# Inclusion Policy Lab: Evaluation results

## HOGAR SÍ: Personalized employment project for homeless people

***April 2024***

Financiado por la Unión Europea NextGenerationEU
MINISTERIO DE INCLUSIÓN, SEGURIDAD SOCIAL Y MIGRACIONES
Plan de Recuperación, Transformación y Resiliencia
HOGAR SÍ FUNDACIÓN RAIS
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The General Secretariat of Inclusion of the Ministry of Inclusion, Social Security, and Migration has prepared this report within the framework of the Inclusion Policy Lab as part of the Recovery, Transformation, and Resilience Plan (RTRP). It has been funded by the Next Generation EU funds. HOGAR SÍ has collaborated in the preparation of this report as the entity responsible for implementing the project. 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 CEMFI (Center for Monetary and Financial Studies) has substantially contributed to this study. Specifically, Miguel Almunia, professor at the University of CUNEF, has participated under the coordination of Mónica Martínez-Bravo (until January 8, 2024) and Samuel Bentolila, professors at CEMFI. The researchers have actively participated in all phases of the project, including the adaptation of the initial proposal to the needs of the evaluation through randomized experiments, the evaluation design, the definition of measurement instruments, data processing, and the performance of econometric estimations that lead to quantitative results.

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

This evaluation report has been produced using the data available at the time of its writing and is based on the knowledge acquired about the project up to that date. The researchers reserve the right to clarify, modify, or delve into the results presented in this report in future publications. These potential variations could be based on the availability of additional data, advances in evaluation methodologies, or the emergence of new information related to the project that may affect the interpretation of the results. The researcher is committed to continuing exploring and providing more accurate and updated results for the benefit of the scientific community and society in general.

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# Executive Summary

- The **Minimum Income Scheme,** established in May 2020, is a minimum income policy that aims to guarantee a minimum income to vulnerable groups and provide ways to promote their social and labor integration.
- Within the framework of this policy, the Ministry of Inclusion, Social Security and Migration (MISSM) fosters a strategy to promote inclusion through pilot projects of social innovation, which is 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 "Personalized employment project for homeless people", which has been conducted in **cooperation between the MISSM and HOGAR SÍ**, an organization of the Third Sector of Social Action dedicated to assisting homeless people.
- This study evaluates an **employment and personalized care intervention** compared to a standard intervention model. The **treatment group** received more intense care, with a higher number of support technicians per person. This enabled greater attention and more personalized interventions in terms of job guidance, training, and complementary support in housing, health, and administrative situations, among others. The **control group** received the generic services of vocational guidance and support.
- The project took place in **six cities** (A Coruña, Cartagena, Madrid, Murcia, Palma de Mallorca and Valencia) and involved 344 individuals (154 in the treatment group and 168 in the control group).
- On average, the project participants have been unemployed for more than two years and have almost 8 years of formal education. A quarter of the participants are women and 32% of them report mental health problems. Prior to the intervention, almost 70% of the participants were at a level below 3 on the ETHOS scale, which describes a residential situation without a roof over their heads (staying overnight in public spaces or shelters). This is like this because this group was prioritized for the project.
- The degree of follow-up of the participants in the support activities was 56% for the treatment group and 34% for the control group.
- The main findings of the evaluation are as follows:
    - **Treatment improves housing status:** the treatment group has stable accommodation for 5.5 weeks longer than the control group.
    - **Treatment improves quality of life:** the treatment increases self-perceived quality of life by 0.28 standard deviations.
    - **Improvement of employability:** people in the treatment group apply for 7.5 more job offers than those in the comparison group and apply for approximately 2 more selection processes.

- **Improved employability:** people in the treatment group worked 15 days more on average during the 6 months before the end of the intervention than people in the control group, according to the Social Security register of working lives.
- There are positive effects on the economic situation, although they are inaccurate and not significant.

# 1 Introduction

**General Regulatory Framework**

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

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

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

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

[1] Law 19/2021, of 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 entities, 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 entities, 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 if 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.

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

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

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

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

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 pathways.

This report refers to "Personalized employment project for homeless people", executed within the framework of Royal Decree 938/2021[9] by HOGAR SÍ (“Fundación Red de Apoyo a la Integración Sociolaboral”, RAIS), a Third Sector of Social Action entity, dedicated to the care of homeless people. This report contributes to the fulfillment of milestone 351 of the RTRP "Following the completion of at least 18 pilot projects, the publication of an evaluation on the coverage, effectiveness and success of the MIS, including recommendations to increase the level of application and improve the effectiveness of social inclusion policies".

[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 December 29, 2021, an Agreement was signed between the General State Administration, through the SGI and the RAIS Foundation 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 January 31, 2022 (BOE no. 26).

**Context of the project**

The phenomenon of homelessness, which according to the INE's Homelessness Survey[10] affected in 2022 more than 28,000[11] people in Spain, is determined by a multitude of social, economic and political factors, making it difficult to clearly define the concept. However, the European Federation of National Organizations Working with Homeless (FEANTSA) presents a standardized definition of homelessness: "those persons who are unable to access or maintain adequate accommodation, adapted to their personal situation, permanent and providing a stable living environment, either due to economic reasons, other social barriers, or because they face personal challenges in leading an independent life."

The causes leading to this situation are complex to delimit as they encompass various interconnected areas that feed into each other. People find themselves experiencing homelessness due to lacking employment or income, and this situation hinders their ability to secure employment. In addition, in most cases, physical and mental health problems aggravate this situation.

On the other hand, the lack of information hinders the measurement of this phenomenon at national level. In any case, the INE conducted the last Homeless Survey[12] in 2022, which shows a detailed analysis of the reality of these people.

In relation to the causes of homelessness, the INE survey identifies job loss as one of the main reasons why people turn in this situation[13].

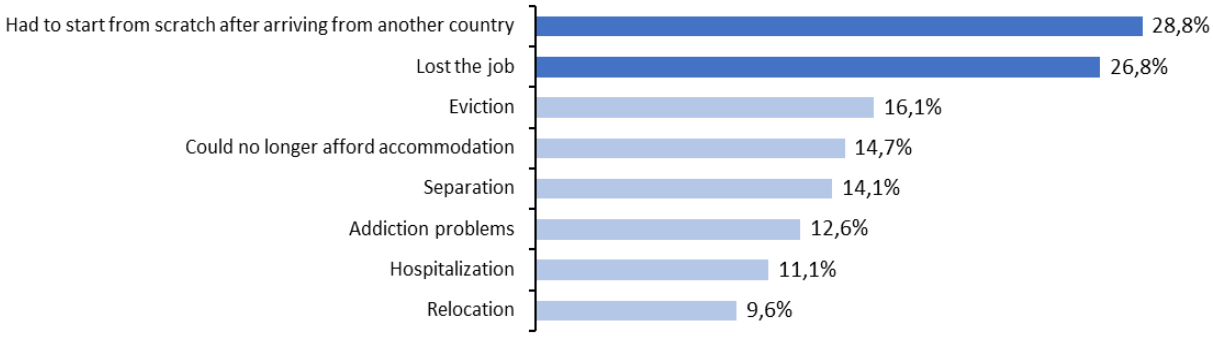
[10] INE survey of homeless people in Spain in 2022: https://www.ine.es/dyngs/INEbase/es/operacion.htm?c=Estadistica_C&cid=1254736176817&menu=ultiDatos&idp=1254735976608.

[11] According to published data, 28,552 people are experiencing homelessness in Spain (INE, 2022). However, this survey only considers users of the care system centers. Data on those who are homeless are usually obtained through night-time counts conducted individually by each municipality, so, according to HOGAR SÍ's calculations, the total number of people who are homeless could be 30% higher than that collected in this survey. This would mean that homelessness affects 37,117 people in our country.

[12] Regarding the reference population of the survey, they are homeless people, aged 18 or over, who go to centers that offer accommodation and/or catering services located in municipalities with more than 20,000 inhabitants. Therefore, it does not include the entire homeless population, as it does not include residents of municipalities with less than 20,000 inhabitants or those homeless people who do not go to the indicated centers.

[13] Survey of homeless people in Spain in 2022 by the INE.

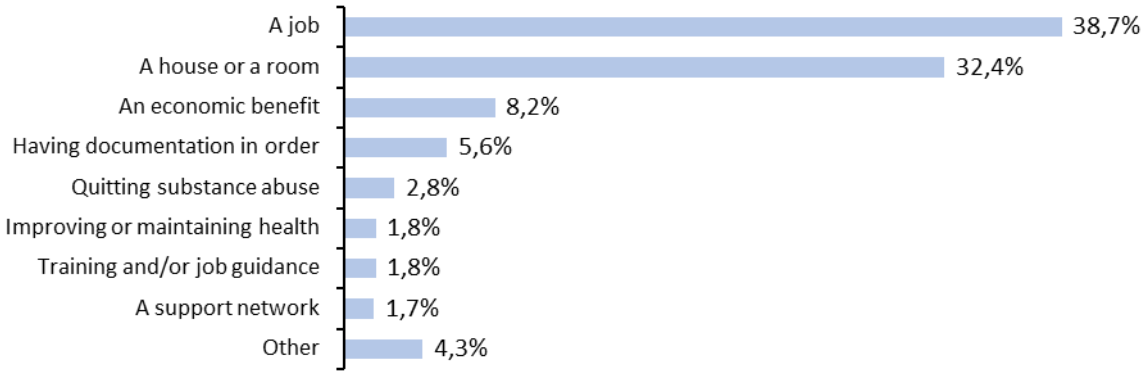
**Figure 1a: Reasons why people experience homelessness (%, 2022)**




Source: INE Survey of Homeless People in Spain 2022

As can be seen in **Figure 1b**, finding a job is the main factor that most people experiencing homelessness consider most necessary to get out of homelessness. Thus, 38.7% of the sample point to it in first place, followed by housing, 32.4%.

**Figure 1b: Main factor in exiting homelessness (% of respondents answering each of the following factors first)**




Note: 97% of the total of 28,552 people surveyed answered this question, so 722 answers have not been recorded.

Source: INE Survey of Homeless People in Spain 2022

In addition, it is noteworthy to highlight the chronic situation of the phenomenon, as it is a long-term event, where approximately 40% of homeless people in 2022 had been without accommodation for more than 3 years.

Social entities, such as HOGAR SÍ, point out that the problem of homelessness is complex and that there is no specific profile for this group. The only feature in common to all homeless people is the lack of housing. The problems and case of each person are very different and, therefore, a general response for all people experiencing homelessness is usually not effective. It is essential to create programs and actions customized to everyone. It is also important to have sufficient staff resources to be able to conduct optimal follow-up and support.

**Regulatory framework associated with the project and governance structure**

The European Pillar of Social Rights (EPSR) stands out at the European Union level and aims to establish the right to housing and offer support people experiencing homelessness, promoting the right to social assistance and protection that promotes their inclusion. In this regard, all Member States are committed to ending this phenomenon by 2030.

The European Parliament's resolution of 24 November 2020 is also remarkable, as it seeks to reduce the number of people experiencing homelessness in the European Union through integrated inclusion policies. Moreover, the Lisbon Declaration of June 21, 2021, presents the foundations of the European Platform to fight homelessness.

At national level, Spain presents a series of national laws and strategies focused on the eradication of this phenomenon, highlighting Law 12/2023, of May 24, 2023, on the right to housing, which aims to regulate and guarantee equal access to decent housing. The **National Strategy for the fight against homelessness in Spain 2023-2030** forms a national framework for the prevention and elimination of homelessness.

Furthermore, there are other state tools such as the National Strategy for Poverty and Social Exclusion Prevention and Combat (2019-2023); the State Plan for Access to Housing 2022-2025 (20 January 2022); the National Deinstitutionalization Strategy for Good Community Life (to be launched in 2024); as well as the Framework Agreement signed by the Government of Spain and the autonomous regions (2022) to address this problem within the Territorial Council of Social Services and the System.

The autonomous regions contemplate certain measures and policies to address the problem of homelessness, such as the regulation of regional minimum incomes with certain characteristics applicable to this specific group. In addition, there are regional and municipal plans to combat poverty and homelessness.

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

The pilot project of this report is aligned with European and national strategies in the field of homelessness, as well as with the 2030 Agenda for Sustainable Development, specifically contributing to SDGs 1, 8, 10, and 11.

Given the context of homelessness in Spain and considering that job loss is one of the main reasons why people experience homelessness, HOGAR SÍ proposes developing a personalized employment model with an intense interaction of support staff. This facilitates the autonomous exit from the specialized care system, through access to and stabilization in the labor market.

The scientific objective of the project is to evaluate the effectiveness and efficiency of this model in relation to other traditional employment models based on the development of pathways for labor insertion. In addition, this study intends to promote the transfer of knowledge to policymaking and to be accountable for the results of the project.

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

- **HOGAR SÍ** (RAIS Foundation), as the entity responsible for the execution of the project. Founded in 1998, it is a non-profit, independent, nationwide social initiative organization. Its primary mission lies in the combat against homelessness, addressing it as a problem that affects society. The organization is distinguished by its strong commitment to transparency, its innovative approach, and its support for empirical evidence as a key decision-making tool.

  HOGAR SÍ advocates for solutions from a rights-based perspective that address homelessness as a problem whose eradication requires changes and actions in the areas of housing, health, employment, security and social services.

  HOGAR SÍ's outstanding experience in assisting homeless people and its extensive collaboration with public institutions, private companies and the Third Sector of Social Action organizations, endorse its suitability as a partner for the execution of this project.

- The **Ministry of Inclusion, Social Security and Migration** (MISSM), as the funding source of the project and responsible for the RCT evaluation. For this reason, the General Secretariat of Inclusion assumes a series of commitments to HOGAR SÍ:
  - Provide the beneficiary organization with support for the design of the actions to be conducted, for the execution and monitoring of the object of the subsidy, as well as for the profiling of the potential participants of the pilot project.
  - Design the randomized controlled trial (RCT) methodology of the pilot project in coordination with the beneficiary organization and scientific partners. Also, conducting the evaluation of the project.
  - Ensure strict compliance with ethical considerations by obtaining the approval of 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.

In view of the above, the current report follows the following structure. **Section 2** provides a description of the project, detailing the issue to address, the specific interventions associated with each of the employment models implemented, and the target audience to which the intervention is directed. The objective is to present a diagnosis of the problems associated with homelessness that justifies the need to implement and evaluate this 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, the results of randomization, and the degree of participation and attrition of the intervention. This section is followed by **section 5,** where **the results of the evaluation** are presented, with a detailed analysis of the econometric analysis conducted and the results for each of the indicators used. Finally, the **conclusions** of the project evaluation are described

in **section 6**. Besides, in the **Economic and regulatory management** appendix additional information is provided regarding the 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 this evaluation on May 20, 2022.

# 2 Description of the program and its context

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

## 2.1 Introduction

This project evaluates a personalized employment model in the field of homelessness, which aims to facilitate the autonomous exit from the specialized care system, through access and stabilization in the labor market. This innovative program will be evaluated in relation to the traditional employment model, based on the development of labor inclusion pathways. In addition, the Ministry intends to promote the transfer of knowledge to the policymaking process and to learn about the results of the project.

The main areas of intervention of the itinerary are employment (key focus of the project); access to social services; health and care; and housing. The duration of the intervention ranged from 6 to 18 months.

The summary of different research conducted by Evans et al. (2019) stands out among the main empirical studies in the field of homelessness. This study offers a detailed view of the strategies that have been most effective in addressing homelessness in the United States using RCTs. Specifically, they highlight the importance of combining two actions: (i) housing aid as a way out of homelessness, thus prioritizing the residential situation over other social services; and (ii) comprehensive support to the individual to address the set of underlying causes of homelessness, such as lack of employment and income, mental health, or addictions.

In relation to housing assistance, the evidence is concentrated in the so-called "Housing First" programs[14], whose intervention strategy prioritizes providing stable housing immediately to people experiencing homelessness, without imposing economic or educational prerequisites. Numerous studies conducted in the United States (Kerman et al., 2018; Aubry et al., 2016; Basu et al., 2011; Tsemberis et al., 2004), Canada (Adair et al., 2017; Aubry et al., 2015), the United Kingdom (Blood et al., 2017; Bean, et al., 2013), Finland (ARA, 2019) or France (Lemonie et al., 2019) have shown that this approach improves the quality and stability of accommodation. Researchers have also documented significant benefits beyond housing, including reduced use of emergency and mental health services (Urbanoski et al., 2018; Stergiopoulos et al., 2016; Greenwood et al., 2005) or improved quality of life (Kozloff et al., 2016; Aubry et al., 2016). In addition, "Housing First" demonstrates greater

[14] This model emerged in New York (United States) in the early 1990s by psychologist Sam Tsemberis, author and main promoter of this approach (Sam Tsemberis et al., 2004 and Sam Tsemberis, 2010).

cost-effectiveness compared to traditional interventions that rely on temporary housing or conditional access to services (Adair et al., 2017, 2015).

In 2014, HOGAR SÍ launched, for the first time in Spain and in the absence of previous experiences, a pilot program called “Habitat” that adheres to the guidelines of the "Housing First" model (Panadero, S., Martín, J., & Martinez, J. L., 2022). Among the main successful results of the program, the level of retention and stability of the accommodation stand out, with 96% of the people who accessed the housing continuing in them after 18 months, thus confirming the evidence previously indicated in other countries.

The second pillar documented by empirical evidence is related to comprehensive support, where there is a greater diversity of results due to the multitude of actions implemented (financial or legal assistance, specialized training, permanent supportive housing, housing vouchers, etc.). This second area, related to comprehensive counseling for individuals, is specifically addressed in the program implemented by HOGAR SÍ within the evaluation project. This constitutes one of the first empirical evidence in Spain on the evaluation of comprehensive programs addressing homelessness using an RCT.

## 2.2 Target population and territorial scope

The target population are people experiencing homelessness who access HOGAR SÍ from different channels and who live in the cities of A Coruña, Cartagena, Madrid, Murcia, Palma de Mallorca and Valencia[15].

Participants access through referral organizations linked to social services and directly at the HOGAR SÍ[16] centers in the indicated cities: a technician from HOGAR SÍ verifies if they meet the established requirements. If they arrive by referral, the technical team first validates the requirements through the entry survey and, subsequently, the HOGAR SÍ technical team contacts the participants (by telephone or in person) to conduct a new validation of requirements and confirm their interest in participation. The requirements are as follows:

- **Economic income:** no regular economic income in the last 9 months.
- **Employment status:** not having worked more than 20% cumulatively in the last year.
- **Administrative status**: in possession of a work permit or renewable asylum red card, with work permit.
- **Language**: to have an adequate level of comprehension of Spanish.

[15] It has been conducted in these territories because the entity already had a presence and trajectory as an employment program in 5 of these cities and therefore it was more feasible to create the control group; only Palma de Mallorca began its activity in the field of employment with the Itineraries Project because it was a potential territory where HOGAR SÍ already had solutions to housing.

[16] The referring entities can be private or public (directly Social Services, Shelters of the Municipal Network of the Homeless, etc.). Private entities do not have to have a direct link with Social Services.

- **Age:** adults.
- **Residential status:** people who have been experiencing homelessness in the last 6 months (live in a public space and/or spend the night in a shelter and spend the rest of the day in a public space).

More details on the recruitment process are provided in **section 3.5** as part of the evaluation design.

## 2.3. Description of interventions

The impact of a personalized treatment compared to a traditional model is the main innovation to be evaluated. To implement the personalized treatment, an HOGAR SÍ technician develops an individual and personalized work plan, which includes specific support to overcome certain structural barriers such as residential stability during the job search process and the first weeks in employment. It also includes specific training in people's professional interests and specific help. The initial hypothesis is that this personalized treatment increases the possibility of accessing and maintaining employment for people affected by homelessness, compared to other traditional job placement treatments. The interventions designed within this program are based on (i) the design of job search activities, (ii) training for employment, and (iii) monitoring and support for job retention.

In this way, there are two interventions: the innovative personalized treatment program that offers a set of personalized and specific services aimed at labor insertion (treatment group) and the traditional model, which consists of the general support traditionally offered by HOGAR SÍ (control group).

The technical staff is predominantly a female team (85% are women) and most of them have university studies (85% of the team) related to the social sector or companies. The professionals were different between the control and experimental groups, only in the cases of Cartagena and Palma de Mallorca the prospecting technique was the same for both groups. At the beginning of the program, they had extensive experience: the average experience in intervention with homeless clients is 2 years for professionals in both the treatment group and the control group; the experience with people in social exclusion is significantly greater in those who have had participants in the control group (87 months on average, compared to 52 months for the experimental group). Regarding the functioning during the intervention, each participant was assigned to a technician, and they only changed in case of rotation or reinforcement of the team. The technicians assigned to the control group, the experimental group and the support have been accompanied by their responsible coordination, conducting a constant follow-up of the cases, in addition to supervision for compliance with each intervention methodology and the quality of the data.

The following are the different actions conducted in the traditional employment model (control group) and in the personalized employment model (treatment group):

| ***Methodological principles*** |
|---|

- **Traditional employment model (control group):** in traditional job search itineraries, support is provided within a structured process where individuals can participate in different predefined activities. The focus is on pre-employment aspects and labor market demands, with professional

guiding the process. People participate in activities like tutorials, training and group workshops. Regarding companies, the relationship is based on the capture of offers, sending applications and the management of non-work internships.

- **Personalized employment model (treatment group):** in this group, training and job search are conducted simultaneously, with the participant guiding their own process. The focus is on initial listening and relationship-building, and greater emphasis is placed on cross-cutting areas impacting employment (housing, health, administrative situation, etc.) through technical and financial support. The focus is not only on access but also on job retention and improvement, providing support in this regard. The relationship with companies is closer and more intensive, aiming to cover the interests of both parties and create or negotiate positions adapted to the individual, along with follow-up for job retention. The project offered job placement in insertion companies for 22 participants in this model.

## *Provision of the service*

### Phases

- **Traditional employment model (control group):** there is a defined itinerary with phases, time and established actions. The participant must adapt to this route.
- **Personalized employment model (treatment group):** it consists of a system of tailored and flexible support, which are activated or not based on the decisions and interests of the participant. Individuals design their own process, and the program adapts according to the decisions made by the clients.

### Technical support

- **Traditional employment model (control group):** the technical team designs a work itinerary with objectives, activities and set times. The support is based on carrying out the activities and monitoring the execution that is being conducted. The activities are career guidance tutorials, trainings, or group workshops. When the person enters the labor market, only occasional follow-ups are conducted.
- **Personalized employment model (treatment group):** the technical supports of personalized employment, although applying technical criteria, focus on people's interests in terms of both type and intensity. Any existing support in the program or community is activated. The technical support contemplates the following activities: tutoring and support for job guidance or transversal areas (housing, health, administrative situation, etc.), on-demand training, approach to companies, job prospecting, and job maintenance.

### Financial support

- **Traditional employment model (control group):** traditional itineraries include the possibility of receiving aid to cover public transportation costs for participating in defined training and support activities, along with scholarships for training attendance.

- **Personalized employment model (treatment group):** customized employment includes a wide range of financial support aimed at facilitating access, maintenance and improvement of employment. Among the supports included are housing, transportation, food, personal appearance, on-demand training, connectivity, and job equipment. In the case of placements in insertion companies, they include salary and associated rights.

### Training

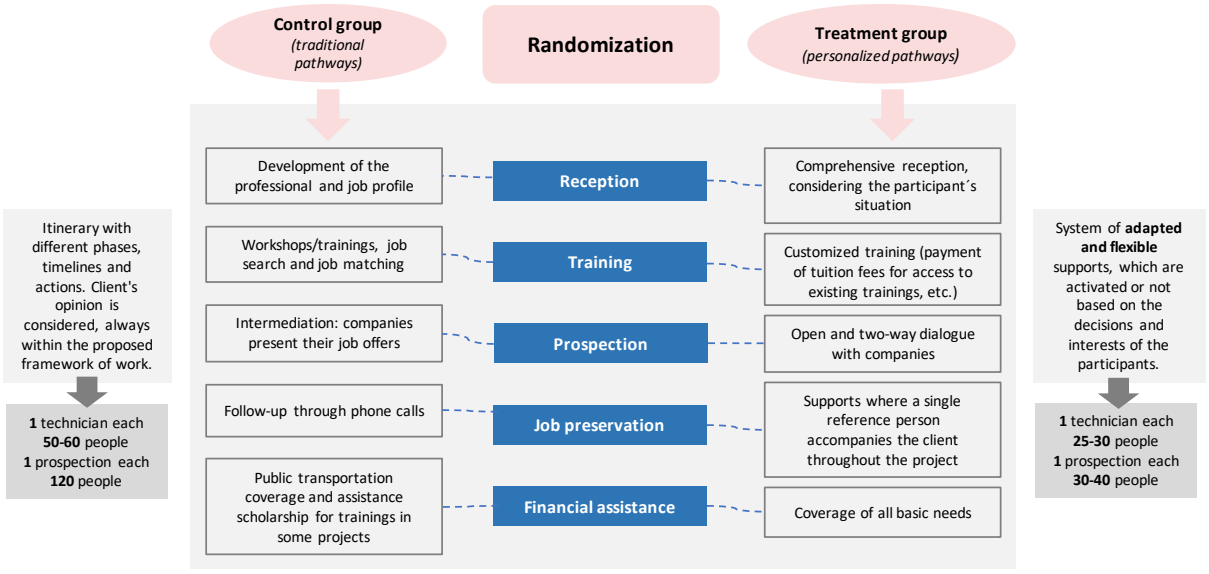
- **Traditional employment model (control group):** it is based on the development of predefined workshops and group trainings. The workshops are pre-employment or skills ones (socio-labor or digital) while the training address professional skills.
- **Personalized employment model (treatment group):** includes on-demand training based on each person's professional goal. The payment of tuition fees for access to training is facilitated.

### *Attention ratios*

- **Traditional employment model (control group):** there is one employment technician for every 45-55 people, and one prospecting technician for every 100 people. The ratio of the equipment prevents an intense intervention from being conducted.
- **Personalized employment model (treatment group):** there is one employment technician for every 20-25 people, and one prospecting technician for every 30-40 people. The intervention of both roles is much more intense, being able to delve into different aspects that impact employment.

The following figure shows the interventions conducted and the difference in the intervention between the two groups, the personalized treatment, and the traditional treatment group:

**Figure 2: Itinerary outline**



**Summary of the differences between personalized and traditional treatment**

The personalized model compared to the traditional one presents as its most notable differences the reduction in attention ratios for both the employment technician (25-30 in personalized; 45-55 in tradition) and the prospecting position (30-40 in personalized; 100 in traditional), besides the availability of flexible and tailored technical and financial support to the individual. The first type of support, which the traditional model also offers, is translated from the personalized model into a service where the client relationship is strengthened. In fact, participants and technicians build a relationship of trust from the beginning that allows detecting needs and above all strengths, which will lead to activate support from the program, or the community based on what the person requires, both in their process of accessing to employment and in the process of maintaining or improving it. These technical supports include those areas that may have an impact on employment (training, housing or administrative procedures, among others). Another differentiating aspect of the personalized methodology, not present in the traditional model, is the financial support. This support will help deactivate or minimize barriers to job access and maintenance in all those areas that impact employment.

The personalized model therefore includes comprehensive care, which without losing focus on employment or technical criteria, seeks to respond to any person in a situation of homelessness with interest and motivation to find work. It focuses on the person's strengths and on the quick access to employment if the client agrees. Unlike a traditional standard model and with the itinerary controlled by the professional, in the personalized model the professionals provide support while the individual is responsible for the plan and its actions, thus promoting the path to autonomy. The relationship with companies, where a more active role is promoted, is closer and more intense, seeking to cover the interests of both parties. They should know the person and not simply a *curriculum*, which aims to increase the possibilities of creating or negotiating adapted positions, in addition to the follow-up for job retention.

The phases of treatment are broadly as follows:

**Figure 3: Phases of treatment**


- In the **Start**, the program begins and the first contact between professional and candidate takes place, where the professionals explain the program, collect the first data, and the candidate accepts or not to participate. This phase is similar in both the traditional and customized model.
- In the **Intervention**, the bulk of the treatment occurs in both models. The personalized model includes the phases of Discovery of the person, Activation of supports, Incorporation into Employment and Maintenance of employment. These phases allow us to guide the intervention and focus on aspects that respect the methodological principles, but each of them will be adapted to each case in time and intensity and may also overlap between them.

In the traditional model, this phase is a continuum, without a specific methodological design. Furthermore, it is usually based on the actions contemplated by the funders, and which include pre-employment actions, group training and incorporation into employment.

- The **Exit phase** focuses on treatment closure planning, identifying needs and potential supports to activate, in addition to client satisfaction assessment. In the traditional model, this phase may be absent or brief as the attention ratios do not allow time for dedication, or do not consider methodological principles.

# 3 Evaluation design

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

## 3.1 Theory of Change

This report, with the aim of designing an evaluation that enables us to understand the causal relationship between the intervention and its final objective, develops a Theory of Change. The Theory of Change schematizes the relationship between the needs identified in the target population, the benefits, or services that the intervention provides, and the immediate and medium-long term results sought by the intervention, understanding the relationships between them, the assumptions on which they are based, and outlining measures or outcome indicators.

**Theory of Change**

A Theory of Change begins with the correct identification of the needs or problems to address and their underlying causes. This situational analysis should guide the design of the intervention, i.e., the activities or products that are provided to alleviate or resolve the needs, as well as the processes necessary to properly implement the treatment. Next, this theory identifies the expected effects 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 achieved, 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 needs identified by HOGAR SÍ in the population experiencing homelessness in Spain are the scarcity of income or resources and the low intensity of employment, which leads to social housing exclusion and low quality of life. The causes that lead to this situation are complex to define, as they involve various interconnected areas that feed into each other. Given that individuals experience homelessness due to unemployment or lack of income, their capacity to secure employment is hindered. Moreover, in most cases, physical and mental health problems aggravate this situation.

This need or problem defines the different areas of action of the project and the activities associated with each of them. HOGAR SÍ points out that the one trait common to all individuals in a situation of homelessness is the lack of housing and that each person's circumstances vary widely. Therefore, the creation of a personalized program is key. Personalized intervention addresses scarcity of resources through financial support aimed at covering participants' basic needs (transportation, food, personal care and training), which in turn helps to deactivate or minimize barriers to employment access. Additionally, to reinforce improvements in participants' employability and labor market insertion, the program offers personalized job support services through training tailored to individual needs and focused on personal strengths (tutoring and mentoring services). With this same objective, strategic partnerships are established, aiming to increase the chances of creating or negotiating personalized positions through mutual understanding between individuals and companies.

All these resources and activities carried out result in a series of outputs. By measuring the outputs obtained, one can identify whether the beneficiaries have received the activities or inputs and to what extent. Receiving the resources and activities properly is essential for the program to achieve the expected intermediate and final results. Indeed, if beneficiaries do not effectively receive the program, it is difficult to observe improvements in the indicators of employment, housing situation or quality of life. In this project, outputs are defined as the number of people receiving the services or aid provided. For example, residential support, health, administrative and financial aid seek to increase the number of people receiving financial and social support. On the other hand, personalized labor support aims to enhance skills for employment, active search, job support and job detection. Likewise, on-demand training has as a product promoting active job search and the development of employability skills; partnerships with companies; and job identification. Without the receipt of these outputs or benefits, improvements in the economic, employment and housing situation of beneficiaries cannot be expected.

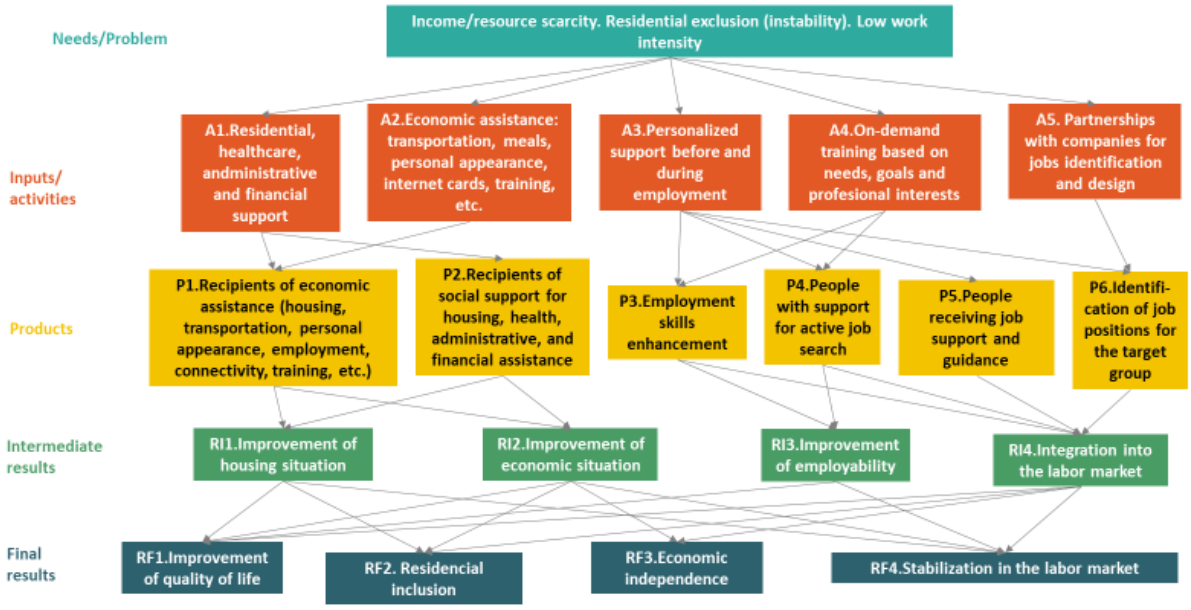
In the short term, the personalized intervention expects an improvement in the housing and financial situation of the beneficiaries through the receipt of financial aid and social support. In addition, this evaluation expects an improvement in employability through the enhancement of skills and support for active job searching. Finally, the program aims to achieve incorporation into the labor market thanks not only to the active search for employment and the development of skills, but also to labor support and the detection of jobs for the group.

In the medium to long term, the improvement of the above-mentioned intermediate indicators should lead to an improvement in the quality of life of the participants and their stabilization in the labor

market. In addition, this study anticipates that improvements in residential, economic, and labor insertion will lead to their residential inclusion. A better economic and labor situation will enable them to achieve economic independence.

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

**Figure 4: Theory of Change of the personalized employment model in the field of homelessness**




## 3.2 Hypotheses

The primary goal of the personalized intervention is to help individuals facing homelessness access and stabilization in the labor market.

As detailed in the Theory of Change, this project is not limited exclusively to the improvement in the employability (insertion in the labor market or improvement of the employment situation), but also aims to improve the housing and economic situation of the beneficiaries and their quality of life. Consequently, when evaluating the model, several hypotheses compare personalized treatment with traditional treatment in each of the aforementioned areas, using specific indicators for each of them. This multidimensional approach enables a comprehensive assessment of the impact of the intervention on the lives of the beneficiaries and a more complete understanding of its effectiveness in different dimensions.

Below, this section presents the hypotheses to test in each of the major areas. In most sections, there is a hypothesis to objectively improve the situation (main hypothesis) and an improvement in the self-perceived situation of the participant (secondary hypothesis). The following sections will describe the sources of information for the indicators used in each hypothesis.

### 1. Improvement of the housing situation

This hypothesis proposes that personalized treatment (relative to the traditional approach) will improve participants' housing situation. The primary hypothesis will use objective measures of their housing situation, while the secondary hypothesis will use measures of participants' perception and satisfaction.

### 2. Improvement of the economic situation

The main hypothesis postulates that, compared to the traditional approach, participants will achieve a higher level of monthly income. A secondary hypothesis contemplates a more positive perception of this income.

### 3. Improved employability

The main hypothesis postulates that personalized support treatment will enhance employability in terms of skills development to acquire and keep a job, compared to traditional treatment, from the perspective of professionals.

As a secondary hypothesis, the services provided to the participants will increase the positive perception of the participants own employability.

### 4. Labor market integration

This hypothesis focuses on insertion into the labor market. Specifically, it postulates that personalized treatment, in relation to traditional treatment, will have a positive effect on the employment situation and activity (main hypothesis), as well as subjectively, on one's own self-perception of that situation (secondary hypothesis).

### 5. Quality of life improvement

The main hypothesis of this section points out that personalized employment, compared to traditional employment, will lead to an improvement in the self-perceived quality of life.

## 3.3 Sources of information

To gather the necessary information to construct the outcome indicators, HOGAR SÍ conducted surveys targeting both participants in the itinerary and the professionals in charge of carrying out the socio-labor inclusion support. Additionally, the technical team collected information through direct attention (interview, personal engagement) at the three measurement moments. For example: number of weeks in stable housing in the last six months, number of days worked in the last six months, etc.

The technicians of HOGAR SÍ conducted the surveys to the participants at three moments: **before the intervention** (baseline), **after the intervention** (final line) and **6 months after** it**.** The latter enables us to know the persistence of the treatment after the end of the program.

In each survey, the participants answered four types of questionnaires:

- **Employability self-perception questionnaire**: it aims to explore the perception of the level of employability. To this end, it focuses on aspects such as the determination of work objectives, the support of the close environment, the main obstacles to obtaining employment and attitudes during the job search. It also examines the participant's perception of their own abilities, such as their self-image projection, their capacity for self-control, and their abilities to communicate and work in a team.
- **Ontological security questionnaire:** this part contains questions related to the sense of security provided by the place where the individual currently resides. The questions focus on the individual's perception of their housing environment, addressing aspects such as autonomy to make decisions, the performance of daily routines, the feeling of privacy, the influence on the construction of identity, the emotional connection with the place or the perception of security.
- **Well-being perception questionnaire:** the technical team interviewed participants about their level of satisfaction in several life spheres, such as life in general, housing, leisure, physical health, emotional well-being, support network (family, friends, co-workers), work situation and economic situation.
- **Rosenberg self-Esteem questionnaire:** the Rosenberg Self-Esteem Scale assesses the subjective perception of self-worth. This scale, which includes statements that address positive and negative aspects of self-image and emotional self-evaluation, provides a quantitative measure of self-esteem.

If participants get a job, information about the employment contract and satisfaction with working conditions is also collected. A questionnaire has been conducted for each job placement (there are people who have been inserted several times during the program).

In addition, this study uses complementary sources of information from the following administrative register: Social Security working lives.

In addition, professionals have collected information about the participants assigned to them, at the beginning, during and at the end of the intervention:

- **Professional assessment employability questionnaire**: this form aims to assess the employability of participants and verify the development of competencies after their participation in the program in four key dimensions. The first focuses on the professional and training profile, exploring aspects such as the professional trajectory, the definition of professional objectives, the training trajectory, and the adaptation of the profile to the demands of the labor market. The second deals with competencies for active job search, analyzing areas such as dedication, management of channels and tools, as well as relational competencies. The third focuses on digital skills, assessing the participant's orientation towards technology and its use for job search. Finally, the fourth dimension assesses the participant's socio-occupational skills, such as communication, teamwork, or initiative.

In addition to the questionnaires, although they are not linked to any of the indicators used to measure the intervention hypotheses, the following sources of qualitative information have been used to obtain information on program satisfaction:

- **Satisfaction calls** to those people who have left the program, to know their satisfaction with the program and aspects of improvement.
- **In-depth interviews:** professionals have performed in-depth interviews with both control and treatment group participants, to gather qualitative information on intervention methodologies.
- **Focus groups:** periodically, HOGAR SÍ has established focus groups with the professionals of the control group and the treatment group to extract information related to the intervention and the evaluation of the itinerary. Likewise, HOGAR SÍ has defined spaces for reflection with the insertion companies.
- **Workshops linked to the Customer Journey:** the entire intervention process has been analyzed with the Customer Journey tool, reflecting all the points of interaction of the participants with HOGAR SÍ during the personalized treatment process. This analysis included a total of four workshops with the participants and two workshops with the foundation's professionals, providing very relevant qualitative information.
- **Survey to evaluate satisfaction with the program**: the technical team conducted a questionnaire a few days after the end of the program. This survey specifically asked about satisfaction with exit support. It was performed to both groups (control and treatment), allowing for an understanding of the difference in satisfaction at a specific moment between both methodologies.

## 3.4 Indicators

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

### 1. Housing situation

This study uses four indicators for the housing situation of the participants:

**ETHOS scale**: this scale takes values between 1 and 13[17], where values 1-2 refer to roofless people, 3-7 to people who sleep under a roof, but without a fixed home (who sleep, for example, in shelters), 8-10 to people in unsafe housing and 11-13 to people in inadequate housing[18]. This report constructs this scale based on data collected in participants' interviews.

[17] For the construction of the indicator, the situation in which the participant is outside the ETHOS scale has been considered as a value of 14.

[18] For more information, see https://www.feantsa.org/en/toolkit/2005/04/01/ethos-typology-on-homelessness-and-housing-exclusion.

**Residential stability:** measured by the number of weeks participants have spent in decent housing (outside the ETHOS scale) in the six months prior to measurement.

**Residential safety:** measured through a composite indicator composed of six questions regarding the sense of security the person feels about their place of residence. It is a composite indicator derived from responses to multiple questions. Like other indicators with similar characteristics described below, it is 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).

**Satisfaction with the accommodation**: measured from a direct question to the participants, it takes values between 1 (not at all satisfied) and 5 (very satisfied).

### 2. Economic situation

Three indicators measure the economic situation:

**Total income:** considering formal and informal monthly income, such as labor income or public benefits, among others. They are measured based on the total income in the last month (considering any source of income) indicated by the participants.

**Labor income:** gross monthly salary that the participant receives for their formal employment contract (when they do not have a job, the value is 0).

**Economic satisfaction:** the original indicator takes values between 1 (not at all satisfied) and 5 (very satisfied).

### 3. Employability

Two indicators measure employability:

**Self-perceived employability:** questions related to the subjective perception of job readiness.

**Objective employability assessed by the HOGAR SÍ professional:** it is based on a set of questions that capture objective factors such as work experience, training and the specific activities conducted by the participant to look for a job (e.g., digital and work skills, conducting interviews, etc.).

Both indicators, self-perceived employability and the employability assessment conducted by HOGAR SÍ professionals, are calculated using Anderson's (2008) method and subsequently standardized, to have a mean equal to zero and a standard deviation equal to one.

Furthermore, this report presents two specific indicators that reflect employability from a more objective point of view: the number of jobs offered the participant has applied for and the number of selections processes the participant has applied to.

#### 4. Labor market integration

Four indicators measure the differential effect of the treatment on the participants' employment:

**Level of work activity:** measured by the number of days worked in the last six months. The study defines two indicators, one based on information collected in the intervention itself and another based on Social Security labor records[19].

**To be employed or not:** this variable comes from a question about the current employment situation of the participants. In this case, the dependent variable is binary, i.e., it only takes values 0 (non-employed) or 1 (employed). The information on this variable comes from information collected in the intervention itself and from the Social Security records of working lives.

**Employment status:** measured by a composite indicator that takes values between 1 and 10 considering whether the person studies, has a job or is looking for one, as well as the type of contract and working hours if employed.

**Satisfaction with the job situation:** measured from a direct question to the participants, it takes values between 1 (not at all satisfied) and 5 (very satisfied).

#### 5. Quality of life

This study uses a synthetic **quality of life** index, constructed from participants' responses to several questions that explore their perception of personal well-being. Anderson's calculation methodology is used and subsequently standardized. The lower values of the index show an absence of well-being and the maximum value, high level of well-being.

## 3.5 Design of the experiment

To assess the effect of personalized versus traditional treatment on indicators of employment status, economic situation, residential situation, and quality of life, this study uses an experimental assessment (RCT). In this assessment participants are randomly assigned between the personalized treatment group and the traditional treatment group. In this project, there is not a pure control group (no interventions). An essential component of an RCT is to be able to follow participants to the final line of data collection, and, given the characteristics of the target population, the only way to do this was to maintain a comparison group with an intervention, so it will always be compared to traditional treatment. The process of recruiting and selecting the beneficiaries of the intervention, as well as the random assignment and time frame of the experiment, are detailed below.

[19] The number of days registered with Social Security is quantified 6 months before the start and end of the intervention for each participant. From this information and the part-time coefficient, in the case of part-time contracts, the number of days in full-time equivalent terms is obtained. Two intensity indices are also calculated as a quotient between the number of days worked and the days considered in the measurement. Its values therefore range from 0 to 1, with 0 being the minimum work intensity and 1 the maximum.

**Recruitment of intervention beneficiaries**

The target population of the intervention are individuals facing homelessness who interact with HOGAR SÍ through different channels and live in the cities involved (A Coruña, Cartagena, Madrid, Murcia, Palma de Mallorca, and Valencia). HOGAR SÍ coordinates the recruitment of this population. Indeed, HOGAR SÍ meets with public and private organizations, and administrations that serve people experiencing homelessness to explain the project, the objectives, and the profile of the participant, with the intention of raising awareness of the services and reaching as many people as possible.

The recruitment method consists of the referral of people by organizations or social services, or the direct arrival of potential participants through these organizations, bringing the information to them through direct visits or street routes. The participants also arrive thanks to the 'word of mouth' that occurs among the collective, especially due to the interest generated by the personalized methodology.

In this sense, the experiment identifies potential participants through three methods:

1. Public organizations that care for people experiencing homelessness (shelters, social services, hospitals, etc.).
2. Private organizations that work with people in a situation of residential exclusion.
3. Own initiative (people who go directly to the HOGAR SÍ offices after having received the information at some point, from another person in the program, to see the office, etc.).

Depending on the channel through which participants access the experiment, the procedure is slightly different, but it always has the next steps.

First, the technical staff of HOGAR SÍ[20] verifies that the people interested in participating, derived from other entities or who approach the entity directly, meet the following criteria to participate in the program[21]:

- ***Economic Income:*** *no regular economic income in the last 9 months.*
- ***Employment status:*** *not having worked more than 20% cumulatively in the last year.*
- ***Administrative status****: in possession of a work permit or renewable asylum red card, with work permit.*
- ***Language****: have an adequate level of comprehension of Spanish.*
- ***Age:*** *adults.*

[20] A person from the coordination team is the one who makes the checks, supported by the technical staff in the event of a possible lack of information.

[21] Although people in situations of maximum vulnerability normally attend the centers individually, in the event that there is a family relationship between potential beneficiaries, the circumstances of each person are analyzed independently.

- ***Residential status:*** *people who have been homeless in the last 9 months (live in a public space and/or spend the night in a shelter and are forced to spend the rest of the day in a public space)*[22]

After verifying the participation criteria and thoroughly explaining the project, individuals interested in participating sign the informed consent, thereby agreeing to join the program. Thus, the signatory group goes on to define the sample of the study.

**Informed Consent**

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

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

**Random assignment of participants**

After signing the informed consent, the participants in the experiment are randomly assigned to the treatment or the control group. Randomization is the cornerstone of RCTs to identify a causal relationship between treatment and outcomes. When properly conducted, 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 make an accurate measurement of the possible effects derived from the intervention.

The experiment design aims to recruit at least 300 participants[23] who will be equally distributed between the treatment group and the control group. In addition, stratification ensures that the groups are balanced on certain characteristics relevant to the outcome indicators and to prevent possible

[22] Residential situation at the time of entry up to ethos 7, with trajectory of ETHOS 1-2 in the last 9 months. Subsequently, if the number of participants is lower than expected, the criterion is extended, eliminating the obligation of ETHOS 1-2 trajectory. In the last months of the recruitment, people who were already being treated by HOGAR SÍ for less than 3 months and with ETHOS 1-2 status in the last 6 months were incorporated.

[23] Given the high number of cancellations that occurred in the first months of the recruitment, it was decided to increase this number to the maximum possible managed by the technicians of HOGAR SÍ, hence it was finally reached at 344.

imbalances from leading to a mismeasurement of the program's effect. Thus, from a design perspective, a balance is sought in the distribution of both groups according to **gender** (man, woman), **age groups** (under 34 years old, between 34 and 49 years old, over 49 years old), **ETHOS scale** (1-2; 3-7) and **the location of the intervention** (A Coruña, Cartagena, Madrid, Murcia, Palma, and Valencia). To achieve this, the sample is stratified based on participants sharing these characteristics, and random allocation is performed within each stratum.

In the context of this project, where participants enter in a staggered and decentralized manner in six different territories, it is essential to carry out an immediate and random assignment to the treatment and control groups, while ensuring an appropriate level of homogeneity in terms of basic characteristics between the groups. For this purpose, the SGI uses a custom-developed software, always keeping the aim of balancing the strata and ensuring the assignment of at least 150 individuals to the control and treatment groups[24].

Once the random assignment procedure has been advanced, if an imbalance exists between the two groups in each stratum[25], the participant joins the group with fewer individuals within that stratum. When the total number of assigned participants approaches the goal of 300[26], a control mechanism is activated to equalize the total group sizes. From this point on, if the groups differ in size, new participants join the smaller group. If the groups have the same size, participants continue to be randomly assigned by stratum.

The HOGAR SÍ technician enters the person's data in the application (on the computer or tablet), which after making the assignment as described, showed them the group to which the person had been assigned. At that time, the technician explained to the person what services they were going to have access to, depending on whether they were in the personalized or traditional treatment, without explicitly naming treatment or control. At this time, the person began the intervention according to the assigned group. The baseline survey was done at this time or in the first sessions of the intervention, depending on the individual case and adapted to the situations of the group.

[24] The software was installed in each HOGAR SÍ employment service and was used at the entrance of each participant, once it was verified that they met the requirements. By incorporating the data requested by the application, it indicated the group to which the participant had been assigned and the information was stored in the database common to all localities to be considered for the following assignments. The HOGAR SÍ team is sent a user manual for the application, indicating the instructions to follow and the meaning of the result, but not the internal logic of the assignment procedure.

[25] [25] There is no equilibrium when the difference in participants between the two groups is 3.

[26] A total of 290 were established between the two groups.

**Figure 5: Sample Design**

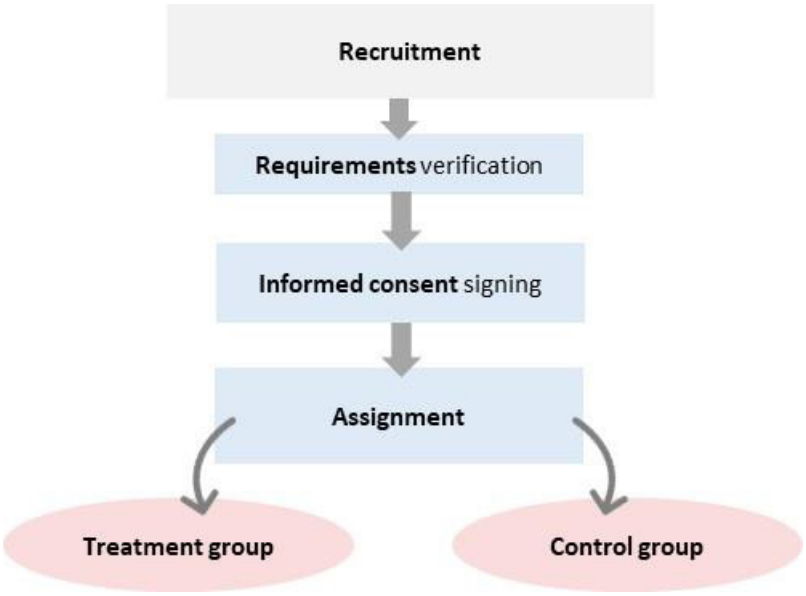
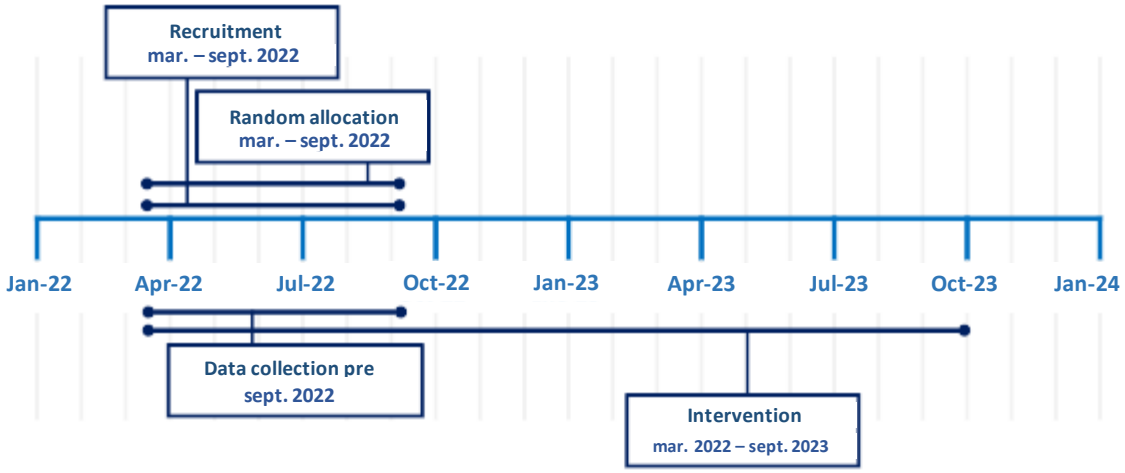



**Figure 6** illustrates the timeline for the implementation and evaluation of the itinerary. After completing the experimental evaluation design, HOGAR SÍ begins the participant recruitment process, assessing potential beneficiaries' eligibility between March 15th and September 30th, 2022. As mentioned above, eligible participants who express interest provide informed consent during recruitment and undergo random assignment. The baseline survey is conducted either at the time of recruitment or in the first few sessions thereafter. Each participant's intervention starts upon entry and continues until the maximum period of 18 months, the implementation deadline of September 30th, or until the participant remains in the program. The technical team performs the final survey when participants leave the intervention, if the participant is still reachable. In addition, the HOGAR SÍ staff records information throughout the intervention, ensuring some data is available even for participants who leave without completing the questionnaires.

**Figure 6: Evaluation timeline**




# 4 Description of the implementation of the intervention

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

## 4.1 Sample description

In the initial phase of engagement, HOGAR SÍ identified 739 potential participants. Out of these, 277 individuals did not access the program because they did not meet the entry requirements (ETHOS situation greater than 7, did not have a work permit, etc.) or due to lack of interest. Moreover, 118 were randomized but did not continue the process, so they did not complete the baseline survey[27], as they did not even start the intervention. Indeed, 344 individuals performed the interventions. The main reason for individuals to not continue in the process after randomization is the **inability to contact** them (40%) or the lack of interest in participating (36%). The high percentage of individuals who cannot be contacted reflects the barriers faced by people experiencing homelessness. Once the participant recruitment was completed, there were 344 individuals, with 51% of people (176) in the treatment group, and the remaining 49% (168) in the control group. Out of those 344 people, 178

[27] The only variables available for these 118 people are age, gender, ETHOS status and locality.

dropped out during the intervention. Again, the main reason was being unreachable or an existing lack of interest in continuing within the program. This report presents these casualties in more detail in **section 4.3**.

**Table 1: Participant entry into the project**

| Attendee input | Total | A Coruña | Cartagena | Madrid | Murcia | Palma | Valencia |
|---|---|---|---|---|---|---|---|
| **Potential participants** | **739** | 111 | 62 | 265 | 110 | 109 | 82 |
| **Participants who do not meet the requirements** | **277** | 55 | 20 | 109 | 29 | 37 | 27 |
| **Participants who drop out of the process after randomization** | **118** | 12 | 6 | 60 | 17 | 14 | 9 |
| **Final participants** | **344** | 44 | 36 | 96 | 64 | 58 | 46 |

### Characteristics of the final evaluation sample

The 344 individuals from the total sample answered the first baseline survey. The information is not complete for all variables because some people did not answer all the questions in this first survey.

Out of the total 344 individuals in the initial sample, only 174 (51%) responded to the final survey. This shows a high level of sample attrition, which is consistent with the characteristics of the project's homeless population. Section **4.3** discusses in more detail the attrition of the sample by experimental groups and robustness tests of the estimates regarding this aspect are conducted.

**Table 2** shows the descriptive statistics of the variables related to the intervention, according to the information collected in the baseline survey. In other words, it reports the characteristics of the participants before the intervention began. The table has six columns: the variable name, the mean, the standard deviation, the minimum value, the maximum value, and the number of observations.

The average age of the participants is 42 years and 25% are women. 54% of the participants have Spanish nationality, while another 12% have another nationality of the European Union and the remaining 33% are non-EU. These sociodemographic characteristics are almost identical to those collected in the Survey of Homeless People conducted by the INE in 2022, which ensures the external validity of the experiment.

Participants have an average of 57 months of total work experience and have been unemployed for an average of 26 months since their last job (formal or informal) prior to their access to the intervention.[28] In terms of educational level, 54% have completed primary education or lower

[28] The variables of work experience and time unemployed in the last 10 years were collected as categorical variables in the baseline survey. For example, using ranges such as "between 3 and 6 months". Using this information, continuous variables are constructed by taking the average value of each interval, to facilitate interpretation.

(illiterate and incomplete primary school), while 24% have completed secondary school, another 14% have completed high school and 7% have university studies. In the case of education, individuals in the sample have a lower level of education than those in the INE survey, where 64% of respondents had completed secondary school (INE, 2022). Transforming educational outcomes into a continuous variable[29], on average, participants have 7.65 years of education. In terms of geographical distribution, 28% of the participants are in Madrid, 19% in Murcia, 17% in Palma, 14% in Valencia, 13% in A Coruña and 10% in Cartagena.

The outcome indicators of the study are below. The first is the housing situation, measured by the ETHOS scale. This scale takes values between 1 and 13, where values 1-2 refer to roofless people, 3-7 to people who sleep under a roof but without a fixed home (who sleep, for example, in shelters), 8-10 to people in unsafe housing and 11-13 to people in inadequate housing[30]. A value of 14 has been the situation outside ETHOS, i.e., outside the situation of residential exclusion. At the time of starting the intervention, all participants were between values 1 and 7 on the scale. This implies that all participants included in the study were roofless (values 1 or 2) or without fixed housing (values 3 to 7), with a mean value of 2.99. Residential stability is measured by the number of weeks participants have spent in decent housing (outside the ETHOS scale) in the previous six months. The average is only 2.84 weeks. As for residential security, measured through an indicator composed of six questions referring to the security that the person feels regarding their place of residence, the average value is -0.34 (with a range of values between –1.75 and +1.39).

This last variable is an indicator composed of responses to various survey questions. Like other indicators with similar characteristics described below, it is 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).

The next section of variables examines the economic situation of the participants. The average level of monthly income (including employment income and public benefits, such as the MIS) is €167, although 57% of people do not report income of any kind. Restricting only formal employment income (i.e., with an employment contract), the average monthly income is €33, and in this case 95% of the participants do not report having formal employment income. This is consistent with the fact that only 5% of participants report being employed at the time of starting the HOGAR SÍ program. The average number of days worked in the previous six months is just 9.2 days. The employment situation,

[29] The level of education is included in the survey as a categorical variable. To convert it into a continuous variable measured in years of education, the following transformation is made: illiterate = 0 years, incomplete primary = 3 years, complete primary = 6 years, secondary = 10 years, baccalaureate = 12 years, university = 16 years.

[30] For more information, see https://www.feantsa.org/en/toolkit/2005/04/01/ethos-typology-on-homelessness-and-housing-exclusion.

measured with a composite indicator, reaches an average value of 2.07 (with a range between 1 and 10).

**Table 2: Descriptive statistics of the sample**

| Variable | N | Mean | Standard deviation | Minimal | Maximum |
|---|---|---|---|---|---|
| Treatment | 344 | 0,51 | 0,50 | 0 | 1 |
| Insertion company | 344 | 0,06 | 0,25 | 0 | 1 |
| *Sociodemographic variables (pre-intervention)* | | | | | |
| Age | 344 | 42,22 | 12,60 | 19 | 67 |
| Woman | 344 | 0,25 | 0,43 | 0 | 1 |
| Non-EU nationality | 344 | 0,33 | 0,47 | 0 | 1 |
| EU Nationality | 344 | 0,12 | 0,33 | 0 | 1 |
| Spanish Nationality | 344 | 0,54 | 0,50 | 0 | 1 |
| Work experience (months) | 337 | 57,17 | 39,52 | 0 | 96 |
| Time of unemployment (months) | 315 | 25,92 | 29,94 | 0 | 96 |
| Educational Level (years) | 338 | 7,65 | 4,12 | 0 | 16 |
| Illiterate | 338 | 0,02 | 0,15 | 0 | 1 |
| Incomplete Primary | 338 | 0,26 | 0,44 | 0 | 1 |
| Complete Primary | 338 | 0,26 | 0,44 | 0 | 1 |
| Secondary school | 338 | 0,24 | 0,43 | 0 | 1 |
| Postsecondary | 338 | 0,14 | 0,35 | 0 | 1 |
| University | 338 | 0,07 | 0,26 | 0 | 1 |
| Mental Health Issue | 344 | 0,32 | 0,47 | 0 | 1 |
| Location - A Coruña | 344 | 0,13 | 0,33 | 0 | 1 |
| Location - Madrid | 344 | 0,28 | 0,45 | 0 | 1 |
| Location - Murcia | 344 | 0,19 | 0,39 | 0 | 1 |
| Location - Palma | 344 | 0,17 | 0,37 | 0 | 1 |
| Location - Valencia | 344 | 0,14 | 0,34 | 0 | 1 |
| Location - Cartagena | 344 | 0,10 | 0,31 | 0 | 1 |
| *Outcome indicators (pre-intervention)* | | | | | |
| ETHOS Scale | 344 | 2,99 | 2,34 | 1 | 7 |
| Residential Stability (weeks) | 332 | 2,84 | 5,72 | 0 | 22 |
| Satisfaction with accommodation | 318 | 2,53 | 1,39 | 1 | 5 |
| Residential Security | 318 | -0,34 | 0,94 | -1,75 | 1,39 |
| Total Income | 342 | 167,37 | 256,12 | 0 | 1100 |
| Economic Satisfaction | 318 | 1,63 | 0,92 | 1 | 5 |
| Employment Income | 343 | 32,59 | 153,16 | 0 | 1100 |

| | | | | | |
|---|---|---|---|---|---|
| Employability (professional) | 325 | -0,15 | 1,00 | -3,28 | 3,03 |
| Employability (self-reported) | 312 | -0,08 | 0,95 | -3,30 | 2,97 |
| Work Activity | 337 | 9,21 | 25,07 | 0 | 170 |
| Employed | 339 | 0,05 | 0,22 | 0 | 1 |
| Employment Status | 325 | 2,07 | 1,01 | 1 | 10 |
| Job Satisfaction | 318 | 1,70 | 0,99 | 1 | 5 |
| Quality of life | 305 | -0,16 | 0,98 | -2,77 | 2,49 |

Among the people assigned to the treatment group, a subgroup (22 people, 6% of the total) were selected to participate in the insertion enterprise program. In the case of these companies, the wage cost of hiring people experiencing homelessness is assumed directly by HOGAR SÍ rather than by the company itself, so the level of support from HOGAR SÍ is much higher. Because assignment to this subgroup within the treatment group was not random, the remainder of this report excludes these individuals from the analysis. Therefore, the experimental sample used in the analysis consisted of 322 people: 154 from the treatment group (47.8%) and 168 from the control group (52.2%).

## 4.2 Random Assignment Results

Randomization was performed for a total of 462 participants, with 224 assigned to the treatment group and 238 assigned to the control group. **Table 3** displays the results of the random allocation by stratification variables.

**Table 3: Randomization results before the project began**

| **Age Group** | | **1** | | | | **2** | | | | **3** | | | | **TOTAL** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Gender** | | **F** | | **M** | | **F** | | **M** | | **F** | | **M** | | |
| **Ethos** | **Group** | ***1-2*** | ***3-7*** | ***1-2*** | ***3-7*** | ***1-2*** | ***3-7*** | ***1-2*** | ***3-7*** | ***1-2*** | ***3-7*** | ***1-2*** | ***3-7*** | |
| A Coruña | CG | 3 | 0 | 7 | 1 | 2 | 1 | 9 | 2 | 0 | 0 | 4 | 0 | **29** |
| | TG | 2 | 0 | 5 | 0 | 1 | 1 | 8 | 2 | 2 | 0 | 3 | 3 | **27** |
| Cartagena | CG | 1 | 1 | 4 | 0 | 4 | 0 | 2 | 1 | 1 | 1 | 3 | 0 | **18** |
| | TG | 0 | 1 | 3 | 2 | 3 | 0 | 5 | 1 | 1 | 0 | 7 | 1 | **24** |
| Madrid | CG | 4 | 1 | 11 | 9 | 4 | 3 | 11 | 5 | 3 | 7 | 14 | 8 | **80** |
| | TG | 1 | 2 | 8 | 10 | 2 | 7 | 9 | 6 | 3 | 9 | 13 | 6 | **76** |
| Majorca | CG | 0 | 0 | 7 | 1 | 2 | 0 | 8 | 2 | 2 | 2 | 9 | 7 | **40** |
| | TG | 1 | 0 | 5 | 2 | 4 | 0 | 9 | 1 | 2 | 0 | 3 | 5 | **32** |
| Murcia | CG | 1 | 3 | 7 | 10 | 3 | 1 | 10 | 2 | 1 | 0 | 5 | 1 | **44** |
| | TG | 1 | 3 | 5 | 7 | 2 | 0 | 7 | 2 | 1 | 0 | 8 | 1 | **37** |
| Valencia | CG | 0 | 1 | 5 | 1 | 3 | 2 | 11 | 0 | 1 | 0 | 3 | 0 | **27** |
| | TG | 2 | 3 | 6 | | 2 | 1 | 9 | 1 | | 0 | 4 | 0 | **28** |
| **TOTAL** | | **16** | **15** | **73** | **43** | **32** | **16** | **98** | **25** | **17** | **19** | **76** | **32** | **462** |

Note: age group: 1 (<35 years); 2 (35-50 years); 3 (>50 years); gender: F (female) and M (male); Ethos: 1-2 (roofless) and 3-7 (homeless).

As mentioned above, 118 participants did not continue with the process, so they are left out of the analysis of results. Therefore, there is available information of 344 participants with the following distribution by strata:

**Table 4: Randomization results of the participants who started the project**

| Age Group | | 1 | | | | 2 | | | | 3 | | | | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Gender | | F | | M | | F | | M | | F | | M | | |
| Ethos | Group | *1-2* | *3-7* | *1-2* | *3-7* | *1-2* | *3-7* | *1-2* | *3-7* | *1-2* | *3-7* | *1-2* | *3-7* | |
| A Coruña | CG | 2 | 0 | 6 | 0 | 1 | 0 | 9 | 1 | 0 | 0 | 2 | 0 | **21** |
| | TG | 1 | 0 | 5 | 0 | 1 | 1 | 8 | 1 | 2 | 0 | 2 | 2 | **23** |
| Cartagena | CG | 1 | 1 | 4 | 0 | 3 | 0 | 2 | 1 | 1 | 1 | 3 | 0 | **17** |
| | TG | | 0 | 3 | 0 | 3 | 0 | 4 | 1 | 1 | 0 | 6 | 1 | **19** |
| Madrid | CG | 2 | 1 | 6 | 3 | 2 | 1 | 8 | 2 | 2 | 4 | 8 | 2 | **41** |
| | TG | 1 | 2 | 6 | 8 | 2 | 5 | 5 | 5 | 2 | 6 | 8 | 5 | **55** |
| Majorca | CG | 0 | 0 | 6 | 1 | 1 | 0 | 6 | 2 | 1 | 2 | 9 | 7 | **35** |
| | TG | 1 | 0 | 4 | 1 | 4 | 0 | 6 | 0 | 0 | 0 | 3 | 4 | **23** |
| Murcia | CG | 1 | 3 | 4 | 10 | 2 | 1 | 4 | 2 | 1 | 0 | 5 | 0 | **33** |
| | TG | 1 | 2 | 4 | 7 | 2 | 0 | 4 | 2 | 1 | 0 | 8 | 0 | **31** |
| Valencia | CG | 0 | 1 | 2 | 1 | 2 | 2 | 10 | 0 | 1 | 0 | 2 | 0 | **21** |
| | TG | 2 | 3 | 6 | 0 | 2 | 1 | 8 | 0 | 0 | 0 | 3 | 0 | **25** |
| **TOTAL** | | **12** | **13** | **56** | **31** | **25** | **11** | **74** | **17** | **12** | **13** | **59** | **21** | **344** |

Note: age group: 1 (<35 years); 2 (35-50 years); 3 (>50 years); gender: F (female) and M (male); Ethos: 1-2 (homeless) and 3-7 (homeless).

To verify that the random assignment defined a statistically comparable control group and a treatment group, a balance test was conducted to show that, on average, the observable characteristics of the participants in both groups were the same. The balance between the experimental groups is key to infer the causal effect of the program by comparing its results.

**Figure 7**[31] shows the results of the balance tests between the control group and the treatment group. All data shown in this figure refer to the survey conducted prior to the intervention (baseline)[32]. For each observable variable, the difference between the mean of that variable in the treatment and control group is represented by a dot and centered on it, the 95% confidence interval of that difference. A confidence interval containing zero, i.e., the vertical axis, will indicate that the difference in means between groups is not statistically significant or, in other words, is not statistically different from zero. Therefore, it will be concluded that the intervention groups are balanced in this characteristic. In the case where the confidence interval of the difference in means does not contain

[31] See **Table 17** in the Sample **Balance** appendix.

[32] Randomization was performed on 462 participants, while equilibrium analysis was performed on the 344 participants who started the intervention, which may impact the exceptions found.

zero, it can be concluded that the difference is statistically significant and, therefore, the groups are unbalanced in this characteristic.

**Figure 7** shows that the treatment and control groups are not statistically different in most variables. Specifically, the variables included in the stratification and controlled by the assignment tool are balanced between both groups, which shows that the tool used is correct. However, there are some exceptions, especially in terms of educational attainment, residential stability, employability, and quality of life indicator. The average number of years of education is 6.57 years in the control group and 8.71 years in the treatment group. This difference is significant at 1%. A detailed analysis of this variable shows that the distribution of educational levels is different in both groups, especially in the Murcia subsample.

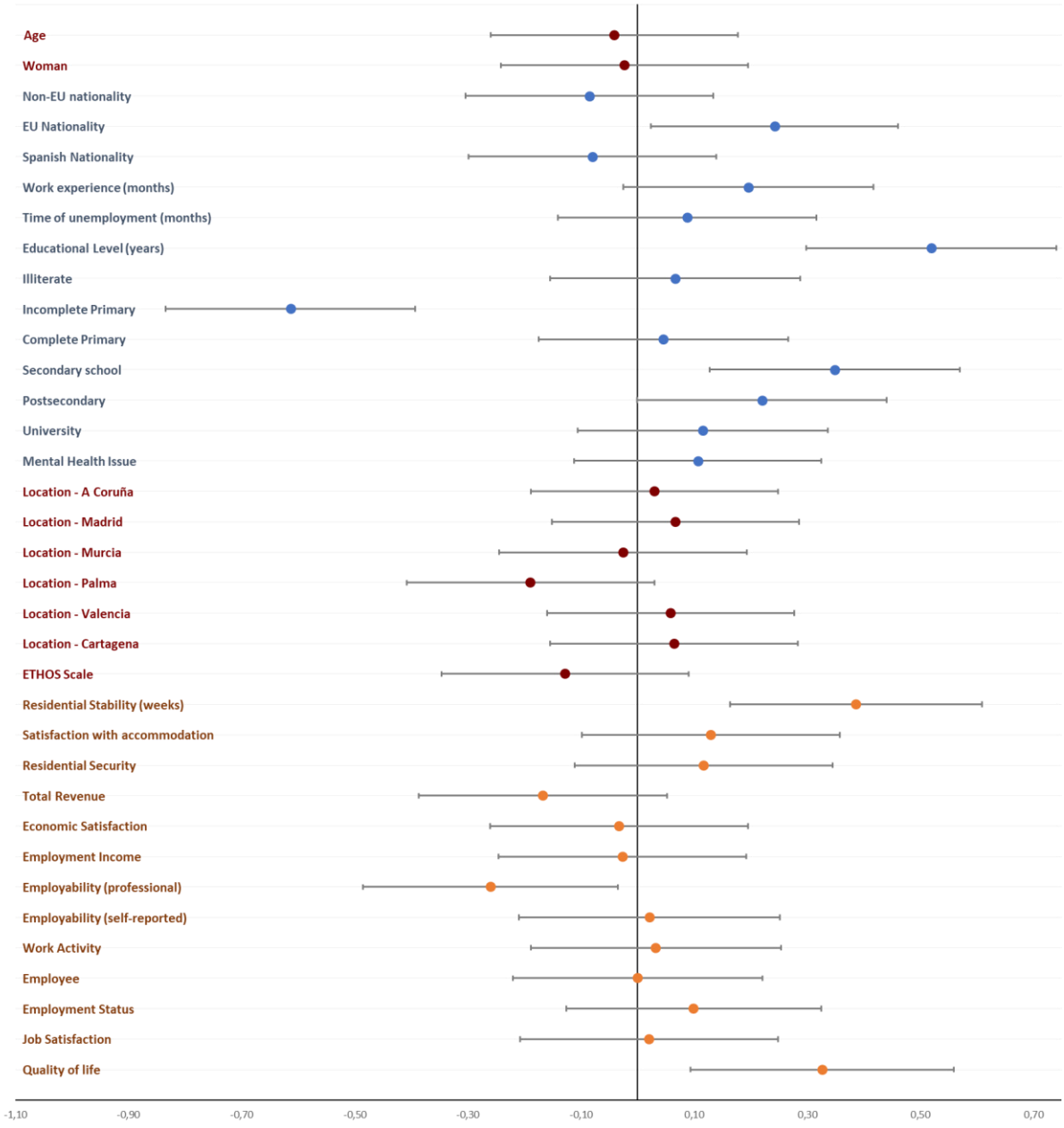
In terms of residential stability, people in the treatment group have spent an average of 4.17 weeks in a stable residential situation (outside the ETHOS scale) in the previous six months, while the average for the control group is 1.96 weeks. This difference is also significant at 1%. The most common value of this variable is zero in both groups, but there are more individuals with positive values in the treatment group than in the control group.

Regarding the employability assessed by the professionals of HOGAR SÍ, the average value of the treatment group was lower than the control group, and the difference was significant at 5%. The opposite is true for the quality-of-life indicator, which is higher in the treatment group than in the control group (0.00 vs. -0.32).

Finally, this analysis detects differences also in the percentage of participants with nationality from a European Union country other than Spain (7 percentage points more common in the treatment than in the control), and in the town of Palma de Mallorca (where there are more people assigned to the control group than to the treatment group). The latter are less concerned for the analysis of the impact of the intervention since they are not outcome variables.

All these differences suggest that there are significant imbalances between the experimental groups that make them not perfectly comparable. These imbalances may be the result of a limited sample size, as the smaller the sample size is, the lower the statistical comparability between intervention groups that randomization can guarantee. Therefore, in the regressions presented in the results section, the value of the dependent variable in the initial period is always controlled for, considering that the treatment and control groups do not necessarily start from the same level. In addition, the results of controlling variables such as educational level, gender, and nationality in the regressions are shown. Additionally, controls such as work experience, time unemployed, and the existence of mental health problems are included, all of which could influence the impact of the intervention.

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




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

## 4.3 Degree of participation and attrition by groups

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

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

**Degree of participation**

The SGI conducted the randomization with 462 participants, assigning 224 people to the treatment group and 238 to the control group. A total of 118 people were dropped from randomization to the start of the program, reducing the number of people to 344, 176 in the treatment group and 168 in the control group.

It is worth highlighting the effort made to attract a sample of more than 300 people, reaching 739 potential participants. Considering the situation of the people facing homelessness and the number of casualties that occurred, it was necessary to strengthen recruitment and exceed the expected number of participants.

**Table 5** shows the percentage of participants who received financial assistance. Transport and training aids were available to both groups (treatment and control) while the rest were exclusively provided to the treatment group[33]

**Table 5: Percentage of participants who have received financial support**

| Financial Aid | Treatment Group | Control Group |
|---|---|---|
| Transport | 59% | 20% |
| Training | 32% | 15% |
| Accommodation | 48% | - |
| Feeding | 55% | - |
| Image | 40% | - |
| Job equipment | 19% | - |
| Connectivity | 46% | - |
| Other | 43% | - |

Note: percentages calculated with a sample of 344 participants, 176 in the treatment group and 168 in the control group.

On the other hand, **Table 6** collects the percentage of participation in different tutoring sessions and activities. Average participation rates are 56% for the treatment group and 34% for the control group, varying significantly by topic. Tutoring sessions on job orientation and related activities related to job offers presentation stands out for their high degree of participation.

[33] There have been 2 cases in which these people in the control group mistakenly received feeding and imaging aids.

**Table 6: Percentage of participation in tutoring sessions and activities**

| | Treatment Group | Control Group |
|---|---|---|
| ***Tutoring sessions*** | | |
| Housing | 67% | 12% |
| Health | 51% | 10% |
| Financial situation | 34% | 2% |
| Administrative situation | 77% | 46% |
| Career Guidance | 96% | 93% |
| ***Activities*** | | |
| Work Practices | 11% | 9% |
| Internal trainings | 15% | 19% |
| External trainings | 52% | 27% |
| Submission of job offers | 84% | 67% |
| Selection process | 75% | 53% |

Note: percentages calculated with a sample of 344 participants, 176 in the treatment group and 168 in the control group.

As the main product outcome, it is worth noting that 38 individuals successfully completed the personalized model independently[34], while 13 did so with the traditional one.

**Attrition by groups**

**Table 7** shows the total number of participants registered in the evaluation, excluding the 22 who were assigned to insertion companies. Among the remaining 322, 154 were assigned to treatment and 168 to control. Of those assigned to treatment, 76 (49%) completed treatment, while the remaining 51% did not complete it for diverse reasons (e.g., voluntary dropout or death). This completion rate would be higher if one considered the 22 participants assigned to insertion companies, who are not considered in the analysis for the reasons explained above. Among those assigned to the control, 74 individuals (44%) completed the intervention and the remaining 56% did not. It is also shown that 59% of the people in the treatment group fully responded to the exit survey (conducted at the time of leaving the program, in some cases, even if the intervention had not been completed), while in the control group 49% did so. This is especially relevant for the variables that are used to construct composite indicators, so the sample size is reduced in some of the regressions presented in the next section. For some indicators, the sample size is larger because HOGAR SÍ professionals were able to collect the necessary information throughout the intervention or at the time of departure, even if the final survey was not conducted.

**Table 7: Early dropout rate**

| Group | Total | Treatment Completed | Final Survey |
|---|---|---|---|
| **Total** | **322*** | **150** (47%) | **174** (54%) |

[34] An autonomous exit is considered when the participant secures employment, expresses no longer needing program support, does not require assistance or receives it from the community and falls outside the ETHOS typology.

| | | | |
|---|---|---|---|
| Treatment | 154 | 76 (49%) | 91 (59%) |
| Control | 168 | 74 (44%) | 83 (49%) |

Note: *The 22 participants who were assigned to the insertion companies on a non-random basis are not included.

To assess the statistical significance of the difference in sample attrition rates between experimental groups, this evaluation estimates a simple regression of the binary variable for incomplete intervention on treatment assignment. **Table 8** shows the results in column 1. The coefficient of the treatment variable is -0.05, but it is not statistically significant.

Estimating similar regressions for all control variables used in the analysis (columns 2 to 6), we see that early dropout is not correlated with gender or mental health problems. However, there is a positive correlation with nationality: Spanish participants leave the intervention with a 14-percentage point higher probability than foreigners, and this difference is significant at 1%. And a negative correlation with educational attainment: for each additional year of education, the probability of not completing the intervention is reduced by one percentage point (this result is only significant at 10%). These differences in the dropout rate justify the inclusion of these variables as controls in the main regressions shown in the evaluation results.

**Table 8: Correlation between sample attrition and other variables**

| | Intervention not completed | | | | | |
|---|---|---|---|---|---|---|
| | (1) | (2) | (3) | (4) | (5) | (6) |
| Treatment | -0.05 | | | | | |
| | (0.05) | | | | | |
| Woman | | 0.05 | | | | |
| | | (0.08) | | | | |
| Spanish Nationality | | | 0.14*** | | | |
| | | | (0.05) | | | |
| EU Nationality | | | | 0.11 | | |
| | | | | (0.08) | | |
| Educational Level (years) | | | | | -0.01* | |
| | | | | | (0.01) | |
| Mental Health Issue | | | | | | 0.10 |
| | | | | | | (0.07) |
| Observations | 322 | 322 | 322 | 322 | 316 | 322 |

Note: Standard errors, grouped by randomization strata, reported in parentheses.

Individuals experiencing homelessness face challenges both in initial contact and in their continuity during the intervention. Their severe exclusion often leads to difficulties in accessing or maintaining means of communication or connection. Additionally, they experience events that change their situation, routines or priorities negatively impacting consistent treatment. This is especially relevant at the beginning of the intervention, where establishing guidelines and creating a bond between professional and participant are crucial. Any difficulty increases the risk of leaving the treatment. During the intervention, some individuals commonly disengage due to the circumstances, a risk that

may be exacerbated in traditional methodologies with higher attention rates, where regularity of care is lower and the risk of disengagement increases.

# 5 Results of the evaluation

Random assignment of the experimental sample to the control and treatment groups ensures that, with a sufficiently large sample, the groups are statistically comparable. Therefore, any differences observed after the intervention can be causally associated with the treatment. Econometric analysis provides, in essence, this comparison. Nevertheless, this analysis has the advantages of allowing other variables to be included to increase accuracy in the estimates and provide confidence intervals for the estimates. In this section, the econometric analysis and the estimated regressions are presented, as well as the analysis of the results obtained.

## 5.1 Description of the econometric analysis: estimated regressions

In a randomized experiment, the regression model specified to estimate the causal effect is just the difference in the outcome variable between the treatment and the control group, as these groups are statistically comparable due to randomization. However, given the imbalances described earlier in balance tests, this analysis includes regressions that always control for the lagged value of the dependent variable, i.e., the value before the intervention. This approach considers existing differences between the treatment and control groups before the intervention, enhancing the accuracy of the estimates. In addition, the analysis includes specifications with additional controls such as gender, nationality, and education level.

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

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

Where $Y_{i,t=1}$ is the dependent variable of interest observed after the intervention for person *i*, $T_i$ indicates whether the person has been assigned to treatment (=1) or control (=0), $Y_{i,t=0}$ is the lagged value of the dependent variable (i.e., before the intervention), $X_{i,t=0}$ is a vector of controls (including gender, nationality binary variables, and years of education) and $\varepsilon_i$ is the error term.

Standard errors are always grouped at the strata level of randomization. As explained above, the variables used in the stratification are gender, age (under 35, 36-50, and over 50), residential status (1-2 vs. 3-7 on the ETHOS scale), and locality (6 cities), so there are a total of 72 randomization strata.

Regarding the time sequence of data collection: the entry of participants into the program occurred between March and October 2022. The average length of stay in the program was 11 months. The follow-up survey took place at the end of the program, either because of voluntary dropout or because the intervention has been completed. As shown above, in over 140 cases, the final survey was incomplete, but some outcome variables were collected through information gathered by HOGAR SÍ professionals during the treatment.

## 5.2 Analysis of the results

### 5.2.1 Primary and secondary outcomes

This section exhibits the results of the evaluation on primary and secondary indicators, following the structure of the evaluation framework. All outcome variables (except the employment binary variable) are standardized to 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 effect sizes across different domains.

#### 1. Housing situation

**Table 9** shows the results of the intervention on the housing situation of the participants. For each indicator, two specifications are presented: one without controls (only controlling for the lagging value of the dependent variable, i.e., the value of this variable before starting the program) and another with controls for gender, nationality, and educational level. The first two columns estimate the impact on the housing situation measured by the ETHOS scale. The coefficient of the treatment variable is close to 2.08 without controls and 2.22 with controls and is statistically significant at 1% in both cases. This means that the personalized treatment led to an improvement, on average, of more than 2 levels on the ETHOS scale, compared to the traditional one. It is important to emphasize that individuals in the control group also experienced an improvement on the ETHOS scale: the mean value before the intervention was close to 3 in both groups and rose to more than 6 in the control group and to more than 8 in the treatment group.

**Table 9: Effects on the housing situation**

| | ETHOS Scale | | Residential Stability | | Satisfaction with accommodation | | Residential Security | |
|---|---|---|---|---|---|---|---|---|
| | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) |
| Treatment | 2.08*** | 2.22*** | 5.11*** | 5.48*** | 0.42** | 0.47*** | 0.24* | 0.34** |
| | (0.48) | (0.43) | (1.19) | (1.19) | (0.17) | (0.16) | (0.13) | (0.15) |
| Observations | 312 | 289 | 307 | 288 | 173 | 162 | 174 | 163 |
| Controls | No | Yes | No | Yes | No | Yes | No | Yes |
| Mean Dep. Var. Pre | 2.84 | 2.75 | 3.02 | 3.13 | 2.50 | 2.49 | -0.34 | -0.34 |

Note: Standard errors, grouped by randomization strata, reported in parentheses.
Levels of significance: * p < 0.10, ** p < 0.05, *** p < 0.01.

Columns 3 and 4 show the results for the residential stability variable, measured by the number of weeks outside the ETHOS scale (i.e., with stable and decent housing) in the last 6 months. The analysis finds a positive effect of more than 5 weeks, which is significant at 1%.

**Table 9** estimates the impact on satisfaction with accommodation in columns 5 and 6, which takes values between 1 and 5. In this case, results propose a positive and significant effect of 0.42 without controls and 0.47 with controls. Finally, columns 7 and 8 show that there is also a positive effect on

residential safety of approximately 0.3 standard deviations (this is a normalized indicator with a mean equal to zero and a standard deviation equal to one).

In short, the personalized support model has a positive effect on the housing situation compared to the traditional model. The effects are large and involve a substantial improvement in the housing situation and in the participants' subjective perception of this situation. It is important to emphasize that these effects capture only the differential impact of personalized support (treatment) compared to traditional (control), but in both cases a positive trend is observed. It is likely that in the presence of a pure control group (no assistance received), the estimated effects for personalized follow-up would be larger.

## 2. Economic situation

**Table 10** reports the results of the effects on the economic situation. The table follows the same structure as the previous one, although in this case there are only three indicators. Columns 1 and 2 show the effects on total monthly income, including earned income and any type of benefit (e.g., MIS or Minimum Income Scheme). The coefficient of the treatment variable is 91.08 (without controls) and 86.30 (with controls), but in neither case is statistically significant at 10% level. Therefore, although participants in the treatment group report higher total admissions than those in the control group after the intervention, the effect is statistically indistinguishable from zero.

Columns 3 and 4 estimate the impact on income earned in formal employment contracts. The magnitude of the coefficient is like columns 1 and 2: 76.15 without controls and 101.55 with controls. The latter coefficient is marginally significant (at 10%).

Finally, columns 5 and 6 assess the change in satisfaction with the economic situation. The original indicator takes values between 1 (not at all satisfied) and 5 (very satisfied). The coefficient is 0.41 without controls and 0.46 with controls, the latter significant at 5%.

In summary, the results suggest that the economic situation improved for the treatment group compared to the control group. Although the estimated impact on income is only marginally significant in one of the specifications (column 4), the coefficients have a stable magnitude of around €90 per month. Given that the average income before the intervention was €167.40 (including benefits) and €32.96 (considering only labor income), this impact has a relevant magnitude from an economic point of view. The lack of significance may be due, in part, to the small available sample size. It is possible that with a larger sample size, this evaluation could have obtained significant results with similar magnitude.

**Table 10: Effects on the economic situation**

| | Total Income | | Employment Income | | Economic Satisfaction | |
|---|---|---|---|---|---|---|
| | (1) | (2) | (3) | (4) | (5) | (6) |
| Treatment | 91.08 | 86.30 | 76.15 | 101.55* | 0.41* | 0.46** |
| | (54.93) | (55.81) | (49.82) | (51.50) | (0.20) | (0.22) |
| Observations | 296 | 274 | 302 | 279 | 173 | 162 |
| Controls | No | Yes | No | Yes | No | Yes |
| Mean Dep. Var. Pre | 167.40 | 178.63 | 32.96 | 35.86 | 1.61 | 1.62 |

Note: Standard errors, grouped by randomization strata, reported in parentheses.
Levels of significance: * p < 0.10, ** p < 0.05, *** p < 0.01.

## 3. Employability

**Table 11a** and **Table 11b** report the results of the intervention on the participants. Employability is measured in two ways. On the one hand, the participant's self-perceived employability, which consists of a set of questions related to the subjective perception of readiness to find a job. On the other hand, the employability assessment conducted by HOGAR SÍ professionals, which is based on another set of questions in the questionnaire to capture objective factors such as work experience, training and specific activities conducted to look for a job (e.g., digital and work skills, conducting interviews, etc.). Both indicators are standardized using Anderson's (2008) method so that they have a mean equal to zero and a standard deviation equal to one.

Columns 1 and 2 report the effects on self-perceived employability. In both cases, the coefficient is close to zero and not significant. Something similar can be observed in columns 3 and 4 with employability assessed by professionals: the coefficients are close to zero (except in column 4, where the coefficient is equal to 0.21 standard deviations) and not significant.

In summary, results indicate that personalized treatment does not have a differential effect on participants' employability compared to the traditional model, whether self-perceived or evaluated by professionals. As noted above, this does not imply that there is no change in these indicators throughout the intervention, since there is a positive evolution of the indicators for both treatments. This is observed because the dependent variable has a negative mean value in the pre-intervention survey, but a positive one in the exit survey.

**Table 11a: Effects on employability**

| | Employability (professional) | | Employability (self-perceived) | |
|---|---|---|---|---|
| | (1) | (2) | (3) | (4) |
| Treatment | -0.01 | -0.05 | 0.05 | 0.21 |
| | (0.12) | (0.13) | (0.14) | (0.14) |
| Observations | 279 | 259 | 169 | 158 |
| Controls | No | Yes | No | Yes |
| Mean Dep. Var. Pre | -0.16 | -0.15 | -0.07 | -0.06 |

Note: Standard errors, grouped by randomization strata, reported in parentheses.
Levels of significance: * p < 0.10, ** p < 0.05, *** p < 0.01.

Adding information on participant employability has been significantly valuable. This includes specific indicators, such as the number of job applications submitted and the number of selection processes engaged in, providing a more objective assessment of employability.

The results show that people in the personalized treatment group apply for more job offers than those in the traditional group, 11 compared to 3.5 offers with a positive effect of 7.5 significant at 1%. Also, individuals in the treatment group apply for a greater number of selection processes, approximately 2 more than in control group.

A limitation of this analysis is that no information on these indicators is available before the intervention, so regressions cannot control the value of the indicator at the beginning of the intervention.

The results show that, in addition to the employability indicators already analyzed, there is no significant impact on self-perceived employability or professional evaluations. However, a significant impact exists when analyzing the intensity of the job search.

**Table 11b: Effects on employability**

| | Offers | | Processes | |
|---|---|---|---|---|
| | (1) | (2) | (3) | (4) |
| Treatment | 7.45*** | 7.06*** | 2.10*** | 1.94*** |
| | (1.53) | (1.72) | (0.45) | (0.43) |
| Observations | 322 | 295 | 322 | 295 |
| Controls | No | Yes | No | Yes |

Note: Standard errors, grouped by randomization strata, reported in parentheses.
Levels of significance: * p < 0.10, ** p < 0.05, *** p < 0.01.

## 4. Insertion into the labor market

**Table 12** reports the results related to the insertion into the labor market. Columns 1 and 2 show the effect on work activity, as measured by the number of days worked in the last six months. The coefficients in both columns are close to zero and not significant. However, it is important to note that there is a significant increase in the number of days worked in both groups: in the personalized treatment, the average goes from 9 to 47 days, while in the traditional treatment (control) it goes from 8 to 46 days. As it is a very similar increase, it does not have a differential effect.

Columns 3 and 4 report the effect on the probability of being employed. This variable comes from a question about employment status asked to participants. In this case, the dependent variable is binary, i.e., it only takes values 0 (non-employee) or 1 (employee). A positive effect is observed: people in the treatment group have a probability between 8 (no controls) and 10 (with controls) percentage points higher of being employed than those in the control group. This effect is significant at 5% once controls are introduced (column 4).

Columns 5 and 6 show the effect on the employment situation, measured by a composite indicator that takes values between 1 and 10 considering whether the person studies, has a job or is looking for one, as well as the type of contract and working hours if employed. In this case, the coefficients are 0.43 without controls and 0.81 with controls, the latter significant at 10%.

Finally, columns 7 and 8 show the impact on self-reported job satisfaction. The coefficients are positive, 0.30 without controls and 0.39 with controls, the latter significant at 10%.

In summary, the results indicate that there is a positive (marginally significant) effect on the likelihood of being employed at the end of the intervention. However, this evaluation finds no significant impact on the number of days worked. Once the controls are added to the specification, there are marginally significant positive effects on the employment situation and satisfaction with the employment situation. Participants self-reported all these labor market participation measures.

**Table 12: Effects on the labor market**

| | Work activity (days) | | Employee (binary) | | Employment Status (1-10) | | Job satisfaction (1-5) | |
|---|---|---|---|---|---|---|---|---|
| | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) |
| Treatment | 0.08 | 2.38 | 0.08* | 0.10** | 0.43 | 0.81* | 0.30 | 0.39* |
| | (7.66) | (7.31) | (0.05) | (0.05) | (0.43) | (0.43) | (0.20) | (0.21) |
| Observations | 310 | 289 | 309 | 287 | 265 | 248 | 173 | 162 |
| Controls | No | Yes | No | Yes | No | Yes | No | Yes |
| Mean Dep. Var. Pre | 8.81 | 9.44 | 0.05 | 0.06 | 2.07 | 2.10 | 1.65 | 1.65 |

Note: Standard errors, grouped by randomization strata, reported in parentheses.
Levels of significance: * p < 0.10, ** p < 0.05, *** p < 0.01.

The data obtained from the Social Security labor records of participants, shown in **Table12bis**, yields similar results to the previous ones. There is a difference in labor activity measured in the number of days registered with Social Security in the 6 months after the intervention, as the average is 15 days more for participants in the personalized treatment compared to the traditional one. This difference is significant at 5% in the specification with controls and with the indicator measured at the beginning of the intervention. In terms of full-time equivalent days, that difference is almost 13 days, which is also significant. The labor intensity, i.e., the ratio between the days worked and the days considered, is also higher in the treatment group and significantly different from 5-10% in the specifications with controls and with the indicator measured at the beginning of the intervention.

**Table 12bis: Effects on the Labor Market (based on data from the Social Security register of working lives)**

| | Employed (binary) | | Work activity (days) | | Work activity (days equivalent to TC) | | Work intensity | | Work intensity equivalent to TC | |
|---|---|---|---|---|---|---|---|---|---|---|
| | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) |
| Treatment | 0.07 | 0.07 | 10.80 | 14.99** | 9.71 | 12.68* | 0.06 | 0.08** | 0.05 | 0.07* |

| | Employed (binary) | | Work activity (days) | | Work activity (days equivalent to TC) | | Work intensity | | Work intensity equivalent to TC | |
|---|---|---|---|---|---|---|---|---|---|---|
| | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) |
| | (0.05) | (0.05) | (7.65) | (7.38) | (6.76) | (6.57) | (0.04) | (0.04) | (0.04) | (0.04) |
| Observations | 322 | 295 | 322 | 295 | 322 | 295 | 322 | 295 | 322 | 295 |
| Controls | No | Yes | No | Yes | No | Yes | No | Yes | No | Yes |
| Mean Dep. Var. Pre | 0.34 | 0.34 | 19.48 | 19.48 | 14.23 | 14.23 | 0.11 | 0.11 | 0.08 | 0.08 |

Note: Standard errors, grouped by randomization strata, reported in parentheses.
Levels of significance: * p < 0.10, ** p < 0.05, *** p < 0.01.

## 5. Quality of life

**Table 13** reports the results on quality of life, measured with an indicator composed of several survey questions. This indicator includes measures of satisfaction with different aspects of life, as well as a health status self-assessment. The variable is standardized, with a mean equal to zero and a standard deviation equal to one. The coefficient is equal to 0.31 without controls and 0.28 with controls, significant at 10% in both cases. This implies that personalized support has improved the perception of one's own quality of life more than the traditional model (control).

**Table 13: Effects on Quality of Life**

| | Quality of life | |
|---|---|---|
| | (1) | (2) |
| Treatment | 0.31* | 0.28* |
| | (0.15) | (0.16) |
| Observations | 165 | 155 |
| Controls | No | Yes |
| Mean Dep. Var. Pre | -0.17 | -0.14 |

Note: Standard errors, grouped by randomization strata, reported in parentheses.
Levels of significance: * p < 0.10, ** p < 0.05, *** p < 0.01.

### 5.2.2 Heterogeneity analysis

This section analyzes the variation in effects based on participant characteristics. Specifically, it examines whether the effects differ by gender, age, and educational level. To achieve this, similar regressions to those in the previous section are specified, with the addition of the variable for which heterogeneous effects are estimated, and the interaction of that variable with the treatment.

**Table 14** reports the heterogeneous results by gender. The table has seven columns, which correspond to the seven primary hypotheses indicated in the evaluation scheme: housing situation, residential stability, labor income, employability, labor activity, employment, and quality of life. The

coefficient of interest in this case is the one that corresponds to the interaction between the treatment and the binary variable that indicates gender ("treatment and woman"). In none of the cases the coefficient is significantly different from zero. Therefore, there are no heterogeneous effects by gender.

**Table 14: Heterogeneous effects by gender**

| | ETHOS Scale | Residential Stability | Employment Income | Employ. (prof.) | Work Activity | Employed | Quality of life |
|---|---|---|---|---|---|---|---|
| | (1) | (2) | (3) | (4) | (5) | (6) | (7) |
| Treatment & Woman | -0.23 | -1.62 | -39.58 | 0.19 | 15.46 | 0.03 | 0.26 |
| | (1.14) | (2.66) | (132.71) | (0.29) | (17.28) | (0.12) | (0.37) |
| Treatment | 2.14*** | 5.49*** | 85.06 | -0.06 | -3.50 | 0.08 | 0.25 |
| | (0.56) | (1.35) | (53.75) | (0.14) | (8.94) | (0.05) | (0.18) |
| Woman | 0.84 | 0.82 | 48.22 | -0.43* | -9.54 | 0.08 | -0.34 |
| | (0.82) | (1.71) | (105.39) | (0.22) | (13.04) | (0.10) | (0.24) |
| Observations | 312 | 307 | 302 | 279 | 310 | 309 | 165 |

Note: Standard errors, grouped by randomization strata, reported in parentheses.
Levels of significance: * p < 0.10, ** p < 0.05, *** p < 0.01.

**Table 15** reports heterogeneous results by age. In this case, this study evaluates whether the intervention has a differential impact on participants over 50 years of age compared to those under that age. As in the previous case, none of the coefficients is statistically significant. This indicates that there is no differential impact of personalized treatment for participants older and younger than 50 years.

**Table 15: Heterogeneous effects by age**

| | ETHOS Scale | Residential Stability | Employment Income | Employ. (prof.) | Work Activity | Employed | Quality of life |
|---|---|---|---|---|---|---|---|
| | (1) | (2) | (3) | (4) | (5) | (6) | (7) |
| Treatment & Over 50 | 0.69 | -1.74 | 48.50 | 0.06 | 16.85 | 0.09 | -0.11 |
| | (0.96) | (2.05) | (103.56) | (0.22) | (15.68) | (0.09) | (0.33) |
| Treatment | 1.85*** | 5.68*** | 58.79 | -0.03 | -5.86 | 0.05 | 0.35* |
| | (0.65) | (1.58) | (63.03) | (0.17) | (9.22) | (0.06) | (0.19) |
| Over 50 | -0.32 | -0.22 | -57.67 | -0.07 | -21.29* | -0.05 | -0.18 |
| | (0.71) | (1.35) | (73.03) | (0.19) | (12.49) | (0.08) | (0.24) |
| Observations | 312 | 307 | 302 | 279 | 310 | 309 | 165 |

Note: Standard errors, grouped by randomization strata, reported in parentheses.
Levels of significance: * p < 0.10, ** p < 0.05, *** p < 0.01.

**Table 16** reports heterogeneous effects by educational level. In this case, this report compares the impact of the intervention on participants with completed primary education or less with those with a higher level of education. The coefficient of interaction between treatment and the indicator of

primary education or lower is negative in almost all specifications (except for column 3 on labor income). However, it is only statistically significant in column 2: the positive effect on residential stability is 4.64 weeks lower for participants with low educational attainment. This effect considerably reduces the positive effect of the program on this variable, suggesting that only people with a higher level of education obtain the benefits in terms of residential stability. For the rest of the variables, there is no differential impact of education on the effect of personalized treatment compared to the traditional model.

**Table 16: Heterogeneous effects by educational level**

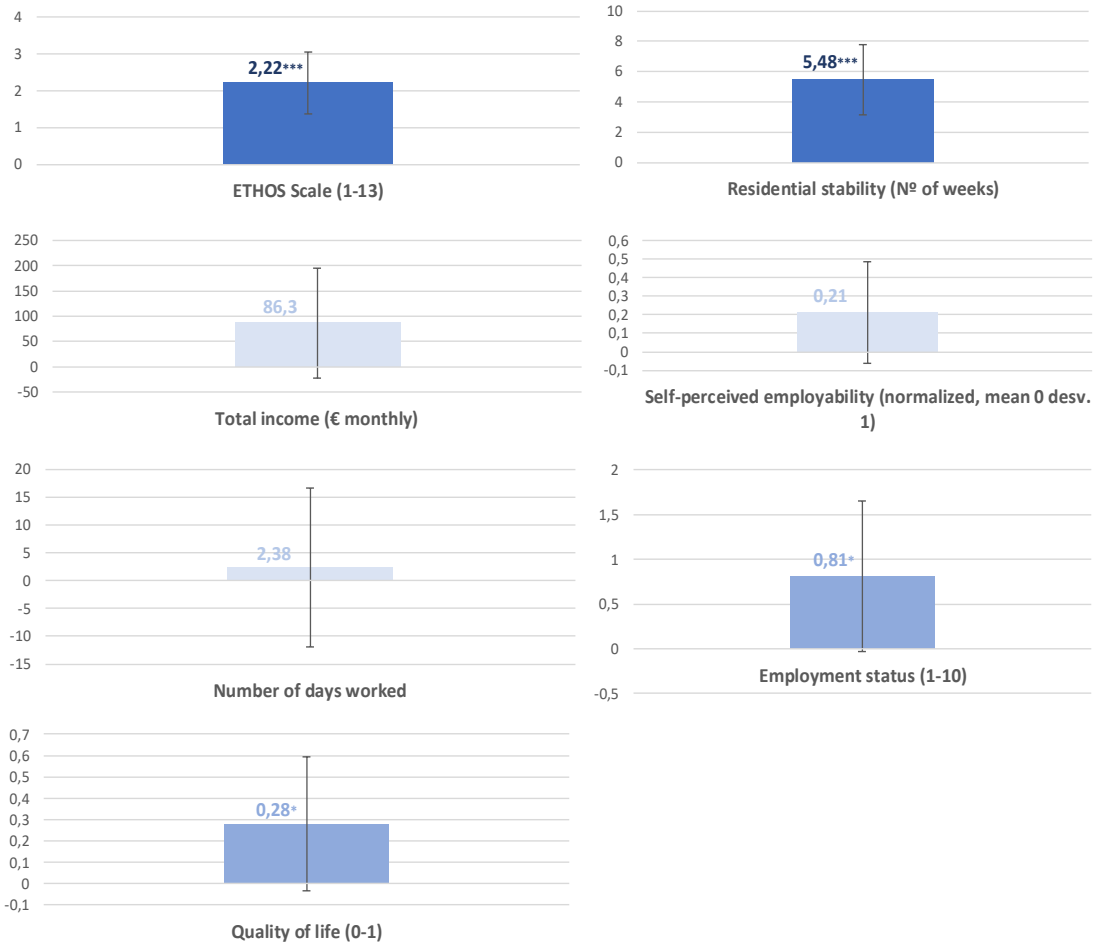
| | ETHOS Scale | Residential Stability | Employment Income | Employ. (prof.) | Work Activity | Employed | Quality of life |
|---|---|---|---|---|---|---|---|
| | (1) | (2) | (3) | (4) | (5) | (6) | (7) |
| Treatment & Primary or Lower | -0.84 | -4.64** | 18.30 | -0.12 | -25.54 | -0.06 | -0.07 |
| | (0.95) | (1.78) | (121.92) | (0.25) | (15.72) | (0.11) | (0.28) |
| Treatment | 2.37*** | 7.52*** | 58.18 | -0.03 | 12.01 | 0.10 | 0.35* |
| | (0.74) | (1.50) | (75.39) | (0.18) | (11.77) | (0.07) | (0.20) |
| Primary or Lower | -0.39 | 1.74 | -56.59 | -0.24 | 4.63 | -0.03 | 0.07 |
| | (0.76) | (1.26) | (84.04) | (0.19) | (11.94) | (0.07) | (0.21) |
| Observations | 309 | 307 | 300 | 279 | 310 | 308 | 165 |

Note: Standard errors, grouped by randomization strata, reported in parentheses.
Levels of significance: * p < 0.10, ** p < 0.05, *** p < 0.01.

# 6 Conclusions of the evaluation

This pilot project has allowed us to evaluate the effects of two types of intervention in assisting homeless individuals for their social and labor reintegration: a new model of personalized support and the traditional labor insertion model. The evaluation is experimental, using stratified randomization (by gender, housing status, age, and location) to randomly assign participants to one group or another. The sample includes 322 participants, as the 22 people who were assigned to insertion companies are excluded.

**Figure 8: Intervention effect on key indicators**




Note: The indicators whose effect of the treatment is significant at 1% (ETHOS scale and residential stability) and 5% (number of days worked according to the Social Security register of working lives) are in dark blue; in blue, the significant effects at 10% (Employment status and level of quality of life); and in light blue those indicators that are not significant (total income, self-perceived employability and number of days worked). The effects included in the graphs refer to regressions with controls.

Personalized treatment has a positive and significant impact on the housing situation, with a substantial increase in the ETHOS scale and in residential stability, measured by the number of weeks

in decent housing. Personalized support is therefore more effective in improving the housing situation of homeless people.

There are also positive effects on the economic situation, with an increase in labor income (and total) of approximately €90 per month, although this effect is only marginally significant and is not significant at 10%. Regarding labor participation, it is observed that individuals who receive personalized treatment work 15 days more on average during the 6 months before the end of the intervention than people in the control group, according to the Social Security Labor Life Registry. There was also an increase in satisfaction with the job situation reported by the treatment participants with respect to the traditional model.

However, the personalized treatment does not show a positive effect on employability measures, either from the self-perceived perspective of the participants or from the objective evaluation of the professionals of HOGAR SÍ. There is a significant effect on the number of positions to which participants apply and on the number of selection processes in which they participate.

Finally, the personalized treatment produces an improvement in the perception of the quality of life reported by the participants, including satisfaction with various aspects of daily life and with their state of health. This suggests that, beyond specific aspects, personalized treatment contributes in a comprehensive way to the general perception of the quality of life of homeless people.

Throughout the subsequent data analysis, this analysis has detected some limitations in the questionnaires used: language difficulty, complexity, lack of objectivity in the answers, etc.

In summary, this project shows that the new model of support for people experiencing homelessness provides significant improvements in the residential situation and quality of life compared to the traditional model of labor insertion. There are also improvements in the economic situation and the probability of being employed, although in these indicators the uncertainty regarding the size of the effects is greater. It would be desirable to complement this assessment of the economic situation with the use of administrative data provided by the Social Security, which has not been available to the research team to date. Finally, the impact on employability indicators appears to be small or non-existent.

This report bases its findings on the final survey conducted at the end of the intervention. Assessing the longer-term impact would be desirable since the intervention aims for sustained improvement in the living conditions of individuals facing homelessness. Although this report does not analyze data collected 6 months after the intervention, this information may be available to assess the maintenance of effects.

The results also underscore the need for a broader and longer-term evaluation, as well as consideration of possible adjustments to maximize the effectiveness of the new model across all relevant dimensions for the social reintegration of individuals experiencing homelessness.

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# Appendix

## Economic and regulatory management

### 1. Introduction

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

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

Royal Decree 938/2021, of October 26, which regulates the direct granting of subsidies from the Ministry of Inclusion, Social Security and Migration in the field of social inclusion, for an amount of €109,787,404, within the framework of the Recovery, Transformation and Resilience Plan[35], contributed to meeting milestone 350 for the first quarter of 2022 as outlined in the Council's Implementing Decision: "Improve the rate of access to the Minimum Income Scheme, and increase the effectiveness of the MIS through inclusion policies, which, according to its description, will translate into supporting the socio-economic inclusion of the beneficiaries of the MIS through itineraries: eight collaboration agreements signed with subnational public administrations, social partners and entities of the Third Sector of Social Action to conduct the pathways. The objectives of these partnership agreements are: (i) improve the MIS access rate; ii) increase the effectiveness of the MIS through inclusion policies". Likewise, along with Royal Decree 378/2022, of May 17[36], "at least 10 additional collaboration agreements signed with subnational public administrations, social partners and entities of the Third Sector of Social Action to implement pilot projects to support the socio-economic inclusion of the beneficiaries of MIS through itineraries" contributed to compliance with

[35] 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.

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

monitoring indicator number 351.1 in the first quarter of 2023, linked to the Operational Arrangements document[37].

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 body for granting them, without prejudice to the delegations of existing competences in the matter, upon request by the beneficiary organizations.

On **December 29, 2021**, the organization "Fundación Red de Apoyo a la Integración Sociolaboral" (RAIS Foundation – known as HOGAR SÍ, trade name registered in the Official Gazette of Industrial Property of June 2, 2020) was notified of the Resolution of the General Secretariat of Inclusion and Social Welfare Objectives and Policies granting a subsidy of €2,891,015 to the RAIS Foundation. On the same date, the General State Administration and the Social and Labor Integration Support Network Foundation, through the General Secretariat of Inclusion and Social Welfare Objectives and Policies, signed an agreement for the implementation of a project for social inclusion within the framework of the Recovery, Transformation and Resilience Plan, which was published in the "Boletín Oficial del Estado" on January 31, 2022 (BOE no.26).[38]

### 2. Timeline of the intervention

Article 16(1) of Royal Decree 938/2021, dated October 26, 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, of May 17, Article 6(4) and Article 16(1) are redrafted to extend the maximum term of the pilot projects of social inclusion itineraries subject to the subsidy until **October 31, 2023**, maintaining the deadline **of March 31, 2024,** for its evaluation.

On July 29, 2022, the RAIS Foundation requested an extension of the execution period until **September 30, 2023**, which was authorized by resolution of the SGOPIPS dated August 15, 2022. Likewise, on May 11, 2023, it requested an extension of the execution period until **October 31, 2023**, which was authorized by resolution of the SGOPIPS dated May 17, 2023.

[37] 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.

[38] Resolution of January 21, 2022, of the General Secretariat OF Inclusion and Social Welfare Objectives and Policies, which publishes the Agreement with the Foundation for the Support Network for Socio-Labor Integration, for the implementation of a project for social inclusion within the framework of the Recovery, Transformation and Resilience Plan, which can be consulted at the following link: https://www.boe.es/diario_boe/txt.php?id=BOE-A-2022-1530.

Within this general timeframe, the implementation begins on **March 16, 2022**, with the incorporation of participants into the project, a phase that ended on September 30, 2022, continuing the execution tasks until **October 31, 2023**, and subsequently 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 are:

- **RAIS Foundation**, as the beneficiary entity, and coordinator of the project. Specially its following units:
  a) Social Economy Unit: insertion Companies.
  b) Employment Unit: job readiness and transition to normalized employment.
  c) Unit to measure and evaluate results.
- The **Ministry of Inclusion, Social Security and Migration (MISSM)** as the sponsor of the project, and the main responsible for the RCT evaluation process. The General Secretariat of Inclusion (SGI) assumes the following commitments:
  a) Assist the beneficiary entity in the design of the activities to be conducted for the implementation and monitoring of the object of the grant, as well as for the profiling potential participants in the pilot project.
  b) Design the randomized controlled trial (RCT) methodology of the pilot project in coordination with the beneficiary entity.
  c) Evaluate the pilot project in coordination with the beneficiary entity.
- The ten **insertion companies** subcontracted to conduct the hiring and support of participants.

| Company Name | Sector of activity |
|---|---|
| ARROUPA SANTIAGO EIL S.L. | Collection, classification, valorization, and marketing of second-hand clothing. |
| ELLAS LO BORDAN S.L. | Textile |
| HISPALED S.L. | Electrical installations |
| MILHISTORIAS S.L. | Hospitality industry |
| RECUMADRID SERVICIOS AMBIENTALES S.L.U. | Integrated waste management |
| UZIPEN | Housekeeping, management, and events |
| WORK IN PROGRESS SERVICIOS Y MANTENIMIENTO S.L. | Cleaning |
| ACTIVIDADES DEPORTIVAS Y DE INSERCIÓN S.L. | Cleaning, gardening, maintenance and environment |
| DEIXALLES INSERCIÓ I TRIATGE S.L.U. | Waste management, transport and storage |
| INTEGRAS. TÚ | Cleaning, gardening, services, maintenance |

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

## Sample Balance

**Table 17** reports the balance test between the control and the treatment group. All data reflected in this table refer to the survey conducted prior to the intervention (baseline). The mean value of each variable for both groups is reported, as well as the number of observations in each group and the p-value resulting from a mean difference test (using *Student-t*). 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 can be rejected at a 5% confidence level. If the p-value is greater than 0.10, then the hypothesis of equal means in both groups cannot be rejected.

**Table 17: Balance test between experimental groups**

| | Mean | | | | Observations | | |
|---|---|---|---|---|---|---|---|
| **Variable** | **Control** | **Treatment** | **Diff.** | **P-value** | **Total** | **Control** | **Treatment** |
| *Sociodemographic variables (pre-intervention)* | | | | | | | |
| Age | 42.48 | 41.96 | -0.52 | 0.71 | 322 | 168 | 154 |
| | (12.46) | (12.62) | | | | | |
| Woman | 0.24 | 0.23 | -0.01 | 0.82 | 322 | 168 | 154 |
| | (0.43) | (0.42) | | | | | |
| Non-EU nationality | 0.35 | 0.31 | -0.04 | 0.45 | 322 | 168 | 154 |
| | (0.48) | (0.46) | | | | | |
| EU Nationality | 0.08 | 0.16 | 0.07** | 0.04 | 322 | 168 | 154 |
| | (0.28) | (0.36) | | | | | |
| Spanish Nationality | 0.57 | 0.53 | -0.03 | 0.55 | 322 | 168 | 154 |
| | (0.50) | (0.50) | | | | | |
| Work experience (months) | 53.51 | 61.25 | 7.74* | 0.08 | 315 | 166 | 149 |
| | (40.07) | (38.44) | | | | | |
| Time of unemployment (months) | 24.13 | 26.76 | 2.63 | 0.44 | 295 | 150 | 145 |
| | (29.38) | (29.29) | | | | | |
| Educational Level (years) | 6.57 | 8.71 | 2.14*** | 0.00 | 316 | 166 | 150 |
| | (4.08) | (3.96) | | | | | |
| Illiterate | 0.02 | 0.03 | 0.01 | 0.61 | 316 | 166 | 150 |
| | (0.13) | (0.16) | | | | | |
| Incomplete Primary | 0.40 | 0.13 | -0.28*** | 0.00 | 316 | 166 | 150 |
| | (0.49) | (0.33) | | | | | |
| Complete Primary | 0.25 | 0.27 | 0.01 | 0.78 | 316 | 166 | 150 |
| | (0.44) | (0.44) | | | | | |
| Secondary school | 0.15 | 0.30 | 0.15*** | 0.00 | 316 | 166 | 150 |
| | (0.36) | (0.46) | | | | | |
| Postsecondary | 0.11 | 0.19 | 0.07* | 0.07 | 316 | 166 | 150 |
| | (0.32) | (0.39) | | | | | |
| University | 0.06 | 0.09 | 0.03 | 0.27 | 316 | 166 | 150 |

| | Mean | | | | Observations | | |
|---|---|---|---|---|---|---|---|
| **Variable** | **Control** | **Treatment** | **Diff.** | **P-value** | **Total** | **Control** | **Treatment** |
| | (0.24) | (0.29) | | | | | |
| Mental Health Issue | 0.30 | 0.35 | 0.05 | 0.37 | 322 | 168 | 154 |
| | (0.46) | (0.48) | | | | | |
| Locality - A Coruña | 0.13 | 0.14 | 0.01 | 0.76 | 322 | 168 | 154 |
| | (0.33) | (0.34) | | | | | |
| Location - Madrid | 0.24 | 0.27 | 0.02 | 0.65 | 322 | 168 | 154 |
| | (0.43) | (0.44) | | | | | |
| Locality - Murcia | 0.20 | 0.19 | -0.01 | 0.85 | 322 | 168 | 154 |
| | (0.40) | (0.39) | | | | | |
| Locality - Palma | 0.21 | 0.14 | -0.07* | 0.09 | 322 | 168 | 154 |
| | (0.41) | (0.34) | | | | | |
| Locality - Valencia | 0.13 | 0.15 | 0.02 | 0.53 | 322 | 168 | 154 |
| | (0.33) | (0.36) | | | | | |
| Location - Cartagena | 0.10 | 0.12 | 0.02 | 0.53 | 322 | 168 | 154 |
| | (0.30) | (0.33) | | | | | |
| *Outcome indicators (pre-intervention)* | | | | | | | |
| ETHOS Scale | 2.99 | 2.69 | -0.30 | 0.24 | 322 | 168 | 154 |
| | (2.41) | (2.13) | | | | | |
| Residential Stability | 1.96 | 4.17 | 2.21*** | 0.00 | 310 | 162 | 148 |
| | (4.52) | (6.87) | | | | | |
| Satisfaction with accommodation | 2.42 | 2.60 | 0.18 | 0.27 | 296 | 157 | 139 |
| | (1.33) | (1.42) | | | | | |
| Residential Security | -0.39 | -0.28 | 0.11 | 0.31 | 296 | 157 | 139 |
| | (0.95) | (0.91) | | | | | |
| Total Income | 187.87 | 145.06 | -42.81 | 0.13 | 321 | 167 | 153 |
| | (278.66) | (223.57) | | | | | |
| Economic Satisfaction | 1.63 | 1.60 | -0.03 | 0.75 | 296 | 157 | 139 |
| | (0.93) | (0.91) | | | | | |
| Employment Income | 34.91 | 30.84 | -4.07 | 0.81 | 321 | 167 | 154 |
| | (164.12) | (144.76) | | | | | |
| Employability (professional) | -0.04 | -0.30 | -0.26** | 0.02 | 303 | 160 | 143 |
| | (1.03) | (0.92) | | | | | |
| Employability (self-reported) | -0.08 | -0.06 | 0.02 | 0.86 | 290 | 152 | 138 |
| | (1.04) | (0.83) | | | | | |
| Work activity (days) | 8.42 | 9.23 | 0.81 | 0.76 | 315 | 165 | 150 |
| | (22.90) | (24.77) | | | | | |
| Employed | 0.05 | 0.05 | -0.00 | 0.96 | 317 | 166 | 151 |
| | (0.23) | (0.22) | | | | | |
| Employment Status | 2.02 | 2.12 | 0.09 | 0.43 | 303 | 160 | 143 |
| | (0.87) | (1.20) | | | | | |

| | Mean | | | | Observations | | |
|---|---|---|---|---|---|---|---|
| **Variable** | **Control** | **Treatment** | **Diff.** | **P-value** | **Total** | **Control** | **Treatment** |
| Job Satisfaction | 1.64 | 1.66 | 0.02 | 0.82 | 296 | 157 | 139 |
| | (0.99) | (0.87) | | | | | |
| Quality of life | -0.32 | 0.00 | 0.33*** | 0.01 | 284 | 146 | 138 |
| | (0.96) | (1.01) | | | | | |

Note: Standard errors, grouped by randomization strata, reported in parentheses.
Levels of significance: * p < 0.10, ** p < 0.05, *** p < 0.01.