variables for the baseline sample: municipality (Alcantarilla, Cartagena, and Murcia); gender (woman or man); employment status (unemployed, employed, disabled, retired, students, housewives, and others); educational level (0 without education, 1 at least primary education, 2 at least secondary education, 3 at least undergraduate, and 4 postgraduate); age; and knowledge of the Spanish language (native, high, medium, or low). Columns (1)-(3) report the statistics for each variable at baseline. Approximately 36% of participants are male; only 5% are working (as the target group are beneficiaries of MIS or similar, a low level of employed individuals is expected); and the average age is 43 years. More than half of the participants did not manage to finish high school, and most have Spanish as their mother tongue. Columns (4)-(6) in **Table 1** report similar statistics, taken after the intervention. After the end of the treatment, the study can monitor 387 individuals. Overall, given a low attrition rate, the sample appears to be balanced between baseline and endline along the dimensions of language ability, location, and educational levels. Some exceptions are that the percentage of employed participants is higher at the finish line, while the percentage of participants with disabilities is higher at the baseline.

Table 1: Descriptive statistics of socioeconomic variables (baseline and final surveys)

	Baseline Survey			Final Survey		
	Mean	Standard deviation	Obs.	Mean	Standard deviation	Obs.
Woman	0.36	0.48	446	0.34	0.47	446
Age	42.49	11.93	446			
Spanish language: Native	0.87	0.33	446	0.89	0.31	387
Spanish language: High	0.04	0.20	446	0.04	0.21	387
Spanish Language: Medium	0.06	0.23	446	0.04	0.21	387
Spanish language: Low	0.03	0.17	446	0.02	0.13	387
Area: Alcantarilla	0.22	0.42	446	0.21	0.41	387
Area: Cartagena	0.32	0.47	446	0.32	0.47	387
Area: Murcia	0.46	0.50	446	0.47	0.50	387
Education: No education	0.20	0.40	446	0.24	0.43	387
Education: Primary	0.41	0.49	446	0.39	0.49	387
Education: Secondary	0.20	0.40	446	0.17	0.37	387
Education: Post-Secondary/Vocational	0.15	0.36	446	0.14	0.35	387

	Baseline Survey			Final Survey		
	Mean	Standard deviation	Obs.	Mean	Standard deviation	Obs.
Education: Higher	0.05	0.21	446	0.05	0.23	387
Employment status: Unemployed	0.72	0.45	446	0.76	0.42	387
Employment Status: Employed	0.05	0.21	446	0.10	0.30	387
Employment status: Disability	0.11	0.32	446	0.02	0.15	387
Employment status: Retired	0.01	0.08	446	0.02	0.12	387
Employment Status: Student	0.01	0.12	446	0.01	0.07	387
Employment Status: Home Care	0.09	0.29	446	0.05	0.21	387
Employment status: Other	0.02	0.12	446	0.05	0.21	387

Note: The total sample size is 446, but only 387 participants can be seen in both surveys (baseline and end). (See **Table 5** on the attrition rate of the sample per survey). This table presents unimputed summary statistics of the observed value of each variable.

Table 2 shows statistics for the main outcome variables at baseline. Each of these variables is constructed from a set of questions contemplated in the questionnaire mentioned above. Initially, each item is normalized, setting the minimum value to zero and the maximum value to one. Subsequently, this study reports an index calculated using the inverse of the weighted covariance according to Anderson (2008). Once the index is created, it is standardized. In this way, the mean is zero and the standard deviation is one.

Table 2: Descriptive Statistics of baseline survey results

Variable	Obs.	Mean	Standard deviation	Minimal	Maximum
Well-being					
Social-Emotional Health					
Level of mental health	446	0	1	-1.92	3.18
Self-esteem level	446	0	1	-2.24	3.37
Level of healthy habits	446	0	1	-3.54	4.17
Perception of health status	446	0	1	-1.8	3.05
Life satisfaction	446	0	1	-1.52	2.3
Satisfaction with economic conditions		N/A	N/A	N/A	N/A
Social participation					

Variable	Obs.	Mean	Standard deviation	Minimal	Maximum
Level of social participation	446	0	1	-2.57	1.5
Index of membership of community entities	446	0	1	-0.61	5.58
Community Resources Knowledge Index	446	0	1	-4.28	1.3
Digital accessibility					
Digital Services Access Index	446	0	1	-1.8	1.69
Digital Service Usage Index	446	0	1	-1.93	1.36
Basic Skills Index	446	0	1	-2.02	3.54
Expectations towards training and employment					
Job Search Habits Index	446	0	1	-0.71	8.18
Index of perception of own employability	446	0	1	-3.38	0.9
Effective days worked		N/A	N/A	N/A	N/A

Note: The total sample size is 446. Each of these variables is constructed from a set of questions. Initially, each element is normalized, setting the minimum value to zero and the maximum value to 1. Subsequently, an index is calculated using the inverse of the weighted covariance following Anderson (2008). Once the index is created, it is standardized so that its mean is 0 and the standard deviation is 1. It should be noted that the pre-intervention level of the measure of "Satisfaction with economic conditions" is not observed.

4.2 Random Assignment Results

After the sample definition, participants are randomly assigned to the treatment or the control group, and an equilibrium test is conducted to verify that, on average, the observable characteristics of the participants in both groups are similar. The balance between the experimental groups is key to infer the causal effect of the program by comparing its results.

The following table shows the result of the random assignment, using the municipality as the only stratification variable.

Table 3: Random assignment results

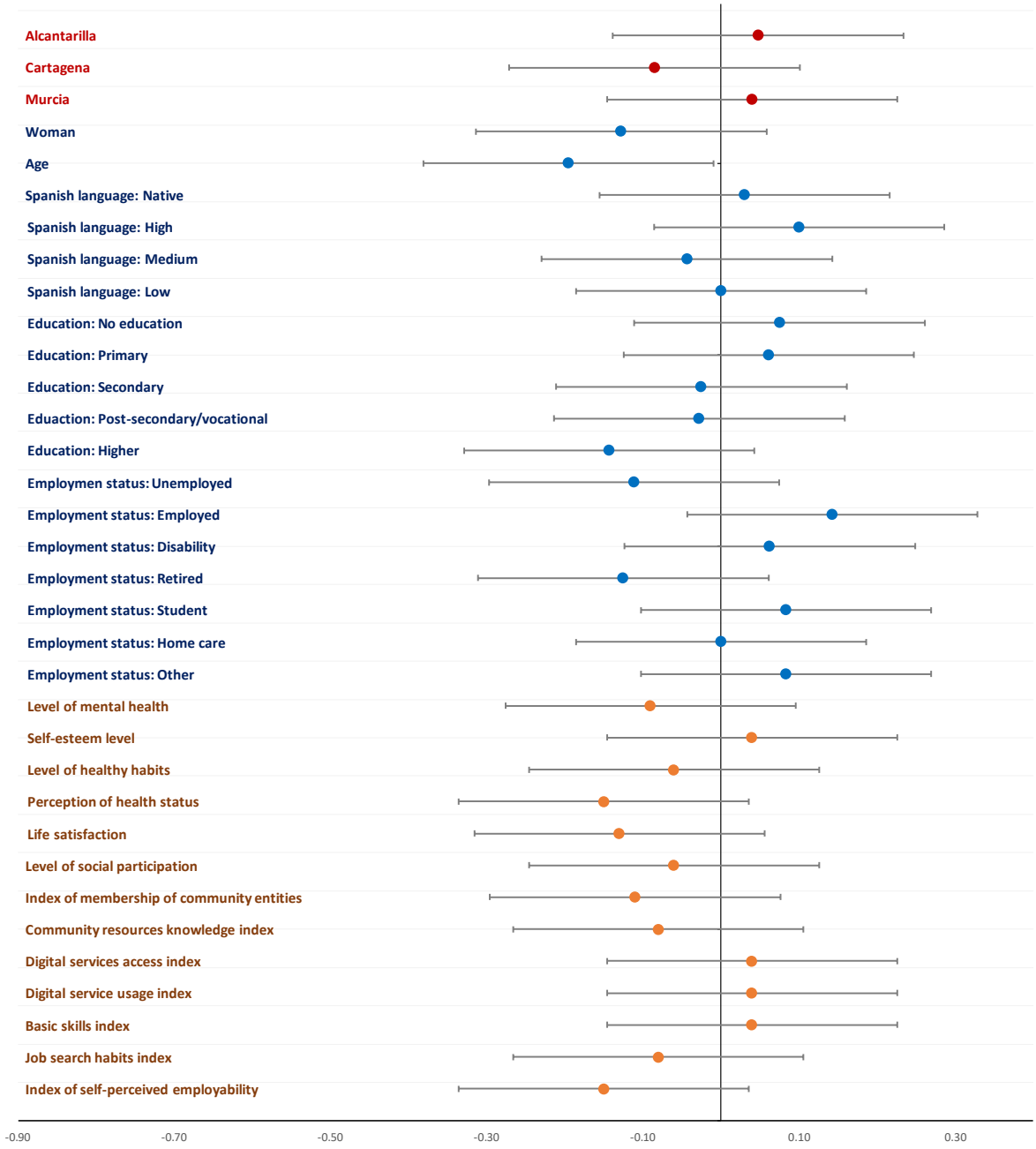
	CG	TG	CG Substitute	TG Substitute	TOTAL
Alcantarilla	41	40	8	**16**	105
Cartagena	75	75			150
Murcia	105	127			232
TOTAL	**221**	**242**	**8**	**16**	**487**

Figure 7 reports the results of the balance test between the control and treatment group. All data reflected in this figure refer to the survey conducted before the intervention (baseline). For each observable variable, the difference between the mean of that variable in the treatment and in the control group is represented by a confidence interval. A confidence interval located at zero will indicate that the mean difference between the two groups is not statistically significant and that, therefore, the sample will be balanced in that variable or characteristic.

Figure 7 shows that the treatment and control groups are balanced in most variables. However, the average age is 43.72 years in the control group compared to 41.39 years in the treatment group. This difference is significant at 5%.

The main indicators do not show differences in balance between the treatment and control groups. The lack of significant differences reflects the absence of relevant imbalances between the experimental groups, facilitating their comparison. Therefore, random assignment ensures comparability between the two groups.

Figure 7: Standardized mean difference between treatment group and control group (95% confidence interval)



Note: The variables used for the stratification of the sample are shown in red, the rest of the sociodemographic variables are shown in blue, and the specific indicators used for the evaluation of the project are shown in orange.

4.3 Degree of participation and attrition by groups

The group that signs the informed consent constitutes the experimental sample randomly assigned to the control and treatment groups. However, participation in the program and the response 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 look very similar, and it will be harder to find an effect. On the other hand, this section examines if differences in the response rate to the final survey between the treatment and control groups affect their comparability after the intervention. It also considers whether demographic characteristics of participants in each group influence the response rate.

Degree of participation

Within the individualized attention, this intervention included a total of 1,612.5 hours, which were detailed as follows: Social care 548 hours-422 sessions-144 people, psychological care 552 hours-422 sessions-153 people, and Personal care 512.5 hours-397 sessions-146 people. While the breakdown of the training agenda included[14]: 3,506 hours for Personal Skills, 3079 hours for Personal Autonomy, 3,055.5 hours of Basic Skills, 3,652.5 hours of Digital Skills, and 2,100 hours of Work Skills. In the case of the Experience Fund, 4,285 hours were taught.

The final number of participants amounted to 487 people, of whom 229 belonged to the control group and 258 to the treatment group. However, only 446 responded to the baseline survey, causing 41 participants to drop out.

Regarding the activities offered, this project comprised 1,241 sessions in the three municipalities, in relation to individualized attention of psychological, social, and personal autonomy reinforcement. In addition, a total of 1,039 sessions of personal skills modules and 1,098 sessions of digital skills modules were conducted, with an attendance of 81%. Regarding the basic skills workshops, there were a total of 896 sessions, of which 684 were individualized and 212 were not individualized. Finally, the participation in the sessions related to individual reinforcement of social care accounted for 95%.

Furthermore, the project included visits to community resources of interest, as part of the activities included in the “Experience Box”. Indeed, it was registered a total of 1,235 sessions, compared to the 1,635 initially planned (75.5% attendance).

[14] It should be noted that in all group activities, each hour is received by several people.

Table 4: Degree of participation in the activities included in the project (People and percentage of attendance)

	Attendance	Scheduled	% Attendance
Individualized attention	1,286	1,357	94.8%
Training agenda	4,573	6,074	75.3%
Experience Box	1,235	1,635	75.5%
TOTAL	9,066	7,094	78.2%

Attrition by groups

Table 5 presents the different levels of attrition in the study. There are 387 respondents, for whom information could be collected from both baseline and final questionnaires, i.e., 87% of all participants initially recruited, while 59 respondents only answered the baseline questionnaire (13%). These 387 people shape the main analytical sample.

Table 5: Participants record and surveys

Group	Total	Baseline and Final Survey	Initial survey only
Total	446	387 (87%)	59 (13%)
Treatment	236	212 (90%)	24 (10%)
Control	210	175 (83%)	35 (17%)

To better understand the characteristics of those who dropped out of the intervention, another regression is performed with the probability of attrition -not being observed in the post-questionnaire survey- as the dependent variable. The total number of observations is 446, which is the initial size of the participants recruited. Potential determinants of attrition included in the regression are the status of the treatment group and the set of outcomes of interest. **Table 6** shows that the probability of dropping out of the intervention is 6 percentage points lower if the participants are in the treatment group (column 1). Column 2 estimates the probability of attrition in the full set of baseline outcomes. In general, the analysis concludes that the probability of attrition does not depend on the welfare state, social participation, exposure to digital services, or the situation of the labor market. To be more precise, the table indicates that a higher level of social participation is related to a higher probability that participants will drop out of the treatment program (at 10% significance), and therefore will not be observed in the final survey.

Table 6: Determinants of sample attrition (outcome indicators)

	(1)	(2)
Treatment	-0.06**	
	(0.03)	
Level of mental health		0.03
		(0.02)

	(1)	(2)
Self-esteem level		-0.02
		(0.02)
Level of healthy habits		-0.01
		(0.01)
Perception of health status		-0.02
		(0.02)
Life satisfaction		-0.00
		(0.02)
Level of social participation		0.03*
		(0.02)
Index of membership of community entities		0.00
		(0.02)
Community Resources Knowledge Index		0.02
		(0.02)
Digital Services Access Index		0.00
		(0.02)
Digital Service Usage Index		-0.03
		(0.02)
Basic Skills Index		0.00
		(0.02)
Job Search Habits Index		0.02
		(0.02)
Index of perception of one's own employability		-0.01
		(0.02)
Constant	0.17***	0.13***
	(0.03)	(0.02)
Observations	446	446
R^2	0.01	0.03

Note: robust standard errors. Significance levels: * p<0.1; p<0.05; p<0.01.

In **Table 7**, the analysis is repeated with the probability of attrition as the outcome variable and estimated for the full set of control variables from the baseline survey (see column 1). In detail, the variables include a set of indicators on educational level, municipality, age group, level of knowledge of Spanish, and being employed. Column (2) presents the probability of attrition with the variables, as well as the status of treatment, along with the interaction of treatment status with each variable. In general, the study did not find statistically significant relationships between the variables and the probability of attrition. However, it is worth mentioning exceptions, such as those participants with a high level of Spanish, who are less likely to drop out of the study (compared to native speakers), and those people from Alcantarilla are more likely to drop out (compared to residents of Murcia), being

significant at 10%. None of the interactions with treatment status are statistically significant, suggesting that there is no sample selection bias caused by receiving the treatment.

Table 7: Determinants of sample attrition (sociodemographic variables)

	(1)	(2)
Treatment		0.11
		(0.13)
Employed	-0.02	-0.01
	(0.07)	(0.15)
Education: Primary	0.01	0.08
	(0.05)	(0.08)
Education: Secondary	-0.02	0.08
	(0.06)	(0.09)
Education: Post-Secondary/Vocational	-0.04	-0.01
	(0.05)	(0.08)
Education: Higher	-0.07	-0.02
	(0.07)	(0.11)
Spanish language: Alto	-0.10***	-0.12**
	(0.02)	(0.05)
Spanish Language: Medium	0.04	0.01
	(0.08)	(0.12)
Spanish language: Low	0.09	-0.01
	(0.12)	(0.15)
Age 29-38	0.04	0.08
	(0.05)	(0.10)
Age 39-48	0.03	0.12
	(0.05)	(0.10)
Age 49-58	-0.01	-0.04
	(0.05)	(0.09)
Age 59-68	-0.04	0.04
	(0.06)	(0.11)
Area: Cartagena	0.01	0.05
	(0.04)	(0.06)
Area: Alcantarilla	0.06	0.14*
	(0.05)	(0.08)
Treatment x Area: Alcantarilla		-0.14
		(0.09)
Treatment x Area: Cartagena		-0.06
		(0.07)

	(1)	(2)
Treatment x Age 59-68		-0.14
		(0.12)
Treatment x Age 49-58		0.08
		(0.12)
Treatment x Age 39-48		-0.13
		(0.12)
Treatment x Age 29-38		-0.08
		(0.12)
Treatment x Education: Higher		-0.13
		(0.13)
Treatment x Education: Postsecondary/Vocational		-0.03
		(0.11)
Treatment x Education: Secondary		-0.18
		(0.11)
Treatment x Education: Primary		-0.11
		(0.10)
Treatment x Spanish language: High		0.22
		(0.26)
Treatment x Spanish language: Medium		0.05
		(0.16)
Treatment x Spanish language: Low		0.06
		(0.06)
Treatment x Employed		-0.01
		(0.17)
Constant	0.11*	0.03
	(0.06)	(0.11)
Observations	446	446
R^2	0.03	0.07

Note: ***, **, * indicate significant levels at 1%, 5%, and 10%, respectively, under robust standard errors in parentheses. The groups omitted are Spanish as their mother tongue; age from 18 to 28 years; without education; of Murcia.

5 Evaluation results

Random assignment of the experimental sample to the control and treatment groups ensures that, with a sufficiently large sample, the groups are statistically comparable. Therefore, any differences observed after the intervention can be causally associated with the treatment. Econometric analysis provides, in essence, this comparison. This analysis has the advantages of allowing other variables to

be included to gain precision in the estimates and of providing confidence intervals for the estimates. In this section, the econometric analysis and the estimated regressions are presented, as well as the results obtained.

5.1 Description of Econometric Analysis: Estimated Regressions

The regression model used to calculate the causal effect of an intervention in an RCT estimates the difference between the average outcome value for the control group and the treatment group. This difference is what is called the impact of the project. This estimate captures the causal impact of the intervention, as the randomization procedure ensures that, on average, the treatment and control groups are comparable, and any differences observed in outcomes between the two groups can be attributed to the intervention.

The project analysis follows an ANCOVA specification for each main result index. The dependent variable is the post-treatment outcome. Pre-treatment results are included to control for potential imbalances seen in the sample. Since randomization was performed at the individual level, robust standard errors are used.

Specifically, the specification of the regressions presented below is as follow:

$$Y_{i,post} = \alpha + \beta_1 T_i^1 + \gamma Y_{i,pre} + \varepsilon_i \qquad (1)$$

where $Y_{i,post}$ is the result measured in the final survey, T_i^1 indicates whether the person has been assigned to treatment 1 (=1) or another. $Y_{i,pre}$ is the dependent variable measured in the baseline survey. β_1 is the parameter of interest capturing the effect of the treatment.

$$Y_{i,post} = \alpha + \beta_1 T_i^1 + \gamma Y_{i,pre} + X_i\delta + \varepsilon_i \qquad (2)$$

This second specification includes a vector of socioeconomic controls. In detail, the vector includes: an indicator if the participant is woman, employment status (whether employed or not), educational levels (0 is no education, 1 at least primary education, 2 at least secondary education, 3 at least a bachelor's degree, and 4 is postgraduate), age group, and indicator for Spanish as a mother tongue. The standard errors for all regressions are grouped by municipality.

For the case of the variable "satisfaction with economic conditions", which is only observed in the post-treatment questionnaire, Equations (1) and (2) are estimated *without* $Y_{i,pre}$. It should be noted that, for this result, the interpretation of the treatment coefficients is different from the main specification, and they are more likely to suffer from bias due to omitted variables.

5.2 Analysis of the results

5.2.1 Main results

This section presents the results of an ANCOVA specification described above for each result.

1. Welfare

Table 8A, **Table 8B,** and **Table 9** present the estimates of the treatment's effect on the outcome variables of interest. Two specifications are included: (1) controlling only for the initial value of the dependent variable and (2) with additional controls, including the initial value of the dependent variable. The analysis uses a sample of 387 participants observed in both the initial and post-treatment surveys.

Regarding the coefficients of the indicators without added controls, this study observes that the effect of the treatment, compared to the control group, is substantial and significant for the well-being results. On the one hand, participating in the program significantly reduces the level of the treated subject in the selected measures. Specifically, a reduction of 0.34 standard deviations in mental well-being, a reduction of 0.26 standard deviations in self-esteem; and a decrease of 0.32 standard deviations in healthy habits. On the other hand, when looking at the overall measure of well-being, i.e., life satisfaction, the effect is positive and considerable (an increase of 0.30 standard deviations). It is also observed that the size of the positive effect is comparable to the size of the negative effects. In addition, the treated participants also indicated greater satisfaction with economic conditions compared to the control group by 0.21. They also report a better perception of health status (at 0.14), and it is statistically significant at 10%.

On the other hand, after the inclusion of control variables, the findings do not vary excessively, either the statistical significance or the magnitude of the treatment effect (intention to treat), although the coefficient related to satisfaction with economic conditions is no longer significant. The negative effects of the intervention on mental health, self-esteem, and healthy habits remain robust, while a considerable positive effect is observed on life satisfaction and perception of health status.

Table 8A: Effects on well-being

	Level of mental health		Self-esteem level		Level of healthy habits	
	(1)	(2)	(3)	(4)	(5)	(6)
Treatment	-0.34***	-0.34***	-0.26***	-0.29***	-0.32***	-0.30***
	(0.09)	(0.09)	(0.09)	(0.09)	(0.10)	(0.11)
Observations	387	387	387	387	387	387
R^2	0.30	0.34	0.24	0.27	0.07	0.10
Media control was. Dep.	0.21	0.21	0.15	0.15	0.19	0.19
Initial value var. Dep.	Yes	Yes	Yes	Yes	Yes	Yes
Additional controls	No	Yes	No	Yes	No	Yes

Note: The table shows the effect of the intervention in each column. Each row represents each regression. , **, * indicate a significant level at 1%, 5%, and 10%, respectively, with robust standard errors in parentheses. Each result is constructed from a combination of a set of responses. Each item-detailed item is normalized, and the value added is standardized to have a mean of 0 and a standard deviation of 1. The estimates follow an ANCOVA specification where the same dependent variable is considered in the initial situation. An exception is "satisfaction with economic conditions", where an estimate of MCO is made due to the absence of this result in pre-intervention. The additional controls are an indicator of whether the participant is female, employment status (whether employed or not), educational levels (0 is no education, 1 at least primary education, 2 at least secondary education, 3 at least a bachelor's degree, and 4 is postgraduate), indicators by age groups, and an indicator for Spanish as a mother tongue.

Table 8B: Effects on well-being

	Perception of health status		Life satisfaction		Satisfaction with economic conditions	
	(1)	(2)	(3)	(4)	(5)	(6)
Treatment	0.14*	0.14*	0.30***	0.29***	0.21**	0.16
	(0.08)	(0.08)	(0.09)	(0.09)	(0.10)	(0.10)
Observations	387	387	387	387	387	387
R^2	0.43	0.45	0.31	0.33	0.01	0.09
Media control was. Dep.	-0.14	-0.14	-0.20	-0.20	-0.12	-0.12
Initial value var. Dep.	Yes	Yes	Yes	Yes	No	No
Additional controls	No	Yes	No	Yes	No	Yes

Note: The table shows the effect of the intervention in each column. Each row represents each regression. ***, **, * indicate a significant level at 1%, 5%, and 10%, respectively, with robust standard errors in parentheses. Each result is constructed from a combination of a set of responses. Each item-detailed item is normalized, and the value added is standardized to have a mean of 0 and a standard deviation of 1. The estimates follow an ANCOVA specification where the same dependent variable is considered in the initial situation. An exception is "satisfaction with economic conditions", where an estimate of MCO is made due to the absence of this result in pre-intervention. Additional controls are an indicator of whether the participant is female, employment status (whether employed or not), educational levels (0 is no education, 1 at least primary education, 2 at least secondary education, 3 at least a bachelor's degree, and 4 is postgraduate), age, and an indicator for Spanish as a native language.

On the other hand, **Table 9** shows no significant effects in the dimensions of community participation.

Table 9: Effects on social participation

	Level of social participation		Index of membership of community entities		Community Resources Knowledge Index	
	(1)	(2)	(3)	(4)	(5)	(6)
Treatment	0.14	0.12	0.04	0.02	0.13	0.12
	(0.09)	(0.09)	(0.10)	(0.10)	(0.09)	(0.09)
Observations	387	387	387	387	387	387
R^2	0.32	0.35	0.07	0.10	0.26	0.28
Media control was. Dep.	-0.05	-0.05	-0.01	-0.01	-0.07	-0.07
Initial value var. Dep.	Yes	Yes	Yes	Yes	Yes	Yes
Additional controls	No	Yes	No	Yes	No	Yes

Note: The table shows the effect of the intervention in each column. Each row represents each regression. ***, **, * indicate a significant level at 1%, 5%, and 10%, respectively, with robust standard errors in parentheses. Each result is constructed from a combination of a set of responses. Each item-detailed item is normalized, and the value added is standardized to have a mean of 0 and a standard deviation of 1. The estimates follow an ANCOVA specification where the same dependent variable is considered in the initial situation. An exception is "satisfaction with economic conditions", where an estimate of MCO is made due to the absence of this result in pre-intervention. Additional controls are an indicator of whether the participant is female, employment status (whether employed or not), educational levels (0 is no education, 1 at least primary education, 2 at least secondary education, 3 at least a bachelor's degree, and 4 is postgraduate), age, and an indicator for Spanish as a native language.

2. Digital accessibility

Table 10 shows the estimates of the effect of the treatment on the outcome variables of interest with respect to digital accessibility, with two specifications specified: (1) controlling only for the initial value of the dependent variable and (2) with additional controls (including the initial value of the dependent variable). Regarding the estimate without controls, the effect of the treatment is positive and notable for the index of use of digital services, at 0.19 standard deviations. For the specification regarding the inclusion of additional controls, the positive effect on the use of digital services maintains its magnitude and is statistically significant at 95% confidence.

However, none of the coefficients relating to access to digital services and the basic skills index is significant.

Table 10: Effects on digital accessibility

	Digital Services Access Index		Digital Service Usage Index		Basic Skills Index	
	(1)	(2)	(3)	(4)	(5)	(6)
Treatment	-0.04	-0.06	0.19***	0.16**	-0.02	-0.02
	(0.06)	(0.06)	(0.07)	(0.07)	(0,08)	(0.09)
Observations	387	387	387	387	387	387
R^2	0.60	0.63	0.51	0.56	0.36	0.39
Media control var. Dep.	-0.00	-0.00	-0.11	-0.11	0.02	0.02
Initial value var. Dep.	Yes	Yes	Yes	Yes	Yes	Yes
Additional controls	No	Yes	No	Yes	No	Yes

Note: The table shows the effect of the intervention in each column. Each row represents each regression. ***, **, * indicate a significant level at 1%, 5%, and 10%, respectively, with robust standard errors in parentheses. Each result is constructed from a combination of a set of responses. Each item-detailed item is normalized, and the value added is standardized to have a mean of 0 and a standard deviation of 1. The estimates follow an ANCOVA specification where the same dependent variable is considered in the initial situation. An exception is "satisfaction with economic conditions", where an estimate of MCO is made due to the absence of this result in pre-intervention. Additional controls are an indicator of whether the participant is female, employment status (whether employed or not), educational levels (0 is no education, 1 at least primary education, 2 at least secondary education, 3 at least a bachelor's degree, and 4 is postgraduate), age, and an indicator for Spanish as a native language.

3. Expectations towards training and employment

Table 11 exhibits the estimates of the effect of the treatment on the outcome variables of interest with respect to expectations towards training and employment, where two specifications are presented: (1) controlling only for the initial value of the dependent variable and (2) with additional controls (including the initial value of the dependent variable).

Thus, this analysis did not find significant effects in the dimension related to expectations towards training and employment, under either of the two estimates.

Table 11: Effects on employability

	Job Search Habits Index		Index of perception of own employability	
	(1)	(2)	(3)	(4)
Treatment	-0.03	-0.01	0.09	0.09
	(0.10)	(0.10)	(0.10)	(0.10)
Observations	387	387	387	387
R^2	0.07	0.11	0.11	0.17
Media control var. Dep.	0.02	0.02	-0.03	-0.03
Initial value var. Dep.	Yes	Yes	Yes	Yes
Additional controls	No	Yes	No	Yes

Note: The table shows the effect of the intervention in each column. Each row represents each regression. ***, **, * indicate a significant level at 1%, 5%, and 10%, respectively, with robust standard errors in parentheses. Each result is constructed from a combination of a set of responses. Each item-detailed item is normalized, and the value added is standardized to have a mean of 0 and a standard deviation of 1. The estimates follow an ANCOVA specification where the same dependent variable is considered in the initial situation. An exception is "satisfaction with economic conditions", where an estimate of MCO is made due to the absence of this result in pre-intervention. Additional controls are an indicator of whether the participant is female, employment status (whether employed or not), educational levels (0 is no education, 1 at least primary education, 2 at least secondary education, 3 at least a bachelor's degree, and 4 is postgraduate), age, and an indicator for Spanish as a native language.

5.2.2 Multi-Hypothesis Testing

Since there are multiple hypotheses in the study, there is a known risk that when testing various hypotheses, some may be validated through random variations in the data. Therefore, two sets of multiple-hypothesis tests (MHTs) are performed that seek to control this possibility. Once this is done, none of these results survive the multiple-hypothesis test, as they become insignificant.

Table 12 presents the regression coefficients for each outcome in column (I), along with their corresponding significance level. Column (II) presents the p-values of the Westfall and Young (1993) family-wise error rate (FWER), which is the indicator of the probability of at least one false positive occurring when testing multiple comparisons, and column (III) reports the p-values of the T-Randomization for the Westfall-Young co-test.

When looking at each p-value related to the multiple-hypothesis test, the following conclusions excel. For the significant results in the above estimates, they are also statistically significant under the MHT (with p-values in both Westfall-Young and T-randomization below 0.10). These outcomes are mental health (-), self-esteem (-), health habits (-), and life satisfaction (+), where the sign in parentheses indicates the direction of the treatment effect. The effect of treatment on perceived health condition is significant (at 10%) under T-Randomization but is not the case under the Westfall-Young criteria.

For other results, the p-values are greater than 0.10, which is the upper limit of statistical significance to reject the null hypothesis of no effect on these dimensions.

In summary, the MHT exercise confirms results like those found in previous estimates.

Table 12: Results with controls and p-values of multiple-hypothesis tests

	Coefficient	Westfall-Young p-valor	P-values of Randomization-T
Well-being			
Social-Emotional Health			
Level of mental health	-0.34***	0.00	0.00
Self-esteem level	-0.29***	0.02	0.00
Level of healthy habits	-0.30***	0.05	0.01
Perception of health status	0.14*	0.56	0.09
Life satisfaction	0.29***	0.01	0.00
Satisfaction with economic conditions	0.16	0.59	0.10
Community Engagement			
Level of social participation	0.12	0.74	0.20
Index of membership of community entities	0.02	0.99	0.87
Community Resources Knowledge Index	0.12	0.74	0.18
Digital accessibility			
Digital Services Access Index	-0.06	0.89	0.36
Digital Service Usage Index	0.16**	0.23	0.03
Basic Skills Index	-0.02	0.99	0.81
Expectations towards training and employment			
Job Search Habits Index	-0.01	0.99	0.88
Index of self-perceived of employability	0.09	0.89	0.35
All Results			0.00

Note: column (1) presents the treatment effect estimated from our baseline ANCOVA, without MHT. Its significance levels are indicated as * = 0.01; ** = 0.05; * = 0.1. Columns (2) and (3) present two multiple-hypothesis tests. Column (2) shows the p-values of the FWER of Westfall and Young (1993) using the wyoung command in Jones et al. (2019), which are presented in square brackets. Column (3) presents the p-values of the T-Randomization for the Westfall-Young co-test in Young (2018). The results are in columns 2 and 3, respectively. Additional controls are an indicator of whether the participant is female, employment status (whether employed or not), educational levels (0 is no education, 1 at least primary education, 2 at least secondary education, 3 at least bachelor's degree, and 4 is postgraduate), age, and an indicator of whether Spanish is the mother tongue.

5.2.3 Treatment effects after accounting sample attrition

Since **section 4.3** presented the selective attrition, it is necessary to verify the extent to which the original estimate is attrition sensitive. Therefore, this project presents an estimation following Lee's (2009) method and it also performs a trimming procedure to delimit the average effects of the

treatment in the presence of sample selection due to attrition. The method involves identifying the excess of individuals who are induced to be selected due to treatment, and then "trimming" the upper and lower ends of the outcome distribution (12% of each end), limiting the most unfavorable scenarios.

Table 13 presents the estimates (upper limits in panel A and lower limits in panel B) for each outcome following Lee's method. On the one hand, it shows a wide range between the results of the lower and upper limits of our estimates for each treatment. On the other hand, the range of estimates for each outcome shows a consistent sign of the treatment effect, like the results in ANCOVA's standard estimates. In detail, as obtained in the analysis of multiple hypothesis tests, the effect of treatment has a negative impact on the level of mental health and self-esteem. In contrast, treatment increases overall life satisfaction and perception of the health condition. However, under Lee's analysis of limits, the effect of treatment on satisfaction with economic conditions is now null. For digital access, positive treatment in the use of digital services among treated participants remains robust.

For other outcome modules, allowing limited estimates leads to statistical significance of treatment effects on other outcomes. That is, a positive effect of the treatment on community participation (measured by the level of social participation and the index of knowledge of community resources) is observed, at least at the lower limit. For employability, the Lee limits result indicates evidence of a negative effect on job search habits, while a positive effect on the perception of one's own employability. That said, given that these significant results are detected only at one of the limits, caution should be observed when concluding about the effects of treatment on these measures.

Table 13: Results with Lee's limits (2009)

	Panel A: Upper Limit Effect			**Panel B: Lower Limit Effect**		
	Coefficient	**Standard deviation**	**R^2**	**Coefficient**	**Standard deviation**	**R^2**
Well-being						
Social-Emotional Health						
Level of mental health	-0.46***	(0.08)	0.34	-0.34***	(0.09)	0.34
Self-esteem level	-0.39***	(0.09)	0.26	-0.18**	(0.09)	0.24
Level of healthy habits	-0.49***	(0.10)	0.15	-0.30***	(0.11)	0.10
Perception of health status	0.14*	(0.08)	0.45	0.25***	(0.08)	0.42
Life satisfaction	0.29***	(0.09)	0.33	0.39***	(0.09)	0.32
Satisfaction with economic conditions	0.03	(0.10)	0.09	0.16	(0.10)	0.09
Community Engagement						
Level of social participation	0.04	(0.09)	0.33	0.21**	(0.09)	0.31
Index of membership of community entities	-0.14	(0.09)	0.12	0.11	(0.10)	0.10

Community Resources Knowledge Index	0.12	(0.09)	0.28	0.22***	(0.09)	0.29
Digital accessibility						
Digital Services Access Index	-0.06	(0.06)	0.63	-0.06	(0.06)	0.63
Digital Service Usage Index	0.16**	(0.07)	0.56	0.29***	(0.07)	0.55
Basic Skills Index	-0.13*	(0.08)	0.37	0.03	(0.09)	0.36
Employability						
Job Search Habits Index	-0.19**	(0.09)	0.11	-0.01	(0.10)	0.11
Index of self-perceived employability	0.09	(0.10)	0.17	0.22**	(0.09)	0.16

Note: significance levels: * =0.01; ** =0.05; *=0.1. These results refer to Lee's (2009) procedure for estimating precise limits on treatment effects. Column set 1 calculates the upper limit while column set 2 calculates the lower limit of the treatment effect. This is done by cutting the sample by 12%, for both tails of the results distribution. Standard errors grouped by residential location in parentheses. Additional checks are an indicator of whether the participant is female, employment status (whether employed or not), educational levels (0 is no education, 1 is at least elementary school, 2 is at least high school, 3 is at least a bachelor's degree, and 4 is a graduate degree), age, and an indicator of whether Spanish is the first language.

5.2.4 Heterogeneity analysis

The heterogeneity analysis aims to observe differential effects in different groups of the participants, focusing on objective characteristics that are considered relevant to the project activities. In this case, this analysis considers the differential effect based on gender.

First, this analysis performs an analysis of a subsample of Equation 2 to verify the heterogeneity of the treatment effect in this sample, along the gender dimension (men and women).

Overall, the negative effects of the program on mental health, self-esteem, and healthy habits remain for both the male and female samples. In particular, the effects on mental health and healthy habits for women are the same size but not significant, presumably due to the small sample size. The positive effect on life satisfaction also remains significant for men and women and has a similar effect size. However, the size of the effect on self-esteem is markedly more intense for men (-0.43 standard deviations) than for women (-0.22 standard deviations); while the positive effect on the perception of the health condition is 0.35 standard deviations for men, and there is no effect for women.

Men seem to benefit more from the treatment in its digital accessibility. Specifically, the effect size does not seem remarkable for women, but it is much higher for men (0.37 standard deviations). Women seem to have a better perception of their employability than men, but this effect is not statistically significant. On the other hand, men would have a more differential effect on the dimension of social participation (0.35 standard deviations), while it is a null effect for women.

Table 14: Treatment Effects for Men

	Coefficient	Standard deviation	Note.	R^2	Media
Well-being					
Social-Emotional Health					
Level of mental health	-0.35**	(0.15)	130	0.37	0.15
Self-esteem level	-0.43**	(0.17)	130	0.36	0.14
Level of healthy habits	-0.30*	(0.18)	130	0.20	0.28
Perception of health status	0.35***	(0.13)	130	0.48	-0.17
Life satisfaction	0.32**	(0.16)	130	0.41	-0.28
Satisfaction with economic conditions	0.13	(0.18)	130	0.16	-0.15
Community Engagement					
Level of social participation	0.35**	(0.17)	130	0.32	-0.18
Index of membership of community entities	0.13	(0.19)	130	0.13	-0.15
Community Resources Knowledge Index	0.06	(0.19)	130	0.25	-0.20
Digital Access Assessment					
Digital Services Access Index	-0.04	(0.11)	130	0.68	-0.16
Digital Service Usage Index	0.37**	(0.15)	130	0.60	-0.39
Basic Skills Index	-0.11	(0.17)	130	0.40	0.19
Employability					
Job Search Habits Index	-0.10	(0.20)	130	0.10	0.01
Index of self-perceived employability	0.21	(0.18)	130	0.16	-0.12

Note: The table shows the effect of the intervention in each column. Each row represents each regression. ***, **, * indicate significance levels at 1%, 5%, and 10% respectively, with robust standard errors. Each result is constructed from a combination of a set of response items. Each item-detailed item is normalized, and the value added is standardized to have a mean of 0 and a standard deviation of 1. The estimates follow an ANCOVA specification where the lagging dependent variable is considered. An exception is "satisfaction with economic conditions", where an ordinary least squares regression is performed due to the absence of this result in the pre-intervention.

Table 15: Treatment Effects for Women

	Coefficient	Standard deviation	Obs.	R^2	Media
Well-being					
Social-Emotional Health					
Level of mental health	-0.32***	(0.11)	257	0.37	0.25

	Coefficient	Standard deviation	Obs.	R^2	Media
Self-esteem level	-0.22**	(0.11)	257	0.24	0.16
Level of healthy habits	-0.26**	(0.13)	257	0.10	0.13
Perception of health status	0.03	(0.10)	257	0.48	-0.12
Life satisfaction	0.32***	(0.11)	257	0.34	-0.16
Satisfaction with economic conditions	0.20	(0.13)	257	0.09	-0.10
Community Engagement					
Level of social participation	0.00	(0.11)	257	0.42	0.03
Index of membership of community entities	-0.03	(0.12)	257	0.12	0.07
Community Resources Knowledge Index	0.08	(0.10)	257	0.41	0.01
Digital accessibility					
Digital Services Access Index	-0.09	(0.08)	257	0.62	0.09
Digital Service Usage Index	0.03	(0.08)	257	0.55	0.05
Basic Skills Index	0.06	(0.10)	257	0.44	-0.08
Employability					
Job Search Habits Index	-0.02	(0.12)	257	0.20	0.02
Index of self-perceived employability	0.03	(0.12)	257	0.21	0.02

Note: The table shows the effect of the intervention in each column. Each row represents each regression. ***, **, * indicate significance levels of 1%, 5%, and 10% respectively. Standard errors are robust and grouped at the area level. Each result is constructed from a combination of a set of response items. Each item-detailed item is normalized, and the value added is standardized to have a mean of 0 and a standard deviation of 1. The estimates follow an ANCOVA specification where we consider its lagging dependent variable. An exception is "satisfaction with economic conditions", where an ordinary least squares regression is performed due to the absence of this result in the pre-intervention.

6 Conclusions of the evaluation

The outcome interpretation of the project appears to be closely linked to the moment of result verification. In the short term, right after the intervention ends, certain indicators might behave differently than they would over a longer time span.

Negative mental health and self-esteem outcomes can be disconcerting, at first glance. But keep in mind that these results are self-reported. Therefore, it is possible that the treatment has made the vulnerability of their situation evident to the participants. There is ~~a~~ solid literature that shows that sometimes it is low self-esteem that leads to action to reverse the situation of vulnerability

(Baumeister et al., 1993, 2013). This awareness of the situation of vulnerability in the short term can be the first step to starting a journey that could reverse this situation.

Within the same area of well-being, this evaluation observes a significant and positive impact of the project on the well-being of the treated people, which would be around 0.3 standard deviations from this indicator, compared to the control group.

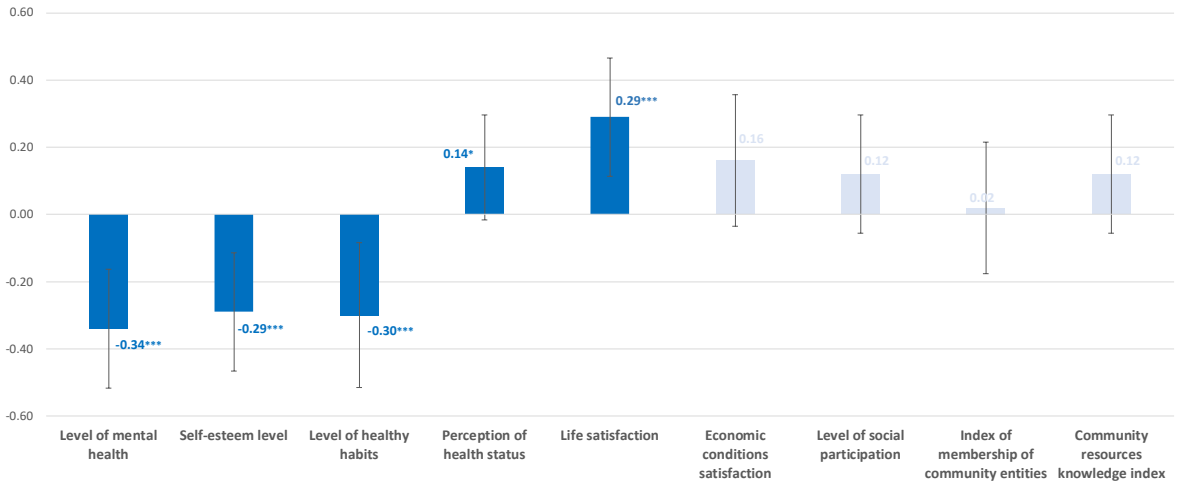
In the field of digital access, a moderate increase in the use of digital services might also occur, though not all estimates confirm this impact.

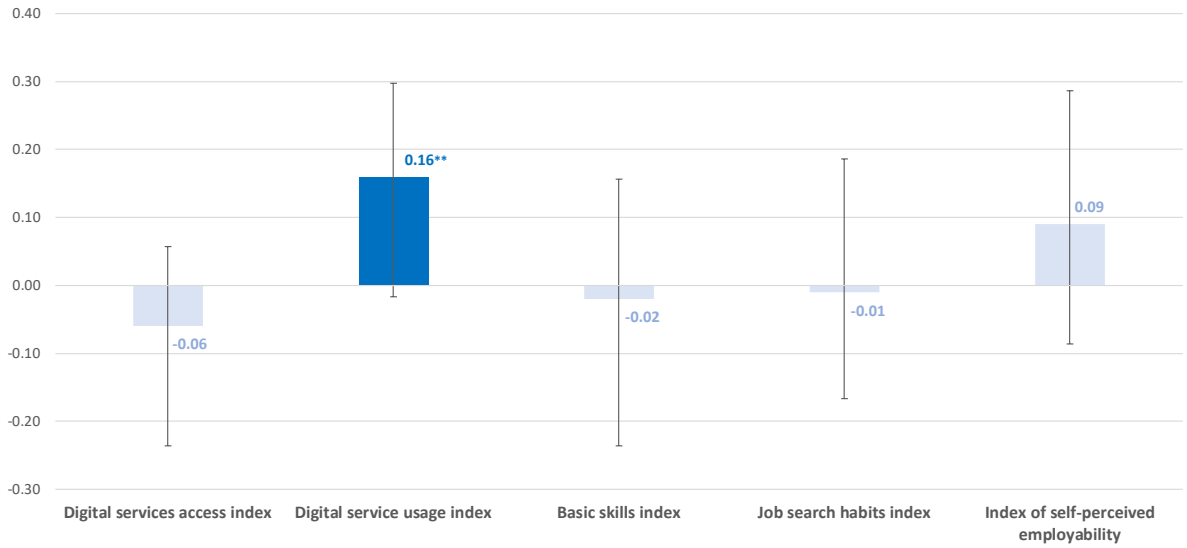
In the areas of community participation and employability, the short-term results show no significant impacts. The time delay negatively affects the ability of this study to verify significant impacts in these areas. In the case of employability, it was aware from the beginning of the difficulty of immediately observing clear progress in this group, due to the situation of special vulnerability at the starting point of the intervention.

It is important to highlight that the evaluation comes from a post-training questionnaire, focusing on the subjective perceptions of the participant right after finishing the training. Without being able to follow the participants (along with the control group) for longer periods of time, it is not known whether these effects will be consolidated in the long term, or whether some of the negative aspects will be reversed. In summary, the analysis performed and the findings to date emphasize the need for further research, especially in the employability indicators most associated with changes in the medium and long term. In this sense, the possible incorporation in the future of information associated with administrative records could offer a perspective more in line with this time horizon.

The following figure exhibits the effects of the intervention on the main indicators analyzed.

Figure 8: Effect of the intervention on headline indicators (normalized indicators)





Note: dark blue shows indicators whose treatment effect is significant and light blue non-significant indicators. The effects included in the graphics refer to regressions with controls. The indicators are standardized. ***, **, * indicate significance levels at 1%, 5% and 10% respectively.

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Appendix

Economic and regulatory management

1. Introduction

Within the framework of the Recovery, Transformation, and Resilience Plan, the General Secretariat of Inclusion 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 model of inclusion 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 the autonomous communities and cities, local entities, and Third Sector of Social Action entities, as well as with the different social agents.

Royal Decree 938/2021, of October 26, 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[15], 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[16], "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

[15] 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 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.

[16] 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[17].

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 **October 3, 2022**, the Autonomous Community of the Region of Murcia is notified of the Resolution of the General Secretariat for Inclusion and Social Welfare Objectives and Policies granting a subsidy of **€3,131,403** to the Autonomous Community of the Region of Murcia through the Murcian Institute of Social Action (IMAS) attached to the Ministry of Women, Equality, LGTBI, Families, Social Policy and Transparency. **On December 19, 2022**, an agreement was signed between the General State Administration, through the General Secretariat of Objectives and Policies of Inclusion and Social Welfare and the Autonomous Community of the Region of Murcia through the Murcian Institute of Social Action (IMAS) attached to the Ministry of Women, Equality, LGTBI, Families, Social Policy and Transparency, for the implementation of a social inclusion project within the framework of the Recovery, Transformation and Resilience Plan, which was published in the "Official State Gazette" on **31 December 2022** (BOE no. 314).[18]

2. Timeline of the intervention

Article 17(1) of Royal Decree 378/2022 of May 17, 2022, established that the deadline for the implementation of the pilot projects of social inclusion itineraries subject to the subsidies provided for in this text must not exceed the deadline of November 30, 2023, while the evaluation of the same, shall not extend beyond March 31, 2024, in order to comply with the milestones set by the Recovery, Transformation and Resilience Plan with regard to social inclusion policies.

Within this generic time frame, the execution begins on **July 3, 2023**, with the start of the intervention itinerary, continuing the execution tasks until **November 30, 2023**, and subsequently developing tasks of dissemination and evaluation of the project until **March 31, 2024**.

3. Relevant Agents

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

[17] 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.

[18] Resolution of December 21, 2022, of the General Secretariat of Inclusion and Social Welfare Objectives and Policies, publishing the Agreement with the Autonomous Community of the Region of Murcia, 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-2022-24662.

- The **Murcian Institute of Social Action (IMAS),** beneficiary entity and coordinator of the project, through the Service of Inclusion and Social Co-responsibility Programs of the General Directorate of Pensions, Valuation and Inclusion Programs.
- The **local entities of Murcia, Cartagena and Alcantarilla,** as responsible for the implementation of the actions in each of the municipalities, especially through their Primary Care Social Services.
- The **Ministry of Inclusion, Social Security and Migration (MISSM)** as the sponsor of the project, and as the main responsible for the RCT evaluation process. To this end, 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 subsidy, as well as for the profiling of the potential participants of 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.
- **CEMFI and J-PAL Europe,** as scientific and academic institutions that support MISSM in the design and RCT evaluation.

Sample Balance

Panel A of **Table 16** presents the balance test for outcomes measured in the baseline survey. This study performed the random allocation in such a way that all results were balanced in the pre-treatment sample, between the treatment group and the control group. Only the perception of the state health status shows a statistically significant difference at the 10% level.

On the other hand, panel B presents the means of the characteristics of the participants between those in the control group and those in the treatment group, using the information collected in the initial survey. Overall, this analysis suggests that the random assignment of the sample was successful in the dimensions of language ability, location, and age. Other differences are not statistically significant between the treatment and control groups.

Table 16: Balance test between experimental groups

Panel A: Outcome Indicators

Variable	Mean			Observations		
	Control	Treatment	P-value	Total	Control	Treatment
Level of mental health	0.05	-0.04	0.34	446	210	236
	(1.01)	(0.99)				
Self-esteem level	-0.02	0.02	0.65	446	210	236
	(1.05)	(0.95)				
Level of healthy habits	0.03	-0.03	0.58	446	210	236
	(1.09)	(0.91)				
Perception of health status	0.08	-0.07	0.09*	446	210	236
	(1.06)	(0.94)				
Life satisfaction	0.07	-0.06	0.18	446	210	236
	(1.02)	(0.98)				
Level of social participation	0.03	-0.03	0.51	446	210	236
	(1.01)	(0.99)				
Index of membership of community entities	0.06	-0.05	0.24	446	210	236
	(1.09)	(0.91)				
Community Resources Knowledge Index	0.04	-0.04	0.41	446	210	236
	(1.01)	(0.99)				
Digital Services Access Index	-0.02	0.02	0.67	446	210	236
	(1.02)	(0.98)				
Digital Service Usage Index	-0.02	0.02	0.65	446	210	236
	(1.04)	(0.97)				
Basic Skills Index	-0.02	0.02	0.68	446	210	236
	(0.96)	(1.04)				
Job Search Habits Index	0.04	-0.04	0.38	446	210	236
	(0.97)	(1.02)				

Panel A: Outcome Indicators

Variable	Mean			Observations		
	Control	Treatment	P-value	Total	Control	Treatment
Index of self-perceived employability	0.08 (1.03)	-0.07 (0.97)	0.11	446	210	236

Panel B: Sociodemographic variables

Variable	Mean			Observations		
	Control	Treatment	P-value	Total	Control	Treatment
Woman	0.37	0.31	0.18	446	210	236
	(0.48)	(0.46)				
Age	43.72	41.39	0.04**	446	210	236
	(11.64)	(12.10)				
Spanish language: Native	0.87	0.88	0.75	446	210	236
	(0.34)	(0.33)				
Spanish language: Alto	0.03	0.05	0.28	446	210	236
	(0.18)	(0.21)				
Spanish Language: Medium	0.06	0.05	0.65	446	210	236
	(0.24)	(0.22)				
Spanish language: Low	0.03	0.03	1.00	446	210	236
	(0.18)	(0.16)				
Area: Murcia	0.45	0.47	0.67	446	210	236
	(0.50)	(0.50)				
Area: Cartagena	0.34	0.30	0.37	446	210	236
	(0.47)	(0.46)				
Area: Alcantarilla	0.21	0.23	0.61	446	210	236
	(0.41)	(0.42)				
Education: No education	0.19	0.22	0.43	446	210	236
	(0.39)	(0.41)				
Education: Primary	0.39	0.42	0.520	446	210	236
	(0.49)	(0.49)				
Education: Secondary	0.20	0.19	0.79	446	210	236
	(0.40)	(0.39)				
Education: Post-Secondary/Vocational	0.15	0.14	0.77	446	210	236
	(0.36)	(0.35)				
Education: Higher	0.06	0.03	0.14	446	210	236
	(0.24)	(0.18)				
Employment status: Unemployed	0.74	0.69	0.24	446	210	236
	(0.44)	(0.46)				
Employment Status: Employee	0.03	0.06	0.13	446	210	236
	(0.18)	(0.24)				
Employment status: Disability	0.10	0.12	0.50	446	210	236
	(0.31)	(0.32)				
Employment status: Retired	0.01	0.00	0.23	446	210	236
	(0.12)	(0.00)				
Employment Status: Student	0.01	0.02	0.361	446	210	236
	(0.10)	(0.13)				

Panel B: Sociodemographic variables

Variable	Mean			Observations		
	Control	Treatment	P-value	Total	Control	Treatment
Employment Status: Home Care	0.09	0.09	1.00	446	210	236
	(0.28)	(0.29)				
Employment status: Other	0.01	0.02	0.398	446	210	236
	(0.12)	(0.13)				

Note: each of these variables is constructed from a set of questions. Initially, we normalized each item, setting the minimum value to zero and the maximum value to 1. Subsequently, an index is calculated using the inverse of the weighted covariance following Anderson (2008). Once the index is created, it is standardized so that its mean is 0 and the standard deviation is 1. , **, * indicate significant levels at 1%, 5% and 10%, respectively.