When Parents Can Spare Time: Paid Sick Leave and Adolescent Mental Health Care*

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Abstract

Adolescents in the United States face rising rates of depression, anxiety, and suicidality, yet structural barriers such as parental work constraints continue to limit timely access to care. This paper provides new causal evidence that state Paid Sick Leave (PSL) mandates improve adolescent mental health. Using the staggered adoption of PSL mandates across states, we find that PSL laws increase the probability that an adolescent received any mental or behavioral health care in the past year by 2.3 percentage points (a 14% increase relative to the baseline mean of 17.1%) and raise parent-reported depression diagnoses by 1.5 percentage points (a 14% increase relative to the baseline mean of 10.9%). Complementary evidence from the Youth Risk Behavior Surveillance System shows that PSL mandates reduce self-reported depressive symptoms by 2.2 percentage points (7.2%) and passive suicidal ideation by 1.42 percentage points (8.6%), with no detectable effects on active suicidal ideation. Mechanism analyses suggest that these improvements operate primarily through enhanced parental time flexibility and increased engagement with the mental health care system. Taken together, the findings highlight the broader public health benefits of labor protections that enable working parents to support adolescents' mental health.

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1 Introduction

Children and adolescents in the United States face a growing mental health crisis, with rising rates of depression, anxiety, and suicidality over the past decade (Centers for Disease Control and Prevention, 2024; Xiang et al., 2024; Warnick and Kolade, 2024). Unmet mental health needs among youth remain widespread, particularly for conditions such as depression and behavioral disorders, which are often underdiagnosed and untreated until symptoms escalate (Lu, 2019; The Pew Charitable Trusts, 2024). These gaps in care have long-term consequences for educational attainment, employment, and health over the life course (Bubonya et al., 2017; Kondirolli and Sunder, 2022; Frijters et al., 2014; Bryan et al., 2022; Fletcher, 2013; Currie, 2024). One frequently overlooked structural barrier to timely detection and treatment is time constraints faced by parents, as mental health appointments and follow-ups typically occur during standard working hours. Limited time flexibility can delay early intervention, reduce treatment adherence, and exacerbate the severity of mental health conditions among children and adolescents, particularly during adolescence when symptoms often first emerge (Mitchell and Selmes, 2007; Hansen et al., 2021). In this study, we focus specifically on adolescents aged 12–17, for whom access to mental health care critically depends on parental involvement in scheduling, consent, transportation, and appointment attendance.

Policies that expand parents' ability to take time off for caregiving are thus particularly relevant in this context. Among such policies, paid sick leave (PSL) mandates have emerged as a key instrument to balance work and family responsibilities. PSL laws allow workers to take protected, paid time off for personal or family health needs without risking income loss or job security (Eisenberg et al., 2025; Seixas and Macinko, 2020; Callison et al., 2025). By increasing the availability of short-term, protected time away from work, PSL mandates may facilitate earlier health-seeking behavior, improve continuity of care, and strengthen family well-being. Prior studies suggest PSL mandates increase parental caregiving time and improve family stability (Assamidanov et al., 2025; Deza et al., 2025; Maclean and Pabilonia, 2025; Guo and Peng, 2025), yet their implications for adolescents' mental health remain largely unexplored. Whether these labor protections translate into measurable improvements in adolescents' mental health remains an open and policy-relevant question.

Unlike most high-income countries, the United States lacks a federal paid sick leave policy, leaving access to this benefit determined by state mandates or voluntary employer provision. As of 2024, 18 states and the District of Columbia have enacted statewide PSL mandates that typically provide 5–7 paid days per year at full wage replacement, with leave explicitly allowed for family caregiving including attending children's medical appointments (Pichler and Ziebarth, 2024; Mitchell, 2024). Because access to PSL remains highly unequal—with low-wage, part-time, and service-sector workers least likely to have coverage (Bureau of Labor Statistics, 2024)—these mandates disproportionately expand benefits among families facing the steepest time and financial constraints in accessing adolescent mental health care.

This paper provides the first causal evidence, to our knowledge, on the effects of state paid sick leave mandates on adolescents' mental health outcomes. We link the timing and location of paid sick leave (PSL) adoption to child-level survey data from the National Survey of Children's Health (NSCH) and the Youth Risk Behavior Surveillance System (YRBSS) to examine impacts on adolescents' engagement with mental health care and mental health status. Specifically, we study effects on (1) receipt of any mental or behavioral health care,

(2) use of mental health medication, (3) parent-reported depression and anxiety diagnoses, and (4) self-reported depressive symptoms and suicidal ideation. Our empirical approach exploits the staggered adoption of PSL mandates across states and employs the interaction-weighted event-study estimator of Sun and Abraham (2021), which is robust to treatment effect heterogeneity and allows us to assess pre-trends and dynamic treatment effects relative to adoption.

Our findings indicate that PSL mandates substantially increase adolescents' engagement with the mental health care system. NSCH estimates show that adoption of a PSL mandate increases the probability that an adolescent received any mental or behavioral health care in the past year by 2.3 percentage points, corresponding to a 14% increase relative to the pre-policy mean of 17.1%. Depression diagnoses increase by 1.5 percentage points, representing a 14% increase relative to the baseline mean of 10.9%. Because these NSCH measures reflect clinical diagnoses and treatment, they are best interpreted as improvements in detection and treatment engagement rather than worsening underlying mental health. Complementary analysis of YRBSS data allows us to examine whether increased detection corresponds to changes in symptoms. We find that PSL mandates reduce self-reported depressive symptoms by 2.2 percentage points and passive suicidal ideation by 1.42 percentage points, relative to pre-policy means of 30.3% and 16.5%, respectively, with no detectable effects on active suicidal ideation. Taken together, these results suggest that PSL mandates ease time-related access barriers, facilitate earlier engagement with mental health services, and are accompanied by improvements in adolescents' reported psychological well-being.

Mechanism analyses provide further support for a time-flexibility interpretation. Following PSL adoption, families report a 0.6 percentage-point increase in unmet mental health need, a 2.1 percentage-point increase in difficulty coordinating care, and a 1.1 percentage-point increase in trouble obtaining appointments. In addition, the probability that a parent reduced or stopped work to care for the adolescent increases by 1.5 percentage points. These patterns are consistent with a mechanism in which PSL expands parents' capacity to engage with the mental health care system and temporarily adjust work responsibilities when adolescents require care, rather than directly alleviating coordination frictions or broader family routines in the short run.

Our study complements recent evidence on PSL mandates and adult mental health care. Eisenberg et al. (2025) show that PSL mandates do not increase overall mental health care use among working-age adults but instead shift treatment toward more time-intensive modalities such as psychotherapy and inpatient care, with suggestive improvements in self-reported mental health. We extend this work by focusing on adolescents aged 12–17, for whom mental health care access depends fundamentally on parental time availability rather than individuals' own labor–leisure choices. Unlike adults, adolescents cannot independently schedule appointments, consent to treatment, or attend therapy sessions without active parental involvement. Consequently, PSL may affect adolescents not only through changes in treatment modality but also through whether care is accessed at all. Moreover, by combining clinical diagnoses, parental reports, and youths' self-reported symptoms, we distinguish increased detection from changes in underlying mental health and identify an intergenerational spillover channel through which labor policies targeting workers generate spillovers for children's mental health.

Against this backdrop, our study contributes to three strands of literature. First, it

extends prior research on the health effects of labor market policies (Chen et al., 2020; Guo, 2025; Pichler and Ziebarth, 2017; Callison and Pesko, 2022) by providing the first causal evidence on the impact of paid sick leave mandates on adolescent mental health outcomes. Second, it advances understanding of the intergenerational and spillover consequences of family-oriented labor protections (Maclean and Pabilonia, 2025; Deza et al., 2025; Dahl et al., 2016; Baker and Milligan, 2008), demonstrating that policies designed to support working parents can yield significant benefits for adolescents' mental health and development. Finally, it informs ongoing policy debates on how employment regulations can function as upstream determinants of population mental health (Reeves et al., 2017; Wang et al., 2024). By easing time constraints faced by working families, relatively low-cost PSL mandates appear to deliver meaningful improvements in child and adolescent mental health, underscoring the broader public health potential of labor-based social policy.

Section 2 reviews U.S. paid sick leave policy and outlines the conceptual framework guiding the analysis. Section 3 describes the data sources and empirical strategy. Section 4 presents the results on mental health care utilization, diagnoses, and mental health outcomes. Section 5 concludes with a discussion of implications.

2 Institutional Background

2.1 Adolescent Mental Health Care in the United States

Adolescent mental health care in the United States spans multiple treatment settings with varying time requirements. Primary care physicians provide initial mental health screening, brief counseling, and medication initiation (Zuckerbrot et al., 2018; Cheung et al., 2018). More intensive outpatient mental health care typically includes comprehensive diagnostic evaluation, individual psychotherapy, and medication management delivered by specialty mental health providers. Outpatient mental health services are provided by psychiatrists and other mental health professionals and commonly involve psychotherapy and psychotropic medication use (Olfson et al., 2019; Centers for Medicare & Medicaid Services, 2025). Standard psychotherapy sessions typically last 45–60 minutes (Walkup et al., 2008; Weisz et al., 2017), with evidence-based treatments such as cognitive behavioral therapy generally requiring weekly sessions over 8–20 weeks (March et al., 2007; Weisz et al., 2017).

A defining feature of adolescent mental health care is the legal requirement for parental involvement in most states. Eighteen states either prohibit independent adolescent consent to mental health treatment or provide no explicit authorization for minors to consent independently (Schleider et al., 2025). Parents must schedule appointments, coordinate with insurance providers, arrange transportation, and often attend family therapy sessions or medication consultations. These logistical requirements create structural dependence on parental time availability that distinguishes adolescent from adult mental health care access. Provider shortages compound these time barriers: approximately 70% of U.S. counties lack a single child or adolescent psychiatrist (McBain et al., 2019), and simulated-patient studies find that fewer than 17% of child psychiatrists have available appointments for new patients (Cama et al., 2017). Consequently, even when families have insurance coverage and motivation to seek care, time constraints—including inflexible work schedules and lengthy wait

times—can delay treatment initiation and reduce treatment adherence.

These structural features of adolescent mental health care delivery create a framework in which parental time availability functions as a critical enabling factor for treatment access. Evidence demonstrates that parental access to paid sick leave significantly increases children's healthcare utilization, including preventive care and routine appointments, while reducing reliance on emergency services (Asfaw and Colopy, 2017; Seixas and Macinko, 2020). The time-intensive and recurring nature of adolescent mental health treatment—requiring repeated appointments during standard work hours over weeks or months—may make this care particularly sensitive to policies that expand parents' ability to take paid time off work. State paid sick leave mandates, which provide workers with protected, compensated leave that can be used for family healthcare needs, represent a policy intervention that could directly address these time-related barriers. By reducing the financial penalty associated with missing work to attend mental health appointments, PSL mandates may facilitate earlier treatment initiation, improve treatment adherence, and enable adolescents to access more time-intensive evidence-based therapies that would otherwise be inaccessible to families facing binding work-time constraints.

2.2 Paid Sick Leave Policy in the United States

Against this backdrop of time-intensive care requirements and parental dependence, state paid sick leave mandates represent a policy intervention that could directly address time-related access barriers. The United States does not have a permanent federal paid sick leave mandate, making it an outlier among high-income countries. The Family and Medical Leave Act of 1993 provides up to 12 weeks of unpaid leave for eligible workers, but eligibility is restricted by firm size, job tenure, and hours worked, and the policy does not cover short-term needs such as attending medical appointments (Appelbaum, 2014; Pichler and Ziebarth, 2024). During the COVID-19 pandemic, the Families First Coronavirus Response Act provided temporary paid leave from April to December 2020, but this policy expired without establishing a permanent national standard (Andersen et al., 2023).

In the absence of federal action, paid sick leave policy has developed through state and local legislation. San Francisco enacted the first employer mandate in 2007, followed by the District of Columbia in 2008 and Connecticut in 2012 (Ober, 2006; Gilliam and Ben-Ishai, 2012). As of 2024, 18 states and DC have enacted statewide PSL mandates (Mitchell, 2024). These mandates share common structural features: employees typically accrue paid sick leave at a rate of one hour per 30–40 hours worked, with annual caps of 24–56 hours (3–7 days) compensated at 100% wage replacement (U.S. Department of Labor, 2023; Paycor, Inc., 2025). Critically, leave can be used not only for employees' own health needs but also for family caregiving, with all state mandates explicitly including care for children such as attending medical appointments or providing care during illness. Mandates include job protection and anti-retaliation provisions and limit employers' ability to require extensive documentation (Pichler and Ziebarth, 2017).

A growing body of evidence demonstrates that state mandates meaningfully expand PSL access and utilization. Regarding first-stage effects, using establishment-level data, Maclean and Pabilonia (2025) show that PSL mandate adoption increases the probability that employers offer PSL by 32% and employee use of PSL by 22%. Other studies document similar

increases in self-reported PSL access (Ahn and Yelowitz, 2016; Callison and Pesko, 2022). Despite concerns about business costs, Maclean and Pabilonia (2025) find that PSL mandates increase employer costs by only 6 cents per employee-hour worked, and Miller (2022) documents no change in business bankruptcies post-mandate while consumer bankruptcies decline. Research also shows that PSL mandates increase health care utilization—including prescriptions, vaccinations, and screenings—while reducing potentially unnecessary emergency department visits (Ma et al., 2022; Callison et al., 2023; Maclean et al., 2024). Several studies find improvements in general health outcomes and economic security, including increased wages and earnings for women and reduced poverty rates (Slopen, 2023, 2024).

Recent work demonstrates that PSL mandates affect family caregiving and child outcomes. Maclean and Pabilonia (2025) show that parents increase primary childcare time by 6% following PSL adoption, while Deza et al. (2025) find that child maltreatment reports decline by 8%. Eisenberg et al. (2025) provide evidence on adult mental health care, showing that PSL mandates shift treatment composition toward more time-intensive modalities without increasing overall utilization, with suggestive improvements in self-reported mental health. However, effects on adolescent mental health outcomes remain unexplored, despite adolescents' unique dependence on parental time for accessing care.

Access to PSL remains highly stratified: low-wage, part-time, and service-sector workers are substantially less likely to receive employer-provided PSL absent mandates (Bureau of Labor Statistics, 2024). These same populations face elevated barriers to accessing adolescent mental health care (The Pew Charitable Trusts, 2024). Consequently, state PSL mandates disproportionately expand coverage among families for whom time constraints are most binding.

These institutional features of PSL mandates have several implications for adolescent mental health. First, by providing parents with protected time to attend appointments, PSL mandates may increase detection and diagnosis of mental health conditions that were previously unidentified, leading to increases in parent-reported diagnoses and treatment receipt even if underlying mental health remains unchanged. Second, PSL may improve access to evidence-based mental health care—particularly time-intensive modalities such as psychotherapy—by enabling parents to attend initial consultations and maintain weekly therapy schedules. Regular engagement with mental health services has been shown to improve symptoms and reduce suicidal ideation (Kaczkurkin and Foa, 2015; Keles and Idsoe, 2018; van Ballegooijen et al., 2025). Third, PSL mandates may affect adolescent mental health indirectly through improvements in parental mental health (Eisenberg et al., 2025), reduced financial stress (Miller, 2022; Slopen, 2024), and increased parental caregiving time (Maclean and Pabilonia, 2025).

These channels generate distinct and potentially offsetting empirical predictions. Increased detection predicts higher rates of parent-reported diagnoses and treatment receipt, while improved access to effective treatment predicts reductions in adolescent self-reported symptoms and suicidal ideation. Observing both patterns simultaneously—increased formal diagnoses alongside reduced self-reported symptoms—would support an interpretation in which PSL mandates ease time-related access barriers and improve both detection and actual mental health outcomes. Unlike adult mental health care, where individuals can independently navigate the health care system, adolescent mental health care access depends critically on parental time availability for scheduling, consent, transportation, and appoint-

ment attendance, making parental time flexibility a particularly binding constraint for this population.

3 Data

3.1 Paid Sick Leave Policy Data

We begin by constructing a state–year panel of Paid Sick Leave (PSL) mandates, which serves as the primary policy variable in this analysis. Policy data were drawn from the National Partnership for Women and Families' (2023) compilation of Paid Sick Days Statutes, supplemented with legislative texts and state labor department releases to verify effective dates and coverage provisions. Each law specifies key implementation features, including accrual rates (typically one hour of paid leave for every 30–40 hours worked), annual caps ranging from 24 to 56 hours (3–7 days per year), and eligible uses such as personal illness, family caregiving, or school closures. We coded a binary indicator for whether a state had an active PSL mandate in effect during a given survey year. Because NSCH and YRBSS collect information throughout the calendar year, states with laws taking effect after July were coded as treated beginning in the following year to ensure consistent alignment between policy exposure and the survey reference period. The final panel includes 14 states and the District of Columbia with active mandates between 2012 and 2022 (Table 1).

(Table 1 here)

3.2 National Survey of Children's Health (NSCH) Data and Outcomes

Our primary data source is the National Survey of Children's Health (NSCH), a nationally representative cross-sectional survey administered annually by the U.S. Census Bureau on behalf of the Health Resources and Services Administration's Maternal and Child Health Bureau. The NSCH collects detailed information on children's physical, mental, and behavioral health, health care access, family environment, and social determinants of well-being. The survey employs a stratified address-based sampling design and is completed online or by mail by a parent or guardian who is knowledgeable about the child's health and development. Each year, the NSCH includes approximately 35,000 to 45,000 completed child-level interviews, representing the noninstitutionalized population of children aged 0–17 years in all 50 states and the District of Columbia (U.S. Census Bureau, 2023).

Our analysis uses pooled data from the 2016–2022 NSCH waves, corresponding to the period following the NSCH redesign that standardized sampling procedures, weighting, and questionnaire content across years. We begin the study period in 2016 to ensure consistency in outcome measurement and survey design and end in 2022, the most recent wave available at the time of analysis. The analytic sample is restricted to adolescents aged 12–17, the age range for which mental health service use, medication use, and diagnostic indicators are most reliably and consistently reported in the NSCH. After applying these restrictions and excluding observations with missing key covariates, the final analytic sample includes 93,875 adolescent observations.

The unit of analysis is an individual adolescent observed in a given survey year. We use publicly available state identifiers to merge adolescent-level outcomes from the NSCH with a state–year panel capturing the timing of paid sick leave (PSL) mandate adoption and other time-varying state policy and economic conditions. Our primary outcomes are constructed as binary indicators equal to one if an adolescent received any mental or behavioral health care in the past 12 months or used medication for emotional or behavioral conditions, capturing engagement with clinical treatment, and zero otherwise. We additionally examine binary indicators for parent-reported diagnoses of depression, anxiety, and attention-deficit/hyperactivity disorder (ADHD), which reflect clinical identification and diagnosis rather than self-reported symptoms. Together, these measures capture distinct stages of the mental health care pathway, ranging from service utilization to diagnostic recognition.

Importantly, the NSCH mental health diagnosis variables capture parent-reported clinical diagnoses made by a health professional, rather than symptom scales. Parents are asked whether a doctor or other health care provider has ever told them that their child has depression, anxiety, or ADHD. This distinction is central for interpretation, as changes in diagnoses reflect access to care and clinical identification rather than underlying symptom prevalence.

Table 2 reports summary statistics for the analytic sample pooled across survey years and separately for states with and without a PSL mandate in effect during the survey year. In the full sample, 17.6% of adolescents received any mental health care in the past 12 months, 15.8% used medication for emotional or behavioral conditions, and 11.0%, 18.0%, and 15.4% had parent-reported diagnoses of depression, anxiety, and ADHD, respectively. Adolescents residing in PSL mandate states are descriptively more likely to receive any mental health care, 19.0% versus 17.2%, and to have anxiety diagnoses, 19.3% versus 17.7%, compared with adolescents in non-mandate states. In contrast, rates of medication use and ADHD diagnoses are modestly lower in PSL mandate states.

The demographic composition of adolescents also differs across states with and without PSL mandates. Adolescents in mandate states are slightly more likely to reside in households with higher parental educational attainment, with 63.9% having a parent with a college degree or higher compared with 56.9% in non-mandate states. Racial and ethnic composition varies across groups, with PSL mandate states having a lower share of White, non-Hispanic adolescents and a higher share of Hispanic adolescents. Insurance coverage is high in both groups, though slightly higher in mandate states, 95.4% versus 94.4%. At the state level, PSL mandate states tend to exhibit higher minimum wages, broader Medicaid eligibility thresholds for both parents and non-parents, higher housing prices, and greater primary care physician availability, alongside more stringent COVID-19 policy responses. These patterns underscore systematic differences in policy and economic environments across states that motivate the inclusion of rich state-level controls in the regression analysis.

(Table 2 here)

3.3 Youth Risk Behavior Surveillance System (YRBSS) Data and Outcomes

The data on self-reported depression and suicidal ideation among youth are taken from the Youth Risk Behavior Surveillance System (YRBSS), a biennial survey conducted by the U.S. Centers for Disease Control and Prevention (CDC) since 1991. The YRBSS High School Survey is administered to students in grades 9–12, typically aged 12 to 18 years, and is designed to be representative at the state level in participating states for monitoring youth health, safety, and risk behaviors. The YRBSS employs a two-stage cluster sampling design, sampling schools in the first stage and classrooms within schools in the second stage. Survey weights are provided to account for differential selection probabilities and non response. We pooled nine biennial YRBSS waves from 2005 through 2021, covering both the pre and post-policy periods relevant for our analysis.

We used three distinct measures of mental health derived from YRBSS questions. The first is the self-reported depression which is captured by the youth response to the question: "During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?". The question aligns closely with established diagnostic criteria for a depressive episode and widely used as a measure of depressive symptoms in population-based research. The second is the passive suicidal ideation which measures the binary response if the individual seriously considered attempting suicide in the last twelve months. Lastly, the third outcome is active suicidal ideation, measured by a binary indicator for whether the individual reports having made a suicide plan in the past 12 months. Table A.1 reports summary statistics for these outcomes. Approximately 30 percent of students report depressive symptoms, 16.8 percent report suicidal ideation, and 13.7 percent report having made a suicide plan. In contrast to the NSCH, YRBSS outcomes capture adolescents' self-reported emotional states and behaviors rather than clinical diagnoses. For example, the depressive symptoms measure reflects whether respondents experienced prolonged feelings of sadness or hopelessness that interfered with daily activities, aligning with symptom-based screening rather than formal diagnosis.

These three mental health measures were selected because the phrasing of these questions has remained consistent across all survey waves dating back to 2005. This consistency is critical for our research design, as it provides a pre-intervention period prior to the implementation of Connecticut's state-level Paid Sick Leave (PSL) mandate in 2012. Although additional mental health items were introduced in more recent YRBSS surveys, we limit our analysis to these three outcomes because they are the only ones with sufficient pre-policy coverage. In addition to these outcome variables, we incorporate individual-level covariates from the survey—specifically age, sex, and race/ethnicity—which we also use to examine heterogeneous treatment effects.

4 Empirical Strategy

We estimate the causal effect of state paid sick leave (PSL) mandates on mental health outcomes using variation in the timing of PSL adoption across U.S. states. States adopt mandates in different years (Table 1), and once adopted, mandates remain in effect. This

staggered rollout creates a difference-in-differences design with multiple treatment cohorts. In settings with staggered treatment adoption, conventional two-way fixed effects (TWFE) estimators can be problematic. When treatment effects are heterogeneous across cohorts or evolve over time, TWFE implicitly compares early-treated units to later-treated units, using already-treated observations as controls. These comparisons can receive negative or non-convex weights, leading to estimates that are difficult to interpret and potentially biased relative to any meaningful average treatment effect (Goodman-Bacon, 2021). Therefore, we use the interaction-weighted event-study estimator of, which is robust to staggered adoption and heterogeneous treatment effects. The Sun–Abraham estimator constructs treatment effects by comparing each treated cohort only to states that are not yet treated or never treated at the same point in time. The coefficients θ_{gk} represent cohort- and event-time–specific average treatment effects, measuring the effect of PSL adoption k years relative to implementation for states first treated in year g. Aggregate treatment effects is then the weighted averages of these cohort-specific estimates, with weights that are non-negative and sum to one. As a result, both the point estimates and the event-study coefficients have a clear causal interpretation as averages of well-defined cohort-level treatment effects, free from contamination by already-treated units. (Sun and Abraham, 2021)

$$Y_{ist} = \alpha_s + \lambda_t + X'_{st}\beta + I'_{ist}\omega + \sum_{g \in \mathcal{G}} \sum_{\substack{k \in \mathcal{K} \\ k \neq -1}} \theta_{gk} \, \mathbf{1}\{G_s = g\}\mathbf{1}\{t - g = k\} + \varepsilon_{ist}. \tag{1}$$

Here, Y_{ist} is the outcome for individual i in state s and year t; G_s denotes the first year a PSL mandate takes effect in state s; and $k = t - g$ indexes event time, with $k = -1$ omitted as the reference period. The specification includes state fixed effects α_s, year fixed effects λ_t, state-level controls X_{st}, and individual-level controls I_{ist}. We estimate Equation (1) using survey sampling weights to ensure representativeness while clustering standard errors at the state level to account for policy variation and serial correlation. Never-treated states serve as the comparison group. The estimator recovers cohort-specific dynamic treatment effects and aggregates them using non-negative weights, avoiding contamination from comparisons across differently treated cohorts.

Finally, the identification relies on the parallel trends assumption: absent PSL adoption, treated and comparison states would have followed similar trends in mental health outcomes. To assess the plausibility of this assumption, we implement the estimator of Sun and Abraham (2021) in an event-study framework with multiple pre-treatment and post-treatment periods relative to adoption. Pre-treatment leads are used to test for differential pre-trends, while post-treatment lags trace the dynamic evolution of treatment effects. Event-time coefficients are interpreted relative to the year immediately preceding adoption.

5 Results

5.1 Adolescent Mental Health Outcomes from the NSCH

Table 3 reports estimates of the effect of state paid sick leave (PSL) mandates on adolescent mental health care utilization and diagnostic outcomes, estimated using Equation (1). The results indicate that PSL mandates are associated with statistically significant increases in

adolescents' engagement with mental health care. Following adoption of a PSL mandate, the probability that an adolescent received any mental or behavioral health care in the past 12 months increases by 2.3 percentage points ($p < 0.05$), corresponding to a 13.6% increase relative to the pre-policy mean of 17.1%. We also find a positive increase in medication use for emotional or behavioral conditions of 1.4 percentage points, which is statistically significant at the 10% level and represents an 8.8% increase relative to its baseline mean of 15.9%.

(Table 3 here)

PSL mandates are associated with higher rates of parent-reported mental health diagnoses among adolescents. In particular, the probability of a depression diagnosis increases by 1.5 percentage points ($p < 0.05$), corresponding to a 13.8% increase relative to the baseline prevalence of 10.9%. We also estimate a positive effect on anxiety diagnoses of 1.2 percentage points that is marginally statistically significant at the 10% level, representing a 7% increase relative to the baseline mean of 17.5%. The largest and most precisely estimated effects are observed for outcomes related to mental health care utilization and depression diagnoses, and these patterns remain stable across alternative specifications that sequentially add demographic, economic, health care supply, and COVID-related controls, as shown in Table A.2.

Figure 1 reports event-study estimates for receipt of any mental health care and parent-reported depression diagnoses. The coefficients on the pre-treatment leads are small in magnitude and statistically indistinguishable from zero, providing no evidence of differential pre-trends between adopting and non-adopting states prior to policy implementation. Beginning in the first year following adoption, we observe positive and statistically significant increases in adolescents' receipt of mental health care, with effects that persist and modestly grow over subsequent years. For depression diagnoses, post-adoption estimates are generally positive and often marginally statistically significant, suggesting modest increases following PSL adoption, though estimates are less precisely estimated than those for mental health care utilization. Event-study estimates for anxiety diagnoses do not satisfy the parallel trends assumption and are therefore not interpreted dynamically. Estimates for medication use for emotional or behavioral conditions are noisy and do not exhibit a clear or stable post-adoption trajectory.

(Figure 1 here)

Table 5 presents heterogeneous effects of paid sick leave mandates across adolescent and family characteristics. For receipt of any mental health care, statistically significant increases are concentrated among younger adolescents aged 12–14, White adolescents, and females, with positive but imprecise estimates for other groups. In contrast, effects on depression diagnoses are concentrated among older adolescents aged 15–17, White, Asian, and Black adolescents, females, and adolescents with college-educated parents. Estimates for males and for several racial and ethnic subgroups are smaller and not statistically distinguishable from zero. Overall, the subgroup results indicate that increases in mental health care utilization and diagnostic identification are not uniform across populations, with distinct patterns by age, sex, race and ethnicity, and parental education.

(Table 5 here)

Mental health conditions and diagnostic identification vary meaningfully across adolescent developmental stages, with older adolescents exhibiting higher prevalence of depressive and anxiety disorders, greater autonomy in seeking care, and more frequent contact with school-based mental health services. Consistent with these patterns, estimated effects on depression diagnoses are concentrated among adolescents aged 15–17, whereas increases in general mental health care use are observed among both younger and older adolescents. These patterns are consistent with known developmental gradients in symptom onset, recognition, and care engagement rather than differences in economic or labor market exposure.

Taken together, the NSCH results reflect increased engagement with the mental health care system and greater diagnostic identification following PSL adoption. Because these measures capture diagnosed conditions rather than symptoms, they are best interpreted as evidence of improved access and detection rather than worsening underlying mental health. This interpretation is consistent with prior evidence that policy-driven reductions in access barriers increase contact with mental health services and diagnostic identification. In line with Catherine Maclean's work on mental health care access and treatment entry, our results suggest that paid sick leave mandates primarily operate by easing constraints that impede timely contact with the mental health care system, particularly for adolescents.

5.2 Youth Mental Health Outcomes from the YRBSS

In contrast to the diagnosis-based outcomes in the NSCH, the YRBSS captures self-reported symptoms, allowing us to examine whether increased detection and treatment correspond to changes in adolescents' emotional well-being. Table 4 reports estimates from the Sun and Abraham (2021) interaction-weighted event-study specification described in equation (1). In this specification, individual-level covariates include age, race, and gender, and we estimate the model using YRBSS survey weights.

We find statistically significant negative effects of PSL mandates on reported depression and passive suicidal ideation. The estimated coefficient for depression implies a 2.2 percentage point decline, significant at the 5 percent level ($p < 0.05$). Relative to a pre-treatment mean of 30.3 percent, this corresponds to a 7.2 percent reduction in reported depression. Passive suicidal ideation decreases by 1.42 percentage points and is statistically significant at the 1 percent level ($p < 0.01$), representing an 8.6 percent decline relative to a baseline mean of 16.5 percent. In contrast, the estimated effect on active suicidal ideation is not statistically significant at conventional levels ($p = 0.102$), although the point estimate is negative. The estimate corresponds to a 1.21 percentage point change relative to a pre-treatment mean of 13.5 percent.

(Table 4 here)

Figure 2 presents interaction-weighted event-study estimates of the effects of paid sick leave mandates on youth mental health outcomes, based on equation (1). Coefficients are normalized relative to the average of the two immediate pre-treatment periods (t=-1,-2). Across all three reported mental health outcomes, the estimated pre-treatment coefficients

are small in magnitude and statistically indistinguishable from zero, with no systematic patterns prior to adoption. This provides no evidence of differential pre-trends and supports the validity of the parallel trends assumption underlying our identification strategy.

Following adoption, the post-treatment dynamics differ across outcomes. For reported depression, the point estimates turn negative after implementation and remain predominantly below zero across most post-adoption periods, with larger declines emerging in later years, although precision varies across event times. A similar pattern is observed for passive suicidal ideation. The estimates become negative shortly after adoption and remain generally below zero over subsequent periods, consistent with a sustained decline, although with widening confidence intervals at longer horizons.

In contrast, estimates for active suicidal ideation are substantially more imprecise. While post-adoption coefficients are generally negative in sign, some of the post-treatment estimates are statistically significant.

(Figure 2 here)

The aggregate estimates of health measures may mask significant heterogeneity across demographic subgroups. To examine potential heterogeneity in these effects, Table 6 reports subgroup analyses by age, sex, and race/ethnicity. For reported depression (Panel A), the estimated effects are negative and statistically significant for both males and females, with larger magnitudes for females. By age, the decrease in reported depression is concentrated among youth aged 15 or older, while estimates for younger adolescents are small and statistically insignificant. Across racial groups, statistically significant reductions are observed for White and Black youth with the larger magnitude for black youth whereas estimates for Asian, Hispanic, and other racial groups are imprecisely estimated and not statistically significant. Panel B presents results for passive suicidal ideation and are similar to the reported depression. We find statistically significant reductions for both females and males, with larger effects for females. By race, the estimates indicate significant declines for White and Black youth, while effects for Asian, Hispanic, and other racial groups are not precisely estimated. However, unlike depression, reductions in passive suicidal ideation are evident for both younger adolescents and those aged 15 or older. Finally, Panel C reports estimates for active suicidal ideation. The effects are generally smaller in magnitude and less precisely estimated across subgroups. While some subgroups—such as females, youth aged 15 or older, and Black youth—exhibit negative and statistically significant point estimates, the majority of subgroup estimates are statistically indistinguishable from zero. Overall, the subgroup analysis suggests that the mental health benefits of paid sick leave mandates are concentrated among older adolescents and certain demographic group.

(Table 6 here)

5.3 Potential Mechanism

State paid sick leave (PSL) mandates are unlikely to directly affect adolescents' mental health outcomes. Instead, these mandates may operate through changes in parents' ability to navigate the health care system, allocate time to caregiving, and adjust work responsibilities

in response to children's needs. In this section, we examine mechanisms related to health care access, care coordination, and family functioning that may link PSL mandates to adolescent mental health outcomes.

A first mechanism operates through changes in adolescents' engagement with the mental health care system. Table 7 presents evidence on how paid sick leave (PSL) mandates affect mental health care access and coordination. PSL adoption is associated with a statistically significant increase of 0.6 percentage points in reported unmet mental health need, relative to a baseline prevalence of 1.3%, which likely reflects heightened recognition of need as families engage more actively with mental health services. We also observe a 2.1 percentage-point increase in reported difficulty coordinating care and a 1.1 percentage-point increase in trouble obtaining an appointment. Taken together, these patterns are consistent with increased interaction with the mental health care system following mandate adoption, which may both improve identification of mental health needs and expose families to coordination frictions as utilization expands. Estimated effects on the need for home-based care, facility hours not aligning with need, avoidance of changing providers, and receipt of a routine preventive check-up are smaller in magnitude and not statistically distinguishable from zero. These findings align with prior evidence showing that parental time constraints are a key barrier to scheduling and attending children's health care visits, and that policies expanding time flexibility primarily increase engagement with services that require repeated visits and follow-up, such as mental health care (Mitchell and Selmes, 2007; Hansen et al., 2021; Chen et al., 2020).

(Table 7 here)

A second mechanism relates to parental time allocation and family functioning. Table 8 summarizes the effects of PSL mandates on parental labor supply adjustments and family interaction. We find that PSL adoption increases the probability that a parent reduced or stopped work to care for the adolescent by 1.5 percentage points, a sizable change relative to the baseline mean of 5.3%. In contrast, estimated effects on family meals, parent–adolescent communication, and collaborative problem solving are positive but imprecisely estimated. This pattern aligns with prior research showing that paid leave policies primarily affect parents' ability to temporarily adjust work behavior in response to caregiving demands, with more limited short-run effects on broader family routines or interaction patterns (Maclean and Pabilonia, 2025; Deza et al., 2025).

(Table 8 here)

Overall, the mechanism results suggest that PSL mandates primarily operate by expanding parents' capacity to engage with the mental health care system and adjust work responsibilities when adolescents require care. These changes may facilitate increased service use and diagnostic identification, even as families encounter coordination challenges during periods of expanded engagement with care.

5.4 Robustness and Validation Analyses

We conduct a series of robustness and validation exercises to assess the sensitivity of our main findings to alternative specifications, outcome definitions, and sample restrictions.

First, we re-estimate the baseline models using a conventional two-way fixed effects (TWFE) difference-in-differences specification. Tables A.3 and A.4 report TWFE estimates for adolescent mental health care utilization and diagnoses in the National Survey of Children's Health (NSCH), and for youth-reported depression and suicidal ideation in the Youth Risk Behavior Surveillance System (YRBSS), respectively. Although TWFE estimators can be biased in settings with staggered policy adoption, the direction and relative magnitude of the TWFE coefficients are consistent with those obtained using the Sun and Abraham (2021) estimator in the main analysis. In addition, Table A.7 re-estimates the Sun and Abraham (2021) models after excluding observations from 2020, a period characterized by substantial disruptions to health care access and mental health. The estimated effects on receipt of any mental health care remain positive and statistically significant at conventional levels ($p = 0.055$), while the coefficient on depression diagnosis remains positive and marginally significant ($p = 0.097$). Estimated effects on anxiety diagnosis and mental health medication use are attenuated and imprecisely estimated in this restricted sample. These results indicate that the core findings on mental health care engagement and depression are not driven by pandemic-related shocks, though statistical power is reduced when excluding the COVID year.

We further assess the validity of our results by examining outcomes that should be less directly affected by short-run changes in parental time flexibility or mental health care engagement. Table A.5 reports Sun and Abraham (2021) estimates for diagnostic scope outcomes, including parent-reported ADHD diagnosis, autism diagnosis, and special health care needs (CSHCN). We find limited and imprecise effects across these measures, suggesting that the observed increases in depression and anxiety diagnoses are unlikely to reflect broad diagnostic expansion or changes in reporting of neurodevelopmental conditions. In addition, Table A.6 presents placebo tests for non–time-sensitive child outcomes such as hearing impairment, overweight or obesity status, neighborhood safety, oral health problems, and social skills. Across these outcomes, we find no systematic evidence of policy effects. Together, these robustness checks support the interpretation that paid sick leave mandates increase adolescents' engagement with mental health care and the identification of depression and anxiety, rather than reflecting model-specific artifacts, generalized changes in child health, or spurious correlations.

6 Discussion and Conclusion

Overall, the evidence from both the NSCH and YRBSS analyses indicates that Paid Sick Leave (PSL) mandates significantly improve adolescents' mental health outcomes. The policies increase access to mental health care, raise detection of depressive disorders, and reduce self-reported depressive and suicidal symptoms among youth—effects that are most pronounced among adolescents, females, and minority groups. Building on these findings, this section discusses potential mechanisms, implications, and limitations.

The evidence from this study indicates that the effects of Paid Sick Leave (PSL) mandates operate primarily through improved time flexibility for working parents rather than changes in insurance or financial strain. By enabling caregivers to attend appointments and support children's mental health needs, PSL laws reduce time-related barriers to care. These find-

ings align with prior work showing that PSL increases parental caregiving time and family stability, but they extend the literature by documenting downstream mental health benefits for children and adolescents.

The findings are consistent with a time-constraint mechanism: by providing parents with paid, job-protected leave, PSL laws reduce scheduling and income-related barriers to care. In contrast, the absence of effects on insurance coverage, financial strain, or parental aggravation suggests that the policy operates primarily through greater time flexibility rather than through changes in affordability or family stress. These results echo prior work documenting that PSL mandates increase parental caregiving time (Maclean and Pabilonia, 2025), improve family stability (Deza et al., 2025), and raise healthcare utilization among adults (Chen et al., 2020; Guo, 2025). Extending this literature, our findings show that such benefits extend beyond the workplace—facilitating earlier detection, treatment, and prevention of mental health conditions in children and adolescents.

The absence of significant effects on anxiety or ADHD diagnoses provides further evidence of outcome specificity. These conditions typically require longer-term behavioral assessments and multiple clinical evaluations, making them less responsive to short-term increases in parental time flexibility. In contrast, conditions such as depression or emotional distress are more sensitive to early recognition and timely intervention. This pattern reinforces the interpretation that PSL mandates primarily facilitate earlier access to time-sensitive mental health services rather than altering the prevalence of chronic or developmentally rooted disorders.

To assess whether the effects of PSL mandates extend to broader aspects of child health and development, we also estimated models for preventive care use, general health status, and behavioral or developmental diagnoses. We find no meaningful changes in these outcomes. Preventive and general health indicators—typically less time-sensitive—remain unaffected, as do behavioral and developmental conditions such as autism, which are often determined earlier in life. These findings suggest that PSL mandates primarily operate through short-term access and detection channels for mental health care rather than broad improvements in overall child health or developmental conditions.

The policy implications are substantial. In the absence of a federal PSL standard, access to paid leave remains highly unequal, with low-income and service-sector workers least likely to have coverage. Because these workers are also more likely to experience time-related barriers to healthcare, expanding PSL coverage could help reduce inequities in child mental health. Moreover, as policymakers seek upstream strategies to address the youth mental health crisis, PSL offers a scalable, low-cost intervention that simultaneously supports labor market stability and public health. Framing PSL as a family health policy—rather than solely a labor protection—may also broaden bipartisan support for its adoption.

Several limitations merit consideration. Although our difference-in-differences and event-study designs address many confounding factors, unobserved policy or social changes coinciding with PSL adoption could bias estimates. In addition, our outcomes rely on parent- and self-reported survey measures, which may understate underlying mental health conditions. Finally, state-level policy coding may mask heterogeneity in local implementation or enforcement. Future research should examine longer-term effects on treatment adherence, academic outcomes, and broader family well-being.

In conclusion, our results highlight that Paid Sick Leave mandates, while designed as

worker protections, deliver measurable mental health benefits for children and adolescents. By easing time constraints on working parents, these policies promote earlier care-seeking and emotional well-being, particularly among disadvantaged families. As the United States confronts widening disparities in youth mental health, integrating labor-based policies like PSL into public health and family policy frameworks represents a promising and underutilized avenue for prevention.

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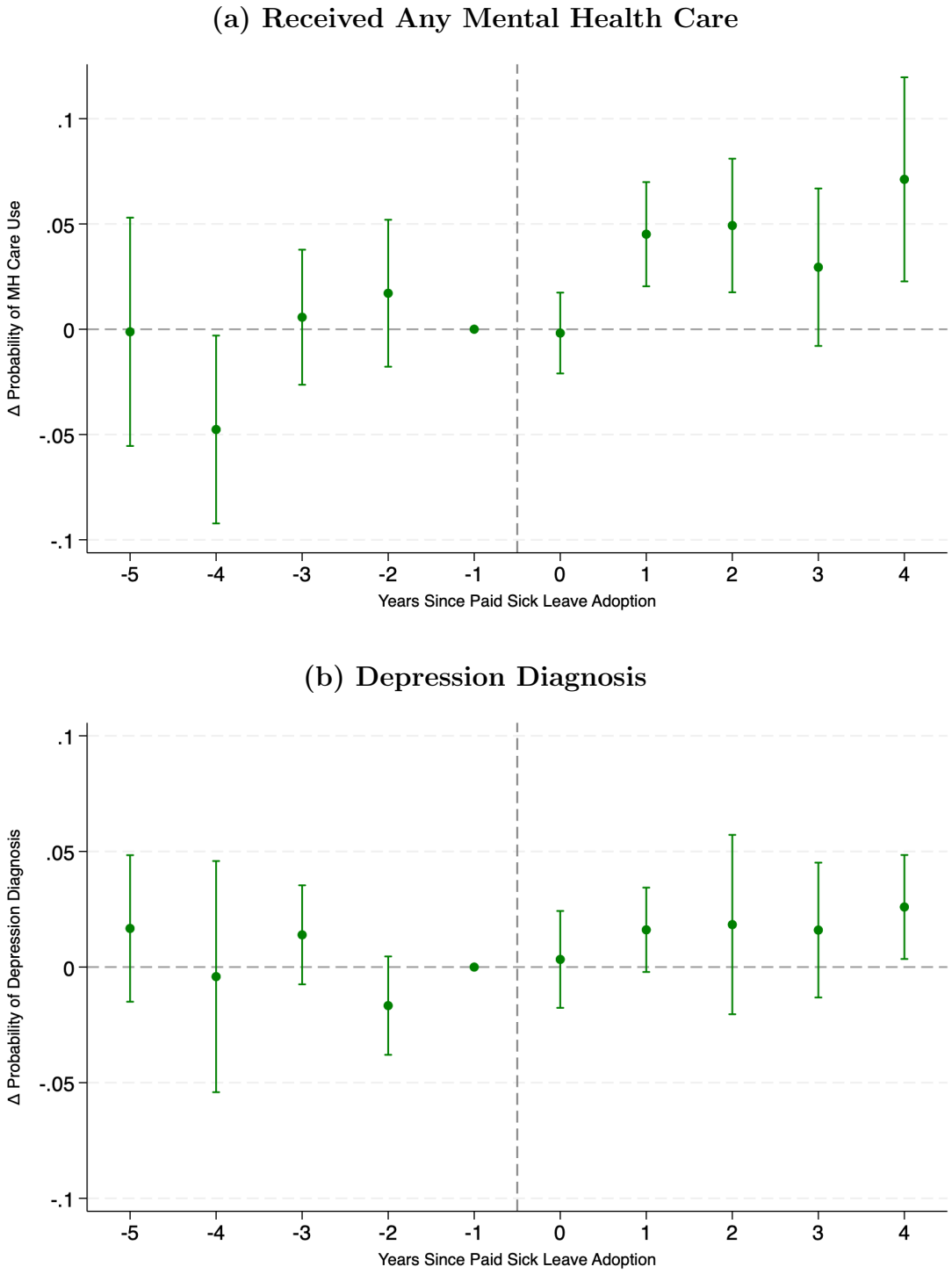
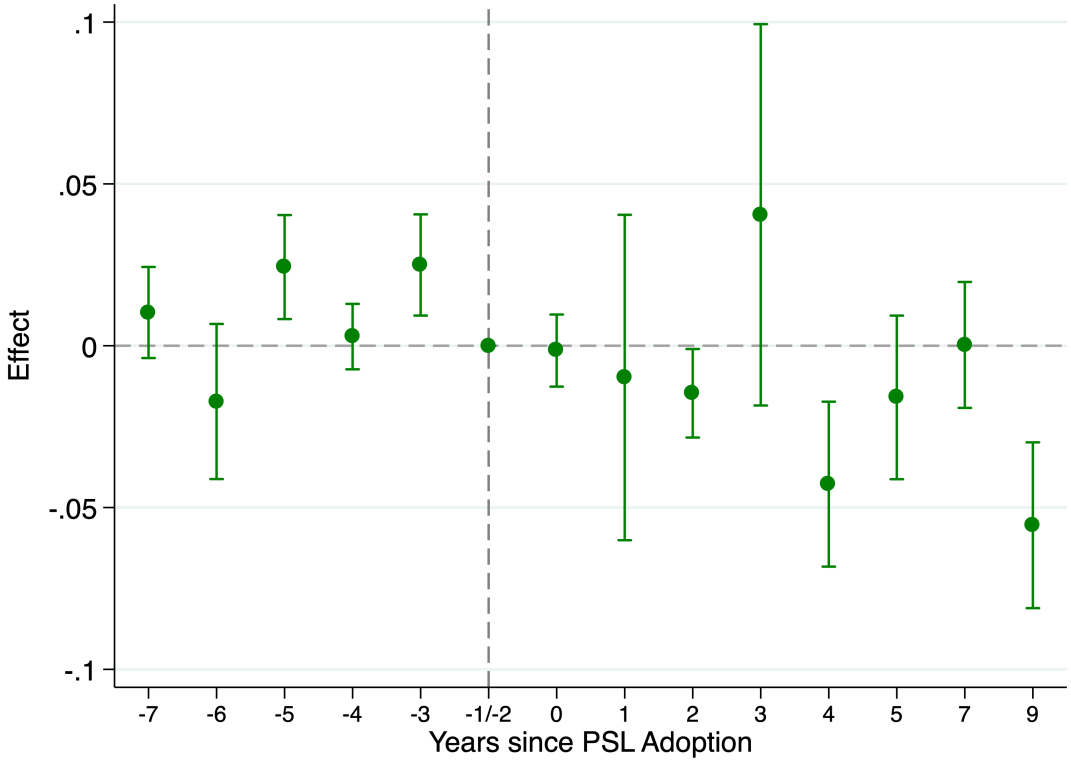
Figure 1: Event-Study Estimates of the Impact of Paid Sick Leave Mandates on Child Mental Health Outcomes



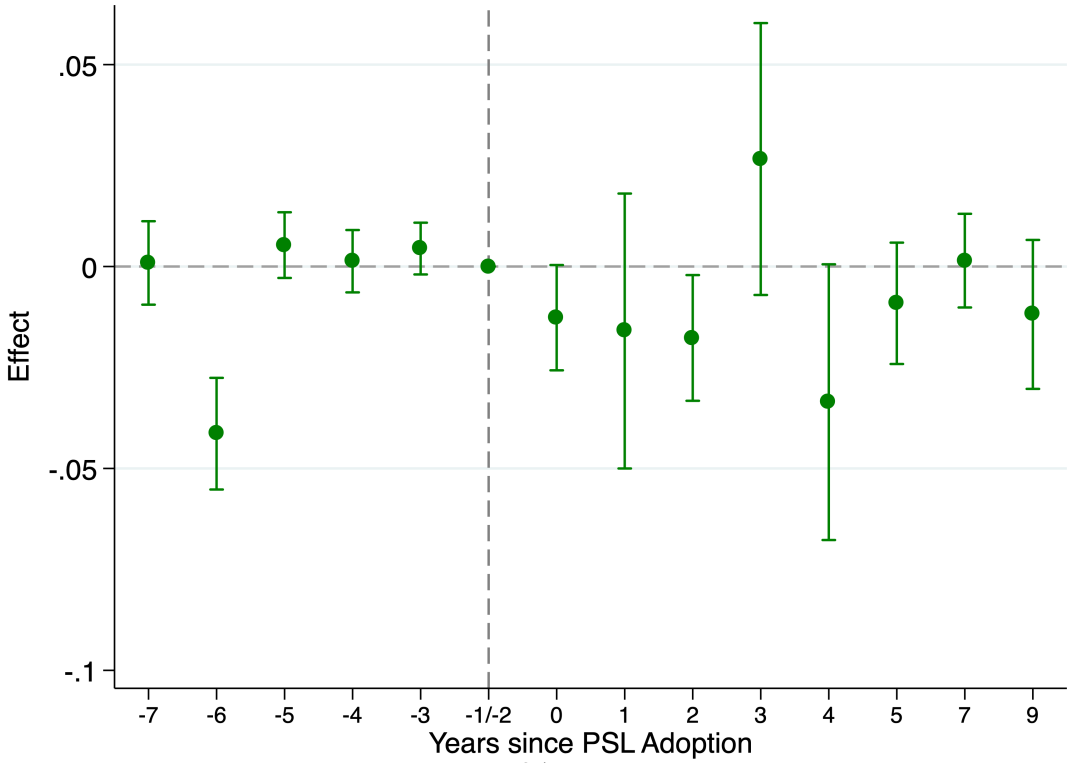
Notes: This figure presents event-study estimates of the effects of state and local paid sick leave (PSL) mandates on two key child mental health outcomes. Panel (a) plots coefficients for receipt of any mental health care, and Panel (b) plots coefficients for parent-reported depression diagnosis. Coefficients are shown relative to the average of the two years prior to mandate adoption ($t = -2$ and $t = -1$), with 95% confidence intervals. All models are estimated using a two-way fixed effects difference-in-differences framework that accounts for staggered policy adoption, controlling for child demographics, family socioeconomic characteristics, and state-level covariates. State and year fixed effects are included, and standard errors are clustered at the state level. Vertical dashed lines mark the policy adoption year; shaded bands denote 95% confidence intervals.

Figure 2: Event-Study Estimates of the Impact of PSL Mandates on Youth Mental Health

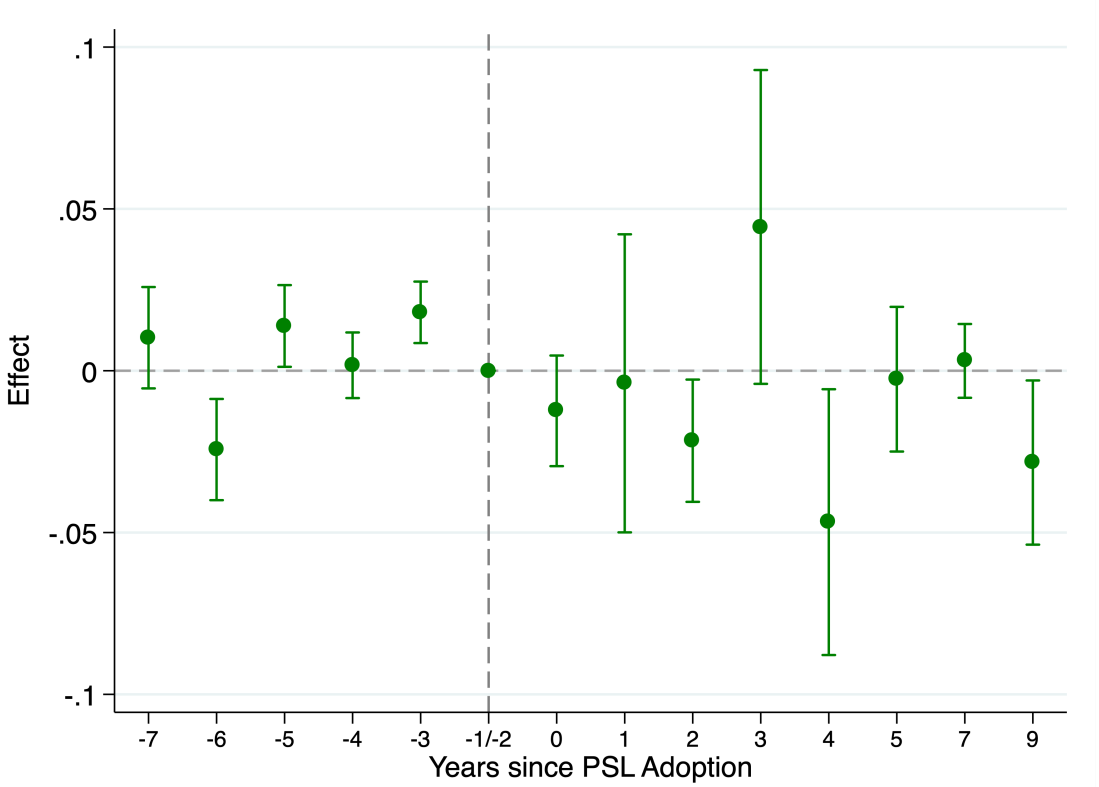
(a) Depression



(b) Passive Suicidal Ideation



(c) Active Suicidal Ideation



Notes: This figure presents event-study estimates of the effects of state paid sick leave (PSL) mandates on three key youth reported mental health outcomes. Panel (a) plots coefficients for the proportion of the youth that reports being sad or hopeless consistently for two weeks in YRBSS (b) plots coefficients for the proportion of the youth that exhibit passive suicidal ideation measured by the self reported thoughts of suicide in YRBSS (c) plots coefficients for the proportion of the youth that exhibit active suicidal ideation measured by the self reported planning of suicide in YRBSS. Coefficients are shown relative to the average of the two years prior to mandate adoption ($t = -2$ and $t = -1$), with 95% confidence intervals. All models are estimated estimated using the Sun and Abraham (2021) interaction-weighted difference-in-differences framework, which accounts for staggered policy adoption across states and heterogeneous treatment effects. Covariates include age, gender and race as well as state-level controls such as unemployment rates, housing price indices, health care provider availability, COVID-19 case and death rates, government response measures, and minimum wage policies. All models include state and year fixed effects and are weighted using survey sampling weights from the Youth Risk Behavior Surveillance System (YRBSS). Standard errors are clustered at the state level. Statistical significance is denoted by *** $p < 0.01$, ** $p < 0.05$, and * $p < 0.1$.

Table 1: State's Adoption of Paid Sick Leave Mandate

State	**Effective Date**
Arizona	July 2017
California	July 2015
Colorado	January 2021
Connecticut	January 2012
District of Columbia	November 2008
Maryland	February 2018
Massachusetts	July 2015
New Jersey	October 2018
New Mexico	July 2022
New York	January 2021
Oregon	January 2016
Rhode Island	July 2018
Vermont	January 2017
Washington	January 2018

Source: National Partnership for Women and Families' (2023) compilation of Paid Sick Days Statutes

Table 2: Descriptive Statistics (NSCH 2016–2022)

	Full Sample	Untreated States	Treated States
Outcomes			
Received Any Mental Health Care	0.176	0.172	0.19
Takes Medication for MH Issues	0.158	0.163	0.139
Depression Diagnosis	0.11	0.111	0.109
Anxiety Diagnosis	0.18	0.177	0.193
Demographics			
Female	0.517	0.518	0.515
Child Age (Years)	14.692	14.695	14.678
Number of Adults in Household	2.228	2.22	2.263
Number of Children in Household	1.705	1.714	1.668
Parent Married	0.73	0.732	0.724
Parent Never Married	0.043	0.042	0.044
Parent Divorced	0.12	0.12	0.119
Parent Separated	0.021	0.02	0.023
Parent Unmarried, Partnered	0.037	0.036	0.04
Parent Widowed	0.021	0.022	0.019
Parental Education: College Degree or Higher	0.583	0.569	0.639
Race/Ethnicity: White, non-Hispanic	0.695	0.707	0.644
Race/Ethnicity: Black, non-Hispanic	0.069	0.07	0.062
Race/Ethnicity: Hispanic	0.117	0.107	0.16
Race/Ethnicity: Other/Multi-racial	0.068	0.07	0.061
Currently Insured	0.945	0.944	0.954
State Controls			
COVID-19 Cumulative Case Rate	0.064	0.061	0.075
COVID-19 Cumulative Death Rate	0.001	0.001	0.001
Medicaid Eligibility: Non-Parents	0.916	0.804	1.38
Medicaid Eligibility: Parents	1.061	0.984	1.38
Community Health Centers per 100k	5.939	6.447	3.831
Primary Care Physicians per 10k	6.146	5.886	7.224
Government COVID Response Index	21.515	20.931	23.931
Housing Price Index	193.611	188.118	216.377
Federal Poverty Level Ratio	289.4	286.945	299.572
Log Per Capita Income	11.011	10.979	11.144
Minimum Wage (Average)	0.46	0.439	0.545
Observations	93,875	75,626	18,249

Notes: This table presents descriptive statistics for the analytic sample drawn from the 2016–2022 waves of the National Survey of Children's Health (NSCH). All estimates are weighted using the NSCH survey sampling weights to produce nationally representative averages of children aged 12–17 years. Variables capture measures of child mental health outcomes, demographic characteristics, and state-level contextual factors. Treated states are defined as those that had an active paid sick leave (PSL) mandate in effect during the survey year.

Table 3: Estimated Effects of Paid Sick Leave Mandates on Adolescent Mental Health Care Access and Diagnoses

	Any Mental Health Care	Medication for Mental Health Issues	Depression Diagnosis	Anxiety Diagnosis
Paid Sick Leave Mandate	0.0232**	0.0137*	0.0154**	0.0122*
	(0.00916)	(0.00695)	(0.00685)	(0.00710)
Baseline Mean	0.171	0.159	0.109	0.175
Observations	90065	89294	89866	89598
R-squared	0.029	0.021	0.033	0.037

Notes: This table reports estimates of the effect of state and local paid sick leave (PSL) mandates on adolescents' mental health care utilization and diagnostic outcomes. Each column presents results from a separate regression estimated using the Sun and Abraham (2021) interaction-weighted difference-in-differences framework which accounts for staggered policy adoption across states and heterogeneous treatment effects. Covariates include age, sex, race and ethnicity, insurance status, parental education and marital status, household income and family size, as well as state-level controls such as unemployment rates, housing price indices, health care provider availability, COVID-19 case and death rates, government response measures, and minimum wage policies. All models include state and year fixed effects and are weighted using survey sampling weights from the National Survey of Children's Health. Standard errors are clustered at the state level. Statistical significance is denoted by *** $p < 0.01$, ** $p < 0.05$, and * $p < 0.1$.

Table 4: Estimated Effects of Paid Sick Leave Mandates on Reported Youth Depression & Suicidal Ideation

	Depression	Passive Suicidal Ideation	Active Suicidal Ideation
Paid Sick Leave Mandate	-0.0219**	-0.0142***	-0.0121
	(0.00938)	(0.00462)	(0.00720)
Baseline Mean	0.303	0.165	0.135
Observations	1064699	957730	1038576
R-squared	0.052	0.022	0.016

*N*otes: This table reports estimates of the effect of state paid sick leave (PSL) mandates on reported Youth's mental health outcomes. Each column presents results from a separate regression estimated using the Sun and Abraham (2021) interaction-weighted difference-in-differences framework, which accounts for staggered policy adoption across states and heterogeneous treatment effects. Covariates include age, gender and race as well as state-level controls such as unemployment rates, housing price indices, health care provider availability, COVID-19 case and death rates, government response measures, and minimum wage policies. All models include state and year fixed effects and are weighted using survey sampling weights from the Youth Risk Behavior Surveillance System (YRBSS). Standard errors are clustered at the state level. Statistical significance is denoted by *** $p < 0.01$, ** $p < 0.05$, and * $p < 0.1$.

Table 5: Estimated Effects of Paid Sick Leave Mandates on Adolescent Mental Health Outcomes by Subgroup

	Age		Race/Ethnicity					Sex		Parental Education	
	12–14	15–17	Asian	Black	Hispanic	Other/Multi	White	Male	Female	No College	College+
Panel A: Received Any Mental Health Care											
Paid Sick Leave Mandate	0.0209**	0.0250	0.00834	0.0312	0.00250	0.0580	0.0252**	0.0295*	0.0174**	0.0265	0.0202
	(0.00967)	(0.0207)	(0.0224)	(0.0218)	(0.0265)	(0.0348)	(0.0108)	(0.0166)	(0.00685)	(0.0181)	(0.0127)
Observations	40341	49724	4524	5969	10378	6169	63025	43486	46579	36828	53237
R-squared	0.031	0.030	0.042	0.034	0.042	0.063	0.029	0.043	0.022	0.031	0.032
Panel B: Depression Diagnosis											
Paid Sick Leave Mandate	0.00909	0.0217**	0.0237**	0.0526**	-0.0134	0.0455	0.0198***	0.00985	0.0193**	0.0109	0.0211***
	(0.00848)	(0.0107)	(0.0115)	(0.0223)	(0.0274)	(0.0385)	(0.00608)	(0.0154)	(0.00838)	(0.0138)	(0.00562)
Observations	40284	49582	4527	5950	10356	6147	62886	43378	46488	36688	53178
R-squared	0.026	0.032	0.049	0.038	0.043	0.064	0.038	0.048	0.022	0.036	0.034

Notes: Each column reports the estimated effect of state and local paid sick leave (PSL) mandates on the specified outcome for a given adolescent subgroup. Panel A reports effects on whether the adolescent received any mental health care in the past year, and Panel B reports effects on parent-reported depression diagnosis. Estimates are obtained using the Sun and Abraham (2021) interaction-weighted difference-in-differences estimator, which accounts for staggered policy adoption across states and heterogeneous treatment effects. The analysis is restricted to adolescents aged 12–17 and is conducted separately by age group (12–14 and 15–17), race/ethnicity, sex, and parental education. Covariates include adolescent age and sex, race/ethnicity, insurance status, parental education and marital status, household income and family size, and state-level controls such as unemployment rates, housing price indices, health care provider availability, COVID-19 case and death rates, government response measures, and minimum wage policies. All models include state and year fixed effects, are weighted using National Survey of Children's Health sampling weights, and report standard errors clustered at the state level. Estimates are suppressed for subgroup cells with fewer than 50 observations. Statistical significance is denoted by *** $p < 0.01$, ** $p < 0.05$, and * $p < 0.10$.

Table 6: Estimated Effects of Paid Sick Leave Mandates on Reported Youth Depression & Suicidal Ideation by Subgroups

	Sex		Age		Race				
	Female	Male	Younger than 15	15 or Older	White	Black	Asian	Hispanics	Others
Panel A: Depression									
Paid Sick Leave Mandate	-0.0243**	-0.0191**	0.00000168	-0.0249**	-0.0122*	-0.0512***	0.00495	-0.000551	0.00147
	(0.0111)	(0.00862)	(0.0110)	(0.00943)	(0.00675)	(0.0122)	(0.0648)	(0.0236)	(0.0148)
Baseline Mean	0.387	0.222	0.292	0.304	0.284	0.293	0.285	0.354	0.364
Observations	539492	525207	159454	905245	609856	136873	43857	178626	95487
R-squared	0.026	0.013	0.063	0.051	0.049	0.041	0.038	0.055	0.056
Panel B: Passive Suicidal Ideation									
Paid Sick Leave Mandate	-0.0156***	-0.0123**	-0.0196**	-0.0133**	-0.00957**	-0.0252***	-0.0115	0.00188	-0.0134
	(0.00531)	(0.00470)	(0.00891)	(0.00505)	(0.00461)	(0.00639)	(0.0273)	(0.0241)	(0.0152)
Baseline Mean	0.209	0.122	0.177	0.163	0.161	0.147	0.156	0.173	0.223
Observations	486299	471431	143193	814537	518483	134473	40404	174621	89749
R-squared	0.012	0.005	0.029	0.021	0.020	0.022	0.019	0.025	0.034
Panel C: Active Suicidal Ideation									
Paid Sick Leave Mandate	-0.0119*	-0.0119	-0.00511	-0.0129*	-0.00587	-0.0265***	-0.0175	0.00125	-0.00183
	(0.00656)	(0.00872)	(0.00758)	(0.00755)	(0.00580)	(0.00925)	(0.0117)	(0.0308)	(0.0225)
Baseline Mean	0.165	0.105	0.153	0.133	0.127	0.127	0.136	0.149	0.186
Observations	526392	512184	156526	882050	587211	136397	43171	177495	94302
R-squared	0.012	0.005	0.025	0.014	0.012	0.018	0.012	0.022	0.019

*N*otes: This table reports estimates of the effect of state paid sick leave (PSL) mandates on reported Youth's mental health outcomes. Each column presents results from a separate regression estimated using the Sun and Abraham (2021) interaction-weighted difference-in-differences framework, which accounts for staggered policy adoption across states and heterogeneous treatment effects. Covariates include age, gender and race as well as state-level controls such as unemployment rates, housing price indices, health care provider availability, COVID-19 case and death rates, government response measures, and minimum wage policies. All models include state and year fixed effects and are weighted using survey sampling weights from the Youth Risk Behavior Surveillance System (YRBSS). Standard errors are clustered at the state level. Statistical significance is denoted by *** $p < 0.01$, ** $p < 0.05$, and * $p < 0.1$.

Table 7: Effects of Paid Sick Leave Mandates on Care Coordination and Access

	Unmet Mental Health Need	Difficulty Coordinating Care	Needed Home-Based Care	Trouble Getting an Appointment	Facility Not Open When Needed	Avoided Changing Providers	Preventive Check-Up Visit
Paid Sick Leave Mandate	0.00624***	0.0210*	0.00577	0.0111***	0.00154	0.00566	0.000916
	(0.00180)	(0.0104)	(0.0585)	(0.00330)	(0.00182)	(0.00510)	(0.0185)
Baseline mean	0.013	0.174	0.302	0.019	0.007	0.061	0.737
Observations	90152	89788	89675	90106	90092	89541	89767
R-squared	0.007	0.006	0.008	0.011	0.010	0.005	0.098

Notes: This table reports estimates of the effect of state and local paid sick leave (PSL) mandates on mechanisms related to adolescents' mental health care access and coordination. Each column presents results from a separate regression estimated using the Sun and Abraham (2021) interaction-weighted difference-in-differences framework, which accounts for staggered policy adoption across states and heterogeneous treatment effects. Covariates include adolescent age and sex, race/ethnicity, insurance status, parental education and marital status, household income and family size, as well as state-level controls such as unemployment rates, housing price indices, health care provider availability, COVID-19 case and death rates, government response measures, and minimum wage policies. All models include state and year fixed effects and are weighted using survey sampling weights from the National Survey of Children's Health. Standard errors are clustered at the state level. Statistical significance is denoted by *** $p < 0.01$, ** $p < 0.05$, and * $p < 0.1$.

Table 8: Effects of Paid Sick Leave Mandates on Family Functioning and Parental Time Allocation

	Parent Reduced or Stopped Work	Family Meals Together	Parent and Adolescent Share Ideas	Parent Talks with Adolescent About Concerns	Family Works Together to Solve Problems
Paid Sick Leave Mandate	0.0148***	0.0612	0.00113	0.0128	0.0230
	(0.00544)	(0.0689)	(0.0116)	(0.0144)	(0.0186)
Baseline mean	0.053	4.467	0.938	0.860	0.868
Observations	89857	89914	89455	89793	89611
R-squared	0.010	0.051	0.010	0.025	0.023

Notes: This table reports estimates of the effect of state and local paid sick leave (PSL) mandates on family functioning and parental time allocation mechanisms relevant to adolescent mental health. Each column presents results from a separate regression estimated using the Sun and Abraham (2021) interaction-weighted difference-in-differences framework. Covariates include adolescent age and sex, race/ethnicity, insurance status, parental education and marital status, household income and family size, as well as state-level controls such as unemployment rates, housing price indices, health care provider availability, COVID-19 case and death rates, government response measures, and minimum wage policies. All models include state and year fixed effects and are weighted using survey sampling weights from the National Survey of Children's Health. Standard errors are clustered at the state level. Statistical significance is denoted by *** $p < 0.01$, ** $p < 0.05$, and * $p < 0.1$.

Appendix Figures and Tables

Table A.1: YRBSS Descriptive Statistics

	Full Sample	**Untreated States**	**Treated States**
Outcomes			
Self-Reported Depression	0.308	0.307	0.312
Passive Suicidal Ideation	0.168	0.167	0.169
Active Suicidal Ideation	0.137	0.137	0.139
Demographics			
Female	0.488	0.488	0.489
Age 16 or Older	0.626	0.626	0.624
Race/Ethnicity: White, non-Hispanic	0.546	0.511	0.578
Race/Ethnicity: Black, non-Hispanic	0.164	0.157	0.182
Race/Ethnicity: Hispanic	0.210	0.188	0.260
Race/Ethnicity: Asian, non-Hispanic	0.031	0.029	0.035
Race/Ethnicity: Other/Multi-racial	0.048	0.048	0.050

Notes: This table presents descriptive statistics for the Youth Risk Behavior Surveillance System (YRBSS). All estimates are weighted using the YRBSS survey sampling weights to produce nationally representative averages/proportions. Treated states are defined as those that had an active paid sick leave (PSL) mandate in effect during the survey year.

Table A.2: Stepwise Estimates of the Effects of Paid Sick Leave Mandates on Adolescent Mental Health

	(1)	(2)	(3)	(4)
Panel A: Received Any Mental Health Care				
Paid Sick Leave Mandate	0.0200***	0.0234**	0.0235**	0.0232**
	(0.00653)	(0.00939)	(0.00988)	(0.00916)
State FE	YES	YES	YES	YES
Year FE	YES	YES	YES	YES
Demographics/HH	YES	YES	YES	YES
State Economic		YES	YES	YES
Health Supply			YES	YES
COVID Controls				YES
Observations	90065	90065	90065	90065
Panel B: Depression Diagnosis				
Paid Sick Leave Mandate	0.0137***	0.0159**	0.0158**	0.0154**
	(0.00387)	(0.00685)	(0.00721)	(0.00685)
State FE	YES	YES	YES	YES
Year FE	YES	YES	YES	YES
Demographics/HH	YES	YES	YES	YES
State Economic		YES	YES	YES
Health Supply			YES	YES
COVID Controls				YES
Observations	89866	89866	89866	89866

Notes: This table reports interaction-weighted difference-in-differences estimates of the effect of state and local paid sick leave (PSL) mandates on adolescent mental health outcomes. Panel A examines receipt of any mental health care in the past 12 months, and Panel B examines parent-reported depression diagnosis. Estimates are obtained using the Sun and Abraham (2021) estimator with state and year fixed effects. Columns (1)–(4) sequentially add demographic and household controls, state economic conditions, health care supply measures, and COVID-related controls. All models are weighted using National Survey of Children's Health sampling weights, and standard errors are clustered at the state level. Statistical significance is denoted by *** $p < 0.01$, ** $p < 0.05$, and * $p < 0.10$.

Table A.3: Estimated Effects of Paid Sick Leave Mandates on Adolescent Mental Health Care Access and Diagnoses (TWFE)

	Any Mental Health Care	Medication for Mental Health Issues	Depression Diagnosis	Anxiety Diagnosis
Paid Sick Leave Mandate	0.0216**	0.0130*	0.0165**	0.00758
	(0.00900)	(0.00687)	(0.00749)	(0.00855)
Baseline Mean	0.171	0.159	0.109	0.175
Observations	90065	89294	89866	89598
R-squared	0.029	0.021	0.033	0.037

Notes: This table reports estimates of the effect of state and local paid sick leave (PSL) mandates on adolescents' mental health care utilization and diagnostic outcomes using a conventional two-way fixed effects (TWFE) difference-in-differences specification. Each column presents results from a separate regression including state and year fixed effects. Covariates include adolescent age and sex, race/ethnicity, insurance status, parental education and marital status, household income and family size, as well as state-level controls such as unemployment rates, housing price indices, health care provider availability, COVID-19 case and death rates, government response measures, and minimum wage policies. All models are weighted using survey sampling weights from the National Survey of Children's Health, with standard errors clustered at the state level. Statistical significance is denoted by *** $p < 0.01$, ** $p < 0.05$, and * $p < 0.1$.

Table A.4: Estimated Effects of Paid Sick Leave Mandates on Reported Youth Depression & Suicidal Ideation (TWFE)

	Depression	Passive Suicidal Ideation	Active Suicidal Ideation
Paid Sick Leave Mandate	-0.0161*	-0.0115*	-0.0139***
	(0.00831)	(0.00573)	(0.00488)
Baseline Mean	0.303	0.165	0.135
Observations	1064699	957730	1038576
R-squared	0.052	0.022	0.016

*N*otes: This table reports estimates from a two-way fixed effects (TWFE) difference-in-differences model examining the effect of state paid sick leave (PSL) mandates on youths' mental health outcomes. Covariates include age, sex, and race/ethnicity, as well as state-level controls such as unemployment rates, housing price indices, health care provider availability, COVID-19 case and death rates, government response measures, and minimum wage policies. All specifications include state and year fixed effects and are weighted using survey sampling weights from the Youth Risk Behavior Surveillance System (YRBSS). Standard errors are clustered at the state level. Statistical significance is denoted by *** $p < 0.01$, ** $p < 0.05$, and * $p < 0.10$.

Table A.5: Effects of Paid Sick Leave Mandates on Diagnostic Scope Outcomes

	ADHD Diagnosis	Autism Diagnosis	Special Health Care Needs
Paid Sick Leave Mandate	0.00971	0.00288	0.0186
	(0.00658)	(0.00380)	(0.0119)
Baseline Mean	0.155	0.036	0.300
Observations	89556	89970	90419
R-squared	0.039	0.015	0.024

Notes: This table reports interaction-weighted difference-in-differences estimates of the effect of state paid sick leave (PSL) mandates on diagnostic scope outcomes. Outcomes include parent-reported ADHD diagnosis, autism diagnosis, and indicators for children with special health care needs (CSHCN). Estimates are obtained using the Sun and Abraham (2021) estimator with state and year fixed effects. All models include individual- and household-level covariates and state-level controls, are weighted using National Survey of Children's Health sampling weights, and cluster standard errors at the state level. Statistical significance is denoted by *** $p < 0.01$, ** $p < 0.05$, and * $p < 0.10$.

Table A.6: Effects of Paid Sick Leave Mandates on Non–Time-Sensitive Child Outcomes (Placebo Tests)

	Hearing Impairment	Overweight / Obese	Neighborhood Safety	Oral Health Problems	Social Skills (Make Friends)
Paid Sick Leave Mandate	-0.00430	-0.00335	0.00878	-0.00705	0.00978
	(0.00472)	(0.00855)	(0.00541)	(0.0115)	(0.00973)
Baseline Mean	0.018	0.279	0.973	0.112	0.269
Observations	90031	87918	89796	90234	89522
R-squared	0.018	0.050	0.040	0.028	0.013

Notes: This table reports interaction-weighted difference-in-differences estimates using the Sun and Abraham (2021) estimator. Outcomes are plausibly unrelated to short-run parental time flexibility and are therefore used as placebo tests. All specifications include state and year fixed effects, individual demographic controls, state-level economic conditions, health care capacity measures, COVID-19 controls, and minimum wage policies. Models are weighted using NSCH survey weights, and standard errors are clustered at the state level. Statistical significance is denoted by *** $p < 0.01$, ** $p < 0.05$, and * $p < 0.1$.

Table A.7: Effects of Paid Sick Leave Mandates on Adolescent Mental Health Outcomes (Excluding COVID Year)

	Any Mental Health Care	Mental Health Medication	Depression Diagnosis	Anxiety Diagnosis
Paid Sick Leave Mandate	0.0212*	0.0119	0.0137*	0.00498
	(0.0107)	(0.00744)	(0.00811)	(0.00731)
Baseline Mean	0.172	0.160	0.109	0.175
Observations	75471	74827	75308	75102
R-squared	0.029	0.020	0.033	0.038

Notes: This table reports interaction-weighted difference-in-differences estimates of the effect of state and local paid sick leave (PSL) mandates on adolescent mental health outcomes, including receipt of any mental health care, mental health medication use, depression diagnosis, and anxiety diagnosis. Estimates are obtained using the Sun and Abraham (2021) estimator with state and year fixed effects. The analytic sample is restricted to adolescents aged 12–17 and excludes observations from the year 2020. All models include individual- and household-level covariates and state-level controls, are weighted using National Survey of Children's Health sampling weights, and cluster standard errors at the state level. Statistical significance is denoted by *** $p < 0.01$, ** $p < 0.05$, and * $p < 0.10$.