Inclusion Policy Lab: Evaluation Results

Ayuntamiento de Barcelona - Social Support and Inclusion Adherence Pathways Project. 'AMUNT!' program

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

A research team coordinated by the CEMFI (Center for Monetary and Financial Studies) has substantially collaborated in conducting this study. Specifically, María Hernández de Benito (Professor at the University of Alicante) and Teresa Molina-Millán (Professor at the University of Alicante), under the coordination of Mónica Martínez-Bravo (until January 8, 2024) and Samuel Bentolila, professors at CEMFI, have participated. The researchers have been actively involved in all phases of the project, including adapting the initial proposal to the needs of the evaluation through randomized experiments, the design of the evaluation, the design of measurement instruments, data processing, and the performance of econometric estimations that lead to quantitative results.

The partnership with J-PAL Europe has been a vital component in the efforts of the General Secretariat of Inclusion to improve social inclusion in Spain. Their team has provided technical support and shared international experience, assisting the General Secretariat in the comprehensive evaluation of pilot programs. Throughout this partnership, J-PAL Europe has consistently demonstrated a commitment to fostering evidence-based policy adoption and integrating empirical data into strategies that seek to 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 the standards of scientific rigor and using the methodology of Randomized Controlled Trials.
- This document presents the evaluation results and main findings of the project "Social Support and Inclusion Adherence Pathways Project. 'AMUNT!' program", which has been conducted in **cooperation between the MISSM and the Barcelona City Council**.
- This study evaluates the importance of recognizing and focusing on addressing the heterogeneous needs and interests of individuals in the allocation of active labor market policies. In fact, this report analyzed how the introduction of an initial assessment of the specific needs of each individual and a subsequent offer of personalized inclusion itineraries improves the socio-labor inclusion of the participants. The **treatment group** received individualized advice and support through a one-stop approach office or device, an inclusion itinerary with modules and activities personalized to each individual and, finally, comprehensive monitoring and support. The **control group** did not receive specialized support, although they had normal access to social services and other direct access services of Barcelona City Council.
- The project took place in **the city of Barcelona** and involved 1,183 people (750 in the treatment group and 433 in the control group).
- On average, the most project participants are women (64% of the experimental sample). In addition, they have an average age of 48 years old and 78% were registered in the Barcelona Social Care System (in Spanish, SIAS). Regarding the composition of the households, the participants have from 0 to 5 children in the household, with an average of 0.88 children per participant. In addition, 61% of the participants have Spanish nationality.
- Of the total participants in the treatment group, almost 79% received foster social care, of which 15% participated in group social care meetings. In addition, 4% of the participants in the treatment group received some certification regarding digital literacy and almost 11% participated in language course training.
- The main results of the evaluation are as follows:
    - **Increase in the adoption of social and labor inclusion services:** this study recorded a positive and statistically significant effect in the adoption of social care programs, while this project does not observe any significant improvements in labor or training programs participation. In general terms, there is a positive impact of 13% on the adoption of social care programs for those participants in the treatment group, compared to those in the control group (significant effect at 5%).

- **Improved mental health:** this evaluation cannot discard that the participants in the treatment group show better mental health, compared to the control group.

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 (onwards, SGI by its acronyms in Spanish) of the Ministry of Inclusion, Social Security, and Migration (MISSM) participates significantly in Component 23 "New public policies for a dynamic, resilient, and inclusive labor market", framed in Policy Area VIII: "New care economy and employment policies".

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

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

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

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

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

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

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

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

[5] Milestone 350 of the RTRP: "Improve the rate of access to the Minimum Income Scheme and increase the effectiveness of the MIS through inclusion policies, which, according to its description, will translate into supporting the socio-economic inclusion of the beneficiaries of the MIS through itineraries: eight collaboration agreements signed with subnational public administrations, social partners and social action organizations 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 organizations 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 euros, within the framework of the Recovery, Transformation and Resilience Plan (BOE-A-2022-8124).

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

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

This report refers to "Social Support and Inclusion Adherence Pathways Project. 'AMUNT!' program", executed within the framework of Royal Decree 938/2021[9] by Barcelona City Council. This report contributes to the fulfillment of milestone 351 of the RTRP: "After the completion of at least 18 pilot projects, publication of an evaluation on the coverage, effectiveness and success of the MIS, including recommendations to increase the level of application and improve the effectiveness of social inclusion policies".

[8] Regulated by Order ISM/208/2022, of 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 28 December 2021, an agreement was signed between the General State Administration, through the SGI, and Barcelona City Council for the implementation of a project for social inclusion within the framework of the Recovery, Transformation and Resilience Plan, which was published in the "Official State Gazette" on 1 February 2022 (BOE no. 27).

Context of the project

Social exclusion goes beyond economic deprivation, it is a multidimensional phenomenon that impacts several aspects of people's lives, hindering their full participation in society. It is a complex process that involves the lack of denial of resources, rights, goods, and services (Levitas et al., 2007; United Nations, 2016). The European Anti-Poverty Network (EAPN) identifies five main dimensions that determine social marginalization: (i) economic dimension, which is evidenced through the lack of resources and essential goods; (ii) social, which includes exclusion from community life; (iii) political, limiting participation in decision-making; (iv) cultural, with limited access to education and cultural identity, and (v) residential dimension, related to the lack of adequate housing. These dimensions interact with each other and shape people's situation of vulnerability or social exclusion.

Among the underlying causes of this phenomenon, unemployment is considered one of the main obstacles in addressing social exclusion. Prolonged absence from employment exacerbates the situation of exclusion, exposing people to a range of personal and social challenges. In this way, the lack of employment and low incomes generate in many cases sustained situations of social marginalization.

The consequences of unemployment are relevant from multiple perspectives. From an economic point of view, it leads to the obsolescence of human capital and a constant loss of skills, which makes it difficult to reintegrate into the labor market. On the other hand, from a social perspective, prolonged ~~long~~ periods of unemployment can lead to poverty, social exclusion, isolation, and deterioration of people's mental health.

Unemployment in Spain is a structural and persistent problem, where the average unemployment rate in Spain stood at 12.1% in 2023. A total of almost 3 million individuals were unemployed in that year. In addition, the at risk at poverty or exclusion (AROPE) rate[10] in Spain stood at 26.5% of the population in 2023, thus affecting 12.6 million people. In relation to the EU-27 context, the unemployment rate in 2022 stood at 6.2% of the labor force, with 21.6% of the EU-27 population at risk of poverty and/or social exclusion. These data reflect the greater vulnerability faced by the Spanish population, which registers an unemployment rate 2 times that registered in the EU-27, and a rate of risk of poverty and/or social exclusion 5 percentage points higher than the average of the EU-27[11].

Limiting this problem to the municipality of Barcelona, object of this study, the results present similar conclusions to those indicated at national level. The unemployment rate in 2023 was 7.5%, 5 percentage points lower than the Spanish rate, although still above the EU-27 average (+1.3 percentage points).[12] With regard to the AROPE rate, the latest data for the city of Barcelona, which

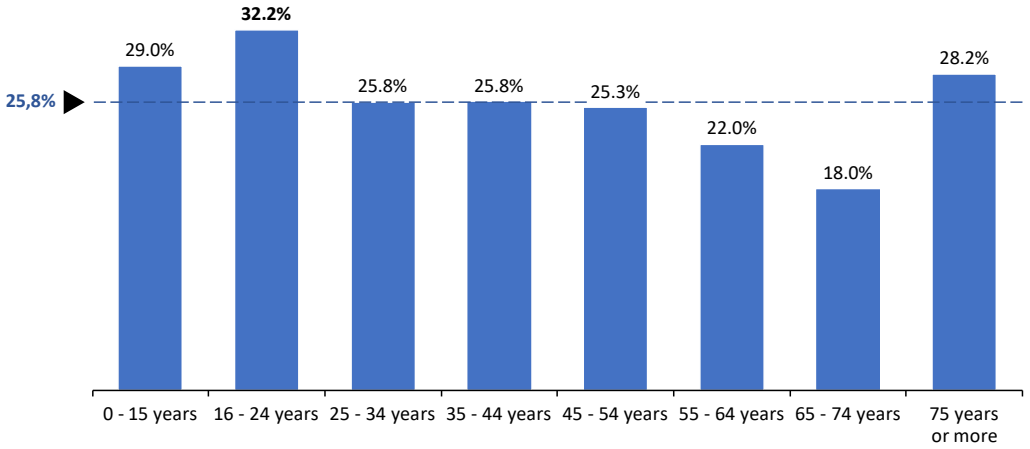
[10] This rate indicates the percentage of people who are in at least one of these three situations: (i) below the at-risk-of-poverty threshold; (ii) suffering severe material deprivation, and (iii) in low-intensity work households.

[11] Unemployment statistics (Eurostat, 2022); Statistics on living conditions in Europe (Eurostat, 2022).

[12] Unemployed population. Barcelona City Council statistics and data dissemination (2023).

correspond to the year 2020, show a rate of 25.8%,[13] with significant differences by age group. Specifically, 32.2% of the population between 16 and 24 years of age was at risk of poverty and/or exclusion, 6.4 percentage points more than the general average, which reflects the greater vulnerability faced by young people.

Figure 1: Poverty and/or social exclusion rate (AROPE) by age group in the city of Barcelona



Source: 2020 Barcelona Sociodemographic Survey by the Barcelona City Council's Municipal Data Office

Historically, the city of Barcelona has strong experience in the design and implementation of training programs and improving the employability of people in vulnerable situations. In particular, the Làbora program stands out, a public-social cooperation project to promote the employment of people with special difficulties in accessing the labor market, led by the Municipal Institute of Social Services (IMSS) and Barcelona Activa, together with other social entities. This program aims to implement and manage a labor market for people in vulnerable situations and who express a demand for employment. In addition, a pool of job applications is offered, with support in the selection of the most suitable jobs. In addition, it is important to highlight the Treball als Barris project and the Pasarel: les cap a l'Ocupació i la Inclusió Program, to promote quality employment and with clear reference to personalized support programs.

Regulatory framework associated with the project and governance structure

The problem of social exclusion has been addressed by several public institutions. For example, at European level, the European Pillar of Social Rights Action Plan was approved in 2021, which aims to complement Member States' actions to provide quality social services and integrate disadvantaged groups into the labor market and society at large.

At national level, the **National Strategy for the Prevention and Fight against Poverty and Social Exclusion** as a reference document, which responds to the commitment of the Government of Spain

[13] Poverty and social exclusion rates and health status of the population. Statistics and dissemination of data from Barcelona City Council (2020).

to maintain and develop the Welfare State to respond to social challenges, especially for the full social inclusion of the most vulnerable people. In addition, Royal Decree 818/2021, of September 28, regulates the employment activation programs of the National Employment System. In a regional context, the **Operational Program of the European Social Fund of Catalonia 2021-2027** is remarkable, to respond to the main challenges in terms of employment, education, training, and social inclusion.

Finally, all European and national regulations are in line with the framework established in the 2030 Agenda and with the Sustainable Development Goals (SDGs).

This pilot project is aligned with regional, European and national strategies in the field of social and labor inclusion, as well as with the 2030 Agenda for Sustainable Development, contributing specifically to SDGs 1, 4, 8 and 10.

Considering the context of social and labor inclusion in Barcelona and that obtaining a job is one of the main reasons for improving social inclusion, a project this report proposes a study that consists of developing a personalized support model with intense interaction with support staff. This project facilitates social and labor inclusion, and greater economic autonomy through the independence of the Minimum Income Scheme (MIS).

The scientific objective of the project is to evaluate the effectiveness and efficiency of this model of personalized training and employment itineraries, in relation to the traditional model of labor insertion. In addition, the aim is to promote knowledge transfer to the policymaking process and be accountable for the project's results.

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

- **Barcelona City Council**, as the entity responsible for the execution of the project. It is the Department of Social Rights, Health, Cooperation and Community of the Barcelona City Council[14] that executes the pilot project. In addition, it has the support of the Municipal Institute of Social Services of Barcelona (IMSS); the teams of the Làbora program; Barcelona Activa; the Barcelona Education Consortium; the Directorate of Community Action Services; and support research staff from the Institut Metròpoli.
- The **Ministry of Inclusion, Social Security and Migration** (MISSM), as the project funder and responsible for the RCT evaluation. Therefore, the General Secretariat of Inclusion assumes a series of commitments with the Barcelona City Council:

[14] The agreement was originally signed with the Department of Social Rights, Global Justice, Feminism and LGBTI of the Barcelona City Council. After the local elections of May 2023 with the new municipal organization, the area is renamed the Area of Social Rights, Health, Cooperation and Community.

- Provide support to the beneficiary entity for the design of the actions to be implemented, for the execution and monitoring of the grant's purpose, as well as for profiling potential participants in the pilot project.
- Design the Randomized Controlled Trial (RCT) methodology of the pilot project in coordination with the beneficiary entity and scientific collaborators. Likewise, conduct the project evaluation.
- Ensure strict compliance with ethical considerations by obtaining approval from the Ethics Committee.

- **CEMFI and J-PAL Europe,** as scientific and academic institutions that support MISSM in the design and the RCT evaluation of the project.

Taking all the above into account, this report follows the following structure. **Section 2** provides a **description of the project**, detailing the problems to address, the specific interventions associated with each of the different itineraries implemented, and the target audience of the intervention. Next, **section 3** contains information related to the **evaluation design**, 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**, analyzing the sample, randomization results, and the degree of participation and attrition of the intervention. This section is followed by **section 5**, which presents the **evaluation results**, with a detailed analysis of the econometric analysis performed and the results for each of the indicators used. **Section 6** describes the general **conclusions** of the project evaluation. Finally, the appendix on **Economic and Regulatory Management provides** additional information on project management instruments and governance of the pilot project.

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 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 the present evaluation on October 20, 2022.

2 Description of the program and its context

This section describes the program that Barcelona City Council implemented within the framework of the evaluation project. Furthermore, it describes the objective of the project, the target population, the territorial scope, and provides a detailed description of the intervention.

2.1 Introduction

This project presents the design and implementation of a unique reception device with a set of socio-occupational inclusion activities, which allow the development of active policy itineraries, in combination with the economic benefit of the MIS. In general terms, this intervention model aims to strengthen the socio-occupational inclusion of beneficiaries of the MIS and to ensure throughout the project that as many participants as possible are no longer dependent on this benefit, strengthening

people's relational and community ties in a complementary way. It is a multidimensional assistance, not focused exclusively on the labor dimension, where the itineraries are adapted according to the profile of each person.

The main areas of intervention of the itinerary are: labor, social, formative, and community.

McFarland (2017) conducted one of the most prominent empirical studies on the fight against social exclusion. This study looks at a series of experiments focused on basic household income. Some of the experiments mentioned in this study use the RCT methodology, reference to understand the effect of the introduction of minimum incomes.

Among the main studies that address the impact of interventions that combine employment and training, Card et al. (2010) excel, whose research shows that programs that integrate both labor insertion and skills development generate positive impacts in the medium and long term, while other employment policies, such as subsidies, have a comparatively lower impact. Likewise, in relation to educational attainment and income obtained, it is relevant to mention the study conducted by Roder et al. (2020), which offers an analysis of the long-term effects on the perception of alternating programs (training and employment) over nine years. This study, conducted through the use of an RCT in the United States, reveals a sustained increase in long-term annual income for the most vulnerable people, which facilitates their escape from poverty. These findings are supported by the RCT performed in Colombia by Attanasio et al. (2011), which implemented an employment and training intervention with a duration of six months, yielding positive results in terms of increased employment and productivity in future jobs.

Thus, different analyses have been accomplished regarding the impact of active employment policies on the reduction of unemployment. However, examples at the national level are still scarce, highlighting the research performed by Rebollo-Sanz and Pérez (2021) on the evaluation of the impact of active employment policies on groups with difficult labor insertion. In general terms, studies show improvements in employment rates and job satisfaction in participants because of the implementation of various active employment policies (training, counselling, hiring incentives, subsidies, etc.).

In this way, Active Labor Market Policies (ALMPs) were introduced in many countries in the 1990s to address persistent unemployment and low incomes of disadvantaged groups through the public provision of training, job creation, subsidized jobs, and wage subsidies. Several studies evaluating these policies have shown limited effects on average, but it has also been seen that the effects vary considerably for different groups, suggesting the presence of heterogeneous effects (Michalopoulos 2004; Crepon and van den Berg 2016). For example, Bitler et al. (2006) reveal that a reform in a U.S. welfare program generated modest effects on average, but hid both significant negative and positive results, in addition to no impact for many beneficiaries. This diversity of outcomes can be largely attributed to the fact that these programs are often accessible to a broad population and do not focus on addressing specific individual needs. As a result, there is a recent trend that emphasizes the need for a better approach in targeting these programs, namely, choosing more carefully the most appropriate program for each beneficiary individually (Eberts 2002; Frölich et al. 2003; Frölich 2008;

Crepon and van den Berg 2016). At the same time, Crepon and van den Berg (2016) emphasize the need to complement traditional active policies with activities that increase self-esteem and other personality traits, as these can foster reintegration into society, which in turn may be necessary to obtain regular, gainful employment.

In relation to the city of Barcelona, there are previous studies that demonstrate positive results of support programs implemented in this area. For example, the study conducted on the B-MINCOME program (Todeschni & Sabes-Figuera, 2019) highlights a pilot project aimed at combating poverty and social exclusion. This program evaluated an innovative policy that combined cash transfers with social and labor inclusion measures, such as training or socialization activities. The findings reflected a reduction in the lack of material resources and food precariousness, as well as improvements in life satisfaction, sleep quality and community participation.

In addition, other experimental projects have been performed, such as the Mobiliza't Mobile program, which offers opportunities in the educational field to improve employability and job placement. This program was designed on an experimental basis to assess the impact of actions such as training, community activities, or support and guidance. The main results of the program result in obtaining higher quality contracts, with a greater number of permanent contracts. Likewise, this study exhibits an educational return among the young participants.

2.2 Target population and territorial scope

The target population of the project includes people between 18 and 65 years of age who receive the MIS within the city of Barcelona.

Barcelona City Council is responsible for contacting potential participants through different channels specified in **section 3.5.** In order to participate in the project, the following requirements must be met:

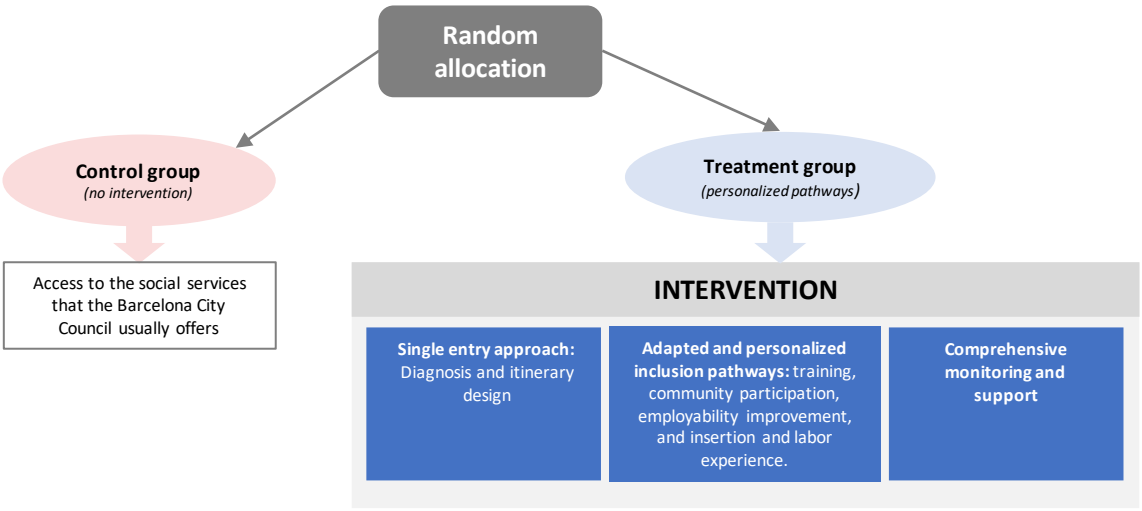
- **New participants**: individuals who have not participated in a similar program recently.
- **Age**: individuals between 18 and 65 years old.
- **Residential situation**: registered in the city of Barcelona.
- **Sanctioning file**: they must not have any open file for aggression in the context of care.
- **Disability**: disability of less than 65%.
- **Benefits**: recipient of the MIS.
- **Other criteria**: due to a professional technical criterion, people from cohabitation units who are under study or with active child protection measures are discarded.

2.3. Description of interventions

Given the multidimensional nature of social and labor exclusion, the aim of the project is to offer specific itineraries to the participants, based on the profile of each person. The intervention has been designed following the methodology of RCTs, with a control group and a treatment group, where the treatment group receives a set of specialized interventions, while the control group does not receive

any type of additional specific treatment, being able to access the benefits and services of Barcelona City Council in the usual way. The **Figure 1** summarizes the proposed intervention scheme.

Figure 1: Intervention scheme



This project presents the different interventions that define the new model of socio-occupational inclusion perceived only by the treatment group:

1. Single Entry Approach

The project designs and implements a single methodology for entry and monitoring (*one-stop approach*) to facilitate access to social and labor insertion services, providing individualized advice and support. Furthermore, the project begins with an initial reception and psychosocial diagnosis conducted by a specialized social services team. Subsequently, professionals from a labor insertion team (guidance, training and prospecting) coordinate with the social care team to conduct a second reception and diagnose the person in terms of employability, needs, and interests, potentially linked to training actions. In this way, this intervention performed a broad and comprehensive diagnosis of the participants. With all this information, an inclusion itinerary is defined with the optimal activities for each participant, prescribing inclusion activities according to the needs and potential interests of the participants. Likewise, this device is responsible for coordinating the entire process and the entities responsible for the activities.

2. Inclusion itineraries, modules, and activities

Once the team completes the diagnosis and develops a personalized action plan for each participant, they proceed with the activities outlined in the intervention. The activities considered in each inclusion itinerary can be grouped into three different modules:

a. Training (basic and oriented to labor sectors): on the one hand, design of basic training to strengthen socio-educational capacities and skills, promoting personal independence. In addition, depending on the profile of each participant, the project assigned activities aimed at specific job sectors, with the aim of accrediting their skills:

- Certifications of knowledge of Catalan and Spanish (tailor-made and in adult training centers)
- Certifications of knowledge of other languages (English)
- Digital Literacy
- Competence recognition and accreditation service.
- Basic Economic Education Training and Mentoring Course
- Training to prepare for and guarantee access to post-compulsory studies.

On the other hand, and based on the diagnosis previously made, activities[15] focused on specific work sectors are assigned:

- Occupational training (FO) Level 1 qualification.
- Information and Communication Technology (ICT) Bootcamps, which are intensive training programs specially designed to learn in an accelerated way in a collaborative environment

b. Community participation to improve people's relational resources, to reduce social isolation and prevent loneliness.

c. Activities in the workplace (care and accompaniment, work experience and entrepreneurship): on the one hand, this intervention includes individual attention and follow-up, actions to improve employability, and job placement. On the other hand, some itineraries include activities linked to work experience (municipal employment plans) and entrepreneurship in the Social and Solidarity Economy.

3. Comprehensive monitoring and support

Each participant receives social and/or psychological support throughout the itinerary provided by a professional from the social care team. In addition, people whose itineraries include objectives linked to labor inclusion, also receive monitoring and labor assistance by a professional in this field, establishing a shared referentiality of the case by these two teams.

Comprehensive monitoring and support involve assisting participants in maintaining and achieving the agreed-upon itinerary, adjusting and redefining it, considering the needs, capacities, context, and interests of the participant. This support also includes support in the procedures related to the receipt of the Minimum Income Scheme. Additionally, all participants are offered a weekly meeting space with professionals at a nearby facility. This stable activity, led by the socio-educational team of Community Action and the social care team in a stable professional tandem model, uses dynamics to promote social cohesion and engagement. In this context, participants are guided to discover nearby resources that can address specific needs and gain access to cultural participation and the city's cultural heritage.

15 Some activities contemplated at the beginning of the project have not been finally developed, either due to lack of interested people or in an eligible or likely situation to carry out the activity (Occupational Training N2 qualification and Second Chances School em2o), or due to the difficulties in carrying out certain activities within the limited calendar of the project (dual vocational training and other *certifiable* reskilling programs).

3 Evaluation design

This section describes the design of the impact assessment of the project described 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, to understand the relationships between them, the assumptions on which they are based, and to outline 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 to properly implement the treatment. Next, we identify the expected effect(s) based on the initial hypothesis, i.e., what changes – in behavior, expectations, or knowledge – are expected to be obtained in the short term with the actions conducted. Finally, the process concludes with the definition of the medium- to long-term results that the intervention aims to achieve. Sometimes, the effects directly obtained with the actions are identified as intermediate results, and one identifies the indirect effects in the final results.

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

The need identified by the Barcelona City Council is the reduced social and labor insertion of MIS recipients in the city of Barcelona. In fact, within this group there is a disconnection with the work environment and the mechanisms of access to it. The origin of this phenomenon is closely related to the educational level and employment situation of people at risk of social exclusion.

This need or problem defines the different areas of action of the project and the activities associated with each of them. Thus, an approach is proposed that is developed around a newly implemented

device, the one-stop-approach office, composed of several activities that cover community participation, training (basic and oriented to labor sectors), improvement of employability and insertion and work experience through local employment plans and other complementary operational elements. In this way, a series of professionals are in charge of managing the single-entry office, where a group of beneficiaries are interested in participating and receiving the training and activities offered.

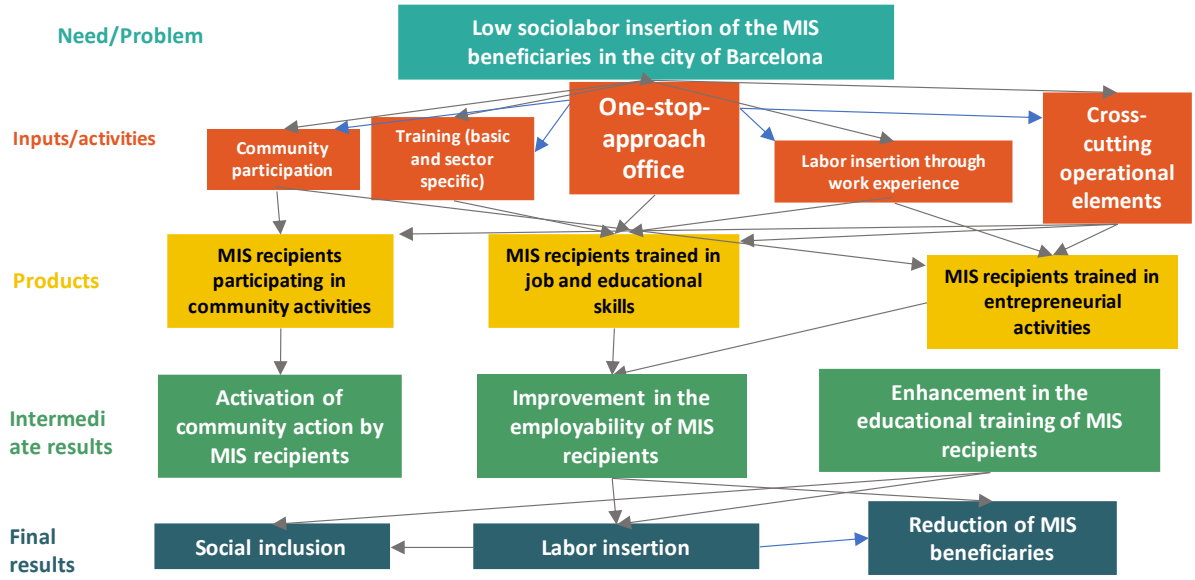
All these resources and activities produced a series of products. By measuring the outputs obtained, it is identified whether the beneficiaries have received the activities or inputs and with what intensity. Receiving the resources and activities performed adequately is essential for the program to achieve the expected intermediate and final results, since, if the beneficiaries do not effectively receive the program, it is difficult to observe improvements in employment, social inclusion or training indicators. In this project, this study defines the outputs as the number of MIS beneficiaries integrated into community activities, as well as the number of students attending each activity offered and the number of entrepreneurship projects valued. The outputs of the project are therefore the direct results of the programmed activities.

In the short term, the project expects a better predisposition to the socio-labor integration of MIS recipients. The training and activities received are reflected in an increase in the management skills and activation of the work skills of the beneficiaries. Thus, MIS recipients' activation of community action correlates with increased satisfaction in community participation outcomes. Moreover, this study anticipates that there will be enhanced employability among MIS recipients, evidenced by an increase in the number of entrepreneurial projects undertaken and greater associated investment in these endeavors. In addition, this project expects an improvement in the employability of MIS recipients, through a greater number of entrepreneurship projects performed and greater investment associated with these projects. In addition, this evaluation also estimates a greater participation of companies offering employment opportunities. Finally, the training and activities provided propose the obtaining of a greater number of certifications by the participating beneficiaries.

In the medium-long term, the improvement of the intermediate indicators should increase the training and social integration of the participants, specifically improving their employability, personal, and social life. Therefore, this analysis expects a lower number of recipients, holders and beneficiaries of the MIS in the city of Barcelona, as their labor inclusion increases. Likewise, the project anticipates greater employability among participants, with a greater number of people with a job at 6 and 12 months after the intervention, accompanied by improved average salaries. For those who remain unemployed, the intervention expects an increase in job seeker registrations due to active employment policies. In general terms, a higher degree of satisfaction with social life, environment and daily life is estimated, translated into a better subjective well-being of the participants.

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

Figure 4: Theory of Change[16]



3.2 Hypotheses

The main objective of the intervention is to improve the socio-occupational inclusion of the MIS beneficiaries of the city of Barcelona and, in turn, to ensure that part of the participants stop depending on this benefit.

It is important to note that, as detailed in the Theory of Change, this project is not limited exclusively to improvement in the workplace, but also aims to improve the training level of the participants, their health, and personal situation. In addition, this report also includes an analysis of social services and their relationships. Consequently, when evaluating the model, the project formulates several hypotheses that compare personalized treatment with traditional treatment in each of the aforementioned areas, which use 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.

The hypotheses to test in each of the major areas of analysis are the following ones.

1. Increase in the social services take-up

This hypothesis postulates that personalized treatment that includes a one-stop approach model increases the take-up of socio-labor inclusion services, compared to a traditional model of inclusion.

[16] The one-stop-approach office is made up of various activities that cover community participation, training (basic and oriented to labor sectors), job placement through regulated work experience and other complementary operational elements

2. Improving the labour market: increasing employment and employability

The main hypothesis is that the new model increases the employment of beneficiaries, compared to the traditional model.

In addition, this report postulates that the beneficiaries of the personalized treatment improve the training skills necessary to get and keep a job, increasing their employability compared to traditional treatment.

3. Increased well-being

The main hypothesis of this block focuses on how the new model improves the well-being of the participants, improving satisfaction with life and physical and mental health, compared to the traditional model.

4. Greater social inclusion and increased community participation

In general terms, this section postulates that the community within a personalized treatment will reduce their social exclusion and they will have an improvement in social support, compared to those beneficiaries of the traditional model.

In addition, a second hypothesis focuses on how personalized treatment improves participation in social and environmental activities with greater community participation, compared to the traditional model of accompaniment.

3.3 Sources of information

To gather the information necessary to construct the outcome indicators, this analysis uses surveys from the participants in the itinerary and from the professionals in charge of performing the socio-occupational assistance. In addition, there is information from administrative sources that complement the information collected in the interviews performed with the participants.

The surveys, performed on the participants through interviews led by Barcelona City Council staff, were accomplished at two follow-up moments: **before the intervention** (baseline) and **after the intervention** (endline), five months after the intervention[17].

Both the baseline survey and the final survey include the following questionnaires:

- **Sociodemographic**: the questions aim to analyze the generic situation of the participant.
- **Cohabitation situation**: the questions aim to analyze the situation in the participants' home, number of cohabitants, and relationship with them.

[17] Initially, the completion of the end-line survey was planned after the completion of the intervention, however, various operational problems prevented it from being carried out after five months. This time may have consequences in the identification of some results in this source

- **Housing**: focuses on the residential situation of households, time in housing, and the regime of home ownership.
- **Employment status**: focuses on the situation presented by the participants; the search for employment; the non-search for employment; the existence of some degree of disability, and the degree of it.
- **Employability (EAS scale):** a series of statements are presented about the behavior or way of thinking towards work by the participants, regarding training and self-confidence.
- **Life satisfaction**: the questions aim to determine the general level of life satisfaction, both currently and over a five-year time horizon.
- **Emotional health and well-being**: focuses on participants' self-perceived health, as well as an analysis of emotional health through questions related to feelings and thoughts.
- **Social relationships**: focuses on the relational situation of the participants with other family members, friends, or environment.
- **Community participation**: this section includes aspects related to participation in proximity activities and belonging to an organization, association, or group.
- **Social services**: focuses on issues relating to participants' relationships with social services, regardless of whether they are used or not. These questions also address assessments about social services.

Only the final survey includes the following questionnaires:

- **Employment Status**: addresses issues related to the current employment status, reasons why the participant is not able to find a job, and the reasons why the participant is not looking for a job. Likewise, it includes questions related to the presence of disability and the degree of satisfaction with the employment situation. Questions are also raised about the probability of finding a job and, in cases that present work, what is the perception of security, or the probability of losing their job.
- **Income**: the questions aim to determine the volume of net monthly income received for the work performed, as well as the total income of the household as a whole. It is also important to consider satisfaction with this income and, if it has increased, what have been the main reasons for the increase in household income. Questions are also presented on the Guaranteed Income of Citizenship (RGC) of Catalonia, on its collection and time of receipt.
- **Energy poverty**: focuses on determining whether the participant can maintain the home at an adequate temperature and the ability to pay bills on time.

In general terms, the final survey also includes a series of observations perceived by the interviewer about the language in which the survey was performed, assessment of the level of understanding of the interview, and additional assessments.

In addition to the surveys fulfilled, this study uses administrative records, which are especially relevant for analyzing the social and labor inclusion of the participants:

- This project uses administrative records to analyze the take-up of active insertion and employment policies, relating to administrative records of municipal services (Làbora,

Barcelona Activa, Social Services, Employment Service of Catalonia, National Institute of Social Security).

- Regarding the analysis of labor insertion, this study uses also administrative records from the Department of Labor (registration of contractual registrations), SOC (Public Employment Service of Catalonia), and Social Security (working life, as well as social security registrations and deregistration).

3.4 Indicators

This section defines the indicators that this report uses to assess the impact assessment of the pathway, divided into the hypotheses described above.

1. Social Services take-up

Four indicators to evaluate the take-up of social services:

Labor take-up: measured through a binary variable on participation in at least one of the activities offered in the Làbora and employability program.

Social care take-up: binary variable based on user participation in social care services.

Training take-u*p*: measured through a binary variable on the perception of training activities (digital literacy, ICT courses, language courses, certifications, professionalization courses).

Aggregate take-up: this is a binary variable, which takes on a value equal to 1 when at least one of the defined take-ups (work, care, training) is equal to 1.

2. Labor market: occupation and employability

This study uses five indicators to analyze the level of employment and employability of the participants:

Number of days worked: measured through the number of days worked, information coming directly from the administrative records exposed.

Number of full-time equivalent days: measured through the number of full-time equivalent days worked in the selected reference period. This information comes from administrative records.

Worker (survey): sum of the days registered in the reference period analyzed.

At least one day of work: binary variable that takes a value equal to 1 if the participant has worked more than one day, in a selected reference period. This information comes from administrative records

Employability index (EAS scale): synthetic indicator measured through a standard employability assessment scale that contains a total of seven indicators on training, skills, confidence, and experience in the job search. This composite index has been constructed using the method proposed by Anderson (2008), which aggregates the information from a set of variables that attempt to measure

a common latent variable. In this way, this project calculates the weighted average of all the variables, where the weight assigned to each of them depends on how correlated it is with the others (the lower the correlation, the greater the weight). Thus, it has been standardized to have a mean equal to 0 and standard deviation equal to 1.

3. Well-being

Three indicators assess the well-being of the participants:

Life satisfaction index: measured through two indicators, a first simple indicator on life satisfaction, and a second complementary indicator on future expectations:

- General satisfaction: simple indicator that takes values from 0 to 10, where 0 is equivalent to totally dissatisfied and 10 totally satisfied.
- Future expectations: a simple indicator that considers the degree of satisfaction with life in the future. Take values on the questionnaire from 1 (much better than now) to 5 (much worse than now).

This index is standardized to obtain a mean equal to 0 and a standard deviation equal to 1.

Self-perceived health status: measured as a constructed index of self-perceived health that takes values in the questionnaire between 1 (very poor health level) and 6 (excellent health level). This rating was taken in reverse to generate the indicator, so that higher values were associated with more positive ratings.

Metal Health Index: measured through a synthetic indicator with eight variables that define the mental health of the participants: general health, usefulness, relaxation, energy, way of coping with problems, internal well-being, confidence and joy. This index has been constructed with Anderson's method (2008) to obtain a mean equal to 0 and a standard deviation equal to 1.

4. Social inclusion and community participation

This study uses the following indicators to measure the level of social inclusion and community participation of the participants:

Social relations index: measured through a simple indicator on participation in some proximity activity in your neighborhood, such as the library, the civic center, the neighborhood center[18], and its frequency.

Community participation: measured from a binary variable that captures whether the participant has participated in the last year in a community activity.

[18] The camps are facilities to offer all kinds of meetings, activities and experiences of coexistence between the residents of the neighborhood (for example, workshops, transfer of spaces to associations, development of neighborhood initiatives). Source: Barcelona City Council.

Trust in social services: captures whether the interviewee considers that Barcelona City Council's social services provide a useful response to address the problems or needs of the participants. The variable takes values between 1 and 5, where 1 means strongly agree and 5 strongly disagree.

1.1 Design of the experiment

To assess the effect of the treatment on each of the above indicators, this study uses an experimental to assess (RCT), where participants are randomly assigned to either the treatment group or the control group. The process of recruitment and selection of the participants of the intervention is detailed below, as well as the random assignment and the time frame of the experiment.

Recruitment of intervention beneficiaries

The starting population consists of beneficiaries of the MIS at Barcelona City Council. After identifying the potential participants, the project applied the following filters:

- Holders and members over 16 years of age and under 65 years of age, belonging to family units or cohabitation recipients of the MIS in Barcelona City Council.
- People in cohabitation units who are under study or with child protection measures.
- Other operational criteria that ensure the viability of executions (cases of aggression, drug addiction, severe mental disorder, judicial incapacitation, homelessness, others).

In addition, the evaluation applied exclusion criteria after sending the list to the Social Services professionals, excluding the following individuals:

- People with open disciplinary proceedings or reports of aggression in the last year.
- People with active drug addiction without tracking or treatment in a care and monitoring center (CAS).
- People with a severe mental disorder (SMD) without psychiatric follow-up or treatment.
- Persons in the process of judicial incapacitation without a sentence and/or assignment of guardianship.
- People in a situation of homelessness who are considered ineligible by technical criteria.

Thus, the recruitment process has two different phases:

1. **First phase of recruitment**: after applying the aforementioned filters, the process begins by calling individuals to attend the information sessions. Thus, they are contacted via postal letter and through a reinforcement phone call, to confirm attendance at the information session. In these sessions or in the days immediately after, consent is obtained, and individuals become part of the project.
2. **Second phase of recruitment**: after the numbers obtained for participation and adhesion to the project, the technical team performed a second phase of recruitment through the sending of SMS and reinforcement phone calls. In this second phase there are also contacts from the first phase of recruitment. In this second phase of recruitment, although it is subject to the treatment of the project, it is not subject to the same evaluation as the

participants of the first phase. Instead, this study performs an RCT evaluation focused on the method of contact, specifically the SMS sent to provide information about the project[19].

After verifying the participation criteria and explaining the project in detail, individuals interested in participating sign the informed consent form, indicating their approval to join the program. This group of signatories then defines the study sample.

Informed Consent

One of the fundamental ethical principles of research involving human beings (respect for individuals) 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 harms the validity of the experiment, informed consent may be avoided, or one can give partial information may be given to participants with the approval of the ethics committee.

Random assignment of participants

After signing the informed consent, the experiment participants are randomly assigned to 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 performed 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.

This study conducted a pre-randomization using available administrative variables, creating a hierarchy of contacts for recruitment. Based on this selection, the professional team invited potential participants to information sessions. During these sessions, participants confirm their interest in the project, and it was collected the informed consent from those who intend to participate.

Thus, the unit of randomization are individuals, using the following stratification variables and obtaining a total of 74 strata:

[19] This evaluation is the subject of a separate document (Barcelona City Council – Social Support and Inclusion Adherence Pathways Project. Non take-up program).

- **Inclusion in social services**, as this information is available during the previous selection process, this variable is included as stratification: SIAS (Comprehensive Social Care Service)/NOT SIAS (Comprehensive Social Care Service).
- **Gender**: male/female.
- **Age**, which is categorized into three states: >25 years; 25 to 55 years; and over 55 years.
- **Studies**, categorized into three states: i) compulsory studies not completed; ii) compulsory (EGB, ESO); iii) other studies.
- **Relationship to employment**, categorized into two states: i) you have worked in the last 6 months; ii) has not worked in the last 6 months.

The following figure shows the design of the sample, from the detection of the initial starting population to the randomization and assignment of participants to the treatment group or the control group.

Figure 5: Sample design

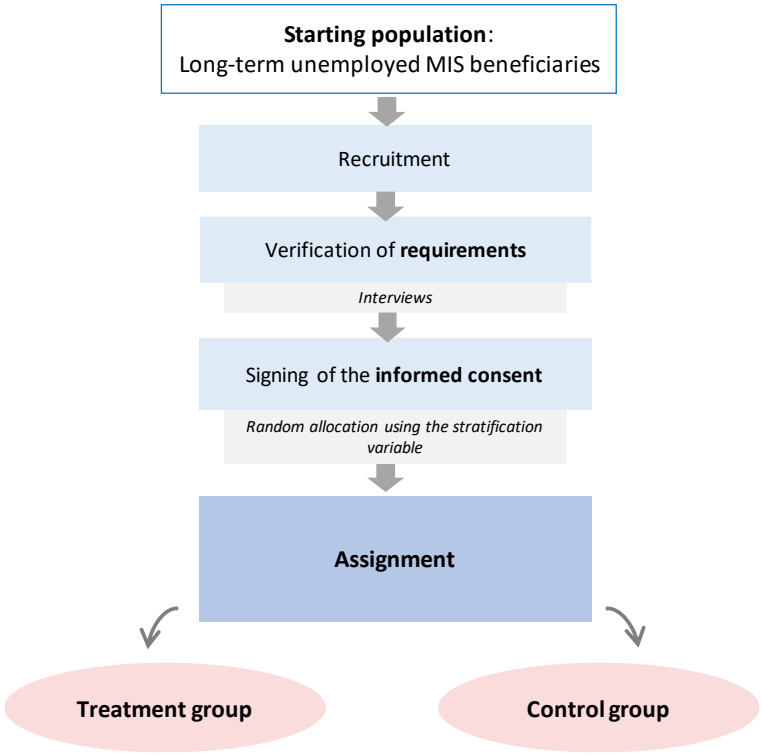
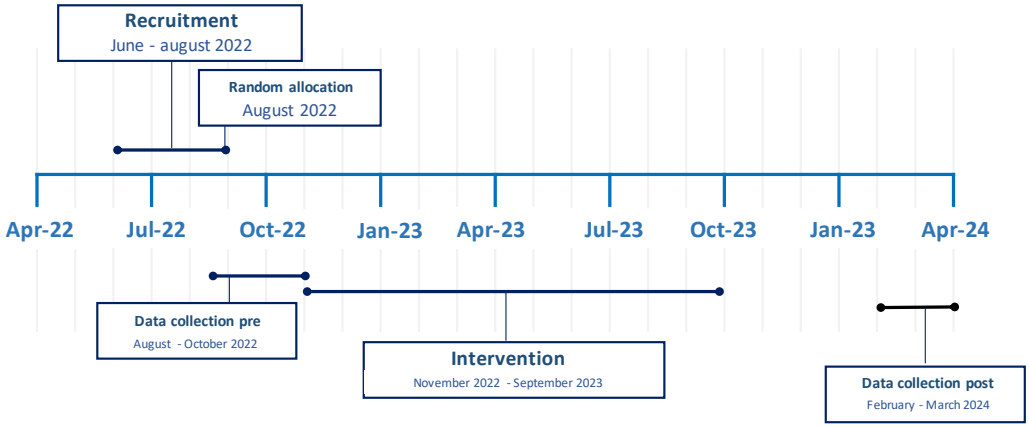


Figure 6 illustrates the timeline for the implementation and evaluation of the itinerary. After the completion of the experimental evaluation design, the Barcelona City Council proceed with the process of recruiting participants– in which potential beneficiaries are recruited by selection from administrative sources.

Figure 6: Evaluation timeframe



4 Description of the implementation of the intervention

This section describes the practical aspects of how the intervention was implemented within the framework of the evaluation design. It presents the outcomes of the participant recruitment process and other relevant logistical aspects to contextualize the evaluation findings.

4.1 Sample Description

The Barcelona City Council attempted to reach out to all 5,472 individuals in the sample for potential participants using several methods. The goal was to invite them to attend an information session about the AMUNT program, but not every individual could be reached. A total of 60 face-to-face information sessions were conducted to secure informed consent from those interested in participating in the pilot program.

For this recruitment process, this study differentiates two phases:

First phase of recruitment

The list comprises 4,070 individuals who are scheduled to attend the information sessions. These individuals are between 18 and 65 years old, residing in Barcelona, and belong to households receiving the MIS. Each household can only have one representative attending.

- It is contacted by post (only 3,980 individuals) and through a reinforcement telephone call (the recruitment team tried to do it with all the people, although there were wrong telephone numbers and even in some cases there is no contact telephone number). This call is intended to confirm attendance at the session and the operator making the call offers the possibility of making an appointment for another date.

- 50 information sessions are held between June 27 and July 8.
- 919 people attended the information sessions, and 729 informed consents were obtained.

Second phase of recruitment

In view of the figures of participation in the sessions and adhesion to the project (far from the initial objective), the project considered a second phase of recruitment. In this way, the recruitment team contacted 3,222 individuals to invite them to new information sessions:

- It is contacted via SMS and through a reinforcement phone call (it is intended for all people). This call is intended to confirm attendance at the session, but in this case the operator making the calls does not offer the possibility of making an appointment for another date.
- 10 information sessions are held between July 18 and July 22.
- 730 people attended the information sessions, and 451 informed consents were obtained.

The following table exhibits the results of the recruitment process.

Table 1: Recruitment process

	Attendees	Average attendance	People who sign the informed consent	
First phase (50 sessions)	919	18	729	79,3%
Second phase (10 sessions)	730	73	451	61,8%
Total	**1.648**	**27**	**1.183**	**71,8%**

To better understand the context of the potential participants, it was considered appropriate to collect the reasons for refusal to attend the information session or to participate in the pilot. However, it was not possible to collect this information for all the people attended by telephone, through the project's email, or in situ at the information sessions. Even so, the project collected the reasons of refusal for a total of 1,191 people (21.8% of the total of 5,472 people to be contacted).

Table 2: Reasons for refusal to attend the briefing or participate in the pilot

	No. of people	%
Currently working	225	18,9%
Disability or illness that does not allow you to work	205	17,2%
Not interested or other personal reasons	102	8,6%
Other	96	8,1%
Live outside Barcelona or will move outside Barcelona	91	7,6%
Take care of other family members	88	7,4%
Incompatibility of schedules	87	7,3%
Holiday, travelling, is outside of Barcelona	79	6,6%
He has appointments with a doctor, social services, courts, etc.	54	4,5%
COVID	36	3,0%
Perform other social and labor insertion programs	36	3,0%
Close to 65 years of age and retire or have already retired	28	2,4%

	No. of people	%
Attend other trainings	24	2,0%
Pregnant/newly mothered	15	1,3%
Studies	13	1,1%
Not recipient of MIS	12	1,0%
Total	**1.191**	**100,0%**

As observed, out of the initially planned sample of 2,000 participants, only 1,183 provided informed consent. Consequently, since the City Council had planned 1,000 vacancies for the treatment group, the Barcelona City Council together with the Ministry of Inclusion, Social Security and Migration and the research team of CEMFI and the Metròpoli Institute, decided to modify the proportion of participants randomly assigned to each treatment group. As a result, 63% (750 participants) of those who signed up were assigned to the treatment group, while the remaining 37 (433 participants) were assigned to the control group.

With the aim of filling the remaining 250 vacancies in the treatment group, the Barcelona City Council conducted a second round of recruitment in November 2022. The group of beneficiaries of this second round of recruitment is not part of this impact evaluation, although their incorporation served to evaluate the usefulness of the project's informative messages to incorporate into the project, using a RCT methodology.[20]

Characteristics of the final evaluation sample

Table 3 reports the descriptive statistics of the variables related to the intervention, according to the information available in the administrative data of the participants, the baseline survey, and information collected in the information session. The table has six columns: the variable name, the number of observations, the mean, the standard deviation, the minimum value, and the maximum value. The information is not complete for all variables because some participants did not respond to the first survey.

In total, 1,183 people participated in the project, with 63% of the participants randomly assigned to the treatment group and the rest to the control group. Of the total number of participants, 64% are women and 78% were registered with the Barcelona Social Care System (SIAS) before the program. The average age was 47.76 years old. Only 21% are married or in a common law partnership, while 51% of the sample is single and 26% are separated or divorced. On average, the number of household members in the sample is 2.81. Participants have between 0 to 5 children in the household, with an average of 0.88 children per participant (0.08 children under 4 years of age). 34% of the participants were born in Spain and 63% have Spanish nationality.

[20] Inclusion Policies Lab: Evaluation Results. Barcelona City Council – Social Accompaniment and Adherence to Inclusion Itineraries Project. "AMUNT!" Program

In terms of educational levels, 24% of the sample has an educational level of primary education or less, 31% have completed compulsory secondary education, 13% have completed post-compulsory secondary education, and 17% have secondary education in vocational training. Finally, 15% have university studies. 24% of the sample reported some degree of disability or incapacitation, of which 18.43% reported having this medically recognized disability, with an average disability among them of 44.98%.

Finally, almost all participants conducted the surveys in Spanish (86.6%) or Catalan (13.4%). The interviewers reported, on average, a high level of comprehension of the language in which the survey was conducted. The variable includes on a scale of 1 to 5 the level of understanding of the participant of the survey accomplished, as well as the language in which the survey has been performed according to the interviewer's assessment, where 1 is not at all and 5 is high. The average value of the scale in the sample is 4.36 for the level of comprehension of the survey and 4.47 for the level of comprehension of the language (4.40 and 4.87 in the surveys implemented in Spanish and Catalan, respectively).

Table 3 shows the values of the outcome indicators measured before the start of the intervention.

In the workplace, this study evaluates the employment status at the time of the survey (baseline survey data). On average, 18% of the sample reported having a job during the survey period. Additionally, three indicators from the Social Security General Treasury's work history records between January 1 and September 30, 2022, are included: a binary variable indicating whether the beneficiary worked at least one day during this period, the number of days worked, and the number of full-time equivalent days worked. According to the Social Security records, 27% of the sample worked at least one day during the reference period, with an average of 45.63 days worked. The range of this variable in the sample varies from 0 to 273 days. On average, the full-time equivalent days worked amounted to 30.17 days.

The next indicator is an index that shows the perception of employability by the participants (Llinares-Insa et al. 2018), which is constructed with data from the individual survey. This index, like the rest of the composite outcome indices used in this assessment, has been constructed using the method proposed by Anderson (2008). This method aggregates information from a set of variables that attempt to measure a common latent variable. Intuitively, the method calculates a weighted average of all the variables, where the weight assigned to each of them depends on how correlated it is with the others (the lower the correlation, the greater the weight). Because it does not have natural measurements, the standardized indicator has been used to have a null mean and unit variance, which allows a better interpretation of the data. The rest of the indices are intended to measure the following constructs: satisfaction with life, mental health, social relationships.

The next indicator is a variable that captures the participant's self-perceived state of health. The variable takes values between 1 and 6, where 1 indicates an extremely poor state of health and 6, an excellent state of health. The average value for the sample is 3.70. The next indicator measures emotional well-being based on how the participant has felt in the past two weeks, adding eight questions, using Anderson's (2008) method. Regarding the social relationships' indicator, it takes a

value equal to one when the participant reports having participated in some proximity activity in his or her neighborhood, like visiting the library, neighborhood center, or civic center. On average, 40% of the sample engaged in such activities before the intervention. Finally, the trust in social services indicator measures whether interviewees perceive Barcelona City Council's social services as effectively addressing their problems or needs. This variable ranges from 1 (strongly disagree) to 5 (strongly agree), with the sample averaging a score of 3.7.

Table 3: Descriptive statistics of the sample

Variable	Obs.	Mean	Standard deviation	Minimum	Maximum
Treatment	1,183	0.63	0.48	0.00	1.00
Sociodemographic characteristics					
Woman	1,150	0.64	0.48	0.00	1.00
SIAS	1,183	0.78	0.42	0.00	1.00
Age	1,148	47.76	10.01	18.00	66.00
Married or in a common law partnership	1,140	0.21	0.41	0.00	1.00
Single	1,140	0.51	0.50	0.00	1.00
Separated or divorced	1,140	0.26	0.44	0.00	1.00
Widow or widower	1,140	0.02	0.14	0.00	1.00
Born in Spain	1,178	0.34	0.47	0.00	1.00
Spanish nationality	1,170	0.61	0.49	0.00	1.00
Primary education or less	1,121	0.24	0.43	0.00	1.00
Compulsory secondary education	1,121	0.31	0.46	0.00	1.00
Post-compulsory secondary education	1,121	0.13	0.34	0.00	1.00
Vocational secondary education	1,121	0.17	0.37	0.00	1.00
University studies	1,121	0.15	0.36	0.00	1.00
Household Members	1,058	2.81	1.48	1.00	9.00
Number of children in the household	1,058	0.88	1.13	0.00	5.00
Number of children under 4 years of age in the household	1,058	0.08	0.30	0.00	2.00
Disability	1,053	0.24	0.43	0.00	1.00
Percentage of disability	190	44.98	14.85	2.00	85.00
Understanding the survey					
Survey language: Spanish or Catalan	1,183	0.89	0.31	0.00	1.00
Level of Survey Understanding	1,058	4.36	0.98	1.00	5.00
Level of language comprehension	1,058	4.47	1.01	1.00	5.00

Variable	Obs.	Mean	Standard deviation	Minimum	Maximum
Indices and outcome variables					
Salaried or self-employed	1,055	0.18	0.39	0.00	1.00
At least one day of work	1,092	0.27	0.45	0.00	1.00
Number of days worked	1,092	45.63	92.16	0.00	273.00
Number of full-time equivalent days	1,092	30.17	67.22	0.00	273.00
Employability index (EAS scale)	933	0.00	1.00	-2.34	2.97
Life Satisfaction Index	920	0.00	1.00	-3.25	1.66
Self-reported health status	1,056	3.70	1.13	1.00	6.00
Mental Health Index	987	0.00	1.00	-2.93	1.72
Community Engagement	1,056	0.40	0.49	0.00	1.00
Social Relationship Index	1,048	0.00	1.00	-2.81	2.11
Trust in social services	1,015	3.70	1.07	1.00	5.00

4.2 Random Assignment Results

The study performed the random assignment at individual level, stratifying by the following information: (i) registration in the Barcelona Social Care System (in Spanish, SIAS) before the program; (ii) long-term unemployment; (iii) gender; (iv) age group (under 25 years old, from 25 to 55 years old; and over 55 years old); and (v) education (compulsory studies not completed, and other studies).

Table 4: Aggregate results of random assignment

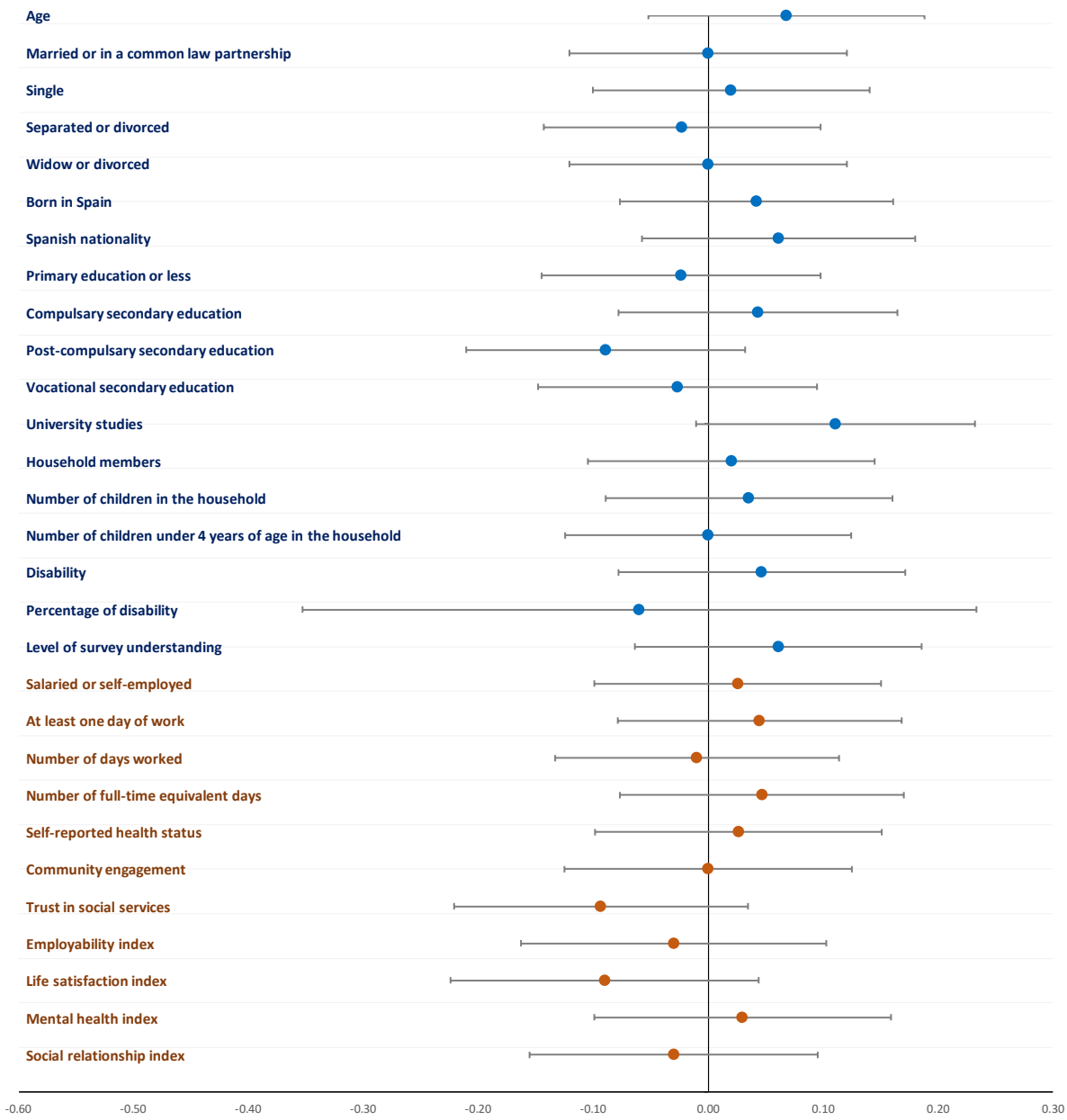
			People	
Sex	Age group	Strata	Treatment	Control
ND	ND	2	20	13
1. Man	ND	1	1	0
1. Man	1	8	12	3
1. Man	2	15	158	93
1. Man	3	13	92	53
2. Woman	ND	0	0	0
2. Woman	1	5	8	3
2. Woman	2	17	368	217
2. Woman	3	13	91	51
		74	750	433

To verify that the random assignment defines a statistically comparable control group and a treatment group, an equilibrium test is accomplished where it is verified that, on average, the observable characteristics of the participants in both groups are the same. The balance between the experimental groups is key to infer the causal effect of the project by comparing its results.

Figure 7 shows the results of the equilibrium contrasts between the control group and the treatment group (see the **Equilibrium Between the Experimental Groups** appendix for the values of the equilibrium contrast between the control and the treatment group). All the data reflected refer to the individual questionnaires given to the participants before and after the intervention, and with respect to administrative data from the Social Security on the Working Lives of the participants, and on the interventions implemented by the social services. For each observable variable, the difference between the mean of that variable in the treatment and control group is represented by a point and centered on it, the 95% confidence interval of this difference. A confidence interval containing zero, i.e., the vertical axis, will indicate that the mean difference between groups is not statistically significant, or in other words, it is not statistically different from zero. It will be concluded, therefore, that the intervention groups are balanced in this characteristic. In the case where the confidence interval of the mean difference does not contain zero, it can be concluded that the difference is statistically significant and, therefore, the groups are unbalanced in this characteristic.

Figure 7 exhibits that the treatment and control groups are not statistically different in all the variables analyzed, i.e., there is no unbalanced variable. The lack of significant differences reflects the absence of relevant imbalances between the experimental groups and therefore, the random assignment performed guarantees comparability between both groups, at least in the predetermined observable variables.

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



Note: Blue presents the default characteristics and level of understanding of the survey; the indices and outcome variables are shown in orange.

4.3 Degree of participation and attrition by groups

The group signing the informed consent form constitutes the experimental sample that was randomly assigned to the control and treatment groups. However, participation in the program and the responses to the initial and final surveys are voluntary. On the one hand, it is convenient to analyze the degree of participation in the program since the estimation of results will refer to the average

effects of offering it given the degree of participation. For example, if participation in treatment activities is low, the treatment and control groups will look-similar, and it will be harder to find an effect. On the other hand, this section checks whether the non-completion of the final survey by some of the participants reduces the comparability of the treatment and control groups after the intervention, in the event that the response rate is different between groups or according to the demographic characteristics of the participants in each group.

Degree of participation

The evaluation conducted the randomization process with 1,183 individuals who signed the informed consent, assigning 750 participants to the treatment group and 433 to the control group. Thus, a total of 1,182[21] individuals received some of the activities or services offered in the project, 749 people in the treatment group and 433 in the control group. In this sense, almost 79% of the participants in the treatment group received foster social care, where 40% received tracking. The following table shows the participation in each of the actions defined within the treatment group. **Table 5** also reports the percentage of participation with respect to the total number of participants in the treatment group, and regarding the total experimental sample.

Table 5: Percentage of participants who have received the activities and services offered within the AMUNT!

	Treatment Group	%	Control group	%	Total	%
TOTAL PARTICIPANTS	749				1,182	
Social care						
Welcome	588	78.5%	0	0	588	49.7%
Accompaniment	54	7.2%	0	0	54	4.6%
Tracking	298	39.8%	0	0	298	25.2%
Group	114	15.2%	0	0	114	9.6%
Collective advice	31	4.1%	0	0	31	2.6%
Community action						
Groups	127	17.0%	0	0	127	10.7%
Leadership	14	1.9%	0	0	14	1.2%
Labor						
Welcome	502	67.0%	0	0	502	42.5%
Tracking	205	27.4%	0	0	205	17.3%
Group actions	178	23.8%	0	0	178	15.1%
Job interviews	47	6.3%	0	0	47	4.0%
Employment contracts	21	2.8%	0	0	21	1.8%
Employment Plan – Interview	71	9.5%	0	0	71	6.0%

[21] One less person is found than in the random assignment

	Treatment Group	%	Control group	%	Total	%
Employment Plan – Hiring	73	9.7%	0	0	73	6.2%
Employment Plan – Completion of probationary period	70	9.3%	0	0	70	5.9%
Occupation Plan – Training	66	8.8%	0	0	66	5.6%
Occupation Plan – Entrepreneurship start	17	2.3%	0	0	17	1.4%
Occupation Plan – Consolidation Entrepreneurship	13	1.7%	0	0	13	1.1%
Training-digital literacy						
Beginning	57	7.6%	0	0	57	4.8%
Certification	33	4.4%	0	0	33	2.8%
Additional course start	19	2.5%	0	0	19	1.6%
Additional Certification Course	9	1.2%	0	0	9	0.8%
ICT bootcamp training						
Starts	10	1.3%	0	0	10	0.8%
Ends	8	1.1%	0	0	8	0.7%
Formation						
Language level test	80	10.7%	0	0	80	6.8%
Language course start	79	10.5%	0	0	79	6.7%
Language Certification Course	45	6.0%	0	0	45	3.8%
Occupational	78	10.4%	0	0	78	6.6%
Occupational Certification	63	8.4%	0	0	63	5.3%
Accreditation of competencies	73	9.7%	0	0	73	6.2%
Preparation for post-compulsory studies	3	0.4%	0	0	3	0.3%
Economic education	80	10.7%	0	0	80	6.8%

On the other hand, **Table 6** shows the percentage of participants who received the standard support and accompaniment offered by Barcelona City Council. Thus, both participants in the treatment group and the control group perceived standard support programs, in fact, 47% of the participants in the experimental sample perceived standard social care services (49% of the participants in the treatment group and 44% of the participants in the control group).

Table 6: Percentage of participants who have received the activities and services offered within the standard programs

	Treatment Group	%	Control group	%	Total	%
Standard work program	4	0,5%	19	4,4%	23	1,9%
Social care services	366	48,9%	189	43,6%	555	47,0%
Labor						
Occupancy plans	6	0,8%	6	1,4%	12	1,0%
Entrepreneurship plan	47	6,3%	8	1,8%	55	4,7%
Employability programs	52	6,9%	37	8,5%	89	7,5%
Formation						
Digital Literacy	8	1,1%	5	1,2%	13	1,1%
ICT Courses	11	1,5%	7	1,6%	18	1,5%
Professional	11	1,5%	14	3,2%	25	2,1%
Language courses home	18	2,4%	10	2,3%	28	2,4%
Courses start certification	18	2,4%	10	2,3%	28	2,4%
Occupational Home	0	0,0%	0	0,0%	0	0,0%
Occupational Certification	0	0,0%	0	0,0%	0	0,0%
Preparation for post-compulsory studies	2	0,3%	0	0,0%	2	0,2%

Attrition by groups

Table 7 yields the total number of participants registered in the evaluation, those who signed the informed consent. Of the 750 people assigned to the treatment group, 218 (29.07%) dropped out of the project. There is no record of the control group leaving the project, nor is there any information about one individual in the treatment group.

Regarding the survey response rates, out of the 1,183 participants, 71.17% completed the final individual questionnaire (64.2% in the control group and 75.2% in the treatment group). Additionally, we obtained a total of 1,092 working life records (92.31%), with 393 from the control group (90.76%) and 699 from the treatment group (93.2%). Therefore, the attrition rate for questionnaire responses was 35.8% in the treatment group and 24.8% in the control group. Regarding the working life records, attrition rates were 9.24% and 6.8% for the treatment and control groups, respectively.

Table 7: Program dropout and final online data availability

	(1) Drop out of the program		(2) Participates in the survey		(3) Availability of working life records	
	Total	Percentage	Total	Percentage	Total	Percentage
Control						
No	0	0	155	35.8	40	9.24
Yes	0	0	278	64.2	393	90.76
Total	433	100	433	100	433	100
Treatment						
No	531	70.8	186	24.8	51	6.8
Yes	218	29.07	564	75.2	699	93.2
Total	750[22]	100	750	100	750	100
Total						
No	531	44.89	341	28.83	91	7.69
Yes	218	18.43	842	71.17	1,092	92.31
Total	1,183	100	1,183	100	1,183	100

To measure whether participation rates in the final surveys are statistically different between the control group and the treatment group, **Table 8** reports the results of linear regressions where the dependent variables are binary variables equal to one if participant data is missing for the primary sources of the outcome data we used in the report: the final individual survey (column 1), and the Social Security working life record (column 2). The independent variable is a binary variable equal to one for assignment to the treatment group. In column 1, the project observes that the participation rate in the final survey is 11 percentage points higher in the treatment group than in the control group, where this difference is significant at 1%. Finally, there are no statistically significant differences in the availability of working history data between the treatment group and the control group.

Table 8: Survey participation by treatment Group

	Participate in the survey	Availability of working life records
	(1)	(2)
Treatment	0.111***	0.025
	(0.028)	(0.017)
Observations	1,183	1,183

[22] The total contains the information of all the people assigned to the treatment group, including the person for whom there is no information about leaving the project.

	Participate in the survey	Availability of working life records
	(1)	(2)
R^2	0.095	0.094
Media Control	0.642	0.908
Controls	No	No
Strata	Yes	Yes

Note: Significance levels * p<0.1, ** p<0.05, and *** p< 0.01. Robust standard errors in parentheses.

Table 9 increases the linear regressions of the previous table by adding interactions between the treatment indicator and predetermined characteristics of the participants, to analyze whether the treatment has a differential effect on the attrition rate in any of these variables (age, gender, level of education, being registered in SIAS, and employment status in the last 6 months), for these cases where we observe a statistically significant attrition between control and treatment groups. This report does not observe that this is the case, at least at 10% of significance.

Table 9: Survey participation by treatment group: heterogeneous effects

	Participation in the survey				
	(1)	(2)	(3)	(4)	(5)
Treatment	0.066 (0.139)	0.115** (0.049)	0.109*** (0.039)	0.046 (0.061)	0.085** (0.033)
Treatment x Age	0.001 (0.003)				
Treatment x Woman		0.013 (0.06)			
Treatment x Advanced studies			0.043 (0.057)		
Treatment x SIAS				0.082 (0.069)	
Treatment x Work last 6 months					0.104 (0.088)
Observations	1,148	1,150	1,121	1,183	973
R^2	0.018	0.02	0.021	0.022	0.014
Media Control	0.633	0.633	0.632	0.642	0.652
Treatment + Treatment x X1	0.07 (0.14)		0,15*** (0.04)	0.13*** (0.03)	0.19** (0.08)

Note: Significance levels * p<0.1, ** p<0.05, and *** p< 0.01. Robust standard errors in parentheses.

5 Evaluation results

The random assignment of the experimental sample to the control and treatment groups ensures that, with a sufficiently large sample, the groups are statistically comparable, and therefore any difference observed after the intervention can be causally associated with the treatment. Econometric analysis essentially provides this comparison. However, it has the advantages of allowing the inclusion of other variables to gain precision in the estimates and of providing confidence intervals for the estimates. In this section, we present the econometric analysis conducted, the estimated regressions, and the analysis of the results obtained.

5.1 Description of Econometric Analysis: Estimated Regressions

The regression model used to estimate the causal effect of an intervention in a Randomized Controlled Trial (RCT) estimates the difference between the average outcome value for the control group and the treatment group. This difference 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. **Table 19** shows that the observed characteristics, for which we have information, are balanced on average for the control group and for the treatment group, therefore, the difference between the average value of the outcome of the groups would capture the mean effect of the intervention. To increase the accuracy of the estimators, we will present the results with two specifications.

The main specification is as follows:

$$Y_{i,t=1} = \alpha + \beta T_i + \delta X_i + \varepsilon_i$$

where $Y_{i,t=1}$ is the dependent variable of interest observed after the intervention for person *i*, T_i is a binary variable that captures whether the person has been assigned to the treatment (=1) or the control group (=0). X_i is a vector that includes the stratification variables and ε_i is the error term robust to heteroskedasticity[23].

The second specification presented is the extension of the previous model by including the lagged value of the dependent variable ($Y_{i,t=0}$), with the aim of reducing standard errors and addressing selection bias in the final survey response:

$$Y_{i,t=1} = \alpha + \beta T_i + \delta X_i + \gamma Y_{i,t=0} + \varepsilon_i$$

[23] An alternative specification has also been estimated that includes as controls the standard social service programs to which both the control group and the treatment group had access. The results are very similar, except for some reduced standard errors in several of the regressions, but without a substantial change that leads to conclusions different from those drawn in this report.

In cases where the lagging value is not available, a binary variable equal to one will be included indicating it and the value of $Y_{i,t=0}$ will be replaced with the value zero. For all specifications, linear regressions are estimated regardless of whether the results are continuous or discrete.

5.2 Analysis of the results

5.2.1 Primary and secondary outcomes

This section presents the results of the assessment on the pre-specified indicators. All variables constructed with composite indices are standardized so that they have a mean equal to zero and a standard deviation equal to one. This allows all regression coefficients to be interpreted in terms of standard deviations, which is useful for comparing the size of effects in different domains.

For each dependent variable, the results of the regressions are reported in two columns. The first column shows the uncontrolled results by the value of the dependent variable before the intervention, and the second adds the lagged value as a control to the regression (ANCOVA).

1. Social Services take-up

Table 10 presents the results of the project on the participation rate in the Barcelona City Council's social services programs. Indeed, the control group has also access to these programs. This project distinguishes between programs in the workplace (Làbora program), social care, and training. Treatment allocation did not significantly increase participation in Barcelona City Council's standard programs, apart from social care programs, where the participation rate for the treatment group was 5.4 percentage points higher (significant 10%) than the control group. Considering the aggregate participation rate, this study observes a slightly larger effect; treatment resulted in a 6.8 percentage point increase in the participation rate in the set of standard social services programs compared to the control group, with this increase being statistically significant to 5%.

Table 10: Take-up

	Working take-up (1)	Social care take-up (2)	Training take-up (3)	Aggregate take-up (4)
Treatment	-0.001	0.054*	-0.022	0.068**
	(0.022)	(0.03)	(0.016)	(0.03)
Observations	1,182	1,182	1,182	1,183
R^2	0.064	0.127	0.085	0.127
Media control	0.139	0.436	0.079	0.508
Controls	No	No	No	No
Strata	Yes	Yes	Yes	Yes

Note: Significance levels * p<0.1, ** p<0.05, and *** p< 0.01. Robust standard errors in parentheses.

2. Labor market: occupation and employability

Table 11 shows the results of the intervention on employment and employability indicators. The first indicator is taken from the individual survey and captures the employment status at the time of the final survey (columns 1 and 2). The following indicators are taken from the register of the General Treasury of the Social Security and refer to the employment situation of the participant from October 1 to December 31, 2023, specifically the labor participation rate (columns 3 and 4), the number of days worked (columns 5 and 6), and the number of full-time equivalent days worked (columns 7 and 8). The last two columns (9 and 10) report the results on the employability index. No statistically significant effects are observed for any of the occupancy indicators. Nor are there any improvements in the employability index.

Table 11: Effects on work situation and employability

	Worker (survey)		At least one day of work		Number of days worked		Full equivalent number of days		Employability index (EAS scale)	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
Treatment	0.036	0.032	0.005	-0.009	-0.176	0.031	0.896	0.071	0.068	0.090
	(0.029)	(0.027)	(0.026)	(0.023)	(2.13)	(1.845)	(1.746)	(1.488)	(0.077)	(0.068)
Observations	840	840	1,092	1,092	1,092	1,092	1,092	1,092	775	775
R^2	0.29	0.385	0.238	0.408	0.246	0.45	0.201	0.425	0.149	0.296
Media control	0.237	0.237	0.275	0.275	21.539	21.539	15.055	15.055	-0.017	-0.017
Strata	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ancova	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes

Note: Significance levels * p<0.1, ** p<0.05, and *** p< 0.01. Robust standard errors in parentheses.

3. Well-being

Table 12 reports the results on the indicators that capture improvements in well-being. Columns (1) and (2) show the effect of the program on the life satisfaction index, columns (3) and (4) show the results on the mental health index, and columns (5) and (6) show the results on the self-reported health indicator. In general, positive results are observed in all outcome indicators, but the coefficients are not statistically significant at 10%, except for the mental health index. In this indicator, remarkable results are found at 10% in the specification in which the lagging value of the dependent variable is not included.

Table 12: Effects on well-being

	Life satisfaction index		Mental Health Index		Self-reported health status	
	(1)	(2)	(3)	(4)	(5)	(6)
Treatment	0.109	0.091	0.147*	0.075	0.092	0.05
	(0.082)	(0.073)	(0.078)	(0.0699)	(0.078)	(0.066)

	Life satisfaction index		Mental Health Index		Self-reported health status	
	(1)	(2)	(3)	(4)	(5)	(6)
Observations	722	722	797	797	841	841
R^2	0.141	0.321	0.076	0.283	0.134	0.353
Media control	-0.065	-0.065	-0.089	-0.089	3.504	3.504
Strata	Yes	Yes	Yes	Yes	Yes	Yes
Ancova	No	Yes	No	Yes	No	Yes

Note: Significance levels * p<0.1, ** p<0.05, and *** p< 0.01. Robust standard errors in parentheses.

4. Social inclusion and community participation

Table 13 presents the findings of the project regarding indicators that measure the social and community inclusion of participants. Specifically, it examines the project's impact on the frequency of participant interactions with family and friends (columns 1 and 2), a binary variable indicating participation in community activities over the past year (columns 3 and 4), and whether the project enhanced participants' perception of social services (columns 5 and 6). The analysis reveals no statistically significant effects on any of these indicators.

Table 13: Effects on social relationships, community participation, and trust in social services

	Social Relations Index		Community Engagement		Trust social services	
	(1)	(2)	(3)	(4)	(5)	(6)
Treatment	0.016	0.031	0.028	0.02	-0.023	0.001
	(0.075)	(0.054)	(0.038)	(0.035)	(0.089)	(0.08)
Observations	821	821	842	842	812	812
R^2	0.107	0.477	0.059	0.212	0.065	0.256
Media control	-0.018	-0.018	0.435	0.435	3.544	3.544
Strata	Yes	Yes	Yes	Yes	Yes	Yes
Ancova	No	Yes	No	Yes	No	Yes

Note: Significance levels * p<0.1, ** p<0.05, and *** p< 0.01. Robust standard errors in parentheses.

5.2.2 Heterogeneity analysis

This section presents analyses of heterogeneity of effects according to participant characteristics. Specifically, it is analyzed whether the effects are different by gender, by being registered in SIAS before the intervention, by age, by level of education, and by nationality. To accomplish this, the study conducted regressions similar to those in the preceding section, incorporating the variable requiring estimation of heterogeneous effects and its interaction with the treatment variables. The specified model is outlined as follows:

$$Y_{i,t=1} = \alpha + \beta T_i + \gamma T_i * Z_i + \delta X_i + \varepsilon_i$$

where Z_i is the binary variable that captures the characteristic on which the heterogeneous effect of receiving the treatment is analyzed (included in X_i). The coefficient of interest in this case is the one that corresponds to the interaction between the treatment and the binary variable Z_i.

Table 14 displays the heterogeneous effects in the main indicators of each area by gender. In general, this study does not observe any gender-heterogeneous effects. When comparing the group of women assigned to the treatment group with the group of women assigned to the control group (p-contrast value in the lower panel of the table), a positive and statistically significant effect of 5% is observed on the participation rate in the standard programs of the City Council, and on the life satisfaction index.

Table 15 reports heterogeneous results for those participants who were registered in SIAS before the intervention. This evaluation observes heterogeneous effects in two areas: employability and community participation. With respect to the former, the treatment has an effect of 0.15 standard deviations in the employability index, statistically significant at 10%, With respect to the control group among those pre-registered in SIAS. However, there is no statistically significant effect of the treatment for those not previously registered. On the other hand, the treatment only has a statistically significant effect on participation in community activities among beneficiaries who were not previously registered in SIAS.

Table 14: Heterogeneous effects by sex

	Take-up	Number of days worked	Employability Index	Life satisfaction index	Mental Health Index	Self-reported health status	Social Relations Index	Community Engagement
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Treatment	0.039	-1.003	0.124	-0.066	0.117	0.003	0.138	0.046
	(0.05)	(2.884)	(0.109)	(0.122)	(0.119)	(0.116)	(0.101)	(0.058)
Treatment x Woman	0.04	0.464	-0.083	0.248	-0.031	0.095	-0.157	-0.039
	(0.063)	(3.757)	(0.14)	(0.153)	(0.144)	(0.141)	(0.12)	(0.073)
Observations	1,150	1,061	752	701	775	817	798	818
R^2	0.13	0.456	0.296	0.332	0.303	0.366	0.481	0.208
Media control	0.512	21.908	-0.008	-0.082	-0086	3.496	-0.014	0.436
Treatment + Treatment x Woman	0.08**	-0.54	0.04	0.18**	0.09	0.1	-0.02	0.01
	(0.04)	(2.42)	(0.09)	(0.09)	(0.08)	(0.08)	(0.06)	(0.04)
Strata	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ancova	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Note: Significance levels * p<0.1, ** p<0.05, and *** p< 0.01. Robust standard errors in parentheses.

Table 15: Heterogeneous effects of being registered in SIAS

	Take-up	Number of days worked	Employability Index	Life satisfaction index	Mental Health Index	Self-reported health status	Social Relations Index	Community Engagement
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Treatment	0.047	1.827	-0.151	-0.004	-0.052	0.155	0.156	0.139**
	(0.059)	(4.414)	(0.128)	(0.146)	(0.144)	(0.149)	(0.11)	(0.069)
Treatment x SIAS	0.027	-2.3	0.305**	0.12	0.161	-0.132	-0.157	-0.150*
	(0.068)	(4.851)	(0.15)	(0.168)	(0.163)	(0.166)	(0.126)	(0.08)
Observations	1,183	1,092	775	722	797	841	821	842
R^2	0.127	0.451	0.299	0.321	0.284	0.353	0.478	0.215
Media control	0.508	21.539	-0.017	-0.065	-0.089	3.504	-0.018	0.435
Treatment + Treatment x SIAS	0.07**	-0.47	0.15*	0.12	0.11	0.02	0	-0.01
	(0.03)	(2.01)	(0.08)	(0.08)	(0.08)	(0.07)	(0.06)	(0.04)
Strata	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ancova	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Note: Significance levels * p<0.1, ** p<0.05, and *** p< 0.01. Robust standard errors in parentheses.

Table 16 and **Table 17** present the heterogeneous effects by age and level of education. For the analysis by age, a binary variable is constructed that takes the value of one if the interviewee is over 55 years old. In terms of educational level, we analyzed the heterogeneous effects for those participants with at least completed secondary education. In general, we did not find significant heterogeneous effects for these two characteristics, except for community participation where treatment has a statistically significant effect with respect to the control group among those over 55 years of age and those with compulsory secondary education or higher.

Table 16: Heterogeneous effects by age group

	Take-up	Number of days worked	Employability Index	Life satisfaction index	Mental Health Index	Self-reported health status	Social Relations Index	Community Engagement
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Treatment	0.059*	-0.232	0.122	0.091	0.075	0.033	0.002	-0.021
	(0.035)	(2.225)	(0.078)	(0.087)	(0.078)	(0.077)	(0.062)	(0.041)
Treatment x Age 56-66	0.023	-1.988	-0.224	0.048	0.086	0.136	0.115	0.164**
	(0.069)	(3.964)	(0.161)	(0.161)	(0.16)	(0.14)	(0.129)	(0.079)
Observations	1,149	1,060	752	701	775	817	798	818
R^2	0.129	0.456	0.298	0.329	0.303	0.366	0.481	0.212
Media control	0.512	21.908	-0.008	-0.082	-0.086	3.496	-0.014	0.436
	0.08	-2.22	-0.1	0.14	0.16	0.17	0.12	0.14**

	Take-up	Number of days worked	Employability Index	Life satisfaction index	Mental Health Index	Self-reported health status	Social Relations Index	Community Engagement
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Treatment + Treatment x Age 55-66	(0.06)	(3.28)	(0.14)	(0.14)	(0.14)	(0.12)	(0.11)	(0.07)
Strata	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ancova	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Note: Significance levels * p<0.1, ** p<0.05, and *** p< 0.01. Robust standard errors in parentheses.

Table 17: Heterogeneous effects by level of education

	Take-up	Number of days worked	Employability Index	Life satisfaction index	Mental Health Index	Self-reported health status	Social Relations Index	Community Engagement
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Treatment	0.055	1.372	0.02	0.119	0.111	0.129	-0.005	-0.041
	(0.041)	(2.267)	(0.098)	(0.112)	(0.104)	(0.098)	(0.078)	(0.05)
Treatment x Age 56-66	0.029	-4.499	0.093	-0.057	-0.028	-0.143	0.046	0.125*
	(0.061)	(3.871)	(0.137)	(0.148)	(0.136)	(0.132)	(0.108)	(0.07)
Observations	1,121	1,037	736	686	757	798	779	799
R^2	0.119	0.446	0.291	0.316	0.3	0.352	0.484	0.209
Media control	0.508	21.769	0.005	-0.065	-0.076	3.51	0.005	0.437
Treatment + Treatment x X	0.08*	-3.13	0.11	0.06	0.08	-0.01	0.04	0.08*
	(0.04)	(3.14)	(0.1)	(0.1)	(0.09)	(0.09)	(0.07)	(0.05)
Strata	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ancova	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Note: Significance levels * p<0.1, ** p<0.05, and *** p< 0.01. Robust standard errors in parentheses.

Table 18 presents the heterogeneous effects by nationality. This report did not observe significant effects on most indicators; however, a positive and statistically significant effect of the treatment on the employability and life satisfaction index was detected among people with Spanish nationality, compared to those in the control group of the same nationality. In addition, a heterogeneous effect on the social relations index is identified: the program has a positive and statistically significant impact for people who do not have Spanish nationality compared to their control group. This effect is not observed among people of Spanish nationality.

Table 18: Heterogeneous effects by nationality

	Take-up	Number of days worked	Employability Index	Life satisfaction index	Mental Health Index	Self-reported health status	Social Relations Index	Community Engagement
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Treatment	0.072	0.26	-0.067	0.001	0.105	0.056	0.173*	0.001
	(0.048)	(2.756)	(0.123)	(0.12)	(0.119)	(0.109)	(0.09)	(0.059)
Treatment x Spanish Nationality	-0.008	-0.391	0.237	0.176	-0.033	0.011	-0.220*	0.037
	(0.062)	(3.653)	(0.149)	(0.153)	(0.145)	(0.139)	(0.118)	(0.073)
Observations	1,170	1,084	768	715	790	834	814	835
R^2	0.128	0.448	0.301	0.321	0.288	0.35	0.485	0.214
Media control	0.511	21.469	-0.013	-0.079	-0.093	3.495	-0.015	0.436
Treatment + Treatment x X	0.06	-0.13	0.17**	0.18*	0.07	0.07	-0.05	0.04
	(0.04)	(2.45)	(0.08)	(0.09)	(0.08)	(0.08)	(0.07)	(0.04)
Strata	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ancova	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Note: Significance levels * p<0.1, ** p<0.05, and *** p< 0.01. Robust standard errors in parentheses.

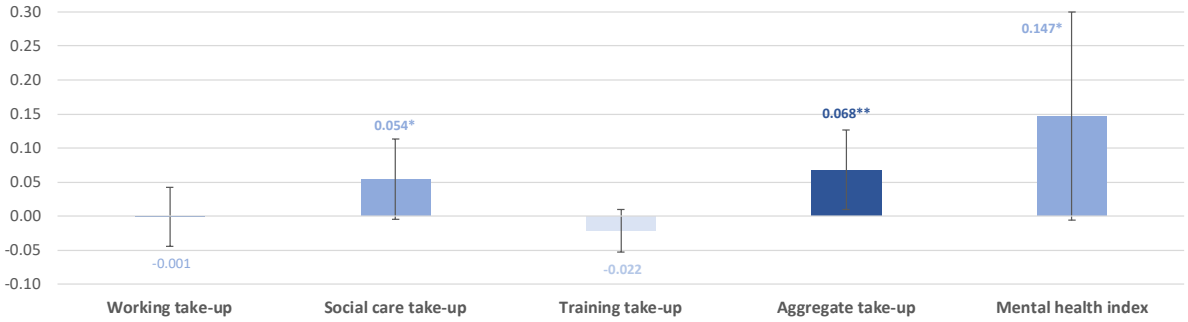
6 Conclusions of the evaluation

This project has evaluated a new integrated and personalized approach to labor and community inclusion, implemented by Barcelona City Council through a single office, and a continuous monitoring process. The office designs personalized itineraries for each participant, considering their individual characteristics and providing care, from a diverse team of professionals. The aim is to facilitate more direct and efficient access to active employment and community participation policies, adjusting to the specific needs of each person. The evaluation uses an experimental design with randomized assignment at the individual level to the treatment and control groups.

The one-stop approach and the accompaniment process have a positive and statistically significant effect on the adoption of the social and labor inclusion services that Barcelona City Council offers on a standard basis. This effect is mainly manifested in social care programs, while no significant improvements are observed in participation in work or training programs. This study did not detect any statistically significant effects of the treatment on the rest of the indicators, whether these were constructed with administrative data (in the workplace) or with data from individual surveys (employability, life satisfaction, social well-being, health, social relations, and community participation). However, the results indicate some improvement in the mental health of participants in the treatment group, although these results are not consistently significant.

The intervention has had some elements that may have conditioned the results and therefore have had an impact on the verification of the effects. These problems can be especially associated with the duration of the project and the recruitment process. The duration of the intervention was not what was initially planned, due to the extension of the recruitment period and the impossibility of modifying the time horizon for the completion of the project for regulatory reasons. Within the recruitment process, a certain lack of knowledge of the specific target group was revealed. of the project, missing possible previous studies that would specify the previous characteristics of this group.

Figure 8: Effect of the intervention on the key indicators



Note: dark blue shows the indicator related to aggregate *take-up*, significant at 5%; blue shows those indicators that are significant at 10% (*take-up* social care and mental health index); and light blue shows the non-significant indicators (*take-up* at work and *take-up* training).

This study observes some heterogeneous effects depending on the characteristics of the participants. The differences are slight and generally unsystematic, being observed only in some of the indicators analyzed. This could be due to the highly heterogeneous nature of the program, which offers a wide variety of activities in a personalized way, each with a possibly greater or lesser impact on the selected indicators. When calculating the average effect, this translates into an impact close to zero and not significant.

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Appendix

Economic and regulatory management

1. Introduction

Within the framework of the Recovery, Transformation and Resilience Plan, the General Secretariat for Inclusion and Social Welfare Objectives and Policies 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[24], contributed to meeting milestone 350 for the first quarter of 2022 as outlined in the Council's Implementing Decision[25]: "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[26], "at least 10 additional collaboration agreements signed with subnational public administrations, social partners

[24] 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.

[25] Revised ANNEX to the COUNCIL IMPLEMENTING DECISION amending the Council Implementing Decision (EU) (ST 10150/2021; ST 10150/2021 ADD 1 REV 1) of 13 July 2021 on the approval of the evaluation of Spain's recovery and resilience plan.

[26] 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.

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 monitoring indicator number 351.1 in the first quarter of 2023, linked to the Operational Arrangements document[27].

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

On **December 24, 2021**, Barcelona City Council was notified of the Resolution of the General Secretariat for Inclusion and Social Welfare Objectives and Policies granting a subsidy of €9,319,398.05 to the Area of Social Rights, Global Justice, Feminism and LGBTI of Barcelona City Council and, on December 28, 2021, an Agreement was signed between the General State Administration, through the General Secretariat for Inclusion and Social Welfare Objectives and Policies and the Area of Social Rights, Global Justice, Feminism and LGTBI of Barcelona City Council for the implementation of a project Social Inclusion Project within the framework of the Recovery Plan, Transformation and Resilience, which was published in the "Official State Gazette" on 1 February 2022 (BOE no. 27).[28]

2. Time frame of the intervention

Article 16(1) of Royal Decree 938/2021 of October 26, 2021, established that the deadline for the implementation of the social inclusion itinerary pilot covered by the subsidies provided for in this text shall not exceed the deadline of June 30, 2023, while the evaluation, shall not extend beyond March 31, 2024, in order to meet the milestones set by the Recovery, Transformation, and Resilience Plan with regard to social inclusion policies.

However, in accordance with section 2 of the first final provision of Royal Decree 378/2022, May 17, within the framework of the Recovery, Transformation and Resilience Plan, section 4 of article 6 and section 1 of article 16 is redrafted, to extend the maximum period of pilot projects of social inclusion itineraries subject to subsidy until **October 31, 2023,** maintaining the deadline **of March 31, 2024,** for its evaluation.

[27] 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.

[28] Resolution of January 21, 2022, of the General Secretariat for Inclusion and Social Welfare Objectives and Policies, publishing the Agreement with Barcelona City Council, for the implementation of a project for social inclusion within the framework of the Recovery, Transformation and Resilience Plan. It can be consulted at the following link: https://www.boe.es/diario_boe/txt.php?id=BOE-A-2022-1639.

On October 20, 2022, Barcelona City Council requested an extension of the execution period until September **30, 2023**, authorizing it by means of a resolution of the SGOPIPS dated October 25, 2022.

Within this general timeframe, the implementation begins on September 7, 2022, with the start of the intervention itinerary, continuing with the execution tasks until **September 30, 2022,** and then developing only dissemination and evaluation tasks of the project until **March 31, 2024**.

3. Relevant Agents

Among the relevant agents in the implementation of the project can be mentioned:

- Barcelona **City Council**, the beneficiary entity and coordinator of the project through:
    a) **Area of Social Rights, Global Justice, Feminism and LGTBI** of the Barcelona City Council.
    b) **Barcelona Activa**, in charge of developing municipal work experience and training in entrepreneurship and digital literacy.
    c) **The Barcelona Education Consortium** has developed training aimed at labor sectors, skills accreditation services and basic training.
    d) **The Municipal Institute of Social Services** has provided social care and support through the team of social technicians, psychologists and TSGs.

- **ECAS (Catalan Social Action Entities),** has been responsible for the deployment of labor inclusion actions (Làbora), developing labor guidance and accompaniment, and the ICT bootcamp.

- The **Ministry of Inclusion, Social Security and Migration (MISSM)** as the founder of the project, and as the main responsible for the RCT evaluation process. To this end, the General Secretariat for Inclusion and Social Welfare Objectives and Policies (MISSM) assumes the following commitments:
    a) 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 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 the RCT evaluation of the project.

Balance between experimental groups

Table 19 reports the balance test between the control group and the treatment group. All the data reflected in this table refer to the survey performed before the intervention (baseline) or to time-invariant variables. The mean value of each variable for each group is reported, as well as the number of observations and the p-value resulting from a contrast of mean difference (using Student's t-statistic, which is not reported for reasons of space). The lower the p-value, the more confidently one can reject the hypothesis that the mean of the variable in both groups is equal. For example, if the p-value is less than 0.05, the hypothesis of equality of means at a 5% confidence level can be rejected.

Table 19 exhibits that there are no statistically significant differences between the treatment and control groups. Therefore, this report concludes that there are no imbalances between the groups and that they are comparable, at least in the predetermined observable variables.

Table 19: Balance test between experimental groups

	Mean				Observations		
Variable	**Control**	**Treatment**	**Dif.**	**P-value**	**Total**	**Control**	**Treatment**
Age	47.33 (103.66)	48.01 (98.33)	0.68	0.31	1,148	420	728
Married or in a common law partnership	0.21 (0.17)	0.21 (0.16)	0	0.73	1,140	416	724
Single	0.5 (0.25)	0.51 (0.25)	0.01	0.66	1,140	416	724
Separated or divorced	0.27 (0.20)	0.26 (0.19)	-0.01	0.67	1,140	416	724
Widow or widower	0.02 (0.02)	0.02 (0.02)	0	0.45	1,140	416	724
Born in Spain	0.33 (0.22)	0.35 (0.23)	0.02	0.58	1,178	428	750
Spanish nationality	0.59 (0.24)	0.62 (0.24)	0.03	0.23	1,170	427	743
Primary education or less	0.24 (0.19)	0.23 (0.18)	-0.01	0.44	1,121	413	708
Compulsory secondary education	0.3 (0.21)	0.32 (0.22)	0.02	0.44	1,121	413	708
Post-compulsory secondary education	0.15 (0.13)	0.12 (0.10)	-0.03	0.21	1,121	413	708
Vocational secondary education	0.17 (0.14)	0.16 (0.14)	-0.01	0.79	1,121	413	708
University studies	0.13	0.17	0.04	0.13	1,121	413	708

Variable	Mean				Observations		
	Control	Treatment	Dif.	P-value	Total	Control	Treatment
	(0.12)	(0.14)					
Household Members	2.79 (2.05)	2.82 (2.27)	0.03	0.61	1,058	393	665
Number of children in the household	0.86 (1.19)	0.9 (1.32)	0.04	0.69	1,058	393	665
Number of children under 4 years of age in the household	0.08 (0.08)	0.08 (0.09)	0	0.93	1,058	393	665
Disability	0.23 (0.18)	0.25 (0.19)	0.02	0.83	1,053	392	661
Percentage of disability	45.53 (253.8)	44.64 (202.15)	-0.89	0.41	190	72	118
Level of Survey Understanding	4.32 (1.04)	4.38 (0.92)	0.06	0.24	1,058	393	665
Salaried or self-employed	0.18 (0.15)	0.19 (0.15)	0.01	0.45	1,055	392	663
At least one day of work	0.26 (0.19)	0.28 (0.20)	0.02	0.23	1,092	393	699
Number of days worked	46.2 (8.690.71)	45.31 (8.394.34)	-0.89	0.85	1,092	393	699
Number of full-time equivalent days	28.16 (4.154.08)	31.31 (4.726.73)	3.15	0.37	1,092	393	699
Self-reported health status	3.68 (1.27)	3.71 (1.29)	0.03	0.48	1,056	393	663
Community Engagement	0.4 (0.24)	0.4 (0.24)	0	0.96	1,056	392	664
Trust in social services	3.76 (1.14)	3.66 (1.16)	-0.1	0.18	1,015	368	647
Employability index (EAS scale)	0.02 (1.06)	-0.01 (0.96)	-0.03	0.66	933	347	586
Life Satisfaction Index	0.06 (0.83)	-0.03 (1.09)	-0.09	0.24	920	338	582
Mental Health Index	-0.02 (0.98)	0.01 (1.01)	0.03	0.37	987	363	624
Social Relationship Index	0.02 (0.93)	-0.01 (1.05)	-0.03	0.71	1,048	389	659

Note: robust standard errors in parentheses.
Significance levels: * p < 0.10, ** p < 0.05, *** p < 0.01.