Talking Therapy: Impacts of a Nationwide Mental Health Service

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Motivation

- Mental ill health is common
  - Over 1 bln people globally (WHO, 2025)
- Mental ill health is costly
  - 4–8% of GDP across regions (Arias et al., 2022)
- Evidence that treatment works
  - Extensive for individual treatment: RCTs of psychological therapy (Roth & Fonagy, 2005; Lambert, 2013; Nathan & Gorman, 2015)
  - Scarce for services at scale

Key question: can mental health problems be treated effectively, and cost-effectively, at national scale?

This Paper

- First causal estimates of a nationwide psychological therapy service
- Questions
  - Does it work at scale, for mental health and for work?
  - Who benefits most and least, and under what conditions?
  - Is it worth the cost?
- Design: oversubscription → waiting lists → patients still waiting are the control group
- Data: every patient treated in England, 2016–2018 (1.25 million courses), outcomes recorded before every session

What We Find

- The programme works
  - 54% recover by the end of treatment: 43pp (causal) + 9pp (natural recovery)
  - Treated: 38pp more likely to improve, 8pp less likely to deteriorate
  - Close to what the trials predicted before the programme began
- It reaches work and social life
  - Impairment down by 65% of a SD in every domain
  - Among those not working: +3pp employed, −3pp on statutory sick pay
- It works for every group we look at, but less for the worse off
  - Smaller effects: higher severity, deprived areas, long-term conditions, unemployed
  - Self-referral improves access: help sought 364 vs 461 days after onset
- Benefit-cost ratio of at least 5.5

Related Literature

- **Closest**: scaling up access to psychotherapy in Denmark (Serena, 2025)
  - health-care savings, no employment effects; private psychologists, ages 18–37
- **Evaluations of this programme, not causal**: before–after comparisons (Clark et al., 2009; Gyani et al., 2013; Clark, 2018)
- **Trials of programmes like it**: Norway (Knapstad et al., 2020), Spain (Cano-Vindel et al., 2022)

- We add
  - vs evaluations: causal effects, net of natural recovery
  - vs small trials: a nationwide programme in a real-life setting, with detailed heterogeneity

The Programme: NHS Talking Therapies (formerly IAPT)

- Since 2008: psychological therapy for depression and anxiety, free at the point of use, within the NHS
- Therapists trained on a standardised national curriculum; manualised, NICE-recommended therapies; the same national guidelines in every service
- Stepped care: low-intensity (guided self-help) or high-intensity (CBT, counselling); average course about 7 sessions
- Patients can refer themselves; treated first come, first served
- Over 7 million treated; 670,000 courses in 2024/25 (NHS England, 2025); copied in Australia, Canada, Norway, Spain, Sweden

Data

- Patient records for everyone starting treatment April 2016 – December 2018
  - 1,246,792 courses; outcomes recorded for 98% of patients
  - about 200 services operating in any month
- Linked to service data (staff, funding, size) and local-area data (incomes, employment, deprivation)

Outcomes, Measured Before Every Session

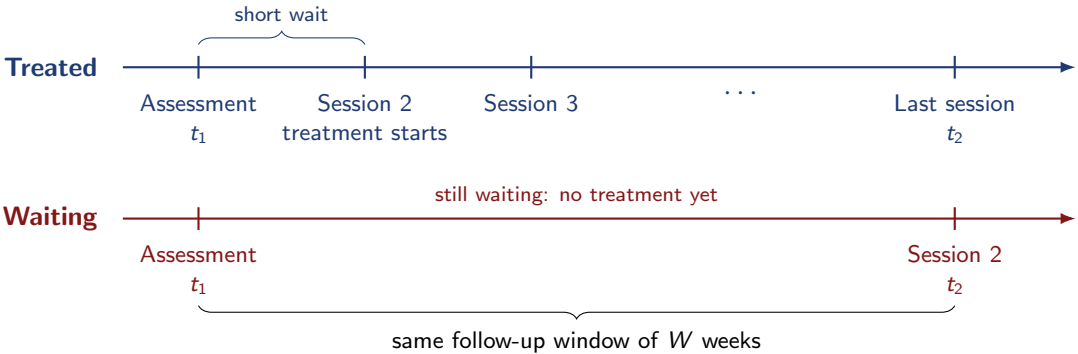
- Depression: PHQ-9 (0–27) [items] Anxiety: GAD-7 (0–21) [items]

- Primary outcomes (clinical definitions used by the NHS)
  - **Reliable improvement**: PHQ-9 and/or GAD-7 fall by more than measurement error, neither rises
  - **Reliable recovery**: reliable improvement *and* both scores below the clinical cut-off at the end
  - **Reliable deterioration**: a reliable rise, neither falls
- Secondary outcomes
  - Work and Social Adjustment Scale (0–40): work, home, social and private leisure, relationships
  - Employment, statutory sick pay; PHQ-9, GAD-7 and their average

Identification: Patients Still Waiting Are the Control Group

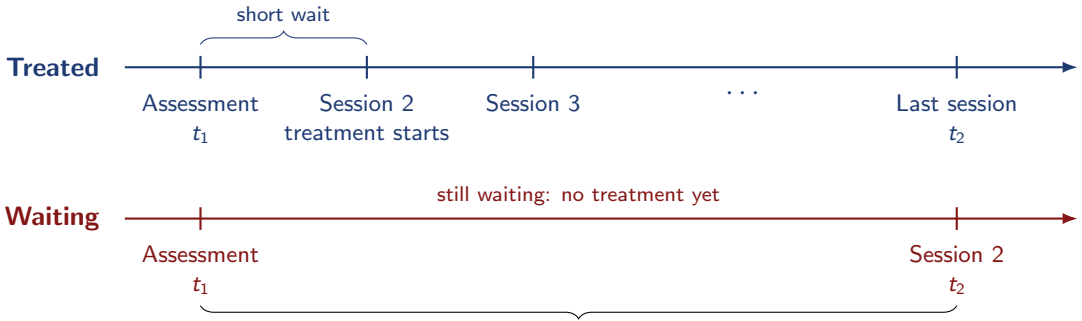


Identification: Patients Still Waiting Are the Control Group



$$\text{ATT} = (Y_{t_2} - Y_{t_1})_{\text{treated}} - (Y_{t_2} - Y_{t_1})_{\text{waiting}}$$

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$$\text{ATT} = (Y_{t_2} - Y_{t_1})_{\text{treated}} - (Y_{t_2} - Y_{t_1})_{\text{waiting}}$$

Treated: wait below the median for their treatment intensity. Waiting: above the median.

What Must Hold

- Two-period difference-in-differences, potential outcomes (see, e.g., Roth et al., 2023); $\Delta Y_i := Y_{it_2} - Y_{it_1}$

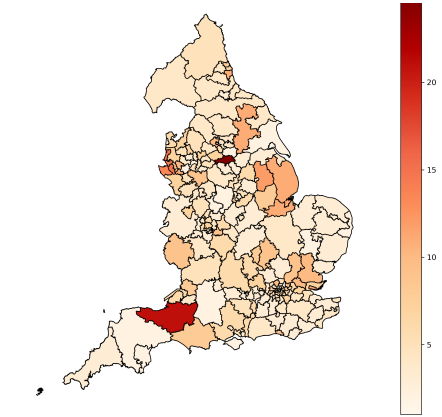
Assumption 1: Parallel trends. Without treatment, treated and waiting patients would recover alike:

$$E\left[\Delta Y_i(0) \mid D_i = 1, X_i\right] = E\left[\Delta Y_i(0) \mid D_i = 0, X_i\right]$$

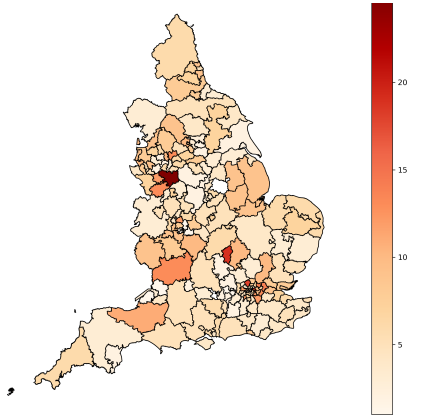
Assumption 2: No anticipation. Being in the treated group does not change the starting outcome:

$$E\left[Y_{it_1}(0) \mid D_i = 1, X_i\right] = E\left[Y_{it_1}(1) \mid D_i = 1, X_i\right]$$

Waiting Times Vary Across Areas and Over Time



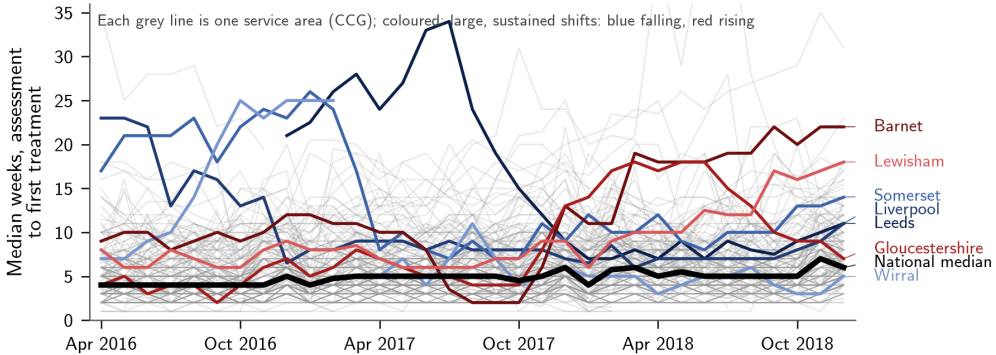
2016



2018

Median weeks from assessment to first treatment, by service area (CCG); same colour scale in both years, from about 2 weeks (light) to 25 weeks (dark).

Where the Variation in Waiting Times Comes From



- National median stays at 4–7 weeks
- Service-level waiting times shift in both directions, at different times
- Supply side: therapists recruited, leaving, or in training (communication with services)

Wait Not Related to Individual Characteristics

Short and long waits look alike

	Shortest 25% of waits	Longest 25% of waits
PHQ-9 at assessment	15.7	15.9
GAD-7 at assessment	14.3	14.5
PHQ-9 at the end	8.8	9.1
GAD-7 at the end	7.9	8.2
Sessions	7.8	7.7

No prioritisation by severity

- First come, first served: a legal requirement
- 1 SD worse symptoms → treatment starts less than one day later
- Correlation of wait and baseline PHQ-9: 0.017

Balance

- Treated and waiting balanced on all observables: normalised differences well below 0.25 [table]

Identification: Summing Up

Large variation in waits (25th percentile $<$ 3 weeks; 75th percentile $\approx$ 10 weeks)

The wait is not related to patients' characteristics

- **Observable patient differences** $\rightarrow$ control for diagnosis, baseline severity, intensity, and more; the effect barely moves with controls (0.443 $\rightarrow$ 0.431)
- **Unobservables** $\rightarrow$ Oster (2019): selection on unobservables would need to be 3.3 times as strong as on observables to remove the effect
- **Drop-out** $\rightarrow$ bounds under extreme assumptions: effect stays large and significant [bounds]
- **Waiting patients treated elsewhere** $\rightarrow$ biases us towards zero: a lower bound

Estimation

- Difference-in-differences, estimated in first differences:

$$\Delta Y_i = \beta_0 + \beta_1 D_i + \beta_2^\top \widetilde{W}_i + \beta_3^\top \widetilde{X}_{it_i} + \mu_{r_i} + \nu_{t_i} + u_i$$

- D_i: treated (wait below the median)
- $\widetilde{W}_i$: follow-up-window fixed effects, one per week, so natural recovery is flexible; the window runs from assessment to the last session if treated, to session 2 if waiting
- $\widetilde{X}$: therapy, individual, service and local-area characteristics
- μ: service fixed effects (222 services); ν: year, month and day-of-week fixed effects
- Standard errors clustered by service

Average Treatment Effects

	Reliable Recovery		Reliable Improvement		Reliable Deterioration	
Treatment	0.443***	0.431***	0.388***	0.377***	−0.085***	−0.084***
	(0.004)	(0.004)	(0.004)	(0.003)	(0.002)	(0.001)
Controls and fixed effects	No	Yes	No	Yes	No	Yes
Treated mean, last session	0.536	0.536	0.745	0.745	0.050	0.050
R squared	0.228	0.289	0.152	0.187	0.022	0.064

Linear probability models. $N = 1{,}246{,}792$ (618,574 treated, 628,218 waiting). Standard errors clustered by service. *** p<0.01.
Controls. *Therapy:* referral route (GP or self), weeks from referral to assessment, treatment mode, medication, initial diagnosis, treatment intensity and change of intensity, baseline mental health index. *Individual:* age, gender, ethnicity, religion, sexual orientation, long-term condition, employment status, armed forces; missing-value indicators. *Service:* staff, registered patients, funding per patient. *Local area:* unemployment rate, median wage, index of multiple deprivation and its seven domains. **Fixed effects:** follow-up window (weekly), service (222), year, month, day of week.

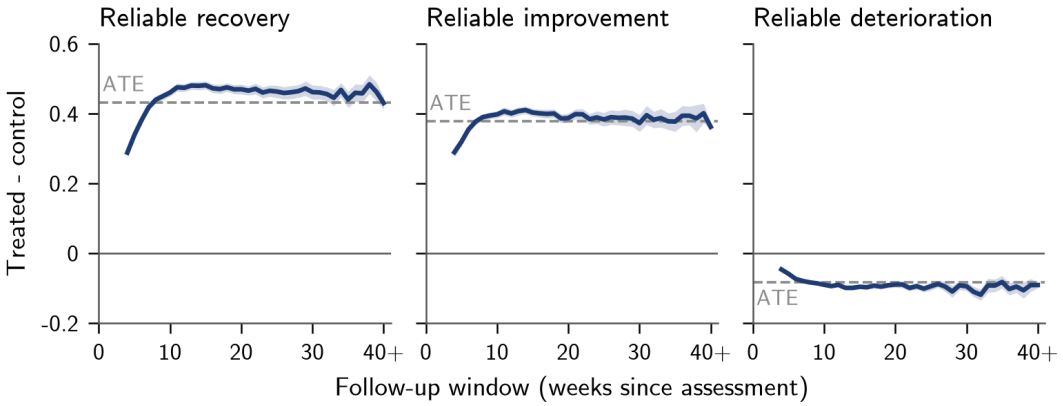
- Controls add explanatory power (R^2 0.23 → 0.29) but barely move the effect
- Oster δ: 3.3 (recovery), 3.0 (improvement), 16.3 (deterioration); all well above 1
- Matching and the causal forest give the same average (0.434, 0.436)

At Scale, Close to What the Trials Predicted

- **Before the programme**: Layard et al. (2007) projected recovery from the clinical guidelines
  - 61% treated vs 22% untreated: a difference of 39pp
- **Trials of similar programmes**
  - 59% recover in Norway (Knapstad et al., 2020), 50% in Spain (Cano-Vindel et al., 2022)
  - controls there received usual care, not a waitlist, so they recovered more often
- **Our estimate at national scale**
  - 54% of treated patients recover vs 9% on the waitlist; causal effect 43pp

- The trial evidence held up when the programme was rolled out nationwide

Is the Effect an Artefact of the Follow-Up Window?



- Treated − waiting difference at each week since assessment, with all controls
- Builds over the first weeks, then flat: not driven by how long patients are followed

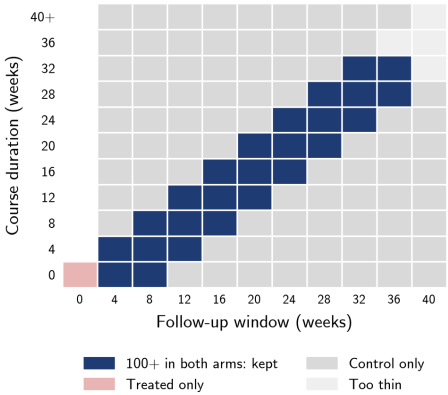
Selection on Outcomes: A Matched-Window Design

Concern

- Treatment ends when patient and therapist decide: the end point responds to progress

Fix

- Compare each treated patient only with waiting patients who have the same window *and* later get a course of the same length
- 4-week cells; keep cells with 100+ patients in each arm



Treated window = short wait + course, so treated sit on or just right of the diagonal. Kept: 828,763 patients, 66%. [figure]

Matched-Window Design: Results

	Reliable Recovery		Reliable Improvement		Reliable Deterioration	
Treatment	0.435***	0.420***	0.371***	0.359***	−0.080***	−0.078***
	(0.004)	(0.004)	(0.004)	(0.004)	(0.002)	(0.001)
Controls and fixed effects	No	Yes	No	Yes	No	Yes

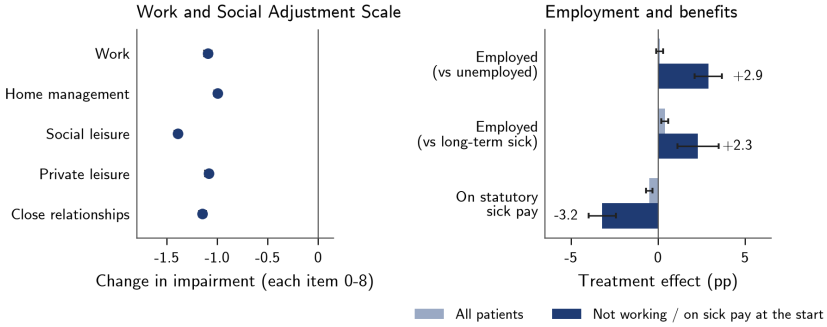
Matched sample: 828,763 patients (66%). Standard errors clustered by service. *** $p<0.01$.

- Essentially unchanged from the headline 0.431
- Same with 2-week cells or quartiles, and within each treatment intensity
- The median patient (median wait, 4–8 weeks; then the median course, 8–12 weeks): effect 0.50

Robustness

- Other cut-offs for treated vs waiting: 25th, 75th, 90th percentile of the wait [table]
- Logit instead of a linear probability model
- Diagnosis mix: without substance-use disorders (Williams et al., 2026); depression and anxiety only [table]
- Continuous outcomes: ΔPHQ-9 -5.1, ΔGAD-7 -4.8 points
- Drop-out: bounds [table]

Beyond Mental Health: Work and Social Life



95% CIs, clustered by service; where not visible they are narrower than the marker. *N*: WSAS 750,351; employment, all patients 721,523 / 694,187 / 1,081,196; not working at the start 80,137 unemployed / 63,546 long-term sick / 83,000 on sick pay.

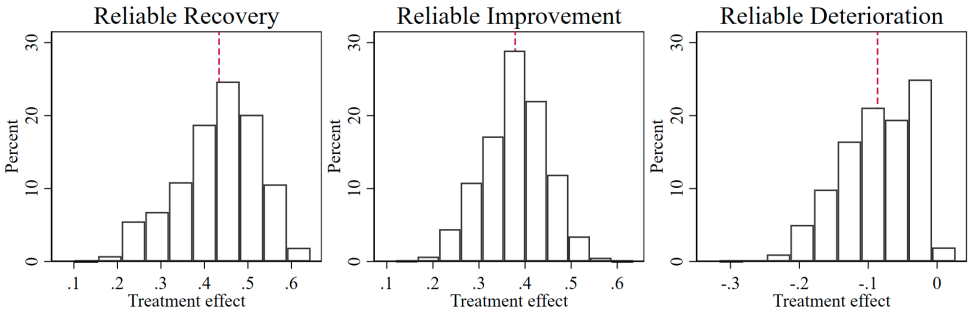
- Impairment falls in every domain: −5.7 points on 0–40, 65% of a SD
- Employment: no change on average (86% employed at the start); suggestive gains for those not working at the start
- Long run, linked tax records: up to +1.5pp paid employment, +3.1pp for job seekers (Rzepnicka et al., 2026)

Who Benefits? Two Complementary Approaches

1. **Predetermined characteristics**
   - Nonparametric matching [details]: cells of similar patients, on characteristics from the clinical literature; treated vs waiting within each cell
   - One effect per group: do the groups clinicians worry about benefit less?
2. **Data-driven characteristics**
   - Generalised random forest (Athey et al., 2019) [details]: trees split where the treatment effect differs; the data choose the characteristics
   - One effect per patient: what did we not think to look at?

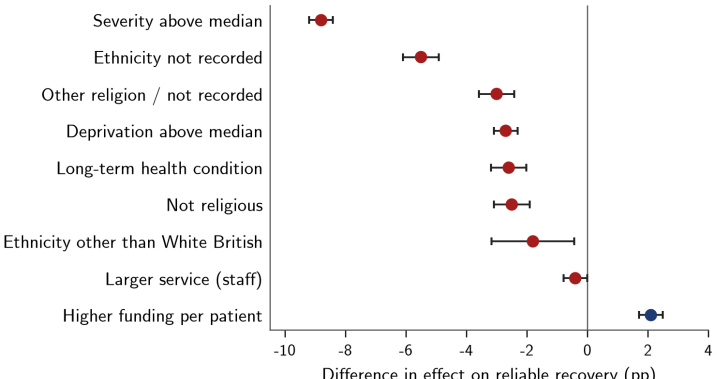
- Both recover the same average effect (0.434 and 0.436 vs 0.431)

Predetermined Characteristics



- Distribution of the cell effects, weighted by treated patients; dashed line: average effect
- Recovery and improvement effects positive for every group; deterioration not reduced for some

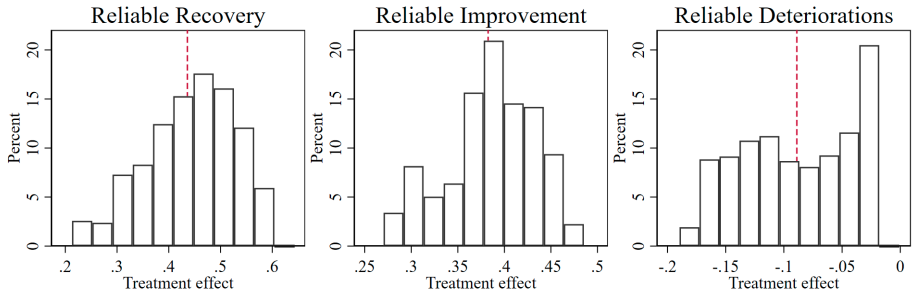
Who Benefits Less?



Interaction of each characteristic with treatment, reliable recovery, 95% CIs. $N = 947{,}547$. [full table]

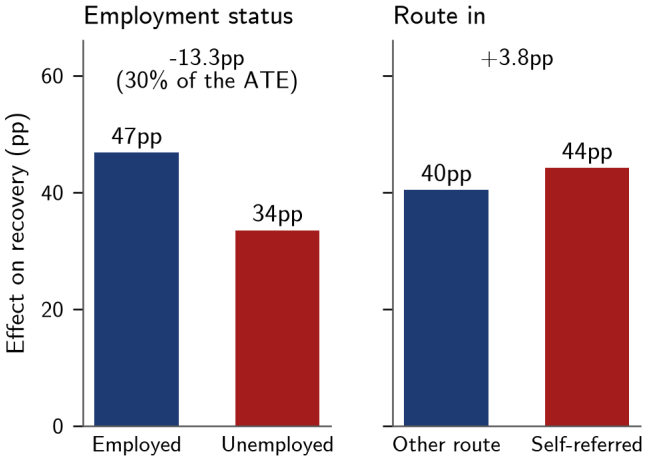
- Effect smaller for more severe symptoms, deprived areas, long-term conditions
- Larger where services are better funded
- A gradient in benefit, not a lack of it
- Long-term conditions: -3pp, vs -14pp in correlational work: most of that gap is natural recovery

Data-Driven Characteristics



- Distribution of patient-level effects; dashed line: average effect
- Smaller recovery effects: more severe symptoms, deprived areas, larger services, missing records, and two features nobody had looked at: unemployment and referral route

Employment Status and the Route into Treatment



Linear probability models, all controls; bars are implied effects for each group. [table]

- Unemployed patients gain 13pp less: 30% of the average effect
- 71.5% refer themselves; they seek help sooner (364 vs 461 days after onset) and gain 3.8pp more

A (Very Conservative) Cost-Benefit Calculation

- Benefits, mental health only: 5 points less on PHQ-9 $\approx +0.03$ on the EQ-5D index (Furukawa et al., 2021)
- Valued at £70,000 per QALY (HM Treasury, 2022)
- Benefits accrue over a stylised two-month course; 40% relapse instantly
- Benefits over 3 years: £3,745 per patient; costs: £680 per patient (Clark, 2018)
- Benefit-cost ratio of 5.5 [algebra]
- A lower bound: relapse is not instant; own mental health only; direct costs only

Summing Up

- First causal evidence on a nationwide psychological therapy service
- It works: +43pp recovery, less deterioration, better functioning at work and at home
- Everyone benefits, but less so the more severe, the deprived, the unemployed
- Self-referral brings people to seek help sooner
- Benefits at least 5.5 times the costs

Mental health problems impose high costs but can be treated cost-effectively at scale.

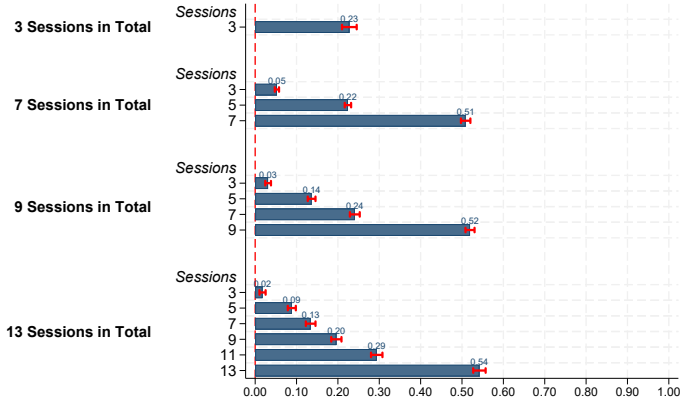
Thank you

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Appendix

Session Value Added



Value added in reliable recovery after a given number of sessions, for courses of 3, 7, 9 and 13 sessions, vs waiting patients with the same total. First five sessions: 22pp (7-session courses), 14pp (9), 9pp (13).

Nonparametric Matching [back]

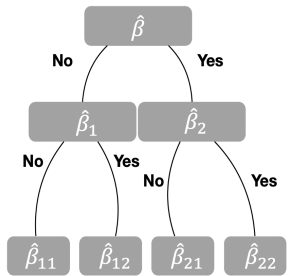
- Form cells of patients who share
  - the same follow-up window and treatment intensity
  - the same pre-selected characteristics: severity, deprivation, long-term condition, service size and funding, ethnicity, religion
- Inside each cell, compare treated with waiting patients: the effect for that cell

$$\theta(w, q) = E\left[\Delta Y_i \mid D_i = 1, W_i = w, Q_i = q\right] - E\left[\Delta Y_i \mid D_i = 0, W_i = w, Q_i = q\right]$$

- Keep cells that have both treated and waiting patients: 1,171 cells, 76% of patients
- Then ask which characteristics predict a larger or smaller effect (interactions with treatment)

Generalised Random Forest (Athey et al., 2019) [back]

- Each tree splits patients where the estimated treatment effect differs most, not where outcomes differ
- Honest trees: one half of a tree's subsample chooses the splits, the other half estimates the effects
- Outcome and treatment are first purged of the covariates' predictable part (orthogonalisation, as in Robinson, 1988)
- 1,000 trees, each grown on 10% of the sample; every leaf holds 500+ treated and 500+ waiting patients
- Then we compare patients in the top and bottom quartiles of the estimated effect



Moving the End Point Earlier [back]

End point	Last session	Penultimate	Antepenultimate
Reliable recovery	0.431	0.268	0.196
N	1,246,792	1,163,530	1,085,869

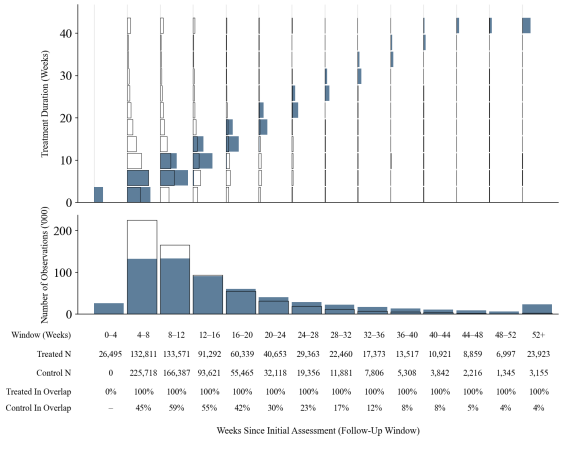
- Effect stays large, but attenuates: much of the gain comes in the last one or two sessions
- Patients are discharged when they are close to recovery: in a real programme, this is how treatment ends
- Whether this end-point choice drives the headline is what the matched-window design tests [design]

Balance: Treated vs Waiting [back]

	Treated (N=618,574)		Waiting (N=628,218)		Norm.
	Mean	SD	Mean	SD	diff.
At assessment					
PHQ-9	15.688	5.504	15.841	5.490	−0.028
GAD-7	14.310	4.350	14.468	4.324	−0.037
WSAS overall	19.849	9.153	20.236	9.298	−0.042
Employed (not unemployed)	0.858	0.349	0.856	0.351	0.007
Employed (not long-term sick)	0.894	0.308	0.867	0.339	0.081
On statutory sick pay	0.084	0.278	0.071	0.257	0.050
At last clinical session					
Reliable recovery	0.536	0.499	0.525	0.499	0.022
Reliable improvement	0.745	0.436	0.742	0.438	0.007
Reliable deterioration	0.050	0.219	0.057	0.231	−0.028

Normalised differences well below the 0.25 rule of thumb. Waiting patients are observed at their own last session after they are eventually treated.

Matched-Window Design: Common Support [back]



Window (Weeks)	0–4	4–8	8–12	12–16	16–20	20–24	24–28	28–32	32–36	36–40	40–44	44–48	48–52	52+
Treated N	26,495	132,811	133,571	91,292	60,339	40,653	29,363	22,460	17,373	13,517	10,921	8,859	6,997	23,923
Control N	0	225,718	166,387	93,621	55,465	32,118	19,356	11,881	7,806	5,308	3,842	2,216	1,345	3,155
Treated In Overlap	0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Control In Overlap	–	45%	59%	55%	42%	30%	23%	17%	12%	8%	8%	5%	4%	4%

Course duration at each follow-up-window bin: treated (navy) vs waiting (outline).

Drop-Out: Bounds [back]

	Main result	Scenario 1	Scenario 2	Scenario 3	Scenario 4
Reliable recovery					
Treatment	0.431***	0.218***	0.296***	0.404***	0.483***
	(0.004)	(0.009)	(0.007)	(0.004)	(0.004)
Reliable improvement					
Treatment	0.377***	0.195***	0.273***	0.381***	0.460***
	(0.003)	(0.008)	(0.005)	(0.005)	(0.004)
Reliable deterioration					
Treatment	−0.084***	0.016***	−0.063***	−0.171***	−0.249***
	(0.001)	(0.005)	(0.001)	(0.007)	(0.007)
Number of individuals	1,246,792	1,507,012	1,507,012	1,507,012	1,507,012
Treatment group	618,574	684,786	684,786	684,786	684,786
Control group	628,218	822,226	822,226	822,226	822,226

Scenario 1 (extreme lower bound): treated drop-outs all deteriorated; waiting drop-outs all recovered. *Scenario 2*: all drop-outs recovered. *Scenario 3*: all drop-outs deteriorated. *Scenario 4* (extreme upper bound): treated drop-outs all recovered; waiting drop-outs all deteriorated. Linear probability models, all controls, SEs clustered by service.

Other Cut-Offs for Treated vs Waiting [back]

	Reliable Recovery		Reliable Improvement		Reliable Deterioration	
25th percentile	0.443***	0.458***	0.402***	0.419***	−0.079***	−0.076***
	(0.004)	(0.004)	(0.004)	(0.004)	(0.002)	(0.001)
Treated / waiting			294,571 / 952,221			
75th percentile	0.438***	0.464***	0.373***	0.396***	−0.092***	−0.093***
	(0.004)	(0.004)	(0.003)	(0.003)	(0.002)	(0.001)
Treated / waiting			926,894 / 319,898			
90th percentile	0.437***	0.456***	0.365***	0.385***	−0.097***	−0.095***
	(0.004)	(0.005)	(0.003)	(0.004)	(0.002)	(0.002)
Treated / waiting			1,121,181 / 125,611			
Controls and fixed effects	No	Yes	No	Yes	No	Yes

Linear probability models, $N = 1{,}246{,}792$. Standard errors clustered by service. *** $p<0.01$.

Other Outcomes and Diagnosis Mix [back]

	Reliable Recovery			Other Outcomes		
	Logit marg. effect	Without substance use	Depression, anxiety only	ΔPHQ-9 (0–27)	ΔGAD-7 (0–21)	ΔMental Health Index (z)
Treatment	0.381***	0.431***	0.431***	−5.126***	−4.808***	−0.800***
	(0.003)	(0.004)	(0.004)	(0.052)	(0.044)	(0.008)
Number of individuals	1,246,729	1,246,155	996,358	1,246,792	1,246,792	1,246,792
(Pseudo) R squared	0.263	0.289	0.290	0.286	0.281	0.324

All controls and fixed effects. Standard errors clustered by service. *** $p<0.01$.

Low vs High Intensity

	Reliable Recovery		Reliable Improvement		Reliable Deterioration	
Low intensity (N=491,942)	0.440***	0.430***	0.368***	0.360***	−0.078***	−0.078***
	(0.005)	(0.005)	(0.003)	(0.004)	(0.002)	(0.002)
R squared	0.216	0.284	0.138	0.179	0.020	0.053
High intensity (N=275,990)	0.439***	0.429***	0.404***	0.393***	−0.084***	−0.084***
	(0.008)	(0.008)	(0.007)	(0.006)	(0.003)	(0.002)
R squared	0.234	0.298	0.164	0.198		0.069
Controls and fixed effects	No	Yes	No	Yes	No	Yes

	ΔPHQ-9		ΔGAD-7		ΔMental Health (z)	
Low intensity	−4.579***	−4.514***	−4.488***	−4.409***	−0.732***	−0.720***
High intensity	−5.458***	−5.486***	−5.047***	−5.035***	−0.846***	−0.847***

Linear probability models. Standard errors clustered by service. *** p<0.01.

Who Benefits Less: All Three Outcomes [back]

	Reliable Recovery	Reliable Improvement	Reliable Deterioration
Severity above median × treated	−0.088*** (0.002)	−0.071*** (0.002)	0.096*** (0.001)
Deprivation above median × treated	−0.027*** (0.002)	0.004** (0.002)	−0.014*** (0.001)
Long-term health condition × treated	−0.026*** (0.003)	0.003 (0.003)	−0.008*** (0.002)
Service size above median × treated	−0.004** (0.002)	−0.006*** (0.002)	0.003** (0.001)
Service funding per patient above median × treated	0.021*** (0.002)	0.026*** (0.002)	−0.010*** (0.001)
Not religious × treated	−0.025*** (0.003)	−0.013*** (0.003)	0.007*** (0.002)
Other religion / missing × treated	−0.030*** (0.003)	−0.021*** (0.004)	0.006*** (0.002)
Other ethnicity × treated	−0.018** (0.007)	0.000 (0.008)	−0.016*** (0.005)
Missing ethnicity × treated	−0.055*** (0.003)	−0.030*** (0.003)	0.002 (0.002)
Number of individuals	947,547	947,547	947,547
R squared	0.26	0.16	0.05

Omitted: Christian; White British. Intensity interactions also included. Standard errors clustered by service.

Employment Status and Self-Referral

	Reliable Recovery	Reliable Improvement	Reliable Deterioration
Unemployed vs employed			
Treated	0.468*** (0.004)	0.387*** (0.004)	−0.085*** (0.001)
Unemployed	−0.012*** (0.001)	−0.083*** (0.003)	0.029*** (0.002)
Unemployed × treated	−0.133*** (0.004)	−0.042*** (0.004)	0.009*** (0.002)
N	828,356	828,356	828,356
Self-referral vs other routes			
Treated	0.404*** (0.005)	0.373*** (0.004)	−0.089*** (0.002)
Self-referral	0.016*** (0.006)	0.043*** (0.006)	−0.022*** (0.004)
Self-referral × treated	0.038*** (0.005)	0.006 (0.004)	0.007*** (0.002)
N	1,246,792	1,246,792	1,246,792

Linear probability models, all controls. Standard errors clustered by service. *** $p<0.01$, ** $p<0.05$.

Cost-Benefit Calculation: Algebra

- 5-point fall in PHQ-9 $\approx +0.03$ on the EQ-5D index (Furukawa et al., 2021); £70,000 per QALY (HM Treasury, 2022)
- Benefits accrue linearly over a stylised two-month course
- 40% of patients relapse instantly (conservative: about 40% relapse six years after treatment)

Monetised benefits over 3 years:

$$\left[\left(\tfrac{0+0.03}{2} \times 2 + 0.03 \times 0.6 \times 10\right)/12 + 0.03 \times 0.6 \times 2\right] \times £70{,}000 = £3{,}745$$

Costs: £680 per patient: total 2015–16 investment divided by courses of treatment (Clark, 2018)
Net benefits: £3,065 per patient; benefit-cost ratio 5.5

PHQ-9 Items [back]

Over the past two weeks, how often have you been bothered by:

1. Little interest or pleasure in doing things?
2. Feeling down, depressed, or hopeless?
3. Trouble falling or staying asleep, or sleeping too much?
4. Feeling tired or having little energy?
5. Poor appetite or overeating?
6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down?
7. Trouble concentrating on things, such as reading the newspaper or watching television?
8. Moving or speaking so slowly that other people could have noticed? Or the opposite?
9. Thoughts that you would be better off dead or of hurting yourself in some way?

Not at all, Several days, More than half the days, Nearly every day

GAD-7 Items [back]

Over the past two weeks, how often have you been bothered by:

1. Feeling nervous, anxious, or on edge?
2. Not being able to stop or control worrying?
3. Worrying too much about different things?
4. Trouble relaxing?
5. Being so restless that it is hard to sit still?
6. Becoming easily annoyed or irritable?
7. Feeling afraid, as if something awful might happen?

Not at all, Several days, More than half the days, Nearly every day