Financial Incentives, Health Screening, and Selection into Mental Health Care: Experimental Evidence from College Students in India*

Emily Breza Kevin Carney Vijaya Raghavan Kailash Rajah
Thara Rangaswamy Gautam Rao Frank Schilbach
Sobia Shadbar James Stratton

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Abstract

Young adults worldwide experience high rates of depression and anxiety, but many do not seek treatment. We conducted a randomized controlled trial in Chennai, India (N=340) to test how modest financial incentives and personalized mental health feedback affect the uptake and targeting (by severity of symptoms) of free therapy among college students. Despite 56% of students screening positive for at least mild depression or anxiety, only 3% took up therapy in the control group. A small cash incentive (∼$6 USD) increased appointments by 9 pp ($p = 0.06$) on average and slightly improved targeting. Personalized feedback and recommendations based on a simple mental health screening tool did not increase appointments on average but significantly improved targeting. Combining cash incentives with personalized feedback increased appointments by 21 pp ($p < 0.01$) among symptomatic individuals, without affecting uptake by asymptomatic individuals. These findings suggest that low-cost incentives coupled with screening information can effectively increase uptake while allocating limited mental health care resources to those with greater need.

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1 Introduction

Young people around the world face high rates of mental ill-health, but most do not take up mental health services (Wang et al., 2007; Patel et al., 2010; Mojtabai et al., 2011). While supply-side constraints are well documented (Patel et al., 2016; Alonso et al., 2018), there is growing evidence that demand-side factors also represent a significant barrier (Cronin et al., 2024; Roth et al., 2024). Interventions to increase mental health literacy and reduce stigma through education have shown limited success in changing treatment rates (Thornicroft et al., 2016; Xu et al., 2018). One potential policy tool to address these barriers is to offer cash incentives for trying therapy. The risk of this approach is undesirable selection: those without much need for mental health care could take up therapy purely for the incentive payments, crowding out those with the most need. This challenge is exacerbated by the fact that many mental health conditions cannot be objectively measured.

We study take-up and targeting of therapy among college students in Chennai, India. We recruit our sample ($N = 340$) at an all-women arts and science college.We document alarmingly high rates of mental distress at this college in our baseline survey, mirroring recent evidence from around the world.[1] On the PHQ-ADS—a validated composite screening tool for depression and anxiety (Kroenke et al., 2019)—56% of students screen positive for at least mild symptoms of depression or anxiety, and around a quarter for moderate or severe symptoms.[2] Despite this, take-up of mental health services is very low: only 5% report currently receiving treatment from any mental health professional, despite free-of-charge counseling services at the college.

We experimentally evaluate three interventions aimed at increasing take-up and improv-

[1]For examples of recent evidence from India, see Kumar et al. (2012); Yadav et al. (2016); Singh et al. (2017); Shah and Pol (2020). For similar evidence from other countries, see Duffy et al. (2019); Gao et al. (2020); Demenech et al. (2021); Lipson et al. (2022); Akram et al. (2023). For comparisons across countries, see Auerbach et al. (2018); Li et al. (2022).

[2]Future job prospects, academic stress, social isolation, relationship difficulties, and financial hardship are the most commonly reported sources of distress.

ing the targeting of therapy. In the *Rewards* treatment, students receive a 500 rupee (∼6 USD nominal, or ∼25 USD PPP) cash payment upon attending their first therapy session. Students could complete this therapy session either with college counselors or at an off-campus partner mental health center that offered more specialized services. Rewards may increase take-up through standard incentive effects, by reducing procrastination, countering underestimation of benefits, or providing social cover for using a stigmatized service. But they may induce take-up by students without much need for therapy.

In the *Screening* treatment, students receive personalized feedback on their PHQ-ADS results, informing them of their psychological distress levels (none, mild, moderate, or severe). Those with moderate or severe symptoms were also encouraged to reach out to a counselor. The motivating idea is that some people may not recognize the seriousness of their psychological distress, or may not realize that therapy is indicated as a treatment for the symptoms they are experiencing.[3]

Finally, in the *Rewards & Screening* treatment, students receive both interventions. This third arm aimed to boost take-up while addressing the problem of mistargeting. All students, including in the control condition, were informed that they had access to free therapy by qualified counselors at the college and the off-campus partner.

Our outcome measures focus on students' take-up of mental health services. Within the survey, we ask all students (including in the control condition) whether they would like to initiate contact with therapy services by sending a text message or asking to be contacted themselves. We also acquire administrative data from the college counseling service and the partner mental health center to verify whether students followed through with making an appointment. These constitute our primary outcome measures. We also collect administra-

[3]Consistent with this motivation, about 30% of students with moderate levels of depression or anxiety—for which psychotherapy is recommended as a treatment—do not think of themselves as having depression or anxiety. And, as described in Section 2.1, when presented with a vignette of an individual dealing with persistent sadness, only 10% of college students in a different sample suggest seeing a mental health professional.

tive data on whether students attended at least one therapy session (a secondary outcome) and whether they scheduled additional follow-up sessions if recommended by the therapist (an unregistered exploratory outcome).

Only 3% of students in the control group make an appointment to see a therapist.[4] This share is only 1 pp higher among symptomatic students (those with mild or higher symptoms of depression or anxiety) compared to asymptomatic students, suggesting little selection into therapy based on need in our sample population.[5] The *Rewards* treatment substantially increases take-up of therapy. Students offered a small cash incentive are on average 9 percentage points more likely to schedule a therapy appointment ($p = 0.06$) — four times the level in the control group. Students follow through on these appointments: they are 7 percentage points more likely to attend at least one therapy session ($p = 0.09$).

How do financial reward by themselves affect the targeting of therapy? Our point estimates indicate a 6 percentage point increase in appointments among students we judge to be asymptomatic ($p = 0.29$), and a 12 percentage point increase for symptomatic students ($p = 0.08$). Thus, we find suggestive evidence of both increased usage among low-need students *and* improved targeting due to larger increases among high-need students. These findings must be interpreted with caution for at least two reasons: (a) their statistical imprecision; (b) our proxy for need—scoring above a certain level of symptom severity—is itself imperfect. Some students we classify as asymptomatic may truly benefit from therapy. In an exploratory analysis, we find that the one-time financial reward leads to significantly improved targeting once we examine follow-up appointments (for which there are no financial rewards). Thus, financial rewards may get students in the door, but counselors can then identify the students with the greatest need for continued care.

[4]This is in addition to the 5% of students in the control group who are already seeing a therapist or psychiatrist at baseline.

[5]Patients with higher symptom severity benefit more from psychotherapy (Bower et al., 2013), and better targeting is therefore valuable, particularly given the scarce supply of mental health services in India (Gururaj et al., 2016).

The *Screening* intervention has no significant impact on take-up on average. However, this masks an important and desirable heterogeneity: it reduces appointments made by asymptomatic students by 5 percentage points to nearly zero, while substantially increasing appointments made by symptomatic students by 8 pp ($p = 0.2$). The targeting effect—the difference in effects on symptomatic and asymptomatic students—is thus 13 pp ($p = 0.06$) screening tool improves targeting but does not substantially increase total take-up.

In the combined *Rewards & Screening* intervention, there is a large aggregate effect on making appointments (11 pp; p-value = 0.01). This aggregate effect is 9 percentage points higher than in the *screening* intervention ($p = 0.07$) and similar to the *Rewards* intervention ($p = 0.67$). We find stark heterogeneity in effects: there is a small (insignificant) decrease in appointments made among the asymptomatic, while appointments increase by 21 pp ($p < 0.01$) among symptomatic students. Thus, combining small cash rewards with screening information leads to a large increase in take-up, entirely driven by those in need. This pattern holds not just for making appointments, but also for following through with visiting the therapist (18 pp, $p = 0.01$).

Our paper adds to a growing literature on the economics of mental health. Depression and anxiety are the leading cause of disability worldwide (Friedrich, 2017). In addition to the profound suffering they cause, they may also worsen economic outcomes (Ridley et al., 2020; Lund et al., 2024). Psychotherapy is an effective long-run treatment for these conditions (Cuijpers et al., 2016; Baranov et al., 2020; Bhat et al., 2022). Yet, despite compelling evidence of its efficacy, treatment gaps remain stubbornly high. Recent work in economics has argued that demand for treatment is inefficiently low due to factors such as information frictions and social stigma (Cronin et al., 2024; Roth et al., 2024; Smith, 2025).

We demonstrate how a combination of modest financial incentives and personalized feedback can increase demand for treatment while directing scarce treatment resources to those with more need. In doing so, we provide the first evidence from a randomized evaluation of

financial incentives to increase uptake of therapy for depression and anxiety.[6] This adds to a substantial evidence base that small financial or non-financial incentives can improve health behaviors at least in the short term (Vlaev et al., 2019; Khazanov et al., 2022).

A priori, it is not obvious that financial incentives for trying therapy for depression would be effective. First, depression is associated with pessimism, high perceived effort costs, and inactivity. Therapy is effortful and can be intimidating. One might worry that depressed individuals would therefore not be responsive to (modest) financial incentives. Our findings ease this concern, and are instead consistent with Naik (2025), who finds that individuals with poor mental health are more responsive both to benefits and barriers to take-up of social welfare programs. Second, a practical concern is that depression and anxiety are subjective conditions and incentives could thus be gamed. We find little evidence of this, particularly when incentives are combined with personalized feedback.

Our findings on the effects of personalized feedback and recommendations add to a small body of recent evidence from randomized experiments providing mental health screening results to individuals in online samples and tracking mental health care use (Batterham et al., 2016; Kohlmann et al., 2024). In contrast to our findings, those studies do not find increases in health-seeking behaviors. A plausible explanation for the differences in our findings is that we provide screening results and recommendations while also providing an immediate and relatively frictionless next step of offering appointments with therapists. Such channel factors have long been understood to be important in affecting behavior (Ross and Nisbett, 2011).[7]

More broadly, our study connects the health economics literature on selection into health

[6] Closest to our paper, Post et al. (2006) conducts a non-randomized before vs. after study of the effect of financial incentives on regular attendance of therapy sessions among patients already receiving therapy, and finds increases in attendance after incentives commence.

[7] Our findings are somewhat more consistent with a recent cluster randomized study in schools in Australia, where parents were provided with mental health screening results of their children (Rapee et al., 2025). That study found improvements in mental health among students whose parents were provided screening results, but did not find increases in the use of formal mental health care.

care (*e.g.*, Einav and Finkelstein, 2011; Hackmann et al., 2012) with the literature in public finance on ordeals and self-selection into social program participation (*e.g.*, Alatas et al., 2012, 2016; Finkelstein and Notowidigdo, 2019; Rafkin et al., 2023). We find very low uptake of an effective treatment under business-as-usual, with no evidence of selection based on need. In sharp contrast, combining modest incentives with personalized information generates strong selection into the treatment based on need.

2 Setting and Experimental Design

2.1 Context

India is an especially relevant context for our study because of low take-up of mental health care: India's National Mental Health Survey reports that over 80% of individuals with mental health disorders do not receive appropriate care (Gururaj et al., 2016). This "treatment gap" is acute among college students. In recent surveys of Indian college students, between 50% and 70% of respondents have screened positive for depression, with similar shares for anxiety (Kumar et al., 2012; Singh et al., 2017). College can be an especially challenging time for youth in this setting, as students transition away from tight-knit family environments towards spending considerable time around new peer groups and face a challenging labor market.[8] Nonetheless, as in the general population, take-up of mental health care among students remains low (Sidana et al., 2012; Das and Bhattacharya, 2015; Arun et al., 2022).

Students in our context are broadly familiar with the concepts of depression and anxiety, but don't think of therapy as a relevant solution. Before recruiting study participants, we conducted surveys with similar student populations to better understand knowledge and beliefs about depression, anxiety, and therapy (Appendix Figure 1). About 90% of stu-

[8]Indeed, a survey of students in 19 colleges around eight countries indicates that "colleges around the world are contending with rising rates of mental disorders, and in many cases, the demand for services on campus far exceeds the available resources" (Auerbach et al., 2018, p. 623).

dents reported some basic familiarity with terms such as counselors, anxiety, and depression. Around half reported knowing where to find a psychiatrist. In response to a vignette describing an individual who has lost a job or a family member and who subsequently feels persistent sadness that makes them incapable of completing daily activities, around half the students volunteer that the individual shows symptoms of depression. Yet only one-tenth suggest seeing a mental health professional as a way to improve the individual's situation. And when prompted, only a quarter of students say they would personally see a mental health professional if depressed. Students might doubt the efficacy of mental health care in general, perceive social stigma around receiving it, or simply not think it is helpful for the issues *they* face.

Supply-side barriers also exist. In India, there is both a shortage of mental health facilities and professionals (Patel et al., 2016). For example, there are only 0.3 psychiatrists per 100,000 people in India compared to 10.5 in the US (World Health Organization, 2016). Our partner organization also faces significant capacity constraints, particularly for acute care. Triaging care to patients most in need remains a policy priority for the organization and motivates our screening intervention.

2.2 Sample recruitment

We recruited 340 undergraduate students from an all-women's arts and science college in Chennai. Enrollment took place at the classroom level on a rolling basis. We recruited our sample during college hours by visiting classrooms at times scheduled in coordination with the college administration. There was very little attrition: 98% of students present during our visits consented to participate in the study, and 97% completed the study. Students received an introduction from the research team, who described the study as focusing on student health and well-being. Students who were within the eligible age range (18 to 30) and who consented to the study completed a survey on their personal mobile devices,

including questions on demographics, self-perceived mental health, and treatment history. The survey also included the PHQ-ADS, a 16-point validated composite instrument screening for depression and anxiety. Appendix C contains the full survey instrument.

2.3 Experimental design

The experiment was designed with three broad objectives. First, we measure the effect of modest financial incentives on participants' pursuit of free mental health care. These incentives may operate through standard price effects, help to overcome present bias, relax credit constraints, or provide social cover. Second, we measure the effects of providing students with personalized feedback regarding the severity of their current mental health symptoms and the corresponding clinical recommendations. This personalized screening information may update students' beliefs about their mental health as well as the value or appropriateness of therapy for someone in their condition. Finally, when designing the experiment, we anticipated that financial incentives may increase take-up, whereas screening may improve targeting; a natural question is whether the combination of the two interventions would increase take-up while ensuring therapy is targeted to students most in need. The third treatment group therefore receives both incentives and screening.

Figure 1 presents our simple two-by-two cross-randomization design. We randomize participants into a control group or one of the three treatment groups at the individual level, stratifying by participants' PHQ-ADS scores collected in the baseline (pre-treatment) section of the survey. All participants, including in the control group, (a) watched a video introducing them to the mental health services available in the college, including introductory videos of the college counselors, (b) were informed they had access to therapy at no cost for the duration of the study, (c) were offered links to prefilled WhatsApp messages to each of the study-affiliated counselors to request a therapy session, and (d) received links to download a mental health app and/or web articles on depression and anxiety, if they indicated they

were interested in receiving these resources.

In scoping surveys, some students expressed a preference for college counselors, whereas others expressed a preference for external counselors. We facilitated both options by partnering with college counselors and SCARF, a mental health center in Chennai. Students were able to make therapy appointments either with college counselors or with SCARF at no cost for the duration of the study. Participants who consented (before treatment) to receive further communications from the research team were sent text messages one day, seven days, and 21 days after survey completion, reminding them of the mental healthcare services being offered as part of the study and how they could be accessed.

In addition, the treatment groups received the following interventions:

1. **Rewards:** Participants in the *Rewards* group receive a cash payment of Rs. 500 (∼USD 6) for attending their first therapy session with a study-affiliated counselor.[9] These participants were informed of these incentives in the initial survey and reminded in each follow-up text message. Panel (a) of Appendix Figure 3 shows the offer of rewards provided as part of the survey (see the full survey instrument in Appendix C).

2. **Screening:** Participants in the *Screening* group received feedback on whether their responses to the PHQ-ADS questions corresponded to the standard risk categories of no, mild, moderate, or severe distress. Students whose PHQ-ADS scores indicated moderate or severe symptoms of depression or anxiety saw a message saying that they were "encouraged" or "strongly encouraged" to contact a counselor based on their score. This follows standard clinical practice in India. Participants who scored as having mild or no symptoms of psychological distress were still informed that "you may still reach out to one of the study counselors if you think you will benefit from

[9]Counselors monitored whether students attended therapy sessions and notified the field team accordingly. The field team then approached students in person at regularly scheduled visits to the college campus and paid students in cash, typically a day or two after the appointment. Payments were made only for appointments scheduled within 30 days of students completing the survey.

it." Panel (b) of Appendix Figure 3 shows an example of this information.

3. **Rewards and Screening:** Participants in this group receive both the rewards and screening interventions described above.

For ethical reasons, participants with PHQ-ADS scores of 30 or above (6 percent of the sample)—indicating severe risk of depression and anxiety—were informed of their scores at the end of the survey if they were not randomized to one of the screening arms, and thus did not already receive this information. We still include these observations in the original groups they were assigned to in an intent-to-treat analysis. For the outcome variables that are measured after the conclusion of the participant survey—making an appointment for therapy, attending that appointment, and scheduling a follow-up appointment—we also provide robustness checks that exclude all participants classified as severely distressed in the Appendix.

Appendix Table 1 shows balance tests of baseline characteristics across treatments. Baseline characteristics are generally similar across arms. There is some imbalance on personal income, which is included as one of the controls throughout the analysis. Five students who started the survey did not complete it (1.45$ of students). We do not include these students in the analysis.

Pre-registration. We pre-registered the experimental design and analysis plan (AEARCTR-0015379) and note any deviations from the plan below. Notably, we had registered that we would attempt to reach all the students in the college but had indicated substantial uncertainty in eventual sample size due to high student absence rates and our reliance on the college to provide access to students. Due to an unexpected change in the number of teaching days at the college (resulting from a government policy change), the number of days during which we could recruit students was substantially smaller than we expected. We preregistered several primary and second outcomes, which we describe in the next section.

2.4 Outcome measures

We assess the impacts of these interventions on the full pathway of steps towards taking up mental health treatment, from initial expressions of interest to scheduling appointments to final attendance and follow-up appointments.

Initiating engagement. We measure several steps towards engagement with mental health services:

1. *Contact with counselors.* Within the initial survey, students can message study-affiliated counselors via WhatsApp, and/or request that a study-affiliated counselor contact them to discuss mental health and therapy. For simplicity, our main analysis uses an indicator variable for a participant initiating engagement in either of these ways. We also report results for these two outcomes separately.

2. *Making appointment.* We measured whether participants actually made an appointment with a study-affiliated counselor by tracking administrative records from the counseling offices for a period of 60 days post survey completion.[10]

3. *Interest in mental-healthcare app.* We recorded participants' choice to click a link to learn more about accessing a mental health-related app as part of the survey.

4. *Interest in information about mental health.* We recorded participants' choice to click a link to gain more information about mental health and therapy.

Actual Take-up. Beyond recording interest, we also measure whether participants use mental health services

1. *Attending therapy sessions.* We measured whether participants actually attended a scheduled appointment with a study-affiliated counselor by tracking administrative

[10]Note that contact with counselors and scheduling an appointment are our primary pre-registered outcomes. We pre-registered the other engagement and take-up outcomes as secondary. We hypothesized that we would have the most statistical power over outcomes in the initial stages of subject engagement.

records from the counseling offices at the college and SCARF for a period of 60 days post survey completion. We also used this data to measure whether participants scheduled any follow-up appointments.[11]

2. *Accessing mental-healthcare app.* We recorded participants' clicks on trackable links to the mental-healthcare app provided in the survey.

3. *Accessing mental-healthcare literature.* We recorded participants' clicks on trackable links to mental-healthcare literature (articles on depression and anxiety) provided in the survey, conditional upon their interest.

Preregistered outcomes. We preregistered two primary outcomes of interest: students counseling contacts through the survey (or asking counselors to contact them); and students making an appointment with a counselor. We preregistered students' actual attendance of appointments as a secondary outcome; since it is closely related to these primary outcomes, we report it alongside the primary outcomes throughout our analysis. We also preregistered the other outcomes described above as secondary outcomes.

Although we did not preregister follow-up appointments as an outcome, we include it as part of our exploratory analysis. We report effects on follow-up appointments alongside effects on initial appointments for ease of comparison.

2.5 Baseline mental health

Figure 2 shows indicators of students' mental health at baseline. Panel (a) shows a high incidence of depression and anxiety as measured by PHQ-ADS scores, consistent with other recent surveys of mental health at Indian colleges (Kumar et al., 2012; Yadav et al., 2016; Singh et al., 2017; Shah and Pol, 2020). A little over half of students screen for mild

[11]Note that our intervention was conducted near the end of the semester. Thus, there was limited time for follow-up appointments within the semester.

depression or anxiety (PHQ-ADS scores of at least 10); around a quarter of students screen for moderate (PHQ-ADS scores between 20 and 29) or severe (PHQ-ADS scores of 30 or above) depression or anxiety. Among students who screen for depression or anxiety, around 95% screen for depression, and around 90% screen for anxiety.[12]

Panel (b) shows students' self-assessed mental health. Around one third of students self-assess as currently having depression; the share self-assessing as currently having anxiety is a little lower. One-sixth of students indicate that they believe they have both conditions. Around half of the students indicate that they do not have either condition.

Panel (c) compares students' self-assessed mental health to PHQ-ADS scores. PHQ-ADS scores are strongly correlated with the likelihood that a student believes that she has depression or anxiety (pairwise correlation = 0.43, $p < 0.01$). Nonetheless, panel (c) also demonstrates that around 51% of students who screen for mild depression or anxiety on the PHQ-ADS do not believe they are suffering from depression or anxiety, and around 25% of students who screen for moderate or severe depression or anxiety do not believe they are suffering from either condition. We emphasize that there are reasons for self-assessment to differ from PHQ-ADS scores other than misclassification: for instance, the PHQ-ADS is itself a noisy measure of mental health. Nonetheless, panel (c) suggests that there is some room for students' beliefs to be affected by learning their PHQ-ADS scores, which motivates our *Screening* treatment.

Panel (d) presents the major stated reasons for mental distress among students screening for depression and/or anxiety. The most common reasons for distress are future job/career prospects (62% of students), academic matters (49%), and feelings of isolation (38%).

Despite this high incidence, there is very little engagement with mental health services at baseline. Only around 10% of students have any prior experience with counselors or psy-

[12]Appendix Figure 2 shows the distribution of scores on the depression (PHQ-8, Panel (a)) and anxiety (GAD-7, Panel (b)) components of the PHQ-ADS, respectively. In practice, the correlation between the PHQ-8 and GAD-7 is very high ($\rho = 0.82$), and so most students who screen for depression or anxiety in the joint PHQ-ADS also screen separately for both conditions.

chologists, and only around 5% of students are currently seeing a counselor or psychologist.

3 Results

3.1 Average effects

We begin by assessing the total effects of treatment assignment. We run OLS regressions of the form

$$\mathrm{Y}_i = \alpha + \beta \mathrm{Screen}_i + \gamma \mathrm{Rewards}_i + \delta(\text{Screen and rewards}_i) + X_i'\lambda + \epsilon_i, \tag{1}$$

where Y_i represents the outcomes for individual i described above, and X_i is a vector of controls consisting of fixed effects for categories of PHQ-ADS scores, family support for seeing a therapist, self-reported current mood, mood over the last two weeks, and mood over the last six months, self-reported current and past experiences of depression and anxiety, and level of disposable income.[13]

Table 1 Panel A displays regression coefficients for four outcomes: expressing interest in contacting a counselor, scheduling an appointment, attending an appointment, and scheduling a follow-up appointment. Consistent with low reported experience with mental health care, the level of engagement with mental health services in the control group is low: although almost 19% of students initiate contact with study counselors, only about 3% schedule or attend appointments.

For each of the four outcome variables, the estimated effect of assignment to the screening group (β) is statistically indistinguishable from zero. Though the estimate is imprecise, we can rule out large effects of screening on average: for instance, we can conclude at the 5%

[13] In our pre-analysis plan, we indicated that we would also include a control for level of therapy. Since our final survey instrument asked participants to indicate level of interest in therapy after being informed of their treatment assignment, we do not use this variable as a control in our analysis.

level that the effect of screening on the likelihood of attending an appointment was no more than 6 p.p.

By contrast, financial incentives increase average engagement with mental health services. The estimated effect of assignment to the *Rewards* group (γ) is positive in all specifications, and significant for the first three outcomes. Rewards nearly double students' interest in counselor contact (0.34 vs. 0.19, col. 1), and triple the likelihood of scheduling a therapy appointment (0.12 vs. 0.03, col. 2). Remarkably, these impacts nearly entirely translate into attendance of therapy appointments (col. 3). The estimated effect of assignment to the combined screening and rewards group (δ) is of similar magnitude and statistically indistinguishable from the corresponding estimates for the rewards group.[14]

3.2 Heterogeneity by baseline mental health status

We now turn to heterogeneity by participants' baseline mental health status, as measured by their PHQ-ADS scores. We run

$$\begin{aligned} \mathrm{Y}_i = \alpha_0 &+ \alpha_1 \mathrm{Symptomatic}_i + \beta_0 \mathrm{Screen}_i + \beta_1 \mathrm{Screen}_i \times \mathrm{Symptomatic}_i \\ &+ \gamma_0 \mathrm{Rewards}_i + \gamma_1 \mathrm{Rewards}_i \times \mathrm{Symptomatic}_i \\ &+ \delta_0 (\mathrm{Screen\ and\ rewards}_i) + \delta_1 (\mathrm{Screen\ and\ rewards}_i) \times \mathrm{Symptomatic}_i \\ &+ X_i' \lambda + \epsilon_i, \end{aligned} \tag{2}$$

where $\mathrm{Symptomatic}_i$ is an indicator variable for student i having a PHQ-ADS score of at least 10. This specification enables us to estimate treatment effects for symptomatic and

[14] Appendix Table 2 shows the results from a corresponding regression which pools treatments to compare all students who received rewards (either in the rewards group or in the rewards plus screening group) *vs.* all students who did not receive rewards (either in the pure control group or in the screening group), and likewise for all students who did *vs.* did not receive screening. We interpret these pooled treatment effects of assignment to a given treatment arm as being conditional on the assignment of other treatment arms in the experiment (Kremer 2003; Duflo et al. 2007; Muralidharan et al. 2025). The results are similar to those in Table 1: rewards robustly increase average engagement with mental health services; screening does not tend to affect average engagement.

asymptomatic students separately. For instance, we interpret β_0 as the causal effect of assignment to the *Screening* group on the outcome variable among asymptomatic students, and $\beta_0 + \beta_1$ as the causal effect among symptomatic students.

Table 1 Panel B shows the results. In the control group, we find limited evidence of selection into treatment based on symptom severity. Symptomatic students are more likely to initiate contact with a counselor relative to asymptomatic students (0.30 vs. 0.05, col. 1). However, many of these students do not ultimately schedule or attend appointments. We find no significant differences between symptomatic and asymptomatic students for these outcomes (cols. 2 through 4).

While leaving average engagement with mental health services unchanged, the *Screening* treatment appears to *reallocate* engagement between individuals, as shown in the first two rows of Table 1 Panel B. The *Screening* has a small statistically insignificant negative effect on appointment scheduling for asymptomatic students, but a significantly more positive effect on symptomatic students ($p = 0.06$). In contrast, assignment to the *Rewards* treatment increases the level of engagement with mental health services, without substantially affecting the difference between students with differing levels of symptoms.

Assignment to the *Rewards and Screening* treatment increases take-up among symptomatic individuals without affecting take-up among asymptomatic students. The effects are large in magnitude. For instance, assignment to the rewards and screening group increases the likelihood of scheduling an appointment by 21 percentage points for symptomatic students ($p < 0.01$)—a substantial change relative to the control mean of 4 percentage points.[15]

Figure 3a visualizes these effects. Navy bars display the likelihood of scheduling counseling among asymptomatic students, separately for each of the four treatment arms. Light blue bars display the likelihood of scheduling counseling among symptomatic students in each

[15]Appendix Table 3 replicates Table 1, instead separately analyzing effects on students with no symptoms of depression/anxiety *vs.* mild symptoms *vs.* moderate/severe symptoms. Appendix Table 5 considers the effects of pooled rewards and screening arms, as opposed to the saturated specification. Appendix Table 7 replicates Table 1 for our secondary outcomes.

treatment arm. The panel also displays 90% confidence intervals. Assignment to *Rewards* increases engagement with mental health services among all students; assignment to *Screening* increases engagement with mental health services only among symptomatic students. The *Rewards and Screening* arm substantially increases take-up, with the effect targeted among symptomatic students.[16]

Figure 3b visualizes the effects using a continuous PHQ-ADS score, rather than the discrete categories in Table 1.[17] The figure presents a binned scatterplot of the likelihood of scheduling counseling vs. PHQ-ADS scores, separately for each of the four treatment lines. Dots represent deciles of the data; we also present lines of best fit from the regression:

$$\begin{aligned}\text{Appointment scheduled}_i = \alpha_0 + \alpha_1 \text{PHQ-ADS}_i + \beta_0 \text{Screen}_i + \beta_1 \text{Screen}_i \times \text{PHQ-ADS}_i \\ + \gamma_0 \text{Rewards}_i + \gamma_1 \text{Rewards}_i \times \text{PHQ-ADS}_i + \\ + \delta_0 \text{Screen and rewards}_i + \delta_1 \text{Screen and rewards}_i \times \text{PHQ-ADS}_i + \epsilon_i.\end{aligned} \tag{3}$$

In the navy blue line, representing the pure control group, very few students schedule therapy, regardless of their PHQ-ADS score: as a result, the slope of the relationship between the likelihood of scheduling counseling and PHQ-ADS score in the control group is very close to zero (slope = 0.12, $p = 0.53$). The *Rewards* treatment, presented in light blue, produces a level shift in interest in undertaking therapy: all students are more likely to schedule counseling. By contrast, the screening group, presented in orange, produces a pivot relative to the control group: students at high levels of PHQ-ADS scores are more likely to schedule therapy, whereas there is no effect (or even a marginally negative effect) for students with low PHQ-ADS scores. The rewards plus screening line, in maroon, maintains both the pivot effect of the screening group, and the level increase of the rewards group.

[16] Appendix Figure 6 replicates Figure 3a, distinguishing also between participants with mild *vs.* moderate/severe symptoms of depression/anxiety, and shows that these effects are especially driven by increases in engagement among students with moderate/severe symptoms.

[17] Corresponding regression coefficients are presented in Appendix Table 4.

3.3 Interpretation

Why does providing screening information increase the take-up of counseling for symptomatic individuals? Recall that the screening message contained information about both the severity of each student's symptoms (measured by the PHQ-ADS score) and, for those with moderate to severe symptoms, a recommendation to seek therapy. A priori, there are several possible interpretations. First, treated individuals may learn about their mental health status from the screening information, though this is perhaps less likely given the strong correlation between self-assessed mental health and PHQ-ADS. Second, treated individuals may learn that therapy is appropriate for their condition. Finally, the information might simply serve to bring the student's mental health status top of mind. Given that the intervention makes it simple to make an appointment, this "nudge" might be enough to push some into making an appointment.

While our experiment was not designed to carefully parse these alternatives, we present additional evidence to facilitate interpretation. Appendix Figure 5 shows treatment effects by splitting the sample into those whose self-assessed mental health status matched the results of the PHQ-ADS test (Panel A) and those whose self-assessments did not match (Panel B). We find that our patten of results is driven by students in Panel A whose baseline self-assessment was *congruent* with their PHQ-ADS scores. The results suggest that the value of screening extends beyond correcting a basic misperception of one's mental health status. Instead, the benefit is likely to come from the reinforcement provided by the screening information and the recommendation to seek therapy (or the "nudge"). In Panel B, we see suggestive evidence that rewards increased take-up among students who self-assessed as symptomatic but were classified by the PHQ-ADS scale as asymptomatic, but that the screening treatment dampened their take-up. In our setting, there is limited scope for the screening interventions to decrease take-up because control take-up rates are extremely low. However, this result opens the possibility that in settings with higher take-up, screening

could have the unintended effect of screening out individuals who self-assess as symptomatic but are told otherwise based on the screening tool.

Figure 4 presents data from control students who screened positive for depression or anxiety but who did not express interest in therapy on why they made that choice. The two most common stated reasons are the beliefs that they do not need therapy and that therapy will not help them. This is again consistent with the screening information reinforcing the idea that symptomatic students could benefit from therapy.

4 Discussion and Conclusion

Psychotherapy is an effective treatment for depression/anxiety (Cuijpers et al., 2013, 2023; Barth et al., 2016; Bhat et al., 2022), but take-up remains low. For this reason, it is a policy priority in many parts of the world to increase engagement with mental health services (Patel and Prince, 2010). In light of the scarcity of supply of mental health services, these policies face the challenge of increasing take-up while prioritizing need.

We studied this challenge in a sample of college students in Chennai. A small financial incentive substantially increased engagement with mental health services, including a four-fold increase in the likelihood of scheduling a therapy appointment. However, combining screening information with incentives can improve the targeting of mental health resources and generate large gains in take-up among the population with the greatest need. Moreover, the effects are strongest within the group of symptomatic individuals who also self-assess as having depression or anxiety. These findings raise a series of open questions. For example, how would the results compare in other samples in developing countries? Our study population of college students exhibits high awareness of mental health disorders, though low perceived usefulness of therapy. Similarly, do the increases in take-up induced by incentives and screening lead to sustained engagement with therapy and ultimate improvements in

mental health?

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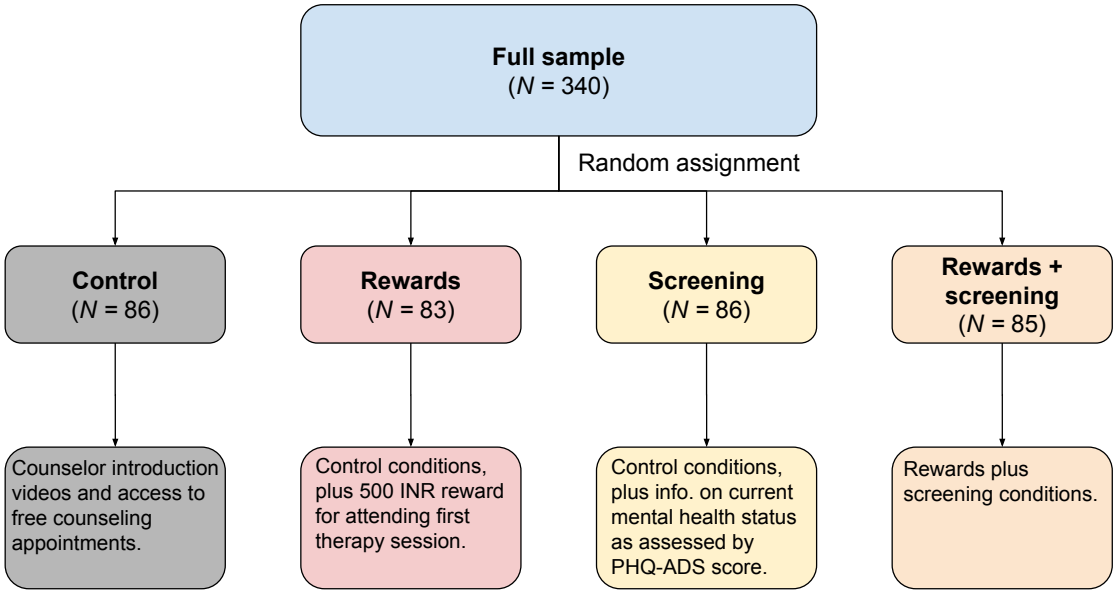
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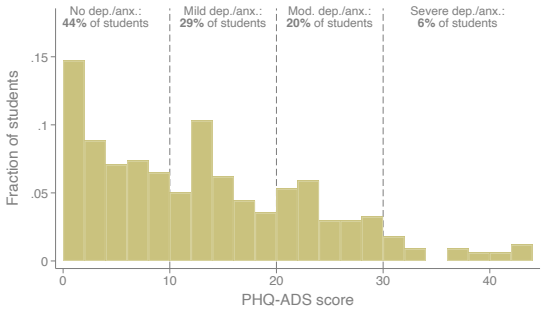
Figure 1: Experimental design



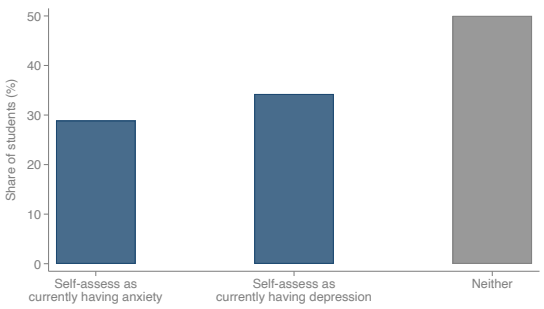
Notes: This figure presents the experimental design. For ethical reasons, we also provide screening results to students who are randomized to the control or rewards groups but screen for severe depression or anxiety (see Section 2.3).

Figure 2: Mental health status at baseline

(a) Distribution of PHQ-ADS Scores



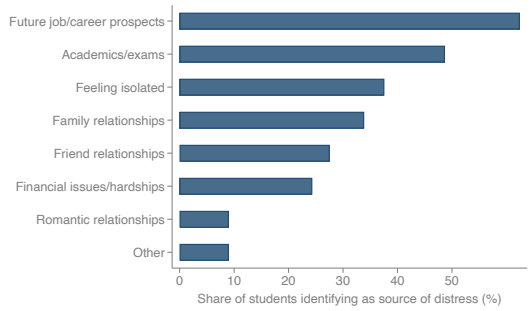
(b) Self-assessed mental health



(c) Current self-assessment *vs.* PHQ-ADS scores



(d) Sources of distress among students screening for depression or anxiety



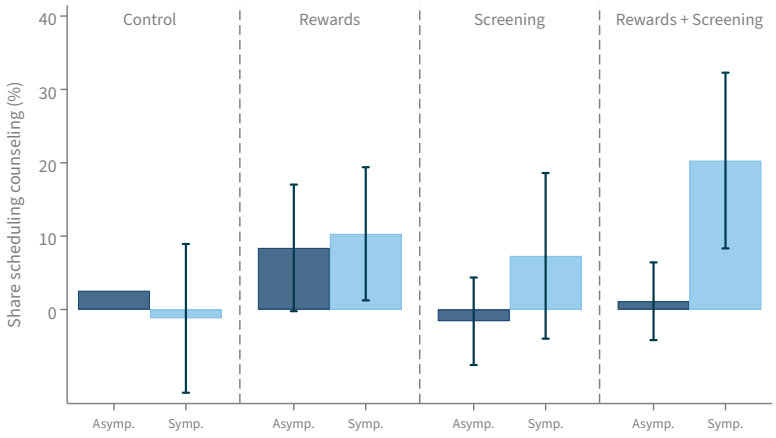
Notes: Panel (a) presents a histogram of PHQ-ADS scores at baseline. The text indicates the share of students screening for no depression or anxiety (PHQ-ADS score of 9 or below), mild depression or anxiety (PHQ-ADS score between 10 and 19), moderate depression or anxiety (PHQ-ADS score between 20 and 29) and severe depression or anxiety (PHQ-ADS score of 30 or above). Panel (b) presents a bar chart of students' self-assessment of their current mental health. Note that bars do not add up to 100% because students can be in multiple navy bars. Panel (c) shows a binned scatterplot of the likelihood that a student self-assesses as experiencing depression or anxiety *vs.* the student's PHQ-ADS score. Ventiles of the data are presented as navy dots; the red line is a line of best fit (estimated on the microdata). The bottom right of the figure displays the point estimate and standard error on β in an OLS regression of the form

$$\text{Self-assess}_i = \alpha + \beta \text{PHQ-ADS}_i + \epsilon_i.$$

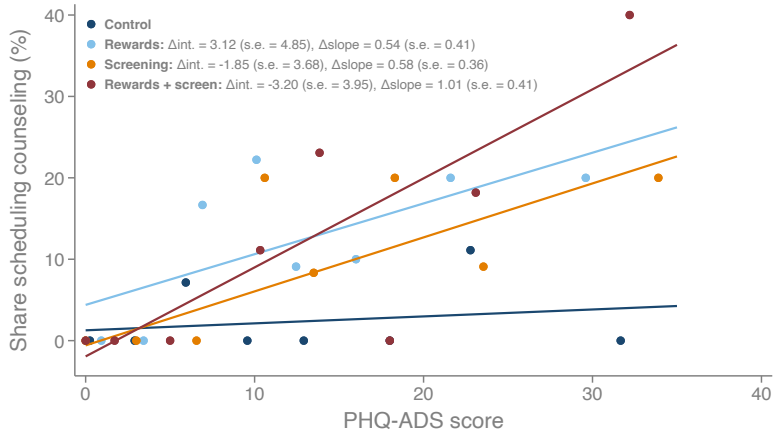
Panel (d) presents a bar chart of the sources of distress among students, restricting attention to students who screen for depression or anxiety (PHQ-ADS score of at least 10). Note that bars do not add up to 100% because students can report multiple sources.

Figure 3: Effects of treatment assignment on likelihood of scheduling counseling, by baseline mental health status

(a) Effects by symptomatic status



(b) Effects by PHQ-ADS score



Notes: This figure shows the likelihood of scheduling counseling by baseline mental health status in each treatment arm. In panel (a), navy bars show the likelihood of scheduling counseling for asymptomatic individuals (PHQ-ADS ≤ 9) in each treatment arm, and light blue bars for symptomatic individuals (PHQ-ADS ≥ 10). Black bars show 90% confidence intervals relative to the control asymptomatic mean, computed using regression specification (2). For instance, the 90% confidence interval on the "screening, symptomatic" bar corresponds to the point estimate for α_0, plus the 90% confidence interval for the value of $\alpha_1 + \beta_0 + \beta_1$.

Panel (b) presents a binned scatterplot. Each navy dot represents a decile of the control group. The navy line is a line of best fit (estimated on the microdata). The orange, light blue, and maroon series replicate the navy series for the rewards, screening, and rewards plus screening groups, respectively. The text reports regressions of (3). The navy text reports estimates of α_0 (as the intercept term) and α_1 (the slope term), with corresponding standard errors. The orange text reports estimates of β_0 and β_1. The light blue text reports estimates of γ_0 and γ_1. The maroon text reports estimates of δ_0 and δ_1.

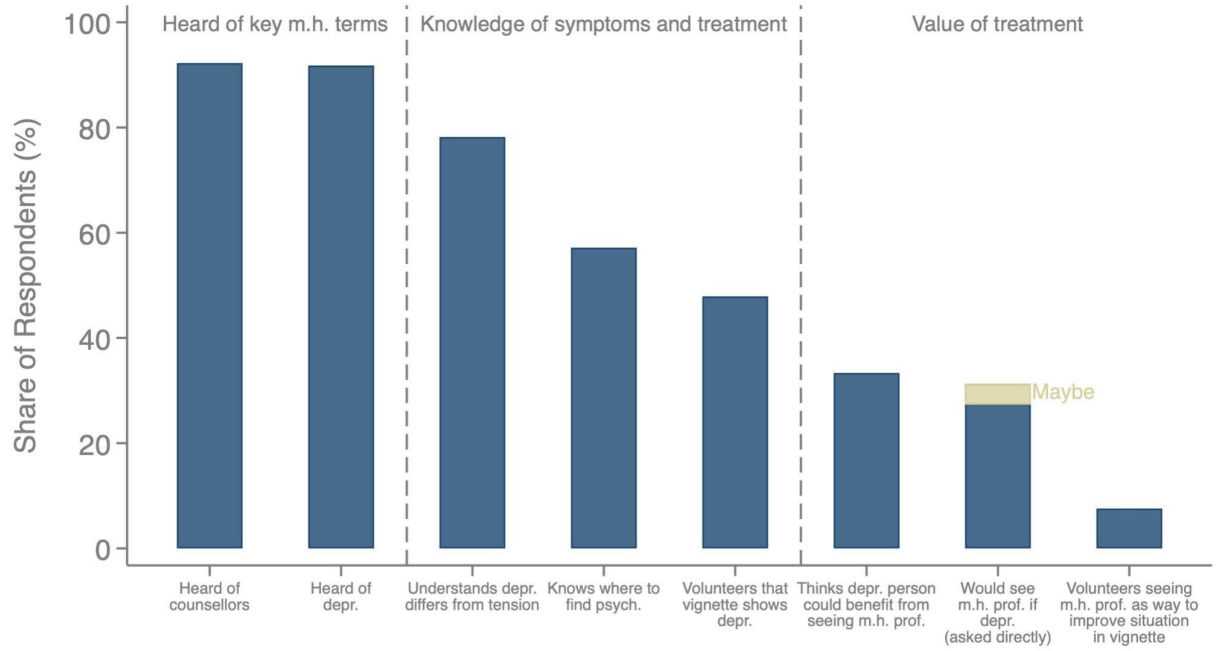
Table 1: Effects of saturated treatment assignment on primary outcomes

	Primary		Secondary	Exploratory
	Total interest in counselor contact (1)	Scheduled Appointment (2)	Attended Appointment (3)	Scheduled Follow-Up Appointment (4)
Panel A: Average effects				
Screening	0.03	0.02	-0.01	0.00
	(0.06)	(0.04)	(0.04)	(0.02)
Rewards	0.15**	0.09*	0.07*	0.03
	(0.07)	(0.05)	(0.04)	(0.02)
Rewards & Screening	0.09	0.11***	0.08**	0.01
	(0.06)	(0.04)	(0.04)	(0.02)
Controls	X	X	X	X
Control mean	0.19	0.03	0.03	0.01
Panel B: Heterogeneous effects				
Screening	0.05	-0.05	-0.05	-0.03
	(0.07)	(0.04)	(0.04)	(0.03)
Screening x Symptomatic	-0.04	0.13*	0.07	0.05
	(0.12)	(0.07)	(0.06)	(0.04)
Rewards	0.23***	0.06	0.05	-0.03
	(0.09)	(0.05)	(0.05)	(0.03)
Rewards x Symptomatic	-0.14	0.06	0.04	0.10*
	(0.13)	(0.09)	(0.08)	(0.06)
Rewards & Screening	0.03	-0.02	-0.02	-0.03
	(0.06)	(0.03)	(0.03)	(0.03)
Rewards & Screening x Symptomatic	0.11	0.23***	0.18**	0.08*
	(0.12)	(0.08)	(0.08)	(0.04)
Control mean, Asymptomatic	0.05	0.03	0.03	0.03
Control mean, Symptomatic	0.30	0.04	0.04	0.00
Observations	340	340	340	340

Notes: This table displays estimates of equations (1) (columns (1), (3), and (5)) and (2) (columns (2), (4), and (6)). The table also displays the baseline levels of the outcome variable in the control group, in total ("Control Mean"), and among individuals with ("Control Mean, Symptomatic") and without symptoms of depression and anxiety ("Control Mean, Asymptomatic").

A Appendix Figures

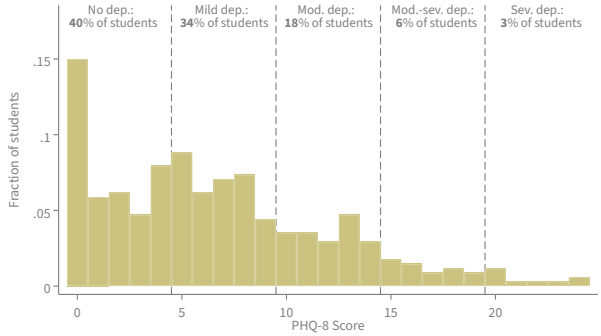
Appendix Figure 1: Knowledge of and engagement with mental health services in scoping surveys collected at another college in Chennai.



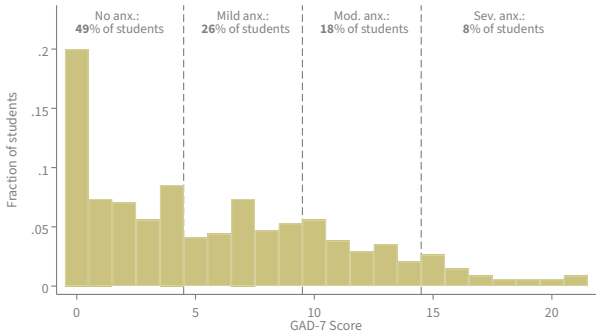
Notes: This figure summarizes responses to scoping surveys collected at another college in Chennai prior to our main experiment ($N = 254$). The first two bars show the share of students who have heard of mental health terms: counsellors (in the first bar); and depression (in the second bar). The third, fourth, and fifth bars summarize students' knowledge of mental health symptoms and treatment. The third bar shows the share of students who agree with the statement that depression is different from tension or stress. The fourth bar shows the share of students who indicate that they would know where to find a psychiatrist in Chennai. The fifth bar presents the share of students who volunteer depression as an accurate description of a vignette involving a student who has been feeling unusually sad, has had difficulty sleeping, has lost weight, and has been finding it difficult to continue with his daily activities. The sixth, seventh, and eighth bars summarize students' beliefs about the value of treatment. The sixth bar shows the share of students who agree with the statement that a person with depression could benefit from seeing a mental health professional. The seventh bar shows the share of students who agree with the statement that they would see a mental health professional if depressed. The eighth bar shows the share of students who volunteer seeing a mental health professional when asked what the individual in the vignette could do to improve their situation.

Appendix Figure 2: PHQ and GAD scores at baseline

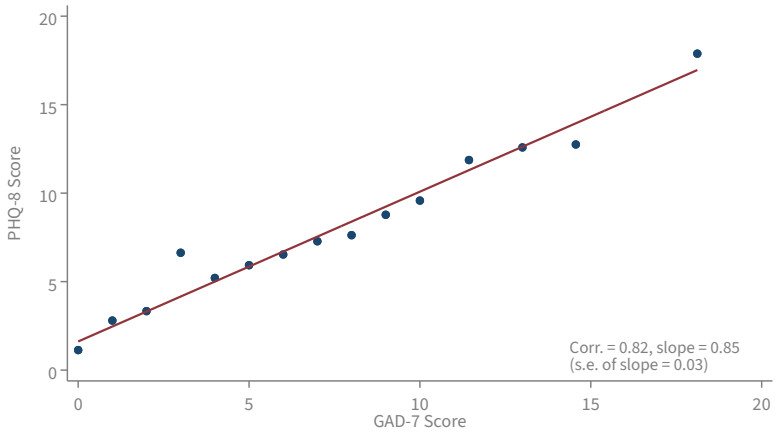
(a) Distribution of PHQ-8 (Depression) Scores



(b) Distribution of GAD-7 (Anxiety) Scores



(c) PHQ-8 (Depression) *vs.* GAD-7 (Anxiety) Scores



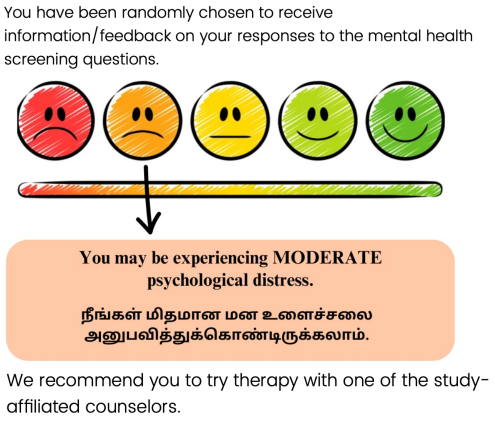
Notes: Panel (a) presents a histogram of PHQ-8 scores at baseline. The text indicates the share of students screening for no depression (PHQ-8 score of 4 or below), mild depression (PHQ-8 score between 5 and 9), moderate depression (PHQ-8 score between 10 and 14), moderately-severe depression (PHQ-8 score between 15 and 19), and severe depression (PHQ-8 score of 20 or above). Panel (b) presents a histogram of GAD-7 scores at baseline. The text indicates the share of students screening for no anxiety (GAD-7 score of 4 or below), mild anxiety (GAD-7 score between 5 and 9), moderate anxiety (GAD-7 score between 10 and 14), and severe depression (GAD-7 score of 15 or above). Panel (c) shows a binned scatterplot of a student's PHQ-8 score *vs.* her GAD-7 score. Ventiles of the data are presented as navy dots; the red line is a line of best fit (estimated on the microdata). The text in the bottom right of the figure displays the correlation between the two scores. The text also displays the point estimate and standard error on β in the OLS regression PHQ-$8_i = \alpha + \beta$GAD-$7_i + \epsilon_i$.

Appendix Figure 3: Examples of information shown to participants as part of treatment assignment

(a) Information provided to participants in rewards treatment arms

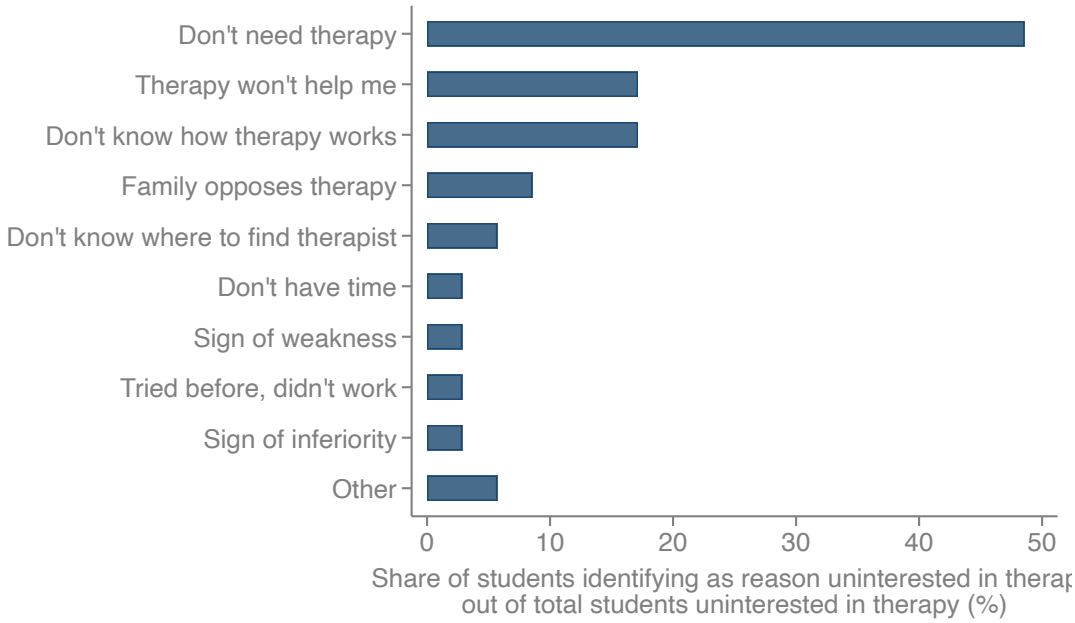


(b) Example of information provided to participants in screening treatment arms



Notes: This figure displays an example of information shown to participants as part of the survey. Panel (a) shows the screen informing participants in the rewards and screening and rewards treatment arms that they would receive payment for attending their first counseling session. Panel (b) shows the screen providing information to participants in the screening and rewards and screening treatment arms ("screening arms") informing them of their level of psychological distress, as indicated by their PHQ-ADS scores. The panel shows an example of the screen received by participants in the screening arms with PHQ-ADS scores between 20 and 29 (inclusive). Participants with PHQ-ADS scores of 9 or below saw a corresponding screen stating that "You are not experiencing any psychological distress," with no recommendation to try therapy. Participants with PHQ-ADS scores of between 10 and 19 saw a corresponding screen stating that "You may be experiencing mild psychological distress," with no recommendation to try therapy. Participants with PHQ-ADS scores of 30 or above received a corresponding screen stating that "You may be experiencing severe psychological distress" and text saying, "We strongly recommend you try therapy with one of the study-affiliated counselors."

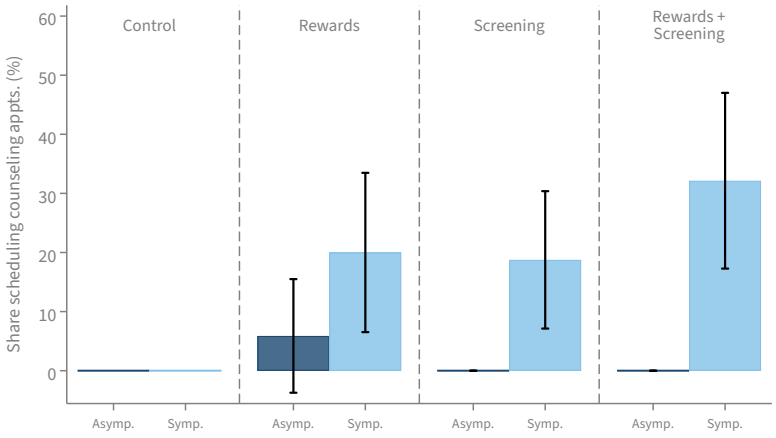
Appendix Figure 4: Reasons not to take up therapy (among control group participants who screen positive but do not contact a counselor)



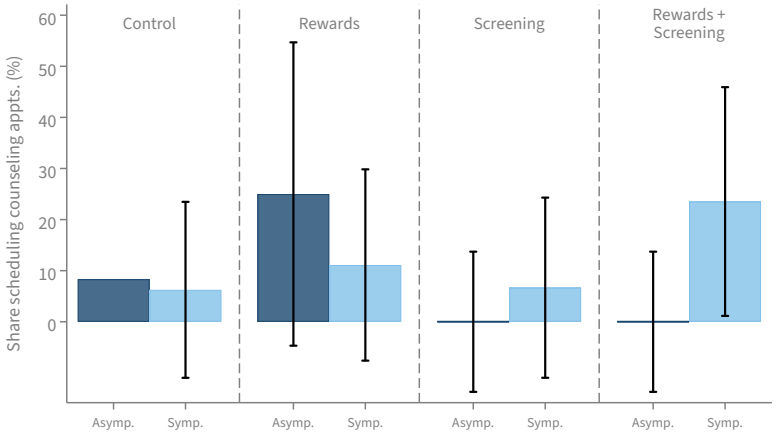
Notes: This figure presents descriptive statistics on mental health treatment perceptions, elicited after the therapy take-up decision. The figure shows participants' stated reasons for not taking up therapy, among individuals in the control group who screen for depression or anxiety (PHQ-ADS score ≥ 10), but who choose not to initiate contact with counselors, either by messaging study counselors, or by requesting that they be contacted by study counselors (61% of the control group who screen positive do not initiate contact.

Appendix Figure 5: Effects of treatment assignment on likelihood of scheduling counseling by consistency of self-assessed mental health with screening tool.

(a) Self-assessment consistent with screening

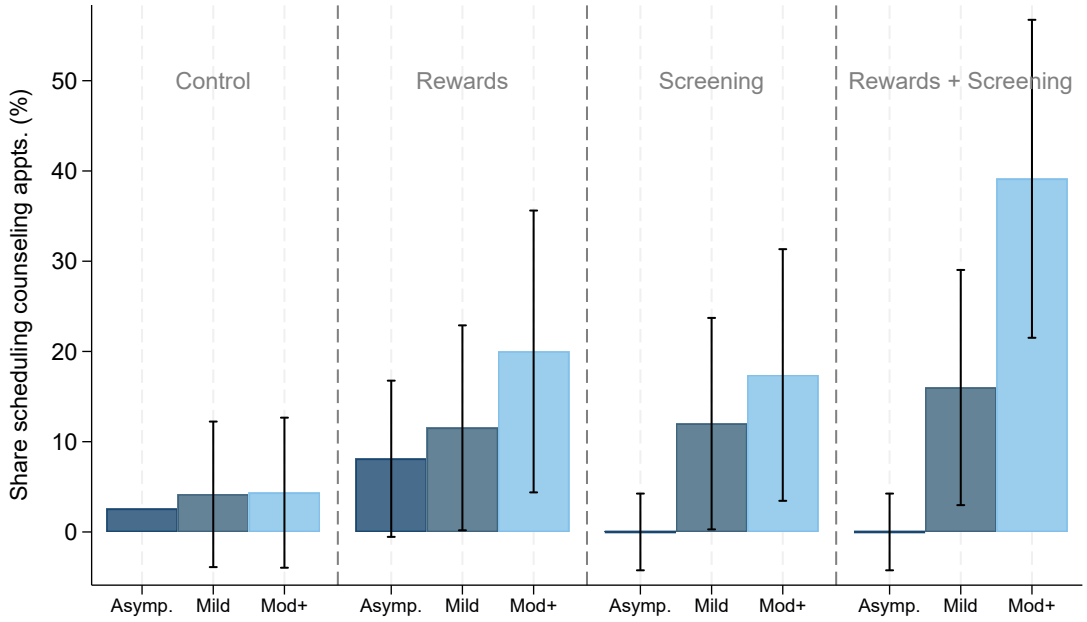


(b) Self-assessment inconsistent with screening



Notes: This figure shows the likelihood of scheduling counseling by baseline mental health status (per the PHQ-ADS screening tool) in each treatment arm. Panel (a) shows those whose self-assessed mental health status is consistent with the PHQ-ADS screening tool, and panel (b) those whose self-assessed mental health status is inconsistent with the PHQ-ADS screening tool. In panel (a), navy bars show the likelihood of scheduling counseling for asymptomatic individuals (PHQ-ADS ≤ 9) in each treatment arm, and light blue bars for symptomatic individuals (PHQ-ADS ≥ 10). We exclude 42 respondents who refuse to respond when asked for their self-assessment. Black bars show 90% confidence intervals relative to the control asymptomatic mean, computed using regression specification (2). For instance, the 90% confidence interval on the "screening, symptomatic" bar corresponds to the point estimate for α_0, plus the 90% confidence interval for the value of $\alpha_1 + \beta_0 + \beta_1$.

Appendix Figure 6: Effects of treatment assignment on likelihood of scheduling counseling, by none, mild, and moderate/severe baseline mental health.



Notes: This figure shows the likelihood of scheduling counseling by baseline mental health status in each treatment arm. The navy bars show the likelihood of scheduling counseling for asymptomatic individuals (PHQ-ADS ≤ 9) in each treatment arm, the blue bars for mildly symptomatic (PHQ-ADS ≥ 10 and PHQ-ADS < 20), and the navy bars for moderate and severely symptomatic (PHQ-ADS ≥ 20). Black bars show 90% confidence intervals relative to the control asymptomatic mean.

B Appendix Tables

Appendix Table 1: Balance on Baseline Characteristics

	Control Mean (1)	Coef. on Screening (2)	Coef. on Rewards (3)	Coef. on Rewards & Screening (4)
A. Demographics				
Age	19.65	-0.21*	-0.01	-0.11
		(0.12)	(0.12)	(0.12)
Has Personal Disposable Income	0.45	0.10	0.12	0.16**
		(0.08)	(0.08)	(0.08)
Is Preparing for Competitve Exam	0.17	-0.03	0.05	0.08
		(0.06)	(0.06)	(0.06)
B. Mental Health (Self Perception)				
Good Mental Health (Current)	0.72	-0.02	-0.01	-0.02
		(0.07)	(0.07)	(0.07)
Good Mental Health (Past 2 Weeks)	0.23	-0.01	0.08	0.06
		(0.06)	(0.07)	(0.07)
Good Mental Health (Past 6 Months)	0.29	0.06	0.03	0.09
		(0.07)	(0.07)	(0.07)
Curently Has Depression or Anxiety	0.48	-0.03	-0.08	-0.04
(Self Reported)		(0.08)	(0.08)	(0.08)
Has Had Depression or Anxiety in the Past	0.65	-0.03	-0.13*	-0.10
(Self Reported)		(0.07)	(0.08)	(0.07)
C. Mental Health (Treatment)				
Currently Seeing Psychiatrist or Counselor	0.03	0.02	0.01	0.01
		(0.03)	(0.03)	(0.03)
Has Previously Seen Psychiatrist or Counselor	0.08	0.01	-0.01	0.01
		(0.04)	(0.04)	(0.04)
Family Support for Mental Health Treatment	0.28	0.03	0.01	0.04
		(0.07)	(0.07)	(0.07)
D. Mental Health (PHQ-ADS Scores)				
PHQ-ADS Score	12.40	0.76	-0.11	0.13
		(1.59)	(1.47)	(1.58)
Symptomatic: PHQ-ADS Score ≥ 10	0.55	0.01	0.01	0.02
		(0.08)	(0.08)	(0.08)
Mildly Symptomatic: PHQ-ADS Score 10 – 19	0.28	0.01	0.03	0.02
		(0.07)	(0.07)	(0.07)
Moderately Symptomatic: PHQ-ADS Score 20 – 29	0.22	-0.02	-0.03	-0.02
		(0.06)	(0.06)	(0.06)
Severely Symptomatic: PHQ-ADS Score ≥ 30	0.05	0.02	0.00	0.02
		(0.04)	(0.03)	(0.04)

* $p < .10$, ** $p < .05$, *** $p < .01$

Notes: This table displays levels of baseline variables in different treatment arms. Each row presents results for a baseline variable from an OLS regression of the form

$$B_i = \alpha + \beta \text{Screening}_i + \gamma \text{Rewards}_i + \delta \text{Screening and rewards}_i,$$

where B_i is the baseline variable. Column (1) shows the point estimate for α; columns (2), (3) and (4) show the point estimates and corresponding standard errors for β, γ, and δ, respectively. Panel A presents results for demographic baseline variables: participants' age; an indicator variable for whether the participant has personal income; and an indicator variable for whether the participant is preparing for a competitive exam or standardized test. Panel B presents results for self-perceived mental health: indicator variables for rating one's well-being currently, over the past two weeks, or over the past six months at least four out of five; and indicator variables for self-identifying as currently or previously having depression or anxiety. Panel C presents results for engagement with mental health treatments: indicator variables for currently or previously seeing a psychologist or counselor; and an indicator variable for family supporting engagement with mental health treatment. Panel D presents results for PHQ-ADS scores: a continuous variable for PHQ-ADS score; and indicator variables for the PHQ-ADS score indicating that a student is symptomatic, mildly symptomatic, moderately symptomatic, or severely symptomatic. $*$, $**$, and $***$ indicate significance at the 10%, 5%, and 1% levels, respectively.

Appendix Table 2: Effects of pooled treatment assignment on take-up of therapy

	Primary		Secondary	Exploratory
	Total interest in counselor contact	Scheduled Appointment	Attended Appointment	Scheduled Follow-Up Appointment
	(1)	(2)	(3)	(4)
Panel A: Effects of pooled rewards				
Pooled Rewards	0.11**	0.09***	0.08***	0.02
	(0.05)	(0.03)	(0.03)	(0.02)
Controls	X	X	X	X
Control mean	0.20	0.06	0.04	0.02
Panel B: Effects of pooled screening				
Pooled Screening	-0.01	0.02	-0.00	-0.01
	(0.05)	(0.03)	(0.03)	(0.02)
Controls	X	X	X	X
Control mean	0.25	0.08	0.07	0.02
Observations	340	340	340	340

Notes: Panel A shows estimates of the OLS regression

$$Y_i = \alpha + \beta(\text{Rewards}_i + \text{Rewards and Screening}_i) + X_i'\lambda + \epsilon_i, \tag{4}$$

where Y_i is one of the four outcome variables listed in the first row of the table, and X_i is the vector of controls described in the notes to Table 1. Panel B replicates Panel A, replacing Rewards_i with Screening_i.

Appendix Table 3: Heterogeneous effects of saturated treatment assignment on primary outcomes among students with no, mild, or moderate/severe symptoms of depression/anxiety

	Primary		Secondary	Exploratory
	Total interest in counselor contact (1)	Scheduled Appointment (2)	Attended Appointment (3)	Scheduled Follow-Up Appointment (4)
Panel A: Heterogeneous effects				
Screening	0.05	-0.05	-0.05	-0.03
	(0.07)	(0.04)	(0.04)	(0.03)
Screening x Mild	0.03	0.08	0.04	0.04
	(0.14)	(0.09)	(0.08)	(0.05)
Screening x Moderate-Severe	-0.11	0.18	0.11	0.08
	(0.17)	(0.11)	(0.09)	(0.05)
Rewards	0.23***	0.06	0.05	-0.03
	(0.09)	(0.05)	(0.05)	(0.03)
Rewards x Mild	-0.17	0.03	-0.03	0.03
	(0.15)	(0.10)	(0.10)	(0.04)
Rewards x Moderate-Severe	-0.11	0.10	0.12	0.19*
	(0.18)	(0.13)	(0.12)	(0.10)
Rewards & Screening	0.03	-0.02	-0.02	-0.03
	(0.06)	(0.03)	(0.03)	(0.03)
Rewards & Screening x Mild	0.15	0.13	0.13	0.07
	(0.14)	(0.10)	(0.10)	(0.05)
Rewards & Screening x Moderate-Severe	0.07	0.35***	0.24**	0.10*
	(0.17)	(0.12)	(0.11)	(0.05)
Control mean, Asymptomatic	0.05	0.03	0.03	0.03
Control mean, Mild	0.21	0.04	0.04	0.00
Control mean, Moderate-Severe	0.21	0.04	0.04	0.00
Panel B: Hypotheses tests (p-values)				
Asymptomatic:				
Screening = Rewards	0.08	0.02	0.02	0.88
Screening = Rewards & Screening	0.79	0.20	0.12	0.88
Rewards = Rewards & Screening	0.03	0.10	0.11	0.80
Mild:				
Screening = Rewards	0.89	0.62	0.64	0.79
Screening = Rewards & Screening	0.50	0.49	0.22	0.63
Rewards = Rewards & Screening	0.40	0.80	0.40	0.36
Moderate-Severe:				
Screening = Rewards	0.25	0.81	0.27	0.19
Screening = Rewards & Screening	0.30	0.12	0.11	0.76
Rewards = Rewards & Screening	0.90	0.20	0.68	0.27
Observations	340	340	340	340

Notes: This table replicates Panels B and C of Table 1, separately interacting treatment assignment with indicators for mild (PHQ-ADS score between 10 and 19) and severe (PHQ-ADS score 20 or above) scores.

Appendix Table 4: Effects of saturated treatment assignment on primary outcomes

	Primary		Secondary	Exploratory
	Total interest in counselor contact (1)	Scheduled Appointment (2)	Attended Appointment (3)	Scheduled Follow-Up Appointment (4)
Panel A: Heterogeneous effects				
Screening	0.154*	-0.064	-0.052	-0.039
	(0.084)	(0.049)	(0.041)	(0.026)
Screening x PHQ-ADS	-0.010*	0.007*	0.003	0.003
	(0.006)	(0.004)	(0.003)	(0.002)
Rewards	0.241**	0.027	0.014	-0.062*
	(0.101)	(0.054)	(0.055)	(0.035)
Rewards x PHQ-ADS	-0.007	0.005	0.005	0.007*
	(0.007)	(0.004)	(0.004)	(0.004)
Rewards & Screening	0.123	-0.073*	-0.035	-0.040
	(0.076)	(0.044)	(0.041)	(0.029)
Rewards & Screening x PHQ-ADS	-0.002	0.015***	0.010**	0.004
	(0.006)	(0.004)	(0.004)	(0.003)
Panel B: Hypotheses tests (p-values)				
Screening x PHQ-ADS = Rewards x PHQ-ADS	0.69	0.64	0.66	0.31
Screening x PHQ-ADS = R&S x PHQ-ADS	0.21	0.11	0.09	0.74
Rewards x PHQ-ADS = R&S x PHQ-ADS	0.49	0.05	0.34	0.48
Observations	340	340	340	340

Notes: This table replicates Panels B and C of Table 1, interacting treatment assignment with continuous PHQ-ADS categories rather than the discrete categories of symptomatic *vs.* asymptomatic.

Notes: This table replicates Appendix Table 2, interacting treatment assignment with indicator variables corresponding to categories for PHQ-ADS scores.

Appendix Table 5: Heterogeneous effects of pooled treatment assignment by baseline degrees of distress

	Total interest in counselor contact (1)	Scheduled Appointment (2)	Attended Appointment (3)	Scheduled Follow-Up Appointment (4)
Panel A: Effects of pooled rewards				
Pooled Rewards	0.10*	0.04	0.04	-0.02
	(0.06)	(0.03)	(0.03)	(0.01)
Pooled Rewards × Mild	-0.02	0.04	0.03	0.03
	(0.11)	(0.07)	(0.07)	(0.04)
Pooled Rewards × Moderate-Severe	0.04	0.14	0.13	0.11*
	(0.13)	(0.09)	(0.08)	(0.05)
Controls	X	X	X	X
Control Mean, Asymptomatic	0.08	0.01	0.01	0.01
Control Mean, Mild	0.22	0.08	0.06	0.02
Control Mean, Moderate-Severe	0.37	0.11	0.07	0.02
Panel B: Effects of pooled screening				
Pooled Screening	-0.06	-0.06**	-0.06**	-0.02
	(0.06)	(0.03)	(0.03)	(0.01)
Pooled Screening × Mild	0.16	0.09	0.10	0.04
	(0.11)	(0.07)	(0.06)	(0.03)
Pooled Screening × Moderate-Severe	0.02	0.21**	0.12	-0.01
	(0.12)	(0.09)	(0.08)	(0.05)
Controls	X	X	X	X
Control Mean, Asymptomatic	0.16	0.05	0.05	0.01
Control Mean, Mild	0.22	0.08	0.06	0.00
Control Mean, Moderate-Severe	0.47	0.12	0.12	0.07
Observations	340	340	340	340

* $p < .10$, ** $p < .05$, *** $p < .01$

Appendix Table 6: Heterogeneous effects of pooled treatment assignment by baseline symptoms

	Total interest in counselor contact (1)	Scheduled Appointment (2)	Attended Appointment (3)	Scheduled Follow-Up Appointment (4)
Panel A: Effects of pooled rewards				
Pooled Rewards	0.10*	0.04	0.04	-0.02
	(0.06)	(0.03)	(0.03)	(0.01)
Pooled Rewards × Symptomatic	0.01	0.09	0.08	0.07*
	(0.09)	(0.06)	(0.06)	(0.03)
Controls	X	X	X	X
Control Mean, Asymptomatic	0.08	0.01	0.01	0.01
Control Mean, Symptomatic	0.29	0.09	0.06	0.02
Panel B: Effects of pooled screening				
Pooled Screening	-0.07	-0.06*	-0.06**	-0.02
	(0.06)	(0.03)	(0.03)	(0.01)
Pooled Screening × Symptomatic	0.09	0.15**	0.11*	0.02
	(0.09)	(0.06)	(0.05)	(0.03)
Controls	X	X	X	X
Control Mean, Asymptomatic	0.16	0.05	0.05	0.01
Control Mean, Symptomatic	0.33	0.10	0.09	0.03
Observations	340	340	340	340

* $p < .10$, ** $p < .05$, *** $p < .01$

Notes: This table replicates Appendix Table 5, interacting treatment assignment with continuous PHQ-ADS categories rather than discrete categories of scores.

Appendix Table 7: Effects of saturated treatment assignment on secondary outcomes

	Secondary			
	Interested in app (1)	Scheduled in lit. (2)	Believes therapy is effective (3)	Would consider therapy (4)
Panel A: Average effects				
Screening	0.01	-0.09	-0.11	-0.02
	(0.09)	(0.09)	(0.09)	(0.09)
Rewards	0.02	-0.04	-0.05	0.05
	(0.10)	(0.10)	(0.09)	(0.09)
Rewards & Screening	-0.08	-0.10	-0.14	-0.01
	(0.09)	(0.10)	(0.09)	(0.09)
Controls	X	X	X	X
Control mean	0.44	0.43	0.64	0.31
Panel B: Heterogeneous effects				
Screening	-0.02	-0.02	-0.04	0.13
	(0.11)	(0.11)	(0.11)	(0.09)
Screening x Symptomatic	0.11	0.01	-0.04	-0.21
	(0.15)	(0.15)	(0.15)	(0.14)
Rewards	0.07	0.04	0.00	0.22**
	(0.11)	(0.11)	(0.11)	(0.10)
Rewards x Symptomatic	0.03	-0.05	-0.08	-0.26*
	(0.15)	(0.15)	(0.15)	(0.14)
Rewards & Screening	-0.04	0.02	-0.02	0.06
	(0.11)	(0.11)	(0.11)	(0.08)
Rewards & Screening x Symptomatic	0.05	0.01	-0.08	-0.01
	(0.15)	(0.15)	(0.15)	(0.13)
Control mean, Asymptomatic	0.33	0.31	0.59	0.13
Control mean, Symptomatic	0.53	0.53	0.68	0.47
Panel C: Hypotheses tests (p-values)				
Asymptomatic:				
Screening = Rewards	0.42	0.57	0.72	0.41
Screening = Rewards & Screening	0.86	0.75	0.90	0.45
Rewards = Rewards & Screening	0.33	0.81	0.82	0.12
Symptomatic:				
Screening = Rewards	0.96	0.99	0.96	0.71
Screening = Rewards & Screening	0.41	0.69	0.84	0.22
Rewards = Rewards & Screening	0.39	0.70	0.80	0.41
Observations	340	340	340	340

Notes: This table replicates Table 1, using various secondary outcomes as the outcome variable. In column (1), the outcome variable is an indicator for a student clicking a link on, or downloading, a mental health app via the participant survey. In column (2), the outcome variable is an indicator for the student clicking a link to access literature on mental health. In column (3), the outcome is an indicator variable for the student indicating that therapy would be very or extremely helpful in improving the student's well-being and quality of life. In column (4), the outcome is an indicator variable for the student indicating that they would consider visiting a therapist in the future if they needed to do so.

C Survey Instrument

This appendix contains our full survey instrument.

Rewards and Screening Experiment: Survey Instrument

Preamble

1. Please start entering your college roll number here and select your name from the dropdown.

2. How old are you?

    a. **If age < 18 or age > 30:** Thank you for your interest in our study! At this time, we are only surveying individuals between the ages of 18 and 30. Since you do not fall within this range, you won't be able to participate. However, we truly appreciate your willingness to be involved!

    b. **If age < 18 or age > 30:** Thank you for your interest in this study! Please read the consent form on the next page carefully. If you have any questions, feel free to reach out to the nearest research team member. If you're ready to participate, kindly provide your consent to proceed with the survey.

3. Informed consent

4. Please provide us with your WhatsApp number. Note: Your phone number will only be used by the research team to contact you for follow-up activities/surveys in the study. It will not be shared with anyone else outside the research team. [If you do not have a WhatsApp number, please enter the number 9 ten times i.e. 9999999999]

5. Is this number an Indian number, starting with +91? [Yes/No]

    a. **If no:** Please provide us with the appropriate country code.

6. Can we use this phone number to contact you in the future? [Yes/No]

Demographics

7. Do you have any personal disposable income like pocket money/allowance received from parents/guardians, income earned from an internship, part time job, freelancing gig, or other sources? If yes, how much is your monthly disposable income?
    - I do not have any personal disposable income.
    - Rs. 1 to Rs. 499
    - Rs. 500 to Rs. 999
    - Rs. 1,000 to Rs. 2,499

- Rs. 2,500 to Rs. 4,999
- Rs. 5,000 to Rs. 9,999
- Rs. 10,000 and above
- Prefer not to say

8. Are you currently preparing for any competitive exams or standardized tests? Note: Competitive exams may include exams for public sector jobs like UPSC, TNPSC, Banking, Railways, etc or entrance exams for professional degrees like CAT, CLAT, GATE, NET, SET, GRE, GMAT, etc

- Yes
- No
- Prefer not to say

9. Pick the color from the list below.

- Paper
- Violin
- Pink
- Mobile

a. If != Pink:



Mental Health Perceptions and Treatment History

10. How are you feeling right now? [Move the slider to change the emoji to the one that most accurately represents your mood at the moment.]

11. How have you been doing with regard to your overall mental well-being in the past 2 weeks?

- Extremely well
- Very well
- Moderately well
- Not too well
- Not well at all
- Prefer not to say

12. How have you been doing with regard to your overall mental well-being in the past 6 months?

- Extremely well
- Very well
- Moderately well
- Not too well
- Not well at all
- Prefer not to say

13. What would you say are the main factors causing you distress, if any, in the past 6 months? Please select all that apply.

- Academics/Exams
- Future job/career prospects
- Financial issues/hardship
- Conflicts with family members
- Conflicts with friends
- Conflicts in romantic relationships
- Feeling lonely/isolated
- Other
- ⊗None
- ⊗Prefer not to say

a. **If Other:** What other factors have been causing you distress in the past 6 months?

14. Do you think you are currently experiencing depression and/or anxiety?

- Depression
- Anxiety
- Both
- Neither
- ⊗Prefer not to say

15. Do you think you have ever experienced depression and/or anxiety in the past?

- Depression
- Anxiety
- Both
- Neither
- ⊗Prefer not to say

16. If you were to seek treatment from mental health professionals such as a counselor, do you think your family would be supportive?

- Yes
- No
- I don't know
- ⊗ Prefer not to say

17. When you feel low, how comfortable do you feel reaching out to friends or family to seek support by having conversations about your feelings, emotions, mental health and well-being?

- Extremely comfortable
- Somewhat comfortable
- Somewhat uncomfortable
- Extremely uncomfortable
- ⊗ Prefer not to say

18. Are you currently receiving treatment from a mental health professional? If yes, from which professional are you receiving treatment?

- Counselor
- Psychiatrist
- Both
- Neither
- ⊗Prefer not to say

19. Have you ever received treatment from a mental health professional in the past? If yes, from which professional have you received treatment?

- Counselor
- Psychiatrist
- Both
- Neither
- ⊗Prefer not to say

20. Which of the following is a fruit?

- Cable
- Mango
- Elephant
- Light
- Fever

a. If != Mango:



<u>Mental Health Screening</u>

This section consists of a few questions about the state of your mental health and well-being. Your responses to these questions help us screen you for symptoms of psychological distress that you may be experiencing. Please take your time to answer these and be as honest as possible.

21. Over the last two weeks, how often have you been bothered by the following problem? Little interest or pleasure in doing things.

- Not at all
- Several days
- More than half the days
- Nearly everyday

22. Over the last two weeks, how often have you been bothered by the following problem? Feeling down, depressed, or hopeless.

- Not at all
- Several days
- More than half the days
- Nearly everyday

23. Over the last two weeks, how often have you been bothered by the following problem? Trouble falling or staying asleep, or sleeping too much.

- Not at all
- Several days
- More than half the days
- Nearly everyday

24. Over the last two weeks, how often have you been bothered by the following problem? Feeling tired or having little energy.

- Not at all
- Several days
- More than half the days
- Nearly everyday

25. Over the last two weeks, how often have you been bothered by the following problem? Poor appetite or overeating.

- Not at all
- Several days
- More than half the days
- Nearly everyday

26. Over the last two weeks, how often have you been bothered by the following problem? Feeling bad about yourself — or that you are a failure or have let yourself or your family down.

- Not at all

- Several days
- More than half the days
- Nearly everyday

27. Over the last two weeks, how often have you been bothered by the following problem? Trouble concentrating on things, such as reading the newspaper or watching television.
- Not at all
- Several days
- More than half the days
- Nearly everyday

28. Over the last two weeks, how often have you been bothered by the following problem? Moving or speaking so slowly that others have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual.
- Not at all
- Several days
- More than half the days
- Nearly everyday

29. Over the last two weeks, how often have you been bothered by the following problem? Feeling nervous, anxious, or on edge.
- Not at all
- Several days
- More than half the days
- Nearly everyday

30. Over the last two weeks, how often have you been bothered by the following problem? Not being able to stop or control worrying.
- Not at all
- Several days
- More than half the days
- Nearly everyday

31. Over the last two weeks, how often have you been bothered by the following problem? Worrying too much about different things.
- Not at all
- Several days
- More than half the days
- Nearly everyday

32. Over the last two weeks, how often have you been bothered by the following problem? Trouble relaxing.

- Not at all
- Several days
- More than half the days
- Nearly everyday

33. Over the last two weeks, how often have you been bothered by the following problem? Being so restless that it's hard to sit still.

- Not at all
- Several days
- More than half the days
- Nearly everyday

34. Over the last two weeks, how often have you been bothered by the following problem? Becoming easily annoyed or irritable.

- Not at all
- Several days
- More than half the days
- Nearly everyday

35. Over the last two weeks, how often have you been bothered by the following problem? Feeling afraid as if something awful might happen.

- Not at all
- Several days
- More than half the days
- Nearly everyday

Treatment Assignment

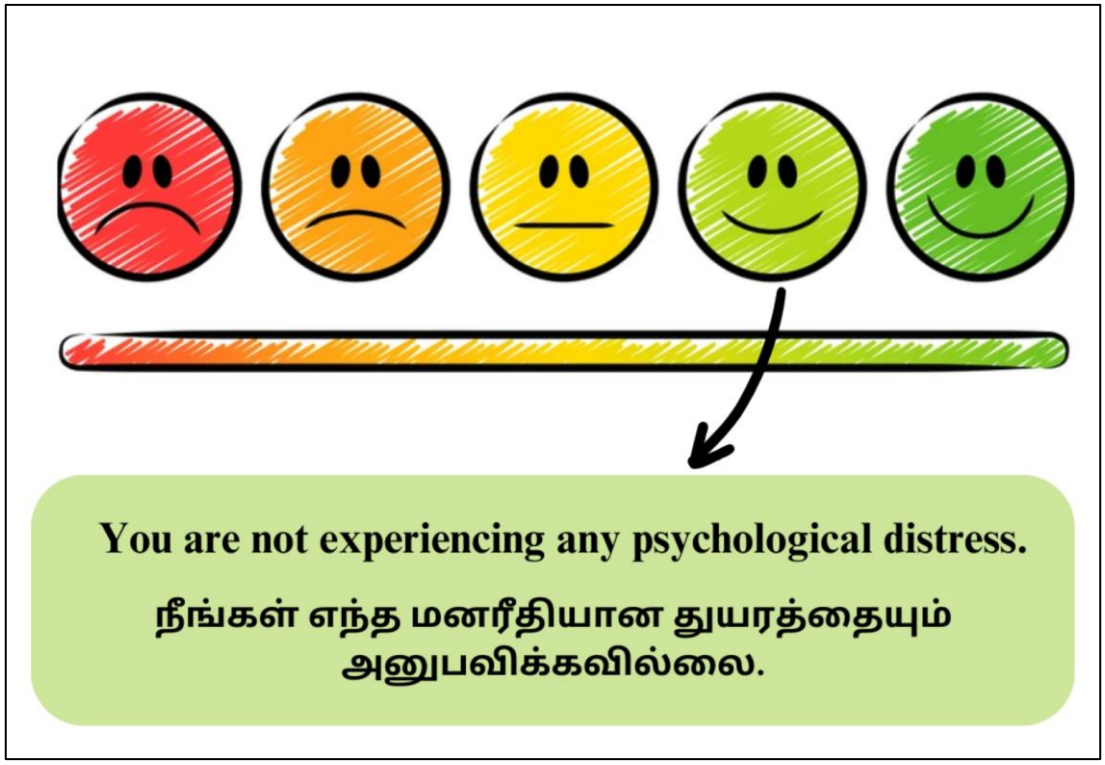
A: Control Group

As a participant of this study, you have the opportunity to try out therapy for free for the next 2 months. Therapy is a form of treatment aimed at relieving emotional distress and mental health problems. To avail this service, book your first session with a study-affiliated counselor within the next 30 days. You will be introduced to the study counselors through a video and will receive instructions on how to book an appointment with them along with their contact information in this survey.

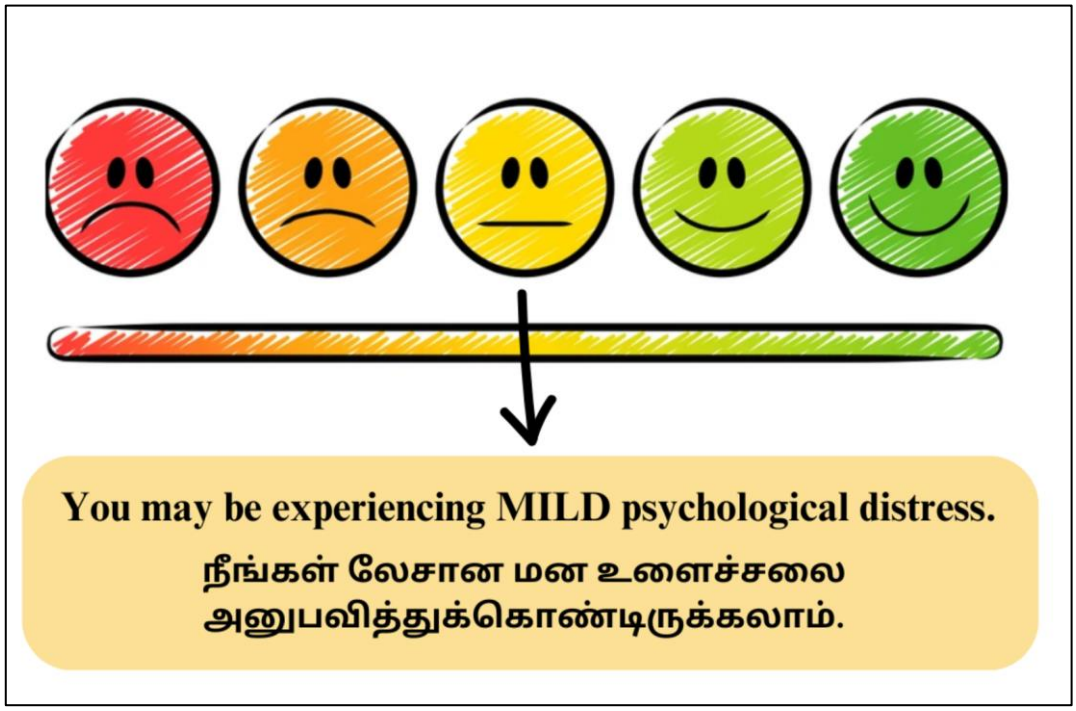
B: Screening

You have been randomly chosen to receive information/feedback on your responses to the mental health screening questions.

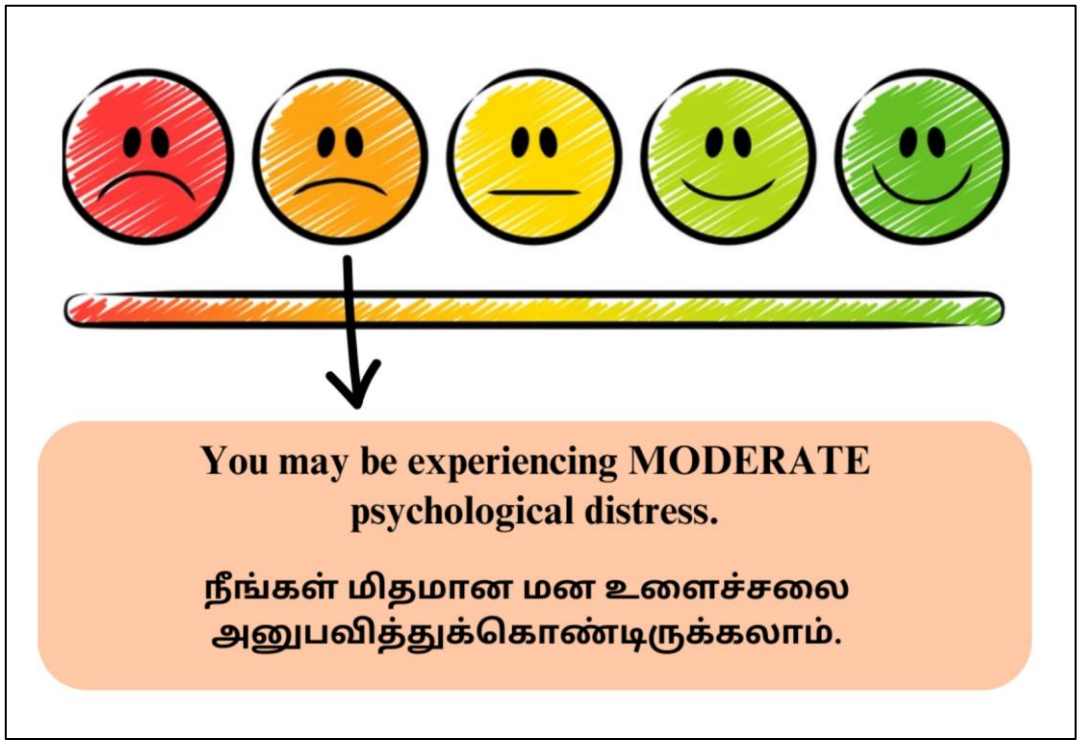
i. **If phq_ads_score < 10:** Your responses to the mental health screening section of this survey indicate that currently:



ii. **If phq_ads_score >= 10 & phq_ads_score < 20:** Your responses to the mental health screening section of this survey indicate that currently:

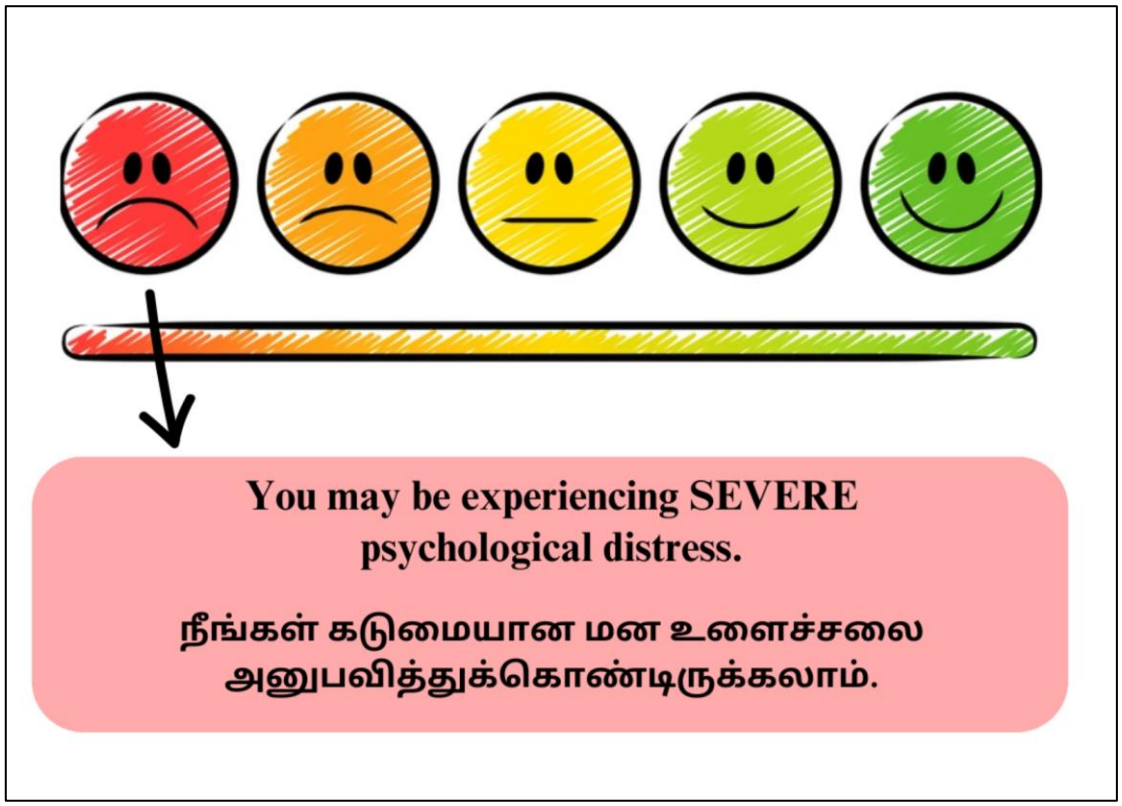


iii. **If phq_ads_score >= 20 & phq_ads_score < 30:** Your responses to the mental health screening section of this survey indicate that currently:



We recommend you to try therapy with one of the study-affiliated counselors.

iv. **If phq_ads_score >= 30:** Your responses to the mental health screening section of this survey indicate that currently:



We strongly recommend you to try therapy with one of the study-affiliated counselors.

As a participant of this study, you have the opportunity to try out therapy for free for the next 2 months. Therapy is a form of treatment aimed at relieving emotional distress and mental health problems. To avail this service, book your first session with a study-affiliated counselor within the next 30 days. You will be introduced to the study counselors through a video and will receive instructions on how to book an appointment with them along with their contact information in this survey.

C: Rewards

As a participant of this study, you have the opportunity to try out therapy for free for the next 2 months. Therapy is a form of treatment aimed at relieving emotional distress and mental health problems. To avail this service, book your first session with a study-affiliated counselor within the next 30 days. You will be introduced to the study counselors through a video and will receive instructions on how to book an appointment with them along with their contact information later in this survey.

Once you complete your first counseling session, you can collect your Rs 500 reward in cash from a research team member. Your counselor will provide the collection details. Alternatively,

you can choose to receive the reward via UPI by sharing your UPI details with your counselor. Please allow up to 7 business days for UPI payments.

You have been randomly chosen to receive a reward of ₹500 if you attend your first session with a study-affiliated counselor.

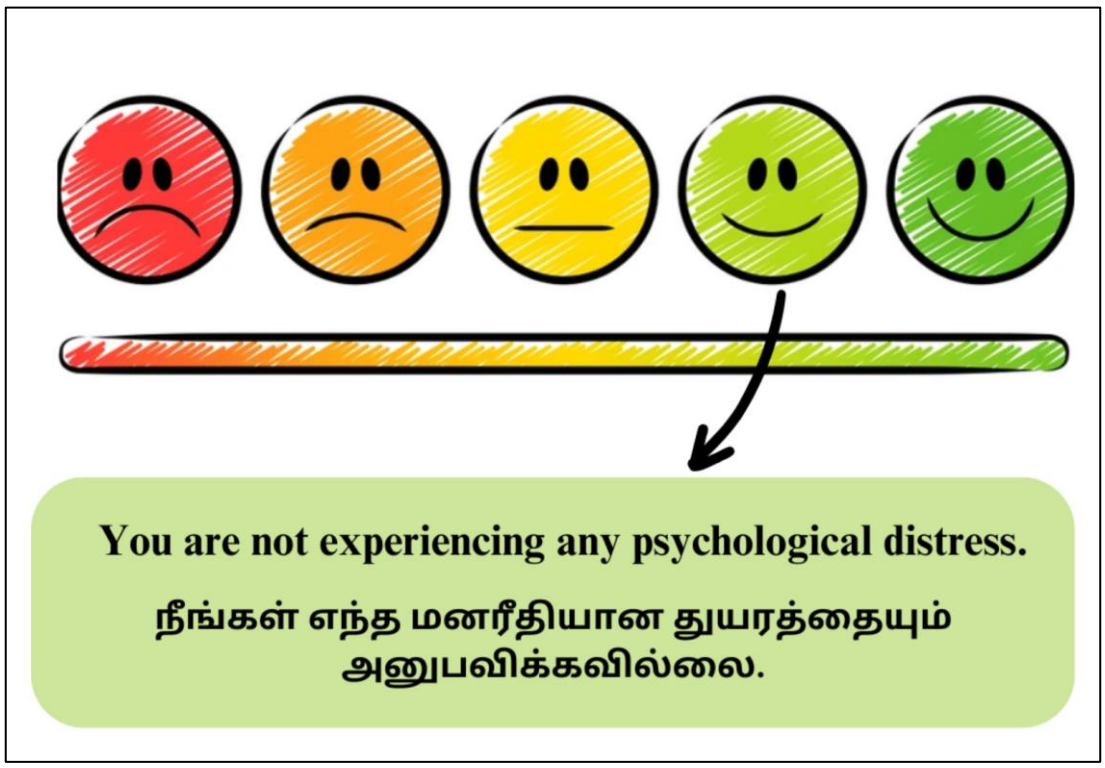
நீங்கள் ஒரு படிப்பு சார்ந்த ஆலோசகருடன் முதல் session-ல் கலந்து கொண்டால், ரூபாய்.500 வெகுமதியைப் பெறுவதற்கு தோராயமாக தேர்வு செய்யப்பட்டுள்ளீர்கள்.



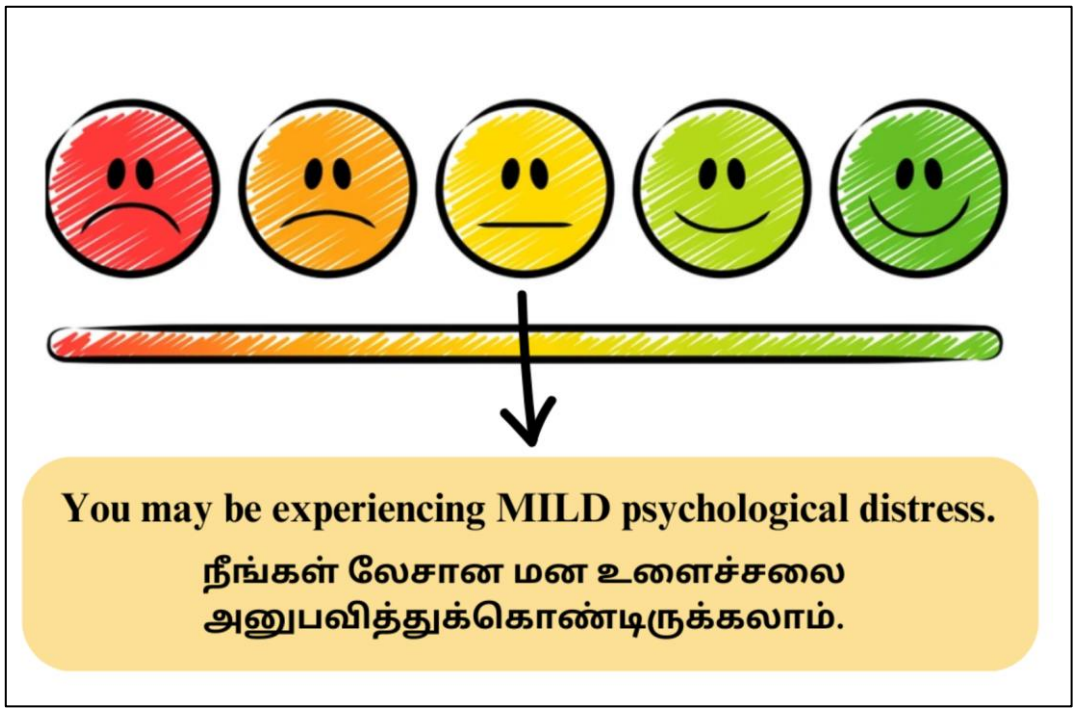
D: Screening + Rewards

You have been randomly chosen to receive information/feedback on your responses to the mental health screening questions.

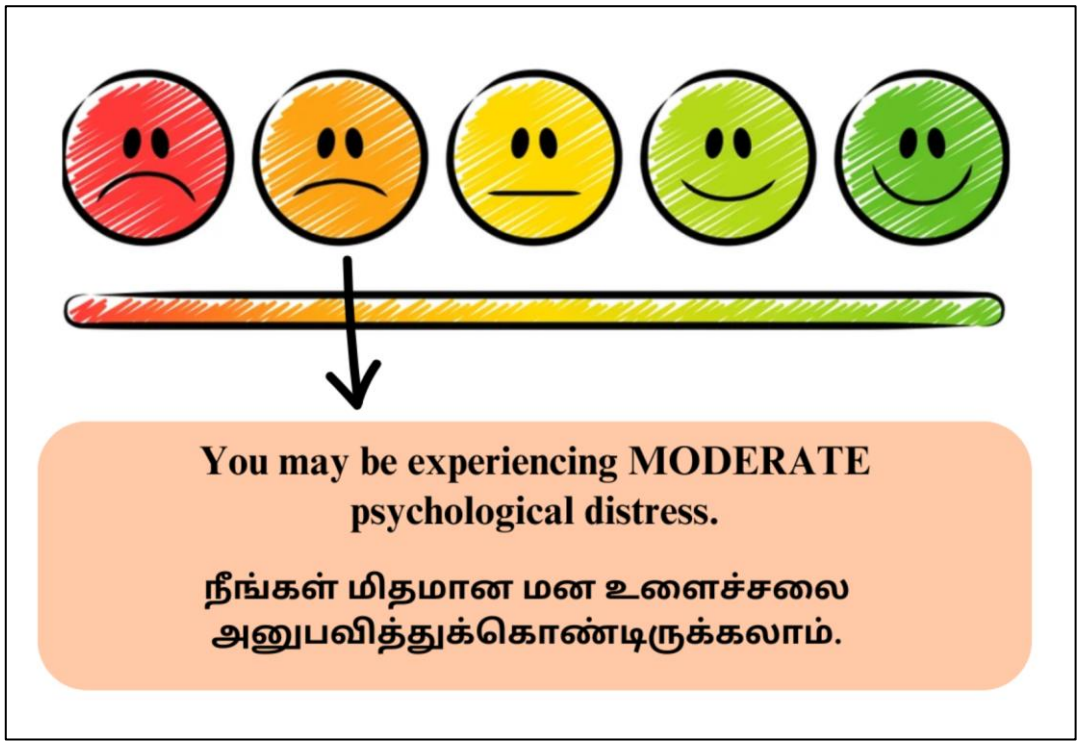
i. **If phq_ads_score < 10:** Your responses to the mental health screening section of this survey indicate that currently:



ii. **If phq_ads_score >= 10 & phq_ads_score < 20:** Your responses to the mental health screening section of this survey indicate that currently:

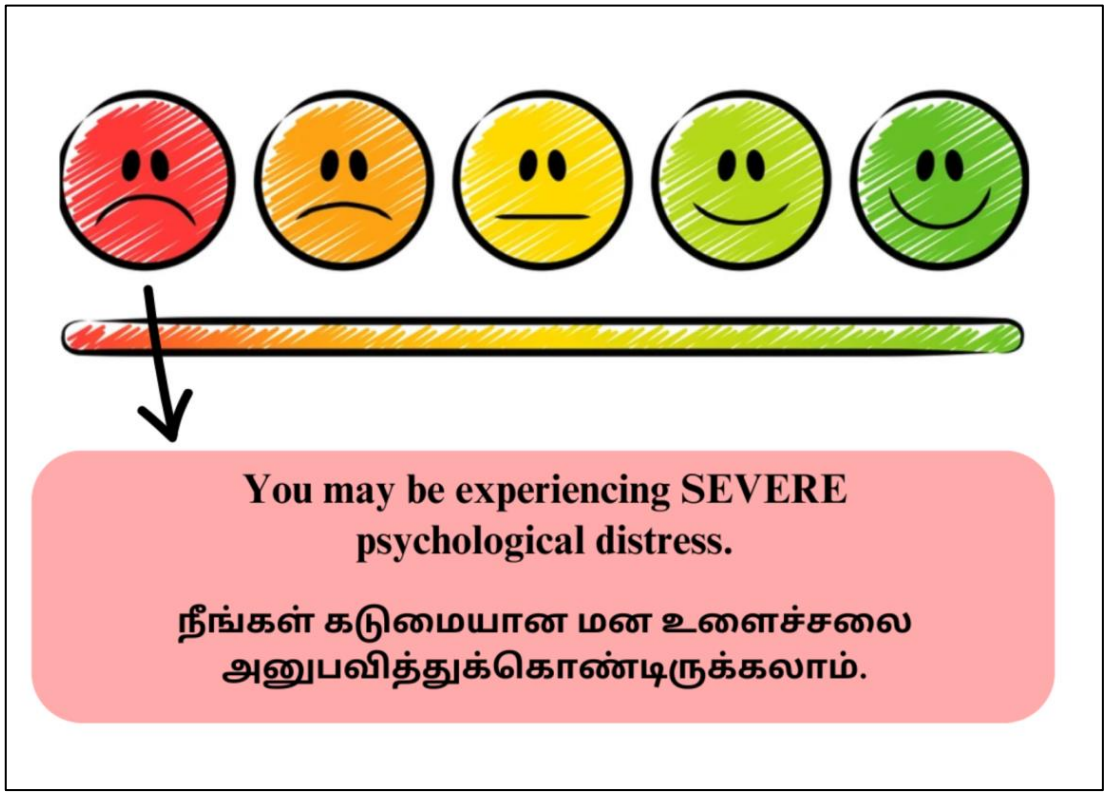


iii. **If phq_ads_score >= 20 & phq_ads_score < 30:** Your responses to the mental health screening section of this survey indicate that currently:



We recommend you to try therapy with one of the study-affiliated counselors.

iv. **If phq_ads_score >= 30:** Your responses to the mental health screening section of this survey indicate that currently:



We strongly recommend you to try therapy with one of the study-affiliated counselors.

As a participant of this study, you have the opportunity to try out therapy for free for the next 2 months. Therapy is a form of treatment aimed at relieving emotional distress and mental health problems. To avail this service, book your first session with a study-affiliated counselor within the next 30 days. You will be introduced to the study counselors through a video and will receive instructions on how to book an appointment with them along with their contact information in this survey.

Once you complete your first counseling session, you can receive your Rs 500 reward in cash from a research team member. Your counselor will provide the collection details. Alternatively, you can choose to receive the reward via UPI by sharing your UPI details with your counselor. Please allow up to 7 business days for UPI payments.

You have been randomly chosen to receive a reward of ₹500 if you attend your first session with a study-affiliated counselor.

நீங்கள் ஒரு படிப்பு சார்ந்த ஆலோசகருடன் முதல் session-ல் கலந்து கொண்டால், ரூபாய்.500 வெகுமதியைப் பெறுவதற்கு தோராயமாக தேர்வு செய்யப்பட்டுள்ளீர்கள்.



Video

Meet the study counselors! Note: You will be able to go to the next slide only after you watch the entire video.

Take-up

36. Would you like to book an appointment with a study-affiliated counselor? Note: You can choose the counselor and schedule the session at a time that works best for you.

- Yes
- No

a. **If Yes:** Which counselor would you like to request an appointment with?
   - Any
   - (College Counselor)
   - (College Counselor)
   - (SCARF Counselor)
   - Unsure? Re-watch the counselor introduction video before deciding
   - Unsure? Contact the research team for more information/clarifications about the process

      i. **If College Counselor:** Click on the link (green text) below to message [counsellor's name] on WhatsApp and book your first session now! Note: Once you click the link, it will open [counsellor's name] chatbox on WhatsApp. All you need to do is hit send on the pre-filled message. Message [counsellor's name] on WhatsApp.

      ii. **If Any/SCARF Counselor:** Click on the link (green text) below to message [SCARF counsellor name] on WhatsApp and book your first session now! Note: Once you click the link, it will open [SCARF **counsellor's** name] chatbox on WhatsApp. All you need to do is hit send on the pre-filled message. Message [SCARF counsellor's name] on WhatsApp.

      iii. **If Unsure, research team:** Click on the link (green text) below to message the research team on WhatsApp. **We** can help you learn more about the counseling services being provided and how you can avail them. Note: Once you click the link, it will open Research Team's chatbox on WhatsApp. All you need to do is hit send on the pre-filled message. Message the Research Team on WhatsApp

      iv. **If Unsure, Re-watch:** *Repeat video and options*

37. Would you like to be contacted by one of the study-affiliated counselors in the next week to learn more about the counseling services being provided?
- Yes
- No

38. Here is the contact information of the study counselors. In case you have decided to not schedule an appointment at this point, you can always choose to reach out to them on these numbers. Please take a screenshot for future reference!

We will periodically send you reminders on your WhatsApp number about the availability of these counseling services and how to book an appointment.

39. Would you be interested in using a mobile app that uses methods like therapy, breathing, meditation, and yoga/stretching to help you improve your mental health and well-being?

- Yes
- No

Perceptions of Therapy

40. In your opinion, how helpful would counseling/therapy be in improving your mental health/well-being and quality of life?

- Extremely helpful
- Very helpful
- Somewhat helpful
- Slightly helpful
- Not helpful at all
- Prefer not to say

41. If "Would you like to book an appointment with a study-affiliated counselor" = Yes OR "Would you like to be contacted by one of the study-affiliated counselors in the next week" = Yes: Which of the following statements best represent the primary factors motivating you to take up therapy? Please select all that apply to you.

- I have heard good things about therapy from my friends/family
- I am in distress and I think therapy will help me feel better
- I feel I don't have anyone to share my problems with and I think therapy will provide me with a safe space to do so
- I think therapy will help me learn to manage my stress and my emotions
- I think therapy will help me improve my relationships
- I think therapy will help me improve my academic/professional performance
- I am doing well overall but I think therapy will help me to keep improving
- Other
- ⊗Prefer not to say

    a. **If Other: What** other factors are motivating you to take up therapy?

42. If "Would you like to book an appointment with a study-affiliated counselor" = No AND "Would you like to be contacted by one of the study-affiliated counselors in the next week" = No: Which of the following statements best represent the primary factors holding you back from taking up therapy? Please select all that apply to you.

- I don’t think I need therapy
- I don’t know if therapy will help me in particular
- I don’t know how therapy works
- My parents/family would oppose my going for therapy
- Going to therapy is time consuming/ I do not have the time to go to therapy
- I don’t know where I can find a therapist
- Going to therapy is generally seen as a sign of being inferior and I do not want to be seen as such
- Going to therapy is generally seen as a sign of being weak and I do not want to be seen as such
- I would be afraid or embarrassed to go to therapy, especially if other people found out about it
- I have tried therapy before but I don't think it worked for me
- Other
- ⊗Prefer not to say

    a. **If Other:** What other factors are **holding** you back from taking up therapy?

43. Would you consider visiting a counselor/therapist in the future if need be?

- Yes
- No
- Prefer not to say

<u>Mental Health Self-Care</u>

44. In the near future, what steps will you take in order to take care of your psychological well-being? Please select all that apply to you.

- I will talk to or spend time with friends/family
- I will go to a counselor (a college or an external counselor)
- I will talk to a teacher or other course related staff in college
- I will focus on academics
- I will try to remain motivated and positive
- I will distract myself from the situation or the problem by doing things I like such as listening to music, watching TV shows/movies, reading, art, etc or trying new hobbies
- I will journal
- I will engage in physical activities i.e. sports, exercise, yoga, etc
- I will practice meditation and mindfulness
- Other

- ⊗Prefer not to say.

    a. **If Other:** What other steps will you take in order to take care of your psychological well-being?

Links

45. If interested in using a mobile app that uses methods like therapy, breathing, meditation…: Earlier in the survey, you indicated that you were interested in accessing an app for mental health. Click on one of the icons below to download the mental health and wellbeing tracker app! Note: This reserach is not sponsored by the app. This recommendation is based on public domain knowledge.

46. Are you interested in reading more about mental health and well-being?

- Yes
- No

    a. **If Yes:** Click here to learn more about Depression and tips on coping with it! Click here to learn more **about** Anxiety and tips on coping with it! We recommend bookmarking these webpages for future reference.

Comprehension

47. Do you think you are currently experiencing depression and/or anxiety?

- Depression
- Anxiety
- Both
- Neither
- ⊗Prefer not to say

48. In your opinion, what degree of psychological distress are currently experiencing?

- No distress
- Mild distress
- Moderate distress
- Severe distress

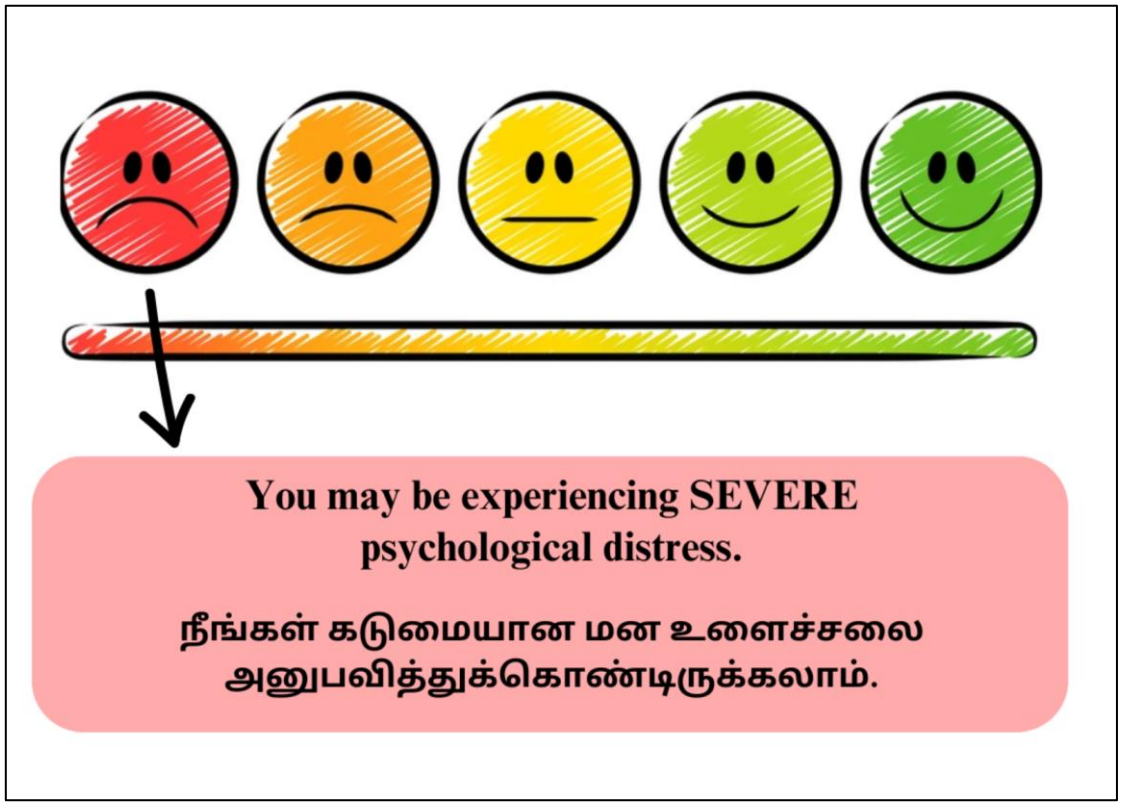
49. If you were to try out therapy with a study affiliated counselor, will you receive any financial rewards?

- Yes

- No
- I don't remember

Severe Depression or Anxiety

50. If phq_ads_score >= 30 & (Control | Rewards): Your responses to the mental health screening section of this survey indicate that currently:



We strongly recommend you to try therapy with one of the study-affiliated counselors.

Conclusion

51. As a reminder, here is the contact information of the study counselors. If you haven't already, please take a screenshot for future reference!

52. You are at the end of the survey! Please re-enter your college roll number below.