

The Oral Contraceptive Pill and Adolescents' Mental Health

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Abstract

What is the impact of the oral contraceptive pill on the mental health of adolescent girls? Using administrative data from Denmark and exploiting the variation in the timing of pill initiation in an event study design, we find that the likelihood of a depression diagnosis and antidepressant use increases shortly after pill initiation. We then uncover substantial variation in primary care providers' tendency to prescribe the pill to adolescents, unrelated to patient characteristics. Being assigned to a high prescribing physician strongly predicts pill use by age 16 and leads to worse mental health outcomes between ages 16-18.

Keywords: Contraceptive pill, mental health, adolescents, prescribing practices.

JEL Codes: I12, J13

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1 Introduction

Mental health disorders affect 15% of children and adolescents globally and are now the leading cause of childhood disability (Polanczyk et al., 2015). The dramatic increase in mental health issues observed among young individuals has sparked interest in their causes, both in the media and within various scientific disciplines. This is undoubtedly a complex question and a variety of factors likely play a role. That said, isolating specific contributors is important for prevention and for crafting policies. In this paper, we study the causal effect of the oral contraceptive pill on the mental health outcomes of adolescent girls.

Our focus on the pill is motivated by ongoing controversy about potential adverse mental health side effects of hormone-based contraception, particularly among adolescents (Skovlund et al., 2016, 2018; Zethraeus et al., 2017; Anderl et al., 2020). The medical literature hypothesizes that the changes in the levels of the two female-sex hormones—estrogen and progesterone—induced by hormonal contraception could impact the functioning of the central nervous system and the endocrine system responsible for stress management, and thus the risk of mood disorders (Skovlund et al., 2016). Despite these concerns, credible causal evidence on this link remains scarce. The handful of randomized controlled trials yield mixed results, in part due to small sample sizes and short follow-up periods, as we detail in Section 2.3.

To investigate whether the pill impacts adolescent mental health,¹ we use population-level Danish administrative data and implement two complementary empirical strategies. We first exploit variation in the timing of pill initiation in an event study framework and document that girls’ mental health deteriorates shortly after they start using combined oral contraceptives. The findings we present are compelling: there is no evidence of pre-trends for any of the outcomes we analyze; however, one quarter after the first pill prescription, the probability of a psychiatric visit and a depression diagnosis increases by 17% and 40%, respectively. We also show that one year after the first combined oral contraceptive prescription the probability of antidepressant use is 65% higher.²

The richness of the register data allows us to probe the key identification assumptions in the event study design. For example, our results remain virtually unchanged when we exclude girls who are at risk of developing mental health problems around the time of pill initiation (e.g., girls who receive an abortion or use emergency contraception). Similarly, we find no evidence of increased risky behavior, as proxied by hospital visits due to alcohol abuse

¹We examine the impact of the combined oral contraceptive pill, which is the most commonly prescribed hormonal contraceptive, unless otherwise noted.

²The means of these three outcomes one quarter before pill initiation are 1.1%, 0.11%, and 0.8%, respectively.

or intoxication, screening for sexually-transmitted diseases (STIs), or chlamydia diagnosis, surrounding the time of combined oral contraceptive initiation. We also present evidence of treatment heterogeneity consistent with a biological pathway. Medical studies suggest weaker associations between the use of progestin-only pills (as opposed to combined oral contraceptives) and mental health outcomes. Consistent with this, we show that there is no evidence of mental health deterioration around the time of pill initiation among girls who use progestin-only contraceptives. This piece of evidence suggests that the observed mental health patterns are unlikely to be caused by girls starting to use contraceptives when their mental health is already declining. Importantly, for both types of pills, we observe similar trajectories in GP visits after pill initiation. However, mental health deterioration is only evident for girls using combined oral contraceptives, suggesting that the observed mental health effects are not driven by increased interactions between patients and physicians (e.g., to refill prescriptions).

In the second part of the paper, we examine the role of primary care provider (GP) type, given by their propensity to prescribe oral contraceptives to adolescents.³ We circumvent key endogeneity concerns related to patient-provider matches by assigning children to the provider treating them at age 12, when extremely few children use the pill. This provider is chosen by the child’s parents (as children cannot choose their own GP before age 15) from the pool of available providers in their catchment area. We measure GP prescribing tendency as a leave-one-out combined oral contraceptive prescription rate among the other 12 to 18 year olds that were seen in that clinic in that year. We document that there is substantial variation in primary care providers’ tendency to prescribe the pill. Importantly, GPs’ pill prescribing tendency is orthogonal to a rich set of observable child and parental characteristics as well as to girls’ outcomes measured at age 12, suggesting that the assignment of provider is unrelated to the determinants of girls’ contraceptive use and mental health outcomes.

Our results suggest that the GP practice style strongly predicts use of combined oral contraception: switching from a provider at the 10th percentile of the distribution to one at the 90th percentile increases the likelihood of contraceptive use by age 15 by 5.4% and by age 16 by 3.5%. Primary care physicians’ pill prescribing tendency is also related to girls’ mental health outcomes. We find that assignment to a GP with one standard deviation higher pill prescribing tendency increases the likelihood of having a psychiatric contact between ages 16 to 18 by 1.6%, the likelihood of a depression diagnosis by 5.4%, and the probability of using antidepressants by 3.9%.

In order to shed light on the mechanisms linking GP practice style and the mental

³In Denmark, women require a medical prescription to obtain oral contraceptives. In our sample of adolescents, 95% of the prescriptions are issued by primary care physicians.

health outcomes of adolescent girls, we first examine the relationship between GPs’ combined oral contraceptive prescribing tendency and the mental health outcomes of adolescent boys. We find no differences in the mental health outcomes of boys assigned to physicians with different pill prescribing tendencies, suggesting that the results are unlikely to be driven by a general tendency to detect mental health conditions. We next show that GPs’ propensity to prescribe progestin-only contraceptives is predictive of girls’ likelihood of using this type of contraceptive but that it has no visible impact on their mental health outcomes. These results mirror those documented in the event study. Finally, we find no evidence that physicians with different pill prescribing tendencies have different effects on hospitalizations for ambulatory care-sensitive conditions, a proxy for their quality of care. While we cannot rule out that primary care providers with different combined oral contraceptive prescribing tendencies affect patient outcomes by not only changing patients’ likelihood of using oral contraceptives but also through other dimensions of care that are correlated with their prescribing tendency, we interpret these findings as suggesting that in our context, combined oral contraceptive use is likely the main channel.

Our project is closely related to the economic literature on the determinants of child mental health disorders. An extensive literature documents the effects of in-utero conditions on mental health during adulthood (e.g. Adhvaryu et al., 2019; Almond and Mazumder, 2011; Chorniy et al., 2020), with emerging evidence indicating the onset of these conditions during early childhood (Persson and Rossin-Slater, 2018). Previous studies also highlight the importance of economic resources (e.g. Baird et al., 2013; Golberstein et al., 2019; Akee et al., 2024), household stressors such as domestic violence (Bhuller et al., 2024), and the presence of a disabled sibling (Currie et al., 2024), as well as social media (Arenas-Arroyo et al., 2022; Braghieri et al., 2022) and peer composition (Bütikofer et al., 2023). Our study adds to this literature by examining the effects of a widely prescribed medication on the mental health outcomes of adolescent girls.

We also add to the economic literature examining the consequences of the introduction of the pill. The majority of this literature focuses on the effects of access to the pill on women’s fertility, marriage, and career trajectories (Goldin and Katz, 2002; Bailey, 2006; Bailey et al., 2012; Bailey and Lindo, 2017; Marie and Zwiers, 2023; Ragan, 2023). Two recent studies are notable exceptions. Valder (2022) exploits variation in laws governing access to the pill in the US to examine the long-term consequences of the early diffusion of the pill. In addition to the well-documented impacts on education and labor market outcomes, this paper also finds a link between pill access at ages 14 to 21 and worse mental health outcomes at age 60. Ragan (2024) studies the association between the geographic variation in hormonal contraceptive sales across Sweden and teen suicides during the 1960s

and 1970s, finding no discernible correlation between the two. We add to this literature by providing novel evidence of the direct link between the contraceptive pill and mental health.

Finally, we contribute to the literature examining the impact of provider practice styles on patient outcomes. Former studies documented consequences of variation in physician prescribing tendency in ADHD medications (Dalsgaard et al., 2014), opioids (Eichmeyer and Zhang, 2022, 2023), and antidepressants (Bhalotra et al., 2023; Currie and Zwiers, 2023; Cuddy and Currie, 2020). We document the variation in providers’ tendency to prescribe the contraceptive pill and analyze its impact on patient outcomes.

More than 50 years since it became available, the pill remains the most popular form of prescribed contraceptive among adolescents. In the United States, for example, between 2015–2017, 16.6% of women under the age of 20 were current users of the pill (Daniels and Abma, 2018).⁴ While the benefits of the pill and its importance for women’s socio-economic outcomes are indisputable and in many instances the benefits may outweigh the costs, our findings suggest that the pill can also play an important role in adolescent girls’ mental health. A back-of-the-envelope calculation suggests that approximately 15% of the rise in antidepressant use among adolescent girls in our context can be attributed to increased oral contraceptive use.⁵ The large number of potentially affected women underscores the importance of providing credible evidence on the pill’s mental health implications.

2 Background

2.1 Organization and Delivery of Health Care Services

Denmark has a universal healthcare system. Children’s health care is organized in primary and secondary systems. Primary care is provided by general practitioners (GPs), who are responsible for regular consultations and the provision of preventive health examinations. GPs are self-employed and need a practice authorization number (*ydernummer*) in order to be reimbursed for their services. The number of practice authorizations is determined by the state as a function of various criteria, such as population density. In 2018, there were 3,476 GPs in Denmark, organized in 1,795 practices.⁶ The median number of practices per municipality was 14 (10th and 90th percentiles were 5 and 60, respectively). Roughly half of these were single-physician practices.⁷ The typical GP served 1,655 patients. GPs receive

⁴This is similarly true in the Danish context, where our study is based: in 2013, more than 40% of girls aged 15 to 19 were using the pill (Lindh et al., 2017).

⁵We provide the calculations in Section 7.

⁶Available [here](#), last accessed in October 2023.

⁷25% of practices had two physicians, 14% had three physicians, 7% had four physicians, and 4% had 5 or more physicians.

income through a mixture of fee-for-service and capitation, with fee-for-service payments making up roughly two-thirds of the total income. In 2022, the fixed capitation fee per patient was 500 DKK (around 66 USD). Importantly, GPs do not have any financial incentive for prescribing medications as they receive no fee from prescriptions.

Children are typically registered in the primary care practice of their parents.⁸ Individuals can freely choose a GP in their municipality of residence as long as it is located within 15km of their primary residence (5km in the Copenhagen Metropolitan Area) and is accepting new patients.⁹ Patients can change their primary care provider free of charge if they move to a residence that is further than the allowed distance from their current clinic. Provider changes in other circumstances require an administrative fee. In 2022, this fee was 215 DKK (approximately 29 USD).

Children receive secondary care from privately practicing specialists and public hospitals. GPs act as gatekeepers for specialist treatment, with only around 10% of consultations for the general population leading to a referral (OECD, 2016). The Danish Health and Medicines Authority, however, recommends universal referral for certain conditions, including suspected mental health disorders among children. According to clinical guidelines, GPs should refer mild cases to private practice child psychiatrists while more severe conditions are referred to hospitals with psychiatric departments. During the period 2008–2018, the average waiting time for a pediatric psychiatric referral declined from 71 days to 24 days, with an average of 48 days. Average waiting times were longer in Northern Denmark relative to Southern Denmark and Zealand (which includes Copenhagen).¹⁰

The National Health Insurance Scheme provides full coverage for all services provided by GPs, child psychiatrists, and public hospitals, thus patients do not incur any out-of-pocket expenses for these treatments. However, costs of prescription drugs are not fully covered, and subsidies have changed over time. Until March 2000, prescription drugs were subsidized using a fixed coinsurance rate, depending on the therapeutic type of the drug. Since then, subsidies are based on a non-linear plan such that the coinsurance rate declines as prescription drug spending accumulates over a coverage year.¹¹ Oral contraceptives are not subsidized but they are inexpensive, with a two-month of supply typically costing around

⁸Up until the age of 15, a child is automatically registered to the same GP as their parents. At the age of 15, they can decide to have another GP.

⁹Clinics are allowed to impose a ceiling of 1,600 patients per general practitioner. According to PLO (2021), 56% of clinics reached this ceiling in 2021.

¹⁰For details, see [here](#), last accessed in October 2023.

¹¹There have been changes to the thresholds corresponding to the step-function as well as the coinsurance rates but children typically pay 40-50% of the first 1,500 DKK (200 USD), 25% of costs between 1,500-3,500 DKK (200-460 USD) and 15% of costs afterwards. There is a stop-loss amount, which was approximately 24,000 DKK (3,200 USD) in 2021. For details, see [here](#), last accessed in October 2022.

30 DKK (4 USD). Mental health prescriptions, on the other hand, are eligible for subsidy. According to Simonsen et al. (2021), Citalopram (a commonly prescribed antidepressant) was among the top-10 prescribed medications and had a coinsurance rate of 25% before Denmark switched to the non-linear subsidy scheme.

2.2 Contraceptive Use in Denmark

The Danish Family Planning Association was founded in 1956 with the aim of reducing unwanted pregnancies by disseminating information on access to contraception. During the 1960s, family planning services were placed within the National Health Insurance Scheme, making contraceptive counseling available and free of charge to all residents. Women need a prescription to obtain an oral contraceptive, the majority of which are provided by GPs. Children aged 15 and above can request oral contraceptives from their GP without needing parental consent.¹² Sex education is a compulsory part of the Danish public school system since 1970. While the specific contents of the curriculum changed over time, contraceptives and sexually transmitted diseases have always been a focus area.

In Denmark, contraceptives are widely used. Currently, two different groups of oral contraceptives are available on the Danish market: combined oral contraceptive pills (COCs), which release both estrogen and progestin hormones, and progestin-only pills (Cooper et al., 2022). Oral contraceptives are further classified according to their estrogen dose and to the type or generation of progestogen they include. According to Løkkegaard and Nielsen (2014), between 1995 to 2012, on average, 85% of Danish girls had at least one hormonal contraceptive prescription by the age of 20. During this period, third-generation COCs dominated the market. Between 1998 and 2010, the market share of third-generation COCs exceeded 60%. Third generation COCs were even more popular among younger women, with a market share above 70% among women aged less than 20 (Wilson et al., 2012).

In light of evidence of increased risk of venous thromboembolism associated with third-generation COCs, the Danish Health and Medicines Authority issued a guideline in 2014 recommending the use of second-generation COCs as the first choice of oral contraception for women under the age of 30.¹³ Despite concerns of serious side-effects, hormonal contraceptive use among adolescents and young adults remains high to this day: more than 50% of 15 to 24 year-old women used hormonal contraceptives in 2019, with combined oral contraceptives as the most used method (Kristensen and Lidegaard, 2021).¹⁴ That same year, the market

¹²Since July 2019, pharmacists can renew a prescription for regular pill users aged 15 and above. For more information, see [here](#) (last accessed October 2022).

¹³More information can be found [here](#). Last accessed on 12 September 2022.

¹⁴The corresponding figure for women of ages 30 to 45 ranged between 31 to 34% (Kristensen and Lide-

share of second-generation COCs was 80% among women younger than 20. It is worth noting that oral contraceptives are not only used to prevent unwanted pregnancies but are often prescribed to young women to regulate or lessen menstruation, improve acne, and treat endometriosis-associated pain (Dayal and Barnhart, 2001). As such, in addition to the ease of use, accessibility, and lack of invasiveness, these conditions may contribute to the steady prevalence of oral contraceptives among adolescents.

2.3 Hormonal Contraception and Mental Health: The Biological Link

The impact of hormonal contraceptives on mood changes has been debated since the early days of the pill and several studies report negative mood alterations as an important reason for discontinuing oral contraceptives (Sanders et al., 2001; Poromaa and Segebladh, 2012). The medical literature argues that hormonal contraceptives may impact mental health by altering the levels of the two female sex hormones—estrogen and progesterone—which are in turn related to the functioning of the hypothalamic-pituitary-adrenal (HPA) axis as well as certain neurotransmitters.

The HPA axis is a neuroendocrine system that plays a central role in mediating the effects of stressors by regulating the metabolism, immune responses, and the nervous system. Brain imaging studies suggest that estrogen regulates the activation of brain regions associated with emotional and cognitive processing, while progesterone is known to promote new nerve growth in the hippocampus, which is the main regulator of the HPA axis (Toffoletto et al., 2014). One hypothesis suggests that hormonal contraceptives blunt an individual’s HPA axis and the resulting deterioration in stress management leads to anxiety and depression.

Neurotransmitters are chemicals that carry messages from one nerve cell (neuron) to the other cells (glands, muscles, or other neurons) in the body. Female sex hormones affect the activity of certain neurotransmitters. For example, low levels of progesterone are linked with low GABA function, an inhibitory neurotransmitter that promotes calmness, good mood, and sleep. Similarly, low estrogen levels are linked with low serotonin and dopamine, two modulatory neurotransmitters that are vital in the brain’s processing of moods and rewards. A second hypothesis argues that hormonal contraceptives interfere with the proper functioning of these neurotransmitters by changing the natural variation in sex hormones. During a typical 28-day menstrual cycle, estrogen levels reach their peak around day 14. At this time many women report high levels of physical and emotional well-being. Most hormonal contraceptives smooth this mountain-shaped hormonal cycle into an even line for

gaard, 2021).

the first 21 days. The levels of estrogen and progesterone plunge during the final 7 days.

Despite the widely known hypotheses suggesting detrimental mental health effects of oral contraceptives, causal empirical evidence on this is scarce. We are aware of only one recent study in economics that links access to contraceptives during ages 14-21 to worse mental health at age 60, exploiting variation in access to the pill across US states (Valder, 2022). Outside of economics, numerous correlational studies investigate the link between oral contraceptive use and mental health, with some studies documenting a positive association (Taggart et al., 2018) and others finding a negative association (Poromaa and Segebladh, 2012; Skovlund et al., 2016).¹⁵ Evidence from the few small-scale randomized controlled trials on the subject also yields mixed results, perhaps due to statistical power limitations.¹⁶ Overall, whether and how the contraceptive pill affects mental health remains an open question.

3 Empirical Strategy

Event Study Design We first exploit the variation in the timing of pill initiation in an event study framework to examine changes in girls’ mental health trajectories after starting combined oral contraceptives. In particular, we construct a balanced panel of girls who started using the combined oral contraceptive pill between the ages of 12 and 17, both included, with observations dating from five quarters before and four quarters after the pill initiation.¹⁷ We then estimate the coefficients of indicator variables for quarters relative to the event of the first filled oral contraceptive prescription (“event time”) with the following equation:

$$Y_{is} = \alpha_i + \sum_{t \neq -1, t=-4}^{t=4} \gamma_t \times I_t + \omega_{is} + \epsilon_{is} \quad (1)$$

¹⁵A well-known study by Skovlund et al. (2016) focuses on Danish women aged 15-34 with no prior depression diagnosis and compares mental health outcomes of women who use oral contraceptives with the outcomes of never and former users. The results show that taking the pill is associated with a higher risk of a depression diagnosis and antidepressant use, especially among adolescents.

¹⁶The largest and most recent RCTs are Lundin et al. (2017) and Zethraeus et al. (2017). In Lundin et al. (2017), 84 women were assigned to the treatment group receiving COCs while 94 women were assigned to the placebo group. The results indicated a small but statistically significant increase in mood side effects in the intermenstrual phase. Zethraeus et al. (2017) conducted an RCT with 332 healthy women aged 18-35 and found that taking the oral contraceptive pill (in comparison with placebo) led to a significant decrease in an index of general well-being within the three-month follow-up period, but a significant increase in depressive symptoms was not detected.

¹⁷In order to be able to observe the outcomes of all individuals during our event window and to have a sufficiently large number of observations with pill initiation in each quarter, we focus on girls who start on the pill from 2001 to 2016, both included.

where Y_{is} is a measure of mental health for girl i in quarter s , α_i are individual fixed effects, I_t are event time fixed effects, and ω_{is} are age in calendar quarter fixed effects. Following Sun and Abraham (2020), we omit two event time dummies ($t = -1$ and $t = -5$) to avoid multicollinearity.¹⁸ Hence, the event time coefficients measure the impact relative to these two periods. We implement the interaction weighted (IW) estimator proposed by Sun and Abraham (2020), with the last-treated cohort (girls who start using the pill in the last quarter of our sample) as control, to address the fact that, in the presence of treatment heterogeneity, the two-way fixed effects regression can result in estimates with uninterpretable weights.¹⁹ Standard errors are clustered at the individual level.

Interpreting these coefficients as representing a causal impact of contraceptive use requires two conditions: (i) that in the absence of the treatment – starting oral contraception – the mental health trajectories of girls with different times of pill initiation (i.e., those who initiate oral contraception in different calendar quarters) would have followed similar trends (parallel trends), and (ii) that individuals do not adjust their behavior prior to pill initiation in ways that impact mental health outcomes (no anticipatory behavior). These assumptions could be violated if, for example, girls who initiate oral contraception earlier in our sample have unobserved characteristics that make them more likely to develop mental health problems over time. While we cannot test these assumptions directly, we bring suggestive evidence on their plausibility in several ways. First, we show that girls in the treatment and control group have very similar mental health trajectories before starting oral contraception: the coefficients corresponding to pre-pill initiation quarters are all very close to zero. The sharp increase in mental health disorders is only visible after pill initiation. Second, we show that our results are robust to excluding girls who are at risk of having mental health problems around the time of pill initiation for independent concurrent reasons (e.g., girls with an unwanted pregnancy), or girls who have a history of mental health problems. Third, we show that there is no evidence of increased risky behaviors—proxied by hospital visits due to alcohol abuse or intoxication, screening for sexually-transmitted diseases, or chlamydia diagnosis—surrounding the time of oral contraceptive initiation. In addition, we provide evidence consistent with a biological pathway by examining treatment heterogeneity by the type

¹⁸According to Sun and Abraham (2020) and Borusyak et al. (2021), one multicollinearity comes from the relative period indicators summing to one for every unit, and the other multicollinearity comes from the linear relationship between two-way fixed effects and the relative period indicators.

¹⁹Sun and Abraham (2020) show that in settings with variation in treatment timing across units, the coefficient on a given lead or lag can be contaminated by effects from other periods. In our main specification, cohorts are defined based on the calendar quarter of pill start. Given (potentially non-linear) trends in mental health outcomes by age, we control non-parametrically for age fixed effects in each calendar quarter. Our results are robust to controlling instead for calendar quarter fixed effects, or to defining cohorts based on the age of first pill use (note that we cannot simultaneously control for calendar quarter and age fixed effects, as these will be collinear given the inclusion of individual fixed effects).

of first contraceptive prescription. The medical literature points at a weaker link between progestin only contraceptives (compared to combined pills) and mental health outcomes. Consistent with this, we find no evidence of mental health deterioration around the time of first pill use among girls who use progestin-only products. Finally, we show that children whose first pill prescription have different hormonal composition have similar trajectories in their GP visits, suggesting that the observed mental health changes are unlikely to be due to increased interactions between patients and physicians (e.g. to refill prescriptions).

GP Practice Variation In the second part of the paper, we examine the relationship between primary care providers’ practice style in terms of their tendency to prescribe the pill, and the mental health outcomes of adolescent girls. As discussed in Section 2.2, women in Denmark need a prescription to obtain an oral contraceptive and the overwhelming majority of these prescriptions are provided by the GP. To the best of our knowledge, there is no quantitative evidence documenting the variation in physicians’ prescription practices regarding the contraceptive pill.²⁰ Yet, several papers discuss the variation in doctors’ attitudes and preferences in this context. For example, survey-based research documents substantial variation in doctors’ beliefs about the appropriateness of the pill use for non-contraceptive reasons, such as menstrual disorders (Chen et al., 2016). Evidence also suggests that there is a notable shortfall in doctors’ knowledge of the WHO guidelines regarding the use of COCs (Grove and Hooper, 2011; Sannisto and Kosunen, 2010), and that many doctors are unlikely to alter their prescribing practices when informed about it (Grove and Hooper, 2011; Briggs et al., 2013). As such, we expect there to be substantial variation in family doctors’ tendency to prescribe oral contraceptives to teenagers.

Our empirical strategy follows recent work linking practice variation to patient outcomes (Cuddy and Currie, 2020; Eichmeyer and Zhang, 2022, 2023) and exploits variation in primary care providers’ tendency to prescribe oral contraceptives to girls aged 12 to 18. In particular, we assign each child i the primary care clinic j they visited most at age 12.²¹ We then construct the GP prescribing tendency as a leave-one-out combined oral contraceptive prescription rate among the other 12-18 year olds that were seen in that clinic in that year.²²

²⁰Several papers document variation in physician practice styles and their consequences in other contexts. See, for example, Dalsgaard et al. (2014); Bhalotra et al. (2023); Eichmeyer and Zhang (2022, 2023).

²¹Information on primary care providers is obtained from the Health Insurance Register, which includes claims for services rendered. Since patients may receive several services in a single visit, we aggregate services claimed in intervals of two weeks to avoid confounding the match to the most visited GP at age 12. Our results are robust to defining the most visited GP using alternative aggregation methods.

²²Our data does not include individual physician identifiers. For that reason, we construct the provider prescribing tendency at the clinic level. As detailed in section 4, half (70%) of the clinics in our sample have at most two (three) physicians.

$$PP_i = \frac{1}{N_{-ij(i)}} \sum_{i \in (N \setminus i)} Pill_{ij} \quad (2)$$

Leaving out a child’s own prescription use from their GP’s prescribing tendency measure allows us to eliminate the mechanical bias from the patient’s own case entering into the GP prescribing tendency measure. For ease of interpretation, we standardize the provider tendency to have a mean of 0 and a standard deviation of 1. The key estimating equation is given by:

$$Y_i = \alpha + \beta PP_i + \theta X_i + \mu_{mob} + \gamma_m \times \delta_{yob} + \epsilon_i \quad (3)$$

where Y_i is an outcome variable for girl i capturing contraceptive use or a measure of mental health, PP_i is the oral contraceptive prescribing tendency of their GP clinic, X_i is a set of child and family characteristics measured when the child was eleven years old, μ_{mob} are month of birth fixed effects, and $\gamma_m \times \delta_{yob}$ are municipality by year of birth fixed effects. Standard errors are clustered at the provider level.

The key coefficient of interest in model (3), β , measures the impact of having a primary care clinic that prescribes combined oral contraceptives to adolescents at a one standard deviation higher rate. Interpreting β as causal requires quasi-random assignment of children to providers. In order to circumvent endogeneity concerns related to patient-GP clinic matches, we assign children to the provider who treats them at age 12, when contraceptive pill use is very low. This provider is chosen by the child’s parents (as children cannot choose their own GP before age 15) from the pool of available providers in their catchment area. In addition, we only focus on the oldest girls in the family to limit the possibility that parents select or change their GP based on the clinic’s pill prescribing rate to adolescents. We provide empirical evidence on the plausibility of the quasi-random assignment assumption by showing that the provider prescribing tendency is orthogonal to a rich set of observable child and parental characteristics as well as to girls’ outcomes measured at age 12, when rates of oral contraceptive use are very low.

Primary care providers with different oral contraceptive prescribing tendencies may impact patient outcomes by changing patients’ likelihood of using oral contraceptives or through other dimensions of care that are correlated with their prescribing tendency. As such, we do not use GP clinic’s prescribing tendency as an instrument for oral contraceptive use. Since almost all contraceptive use originates from primary care clinics, understanding how GP practice style can impact the mental health of adolescent girls is interesting in its own right. That said, we provide several pieces of evidence pointing to contraceptive use as the most plausible channel. First, we find no relationship between GP clinic’s combined oral contra-

ceptive prescribing tendency and the mental health outcomes of adolescent boys. Second, we show that GP clinic’s tendency to prescribe progestin-only contraceptives strongly predicts girls’ likelihood of using that type of contraceptive but has no relation to their mental health. Third, we document that the GP prescribing tendency is unrelated to patient hospitalizations for ambulatory care-sensitive conditions, suggesting that high-prescribing clinics are unlikely to provide different quality of care in other dimensions. Finally, we show that our results are unaffected when we control for observable characteristics of the physicians working at the clinic, as well as for the characteristics of the pool of adolescent patients served by the clinic. While none of these checks are individually sufficient to claim contraceptive use as the main channel linking provider type and adolescent mental health, taken together, they provide consistent evidence this is likely to hold in our context.

4 Data and Sample

We use several population-level administrative data sets from Denmark in our analysis. These data include individual-level records with unique personal identifiers, allowing us to follow the entire population over time and to link family members. We use information from these registers for the period 1997 to 2020.

Outcome Variables Our primary outcome variables capture mental health care utilization during adolescence: psychiatric visits, depression diagnosis, and antidepressant use. We measure psychiatric visits using the *Psychiatric Central Research Register* and the *Health Insurance Register*. The *Psychiatric Central Research Register* is a dataset on all inpatient admissions, outpatient visits, and emergency rooms (ER) visits to psychiatric departments in public and private hospitals, along with International Classification of Disease (ICD) codes (Mors et al., 2011). The *Health Insurance Register* provides information on reimbursements to private clinics – both general practitioners and specialists – for all patient-related services covered by the national health insurance.²³ We define psychiatric visits as an outpatient or ER visit to a hospital psychiatric department or a visit to a private psychiatric clinic (based on physician’s specialty code “24” or “26” in the *Health Insurance Register*).²⁴ For the subsample of hospital-based psychiatric visits, we define an indicator for having a depression diagnosis as determined by ICD-10 codes starting with “F32” and “F33”.²⁵ Finally, we

²³This register does not include diagnosis information.

²⁴Most patients receive mental health treatments on an outpatient basis. Inpatient care is mainly used for patients with schizophrenia (Serena, 2021).

²⁵This definition of depression could potentially include cases of Premenstrual Dysphoric Disorder (F32.89), a diagnosis which is usually treated with combined oral contraceptives. There are only 295 such cases in our sample (with the more general ICD-10 code F32.8). As a result, excluding these cases from the

study antidepressant consumption using the *National Prescription Register*, a database of all prescriptions filled at Danish pharmacies, including information on the Anatomical Therapeutic Chemical (ATC) Classification System and product name (Kildemoes et al., 2011). In particular, we define an indicator for filling a prescription with an ATC code of “N06A”. We measure the outcome variables either in a short window around the time of the first contraceptive prescription (event studies design) or at ages 16-18 (GP practice variation).

Contraceptive Use We obtain the dates of filled oral contraceptive prescriptions from the *National Prescription Register*. We follow Skovlund et al. (2016) and use detailed ATC codes to classify prescriptions as hormonal contraceptives. We mostly focus on the combined oral contraceptive pill, but consider also progestin-only contraception.²⁶ In the event study design, we focus on the date of the first filled prescription. When we exploit variation in practice behavior, we examine the effects on an indicator for filling an oral contraceptive prescription by ages 15 or 16.

Control Variables We observe a rich set of child and parent characteristics. We use the *Population Register*, which provides a snapshot of demographics on all Danish residents as of January 1st of each year, to link each individual to their parents and siblings. Using these data, we measure number of siblings and parental age. We use the *Education Register* to obtain information on parents’ highest level of completed schooling, the *Register-Based Labour Force Statistics* to characterize parental labor force participation, and the *Income Register* to measure parental income. We include the following variables as controls, measured at child age 11: birth order, number of siblings, number of GP visits, parental marital/cohabitation status, average parental income, mother’s use of contraceptives, and each parent’s age, education level (indicators for compulsory education or college degree), employment status, and antidepressant consumption.²⁷

In the GP practice variation design, we additionally employ the *Provider Register*, which includes information on the characteristics of all specialists who are eligible for reimbursement under the National Health Insurance plan.²⁸ Using these data, we explore the robustness of our results to controlling for the following primary care clinic characteristics, measured

definition of depression leaves our estimates virtually unchanged. These results are available upon request. The last available year of the *Psychiatric Central Research Register* in our database is 2017. Hence, we have a smaller number of observations when studying depression diagnoses.

²⁶For the combined pill, we consider the following ATC codes: G03AA01, G03AA03, G03AA05, G03AA07, G03AA09, G03AA10, G03AA11, G03AA12, G03AB03, G03AB04, G03AB05, G03AB06, G03HB. Our definition of progestin-only contraception includes the following codes for the progestin-only pill (G03AC01, G03AC02, G03AC03, G03AC09) and the progestin-only implant (G03AC08).

²⁷We also include indicators for the few instances when parental characteristics are missing.

²⁸The data provide annual snapshots of characteristics at the end of the calendar year between 1995-1998, quarterly snapshots at the end of each quarter between 1999-2009, and is continuously updated after 2009.

when the child is 12: an indicator for being a multi-provider practice, share of female physicians, share of physicians with an immigrant background, the average age of physicians, and the average tenure of physicians. Finally, in order to control for the characteristics of the neighborhoods and schools included in the catchment areas of primary care clinics, we use the *Health Insurance Register* to create snapshots of characteristics of all the other 12-year-olds (boys and girls) that attend that clinic in the year when the child is 12.²⁹ Specifically, we control for average parental income of these patients and for the share of their parents who: are married/cohabiting, have compulsory education, have college degree, are using antidepressants, and are using oral contraceptives (mothers).

Analysis Samples To construct our analysis sample, we begin with the universe of 722,366 girls born between 1986 and 2002. In order to ensure that we have children’s complete history of oral contraception use, we keep children who are observed every year between the ages of 11 and 18. This leaves us with a balanced sample of 539,247 girls (*full sample*). Based on this full sample, we construct our two analysis samples as follows. For the event study analysis, we focus on girls who ever use the combined oral contraceptive pill between ages 12 to 17, both included. This is a sample of 266,344 girls (*event study sample*). For the analysis relying on provider prescribing variation, we make the following restrictions starting from the full sample. First, since this design requires us to link children and primary care providers, we drop girls who do not visit a primary care physician at age 12.³⁰ Second, in order to reduce noise in our measure of provider leniency, we drop children matched with a primary care provider with less than 25 patients aged 12-18. Third, we only keep first-born children with the aim of limiting the possibility that parents choose their child’s clinic based on the provider’s prescribing tendency (e.g., by observing their prescribing behavior to older daughters). Finally, we exclude girls with an immigrant background in order to reduce heterogeneity in the attitudes toward oral contraception use. The resulting sample consists of 238,006 girls (*GP sample*).

Descriptive Statistics Appendix Table A1 presents descriptive statistics, separately for the full sample, the event study sample, and the GP sample.

Around 21% of girls in the full sample fill an oral contraceptive prescription by age 15. The rate of oral contraceptive use sharply increases with age (see Appendix Figure A1a), with around 40% of girls filling an oral contraceptive prescription by age 16. In the full sample, 9% of girls have an immigrant background, and the average girl has around 2 GP

²⁹We do not have access to school identifiers so we cannot control for peer characteristics or school fixed effects.

³⁰Our results are robust to using alternative ages.

visits at age 11. The table shows that mothers are, on average, 40 years old when the child is 11. About 30% of mothers have a college degree, and 4% have completed at most compulsory schooling. Around 33% of mothers use oral contraceptives and almost 9% have an antidepressant prescription in that year. When the child is 11 years old, fathers are, on average, 43 years old, 29% have a college degree, 6% have only compulsory education, and 5% use antidepressants. 81% of mothers and close to 86% of fathers are employed. Approximately 66% of parents are married or cohabiting. Between ages 16 and 18, 7.3% of girls have at least one psychiatric visit, and 1.2% have a depression diagnosis. 4.8% of girls fill at least one antidepressant prescription at those ages, with 3% having prescriptions issued by specialists.

The average girl in the event study and GP samples resembles those in the full population in terms of most characteristics. Girls in the event study sample have, by construction, a higher probability of using the pill by ages 15 and 16. Between ages 16 and 18, they also have a higher likelihood of visiting a psychiatrist (9%), having a depression diagnosis (1.5%), and having an antidepressant prescription (6.2%). Compared to those in the full sample, they are less likely to have an immigrant background, and they have parents who are slightly less educated, have lower income, and are less likely to be married or cohabiting, but who have similar rates of antidepressant use. Their mothers are more likely to also use oral contraceptives (35%).

Compared to the full sample, parents in the GP sample are similar in terms of education, but they are slightly younger, have higher income, and have slightly higher rates of employment. Maternal use of oral contraceptives is slightly higher in this sample (23%), and parental antidepressant use is very similar to the full population. Children in the GP sample have similar GP visits at age eleven but higher rates of contraceptive use at adolescence (around 23% use it at age 15 and 44% at age 16). Around 8.3% of children in the GP sample have a psychiatric visit between the ages of 16 and 18. Rates of depression diagnosis and antidepressant use are similar to the full population of girls.

The last panel summarizes the characteristics of the primary care clinics of the girls in the GP sample when they were 12 years old. The average leave-one-out pill prescription rate among 12-18 year olds is 20% and, during that year, the average primary care clinic treats 248 girls aged between 12 to 18. The primary care clinics in our sample are more likely to be multi-provider practices: 21.45% are two-physician practices, 16.82% have three physicians, 12.75% have four physicians and 16.65% have at least five physicians.³¹ The average clinic

³¹This is due to the requirement that clinics in our sample treat a minimum of 25 girls aged 12 to 18. In the full sample, during the period 1998–2014, 58.6% of clinics were solo-practices, 19.62% had two physicians, 10.39% had three physicians, 5.91% had four physicians, and 5.5% had at least five physicians.

has 37% female physicians and 5% physicians with an immigrant background. Physicians are on average 52 years old and have a tenure of 12.4 years. Parents of adolescent patients served in these clinics resemble the full population in terms of marital status, educational attainment and antidepressant use.

Appendix Table A2 provides estimates from OLS models that relate contraceptive pill use by age 16 to mental health outcomes between ages 16–18. Consistent with previous findings in the medical literature, pill use during adolescence and mental health outcomes are negatively correlated: contraceptive use before age 16 is associated with a 40% increase in the probability of having a psychiatrist visit during ages 16–18 (column 2 including family controls), a 53% higher probability of being diagnosed with depression, and a 49% higher probability of filling an antidepressant prescription.

5 Results – Event Study Design

5.1 Mental Health Outcomes

In this section, we present the results from the event study design that uses variation in the timing of pill initiation. Figure 1 plots the coefficients for the event time dummies from equation (1) along with the 95-percent confidence intervals. In panel (a), we examine the probability of having a psychiatric visit in a given quarter. We observe a marked trajectory break after pill initiation: the probability of having a psychiatric visit one quarter after starting on the contraceptive pill increases by 0.2 percentage points or 17% with respect to the average in the quarter prior to pill initiation. The jump is persistent, and we observe a similar increase in visits four quarters later.³²

Panel (b) examines the likelihood of a depression diagnosis following an outpatient or emergency psychiatric visit at the hospital. We document flat trajectories before starting on the pill. In contrast, the results suggest that one quarter after pill initiation, the probability of receiving a depression diagnosis increases by 40% compared to the mean in $t = -1$.

Finally, in panel (c), we explore antidepressant use. The flat pre-trends again suggest that girls are unlikely to suffer a deterioration in mental health prior to initiating contraceptive use. However, there is an increased probability of taking antidepressants after starting the pill. Moreover, this seems to grow over time: four quarters after pill initiation, the likelihood of taking an antidepressant increases by around 0.5 percentage points (a 65% increase when compared to the mean in $t - 1$).

³²In 2011, the Danish Health and Medicines Authority tightened the guidelines on antidepressant treatment for children, recommending that children and young adults always see a psychiatrist before initiating treatment for mental health conditions.

The timing of the mental health patterns is consistent with the observation that a significant fraction of girls already discontinue using the pill one quarter after initiation. Figure A2 shows that around 6.5% of girls discontinue the pill in the first quarter, representing around 30% of all girls who discontinue the pill during the first year and a half. This is also consistent with previous evidence by Zethraeus et al. (2017), who found a significant deterioration in general well-being just after three months of contraceptive pill use in a general population of women.

5.2 Identification Checks and Mechanisms

The key concern in interpreting these results as causal is that the timing of pill initiation may be correlated with other events or behaviors that affect adolescent girls' mental health trajectories. While we do not observe significant pre-trends in mental health care utilization, we cannot rule out that there is a deterioration in their mental health prior to pill initiation that is not reflected in visits to specialists or consumption of antidepressants.

To alleviate this concern, we first consider potential reasons for pill initiation which could be correlated with adolescent mental health. The medical literature suggests that adolescents may use oral contraceptives due to heavy menstrual bleeding, dysmenorrhea pain, and other irregularities (Davis et al., 2005; Fraser and McCarron, 1991; Davis et al., 2000), acne conditions (Redmond et al., 1997), after an abortion or after using the emergency contraceptive pill.³³ Some of these conditions may have independent effects on mental health trajectories. In Appendix Figure A3, we investigate the trends in these potential reasons of pill use surrounding the pill initiation. Panel (a) shows the likelihood of having an ICD code for menstrual irregularities, diagnosed during a hospital visit. In panel (b), we examine the likelihood of filling a prescription for acne. Panels (c) and (d) investigate the likelihood of using an emergency contraception or having an abortion, respectively. Across all the figures, we document an increased likelihood at $t = 0$, followed by a reduction in other quarters. These results suggest that all these conditions may be contributing to pill initiation.³⁴ Appendix Figure A4 checks the sensitivity of our main findings to excluding such cases and shows that our main results remain unchanged.

In Figure A5, we examine the evolution of risky behaviors around the pill initiation. Panel (a) analyzes teen births. Even though teen pregnancies are extremely rare in Denmark, we

³³Menstrual irregularities are defined with the following ICD-10 Codes: N91-N94. Acne medications are defined as prescriptions with the ATC code D10. Abortions are defined based on hospital records with ICD-10 codes O04-O06. Emergency contraceptives are defined as prescriptions with ATC codes G03AD.

³⁴The results also suggest that, consistent with the medical literature, the pill helps to improve menstrual disorders and acne conditions.

can reject that girls initiate pill use after a pregnancy.³⁵ As we would expect, we see a decrease in teen pregnancies after pill initiation. In panel (b), we examine risky behaviors. We follow the previous literature and define risky behaviors with an indicator for hospital visits due to alcohol abuse or intoxication, screening for sexually-transmitted infections, or chlamydia diagnosis (Janys and Siflinger, 2024; Cawley and Ruhm, 2011; Mulligan, 2016).³⁶ Our results indicate no evidence of elevated risky behavior before pill initiation and a decrease in risky behaviors in the quarters after starting contraception.

Appendix Figure A6 explores the role of biology in driving these relationships. In panel (a), we check whether the main results are driven by girls who have a history of mental health problems: we estimate our model among the sample of girls who had not had any contact with a psychiatrist for at least up to five quarters before the first pill use (the start of the event study window). The figure shows that our previous results are not solely driven by girls with pre-existing mental health conditions, as we also find similar patterns in this group. Panels (b) and (c) compare how the mental health patterns differ depending on the hormonal composition of the first contraceptive prescription. While research on the mental health effects of different types of hormonal contraceptives is limited, studies indicate a weaker association between the use of the progestin-only pill and mood deterioration or depression (FSRH, 2022; Kuntz et al., 2016; Worly et al., 2018). Motivated by this, we compare our main results for combined pill users (panel (b)) with the patterns for girls who instead use a progestin-only product (panel (c)).³⁷ If girls had a higher probability of starting to use hormonal contraceptives during periods of declining mental health or emotional instability (due perhaps to the start of serious romantic relationships) and this was driving our results, we would expect to see similar increases in depression diagnoses and antidepressant consumption after the first use of either type of pill. While the estimates are more noisily estimated in the progestin-only group due to smaller sample size, the results indicate no evidence of a change in mental health outcomes among progestin-only pill users, and we can rule out that the estimated effects four quarters after pill start are the same in both groups.³⁸ We cautiously interpret these patterns as indicative of a biological pathway

³⁵In our sample, we have only 778 cases of teen births (0.3%).

³⁶We define an indicator for risky behavior equal to 1 if the girl had, in a given quarter, any hospital visit with ICD-10 codes F10 (Mental and behavioral disorders due to use of alcohol), T51 (Toxic effect of alcohol), A55 or A56 (Chlamydia), or Z11.3 (Screening for STIs other than HIV).

³⁷The main reason why girls are prescribed a progestin-only product is if they present risk factors for suffering a thrombosis (Mantha et al., 2012). Consistent with this, we see in our data that girls who use progestin-only pills or implants as their first hormonal contraceptive are more likely to have a personal or family history of cardiovascular problems. These girls are otherwise similar to girls who use the combined pill in important aspects such as the age of pill initiation, and we also find no evidence that progestin-only pill users are at a lower risk of mental health disorders, based on their personal or family history.

³⁸Given the smaller sample of progestin-only pill users, we see relatively few girls who start using them

between the pill and mental health outcomes.

Finally, in Figure A7, we probe the possibility that the baseline results are the product of repeated interactions between the GPs and adolescent girls (e.g. to receive repeat pill prescriptions). We first examine changes in GP visits. Panel (a) shows no pre-trends in health care utilization prior to the first combined pill prescription, and a substantial increase in the probability of visiting a GP by more than 0.3 percentage points in the quarter of pill initiation. Panel (b) documents that these patterns are very similar for users of progestin-only contraceptives. This suggests that the patterns found for mental health are unlikely to be driven by differences in healthcare utilization. The last panel of the figure turns to the role of GPs in prescribing antidepressants. We examine antidepressant use focusing only on prescriptions issued by specialists. The results show a very consistent result: there is a significant increase in antidepressant utilization after starting the pill. The overall pattern remains remarkably stable, with a relatively smaller effect size.

Overall, these results provide robust evidence indicating that the timing of pill initiation is unlikely to be correlated with a deterioration of mental health, or that changes in behavior are driving the mental health patterns. Instead, our findings support the interpretation that the observed changes in the mental health trajectories are driven by the hormonal changes associated with the pill.

6 Results – GP Practice Variation

6.1 Contraceptive Use

We next turn to quantifying the role of primary care provider’s practice style for contraceptive use. Figure 2 shows the identifying variation in our data. In particular, we plot our leave-one-out measure of GP tendency to prescribe combined oral contraceptives to girls aged 12 to 18, after residualizing municipality-by-birth-year fixed effects. The histogram shows that there is substantial variation in physicians’ oral contraceptive prescribing tendencies. For example, primary care clinics at the 90th percentile of the distribution have a prescribing rate that is 16.6 percentage points higher than the providers at the 10th percentile. The difference in an interquartile shift is 8 percentage points. These differences are large when

in each quarter. This implies a small number of observations in each “cohort,” in the sense of Sun and Abraham (2020)’s estimator. To gain precision we instead estimate these regressions with a two-way fixed effects (TWFE) estimator as described in equation (1). We replicate in panel (b) the results on antidepressant prescriptions for combined pill users using also a TWFE estimator (and present them on the same scale for comparability). The comparison of Figures 1c and A6b shows that both estimators yield virtually identical results. We see noisier, but null results, for psychiatric visits and depression diagnosis for progestin-only pill users.

compared to the mean prescribing rate of 20% (see Table A1).

The solid line in the figure presents estimates from a local linear regression documenting how the probability of filling a combined oral contraceptive prescription by age 16 changes as a function of GPs’ prescribing tendency. The figure suggests that the probability of using the pill is monotonically increasing in GPs’ prescribing tendency and that this relationship is close to linear.³⁹ Table 1 presents the corresponding regression estimates. The first three columns examine the relationship between GP practice style and contraceptive use by age 15 while the last three columns analyze contraceptive use by age 16. For each outcome, we first present results from a model controlling for municipality-by-birth-year fixed effects. We then check the sensitivity of the estimates to adding additional observable characteristics on children and their parents (column 2) and clinic characteristics (column 3), as described in Section 4.⁴⁰ The results in column 1 suggest that going to a clinic with one standard deviation higher propensity to prescribe the pill is related to a statistically significant increase in the probability of taking the pill by age 16 (15) of 0.6 (0.5) percentage points. Our findings are virtually unchanged when we control for the rich set of observable characteristics on children, parents, and clinics (including proxies for neighborhood characteristics). These results imply that switching from a provider at the 10th percentile of the distribution to one at the 90th percentile would increase the likelihood of contraceptive use by ages 15 and 16 by 5.4% and 3.5%, respectively. In order to gauge the magnitude of these estimates, we can compare them to the role of background characteristics in predicting adolescent pill use. The 3.5% increase implied by a switch in providers is equivalent to 40% of the difference in the probability of taking the pill by age 16 between girls whose mother is a contraceptive pill user and girls whose mother is not, holding constant the other observable characteristics.

6.2 Mental Health Outcomes

Having established the important role of primary care providers in adolescent girls’ oral contraceptive use, we now turn to adverse consequences on mental health outcomes, measured between ages 16 to 18: psychiatric visits, depression diagnosis, and antidepressant use.⁴¹

³⁹Figure A1b shows the cumulative distribution of contraceptive use by GP clinics’ tendency to prescribe combined oral contraceptives. In particular, we divide the sample into two groups: girls assigned to a high prescribing GP clinic (defined as those above the 75th percentile), and girls assigned to a low prescribing GP clinic (defined as those below the 25th percentile). The gap in the probability of taking the pill among these two groups is visible starting at age 13 and widens with age.

⁴⁰The number of observations in these regressions is slightly smaller than that presented in Table A1 for the GP sample, as a few observations are singletons in terms of municipality-year of birth.

⁴¹To avoid concerns that GPs with a higher propensity to prescribe oral contraceptives may also be more likely to prescribe antidepressants, we restrict our attention to antidepressant prescriptions issued by specialists.

The results in columns (1)-(3) of Table 2 suggest that assignment to a GP with one standard deviation higher propensity to prescribe oral contraceptives is related to an increased likelihood of having a psychiatric contact of 0.136 percentage points (an increase of 1.64% at the mean). In columns (4)-(6), we analyze the probability of receiving a depression diagnosis at a psychiatric hospital. We find that having a provider with a standard deviation higher pill prescribing tendency is related to an increase in the probability of depression diagnosis of 0.071 percentage points, a 5.4% increase relative to the mean. Finally, consistent with our finding of increased likelihood of a depression diagnosis, we find that assignment to a high prescribing clinic leads to higher antidepressant use: having a GP clinic with one standard deviation higher contraceptive prescribing tendency increases the likelihood of filling an antidepressant prescription (issued by specialists) by 0.116 percentage points, an increase of 3.9% at the mean. Similar to the results in Table 1, the results are robust to the addition of controls.

6.3 Identification Checks

The key identifying assumption that would allow us to interpret these findings as causal is quasi-random assignment of patients to physicians. As we explain in Section 2.1, individuals can freely choose a GP in their municipality of residence as long as it is located within 15km of their primary residence (5km in the Copenhagen Metropolitan Area), but children are typically registered in the primary care practice of their parents. We bring suggestive evidence that selection is orthogonal to the GP clinic’s propensity to prescribe the pill through a check for balance on observable characteristics. In the left panel of Figure 3, we estimate a linear regression to document the relationship between contraceptive use by age 16 and a comprehensive set of family and individual characteristics. The results show that the listed observable characteristics are highly predictive of pill use with a joint F-statistic of 599. The right panel turns to the relationship between GP clinics’ prescribing tendency and the same set of observable characteristics. In contrast to panel (a), we do not find any evidence that observable characteristics jointly predict physician propensity to prescribe oral contraceptives (the corresponding F-statistic is 6.3). While we observe some individually significant differences, the estimated effects are very small. Interestingly, most of these have the opposite sign to the differences observed in the left panel, suggesting that, if anything, girls assigned to high prescribing clinics may be slightly positively selected.

We visually summarize this finding in panel (b) of Figure 2 where we overlay a local linear regression of predicted pill use (based on a linear model regression including the individual and family observable variables) on GPs’ pill prescribing tendency. As the figure shows,

girls’ predicted oral contraceptive use is not correlated with the physician practice style: the coefficient on the slope parameter is neither economically nor statistically significant.

Finally, we conduct a placebo check where we regress girls’ mental health outcomes at age 12, when the majority of girls are not on the pill yet, on GP’s tendency to prescribe the pill. The results, presented in Table 3, show that there is no association between GP prescribing tendency and patient’s outcomes prior to pill use.

Overall, we do not find evidence of any violations of quasi-random assignment on a rich set of observable characteristics, alleviating concerns of selection of patients based on unobservable determinants of mental health outcomes.

6.4 Mechanisms

While the quasi-random assignment of patients to clinics would allow us to interpret the results presented so far as the causal impact of a lenient prescriber, this assumption is not sufficient to attribute the results to use of oral contraceptives. In particular, GP clinics with different pill prescribing tendencies may differ along other dimensions that impact adolescent mental health outcomes. While we cannot directly test that providers are identical along all dimensions except for their oral contraceptive prescribing tendency, we conduct three checks indicating contraceptive use as the most likely driver of the results we find.

First, an advantage of our context is that we have a very clear placebo test: we can examine whether GP practice style impacts outcomes of boys. To the extent that high pill prescribing clinics differ in other dimensions of care, this should be reflected in the outcomes of boys. To implement this falsification check, we assign each boy to their most visited provider at age 12 and use the prescribing tendency of that provider. Table 4 shows the results of estimating equation (3) for boys’ outcomes. We find no evidence of a relationship between physician pill prescribing tendency and their mental health. Columns (1)-(9) examine psychiatric visits, depression diagnosis, and antidepressant use. Across all columns, the estimated coefficients are small and statistically insignificant. We can reject the null hypothesis that the estimated effects for girls and boys are the same at 5% level.

One may be concerned that the lack of a statistical relationship in columns (1)-(9) is a reflection of the fact that mental health conditions such as depression are more common among girls. To address this concern, columns (10)-(12) examine a more general measure of mental health prescriptions, including treatments such as ADHD medications that are more common among boys.⁴² The results again show no relationship between physicians’ oral

⁴²In particular, this general measure of mental health prescriptions includes antidepressants (N06A), benzodiazepine derivatives (N05BA), antipsychotics (N05A), as well as ADHD medications (N06BA01, N06B04, N06BA0).

contraceptive prescribing tendency and boys’ likelihood of using mental health drugs. These results suggest that high pill prescribing physicians are not more likely to yield worse mental health outcomes for all their patients. They also indicate that high prescribing physicians are not more likely to detect mental health disorders.

We next examine whether GP clinics’ tendency to prescribe progestin-only contraceptives, constructed in a similar fashion to our combined oral contraceptive prescribing tendency measure, has similar effects on adolescent mental health. Table 5 shows that GP clinics’ tendency to prescribe progestin-only contraceptives is significantly related to girls’ likelihood of using such contraception: going to a clinic with one standard deviation higher propensity to prescribe progestin-only pill increases the probability of taking this type of pill by age 16 (15) by 0.6 (0.3) percentage points. In contrast, we find no evidence that GP clinics’ tendency to prescribe progestin-only contraceptives is related to adolescent mental health (see Table 6). These results are consistent with the evidence based on the event study design presented in Section 5.2 and suggest that the hormonal composition of the pill is a likely explanation for the observed effects on mental health.

Finally, we ask whether physicians with different pill prescribing tendencies may be more effective in their care for patients. Following Currie and Zhang (2023), we focus on hospitalizations or ER visits for ambulatory care-sensitive conditions (ACSC) as a measure of provider effectiveness and create separate indicators for any ACSC, acute ACSC, chronic ACSC, and vaccine-preventable ACSC between ages 16 and 18.⁴³ We then estimate our baseline model using these as the outcome. The results yield very precise zeros across the board (Table 7), suggesting that GP clinic’s pill prescribing tendency is not correlated with the provider’s general quality of care.

While we cannot test all dimensions of care, we cautiously interpret the results of these checks as evidence for our conjecture that the main channel linking provider type and adolescent mental health is contraceptive use.

7 Conclusions

The contraceptive pill is a medical treatment used by millions of women around the world (151 million in 2019, according to the UN).⁴⁴ It is indisputable that the ability to control and delay fertility was and is crucial for women’s lives and careers. That said, understanding the potential connection between the pill and adolescent mental health is highly important,

⁴³Some examples of conditions include asthma; diabetes complications; ear, nose, and throat infections. We construct ACSC hospitalizations using the full list of conditions in Appendix 1 in Barker et al. (2017).

⁴⁴Available [here](#). Last accessed in October 2022.

especially considering that one in seven 10-19-year-olds experience a mental health disorder (WHO, 2021). While this connection has been debated since the introduction of the pill itself, there is scarce causal evidence on it.

This paper provides novel evidence on the relationship between the contraceptive pill and young girls’ mental health. We first use an event study framework to show a very clear break in teenage girls’ mental health trajectories: soon after initiating oral contraception, there is an increase in the likelihood of psychiatric contact, of a depression diagnosis, and of antidepressant use. The size of these increases is economically significant. One quarter after pill initiation, the likelihood of a psychiatric visit and of a depression diagnosis increases by 17% and 40%, respectively. Four quarters after starting oral contraceptives, the probability of using antidepressants increases by 65%.

In the second part of the paper, we focus on an important determinant of girls’ pill consumption: primary care doctors’ tendency to prescribe oral contraceptives to adolescents. We show that there is substantial variation in GPs’ pill prescribing tendency and that moving from the 10th percentile of this distribution to the 90th percentile increases the likelihood of oral contraceptive use by ages 15 and 16 by 5.4% and 3.5%. We next document how physician pill prescribing behavior is related to adolescent mental health outcomes. Our results suggest that having a GP with a one standard deviation higher oral contraceptive prescribing tendency increases the likelihood of a psychiatric visit between ages 16 and 18 by 1.6%, the likelihood of a depression diagnosis by 5.4%, and the likelihood of antidepressant use by 3.9%.

Each of the distinct sources of variation we exploit relies on different identification assumptions. While we acknowledge the empirical challenges each strategy entails, we show that the results from both strategies consistently indicate a negative relationship between contraceptive pill use and adolescent girls’ mental health and survive a host of robustness checks probing the key identification assumptions.

What do these results imply about the role of oral contraceptives in the increased use of antidepressants among adolescent girls? To answer this question, we perform a back-of-the-envelope calculation. We observe a rise of 16% in oral contraceptive use by age 16 among cohorts born between 1986 and 1994. Our results imply that the pill increases the probability of antidepressant use by 65%. This translates into an increase in antidepressant consumption of 10.4% among these cohorts. The raw data shows that the use of antidepressants during teenage years among these cohorts increased by 71%. Therefore, approximately 15% of the upsurge in antidepressant utilization among adolescent girls can be attributed to increased oral contraceptive use.

A complete welfare assessment is outside the scope of this paper, and in many instances

the benefits of the pill may outweigh the costs. However, our findings indicate that it is crucial for women, physicians, and policymakers to carefully assess the potential costs of the pill. Our results also suggest that primary care providers have a significant influence on their patients’ oral contraceptive use. Given the substantial variation in pill prescribing tendency across GPs, this finding highlights the possibility of addressing the detrimental consequences of the pill on adolescent mental health through supply-side education policies.

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Tables and Figures

Table 1: Contraceptive pill use

| | Any pill by 15 | | | Any pill by 16 | | |
|-------------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|
| | (1) | (2) | (3) | (4) | (5) | (6) |
| PP | 0.006*** (0.001) | 0.005*** (0.001) | 0.005*** (0.001) | 0.007*** (0.001) | 0.007*** (0.001) | 0.006*** (0.001) |
| N | 237985 | 237985 | 237985 | 237985 | 237985 | 237985 |
| Adjusted R ² | 0.022 | 0.078 | 0.078 | 0.027 | 0.082 | 0.082 |
| Outcome mean | 0.234 | 0.234 | 0.234 | 0.440 | 0.440 | 0.440 |
| F-stat PP | 32.48 | 31.64 | 29.46 | 37.56 | 34.72 | 31.96 |
| Municipality x YOB FE | Yes | Yes | Yes | Yes | Yes | Yes |
| Family controls | | Yes | Yes | | Yes | Yes |
| Clinic controls | | | Yes | | | Yes |

This table shows the results of regressions of the probability of having taken the pill by ages 15 and 16 on the propensity to prescribe of their GP clinic (standardized). See equation (3) for details. We use our GP sample from Table A1, which includes girls born from 1986 to 2002 (first-borns, and from non-immigrant backgrounds). Standard errors in parentheses are clustered at the GP level. * p<0.1, ** <0.05, *** p<0.01

Table 2: Impact of GP’s propensity to prescribe on girls’ mental health outcomes (ages 16-18)

| | Psychiatrist visit | | | Depression diagnosis | | | Antidepressant | | |
|-------------------------|--------------------|--------------------|--------------------|----------------------|--------------------|--------------------|---------------------|---------------------|---------------------|
| | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) |
| PP | 0.158** (0.067) | 0.168** (0.066) | 0.136** (0.067) | 0.065** (0.027) | 0.066** (0.027) | 0.071** (0.028) | 0.114*** (0.040) | 0.114*** (0.040) | 0.116*** (0.041) |
| N | 237985 | 237985 | 237985 | 225374 | 225374 | 225374 | 237985 | 237985 | 237985 |
| Adjusted R ² | 0.012 | 0.033 | 0.033 | 0.003 | 0.005 | 0.005 | 0.002 | 0.008 | 0.008 |
| Outcome mean (x 100) | 8.262 | 8.262 | 8.262 | 1.304 | 1.304 | 1.304 | 3.008 | 3.008 | 3.008 |
| Municipality x YOB FE | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Family controls | | Yes | Yes | | Yes | Yes | | Yes | Yes |
| Clinic Controls | | | Yes | | | Yes | | | Yes |

This table shows the results of regressions of mental health outcomes at ages 16-18 on the propensity to prescribe of their GP clinic (standardized). See equation (3) for details. We use our GP sample from Table A1, which includes girls born from 1986 to 2002 (first-borns, and from non-immigrant backgrounds). Standard errors in parentheses are clustered at the GP level. * p<0.1, ** <0.05, *** p<0.01

Table 3: Impact of GP's propensity to prescribe on girls' mental health outcomes (age 12)

| | Psychiatrist visit | | | Depression diagnosis | | | Antidepressant | | |
|-------------------------|--------------------|------------------|------------------|----------------------|-------------------|-------------------|-------------------|-------------------|-------------------|
| | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) |
| PP | 0.005 (0.024) | 0.004 (0.024) | 0.001 (0.024) | -0.005 (0.004) | -0.005 (0.004) | -0.004 (0.004) | -0.001 (0.009) | -0.002 (0.009) | -0.004 (0.009) |
| N | 237985 | 237985 | 237985 | 237985 | 237985 | 237985 | 237985 | 237985 | 237985 |
| Adjusted R ² | -0.000 | 0.006 | 0.006 | -0.002 | -0.001 | -0.001 | -0.002 | -0.000 | -0.000 |
| Outcome mean (x 100) | 1.028 | 1.028 | 1.028 | 0.032 | 0.032 | 0.032 | 0.166 | 0.166 | 0.166 |
| Municipality x YOB FE | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Family controls | | Yes | Yes | | Yes | Yes | | Yes | Yes |
| Clinic Controls | | | Yes | | | Yes | | | Yes |

This table shows the results of regressions of mental health outcomes at age 12 on the propensity to prescribe of their GP clinic (standardized). See equation (3) for details. We use our GP sample from Table A1, which includes girls born from 1986 to 2002 (first-borns, and from non-immigrant backgrounds). Standard errors in parentheses are clustered at the GP level. * p<0.1, ** <0.05, *** p<0.01

Table 4: Impact of GP's propensity to prescribe on boys' mental health outcomes (ages 16-18)

| | Psychiatrist visit | | | Depression diagnosis | | | Antidepressant | | | MH prescription | | |
|-------------------------|--------------------|-------------------|-------------------|----------------------|-------------------|-------------------|--------------------|-------------------|-------------------|------------------|------------------|------------------|
| | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) | (12) |
| PP | -0.036 (0.050) | -0.027 (0.049) | -0.016 (0.050) | -0.021 (0.015) | -0.020 (0.015) | -0.017 (0.016) | -0.046* (0.027) | -0.044 (0.027) | -0.044 (0.028) | 0.047 (0.049) | 0.047 (0.048) | 0.022 (0.050) |
| N | 246897 | 246897 | 246897 | 233707 | 233707 | 233707 | 246897 | 246897 | 246897 | 246897 | 246897 | 246897 |
| Adjusted R ² | 0.009 | 0.028 | 0.028 | 0.000 | 0.001 | 0.001 | -0.001 | 0.003 | 0.003 | 0.008 | 0.031 | 0.031 |
| Outcome mean (x 100) | 5.071 | 5.071 | 5.071 | 0.435 | 0.435 | 0.435 | 1.347 | 1.347 | 1.347 | 4.783 | 4.783 | 4.783 |
| Municipality x YOB FE | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Family controls | | Yes | Yes | | Yes | Yes | | Yes | Yes | Yes | Yes | Yes |
| Clinic Controls | | | Yes | | | Yes | | | Yes | | | Yes |

This table shows the results of regressions of boys' mental health outcomes at ages 16-18 on the propensity to prescribe of their GP clinic (standardized). See equation (3) for details. We use the sample of boys born from 1986 to 2002 (first-borns, and from non-immigrant backgrounds). Standard errors in parentheses are clustered at the GP level. * p<0.1, ** <0.05, *** p<0.01

Table 5: Progestin-only contraceptive use

| | Any POC pill by 15 | | | Any POC pill by 16 | | |
|-------------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|
| | (1) | (2) | (3) | (4) | (5) | (6) |
| PP POC | 0.004*** (0.001) | 0.003*** (0.001) | 0.003*** (0.001) | 0.007*** (0.001) | 0.006*** (0.001) | 0.006*** (0.001) |
| N | 237985 | 237985 | 237985 | 237985 | 237985 | 237985 |
| Adjusted R ² | 0.006 | 0.017 | 0.017 | 0.010 | 0.025 | 0.025 |
| Outcome mean | 0.014 | 0.014 | 0.014 | 0.029 | 0.029 | 0.029 |
| F-stat PP | 44.36 | 42.73 | 41.42 | 41.89 | 40.05 | 39.35 |
| Municipality x YOB FE | Yes | Yes | Yes | Yes | Yes | Yes |
| Family controls | | Yes | Yes | | Yes | Yes |
| Clinic control | | | Yes | | | Yes |

This table shows the results of regressions of the probability of having taken the progestin-only pill or using the progestin-only implant by ages 15 and 16 on the propensity to prescribe progestin-only contraceptives of their GP clinic (standardized). See equation (3) for details. We use our GP sample from table A1, which includes girls born from 1986 to 2002 (first-borns, and from non-immigrant backgrounds). Standard errors in parentheses are clustered at the GP level. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$

Table 6: Impact of GP's propensity to prescribe the progestin-only pill on girls' mental health outcomes (ages 16-18)

| | Psychiatrist visit | | | Depression diagnosis | | | Antidepressant | | |
|-------------------------|--------------------|-------------------|-------------------|----------------------|-------------------|-------------------|------------------|-------------------|-------------------|
| | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) |
| PP POC | 0.027 (0.068) | -0.012 (0.066) | -0.015 (0.066) | -0.010 (0.029) | -0.016 (0.029) | -0.019 (0.029) | 0.009 (0.045) | -0.005 (0.045) | -0.006 (0.045) |
| N | 237985 | 237985 | 237985 | 225374 | 225374 | 225374 | 237985 | 237985 | 237985 |
| Adjusted R ² | 0.012 | 0.033 | 0.033 | 0.003 | 0.005 | 0.005 | 0.001 | 0.008 | 0.008 |
| Outcome mean (x 100) | 8.262 | 8.262 | 8.262 | 1.304 | 1.304 | 1.304 | 3.008 | 3.008 | 3.008 |
| Municipality x YOB FE | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Family controls | | Yes | Yes | | Yes | Yes | | Yes | Yes |
| Clinic Controls | | | Yes | | | Yes | | | Yes |

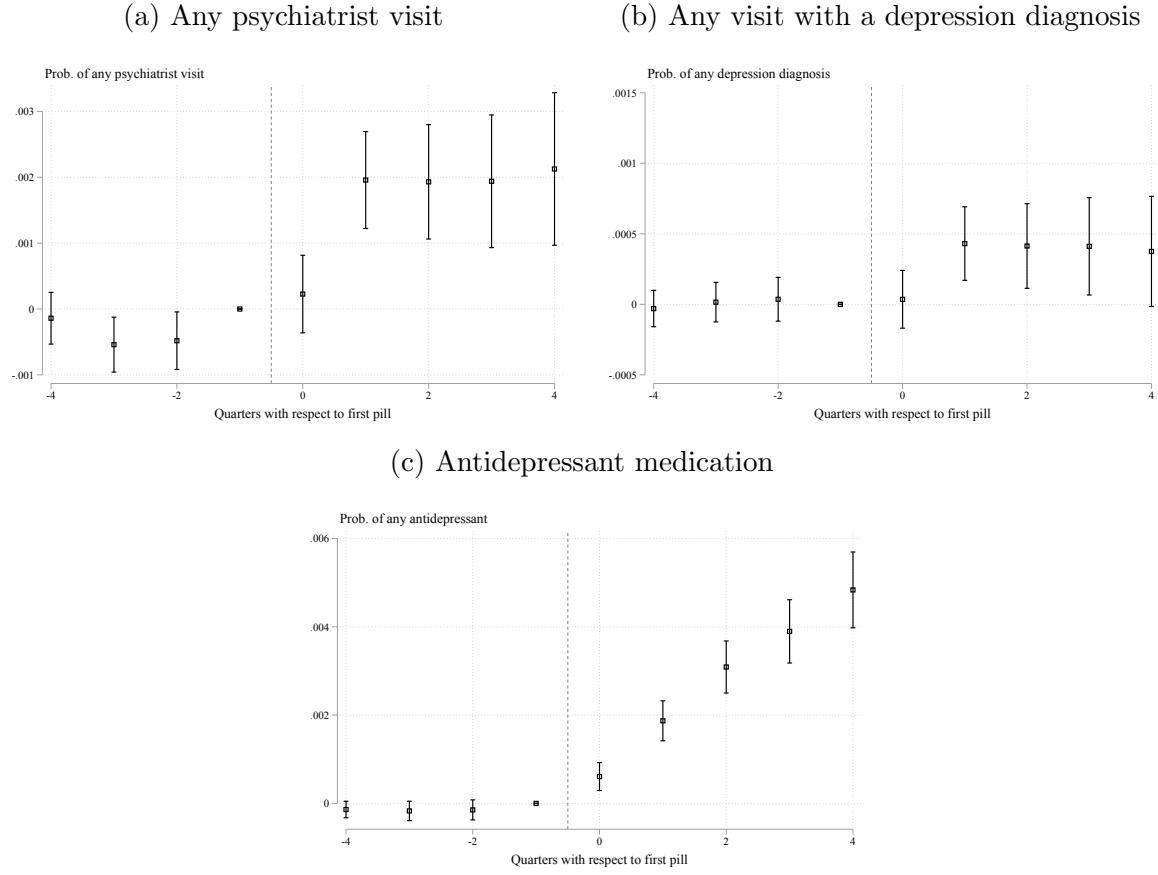
This table shows the results of regressions of mental health outcomes at ages 16-18 on the propensity to prescribe progestin-only contraceptives of their GP clinic (standardized). See equation (3) for details. We use our GP sample from table A1, which includes girls born from 1986 to 2002 (first-borns, and from non-immigrant backgrounds). Standard errors in parentheses are clustered at the GP level. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$

Table 7: Impact of GP's propensity to prescribe on hospitalizations for ambulatory care-sensitive conditions

| | Any ACS | | Acute ACS | | Chronic ACS | | Vaccine-preventable ACS | |
|-------------------------|-------------------|-------------------|-------------------|-------------------|------------------|------------------|-------------------------|------------------|
| | (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) |
| PP | -0.018 (0.048) | -0.019 (0.049) | -0.044 (0.038) | -0.051 (0.040) | 0.024 (0.029) | 0.027 (0.030) | -0.004 (0.010) | 0.000 (0.010) |
| N | 225374 | 225374 | 225374 | 225374 | 225374 | 225374 | 225374 | 225374 |
| Adjusted R ² | 0.022 | 0.022 | 0.023 | 0.023 | 0.006 | 0.006 | -0.000 | -0.000 |
| Outcome mean (x 100) | 4.063 | 4.063 | 2.513 | 2.513 | 1.470 | 1.470 | 0.187 | 0.187 |
| Municipality x YOB FE | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Family controls | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Clinic controls | | Yes | | Yes | | Yes | | Yes |

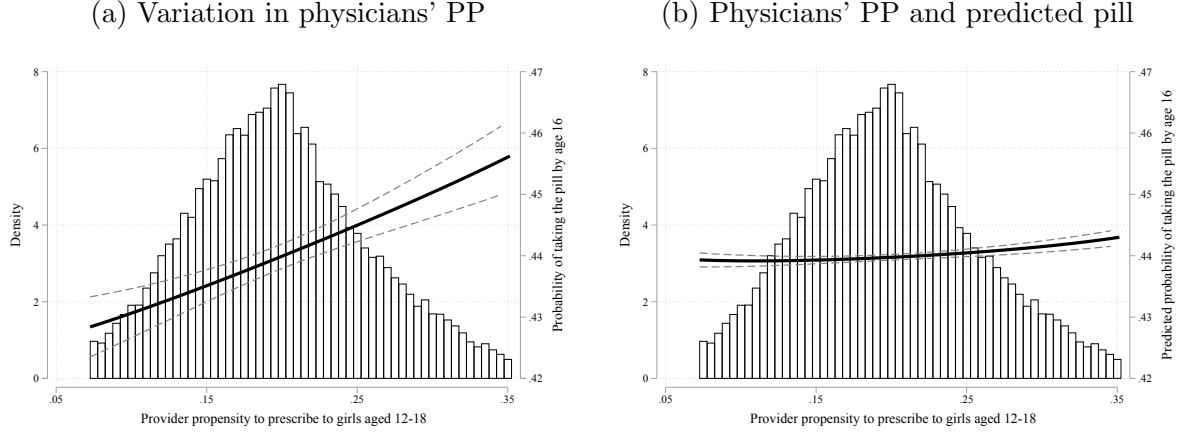
This table shows the results of regressions of hospitalizations for ambulatory care-sensitive conditions at ages 16-18 on the propensity to prescribe of their GP clinic (standardized). See equation (3) for details. We use our GP sample from Table A1, which includes girls born from 1986 to 2002 (first-borns, and from non-immigrant backgrounds). Standard errors in parentheses are clustered at the GP level. * p<0.1, ** <0.05, *** p<0.01

Figure 1: Event Study



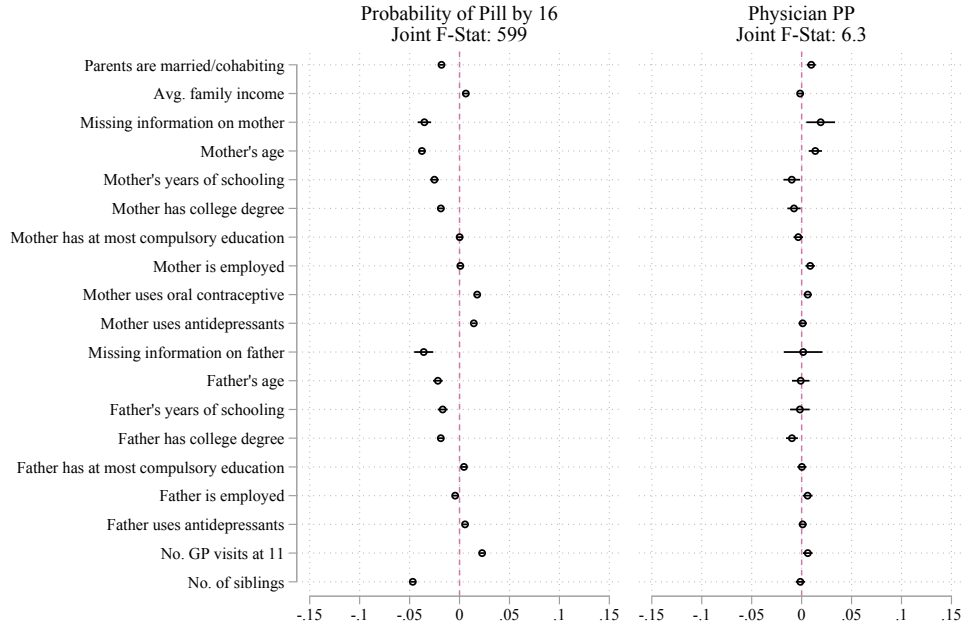
Notes: This figure plots the event time dummies' coefficients for the probability of having any psychiatrist visit (in panel (a)), the probability of being diagnosed with depression during a medical visit (in panel (b)), and the probability of redeeming any prescription for antidepressant medication (in panel (c)), estimated using Sun and Abraham (2020)'s IW estimator (see equation (1) for details). Our sample consists of a balanced panel of girls born from 1986 to 2002 who started taking the pill between the ages of 12 to 17 (event study sample in Table A1). Standard errors are clustered at the individual level.

Figure 2: Physicians' tendency to prescribe (PP) and selection



Notes: This figure plots the histogram of the PP (equation (2)), residualized of municipality by birth year fixed effects. In panel (a), a local-linear regression of the fitted probability of filling a contraceptive pill prescription by age 16 on the PP, residualized of municipality by birth year fixed effects, is overlaid and displayed on the right y-axis. Panel (b) overlays a local linear regression of predicted contraceptive pill prescription on the PP, where contraceptive pill prescription status by age 16 is predicted using a comprehensive set of demographic variables. We use our GP sample from Table A1, which includes girls born from 1986 to 2002 (first-borns, and from non-immigrant backgrounds).

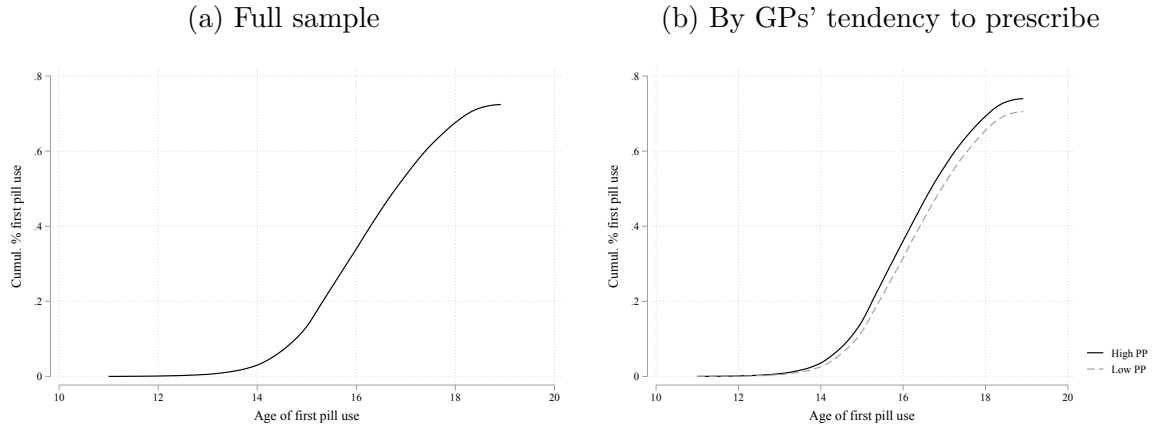
Figure 3: Selection into pill-taking and by provider's PP



Notes: The first panel of this figure plots the coefficients and 95% CI of regressing the probability of taking the pill by age 16 on a comprehensive set of family and girl characteristics. The panel on the right plots the coefficients and 95% CI from a regression of the provider's PP on the same set of variables. We use our GP sample from Table A1, which includes girls born from 1986 to 2002 (first-borns, and from non-immigrant backgrounds).

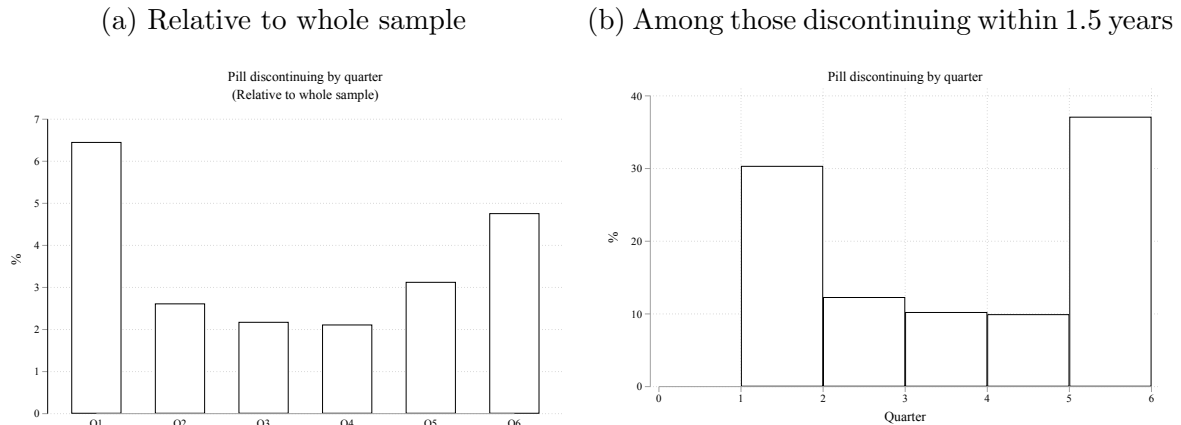
Appendix

Figure A1: Cumulative distribution of contraceptive use by age



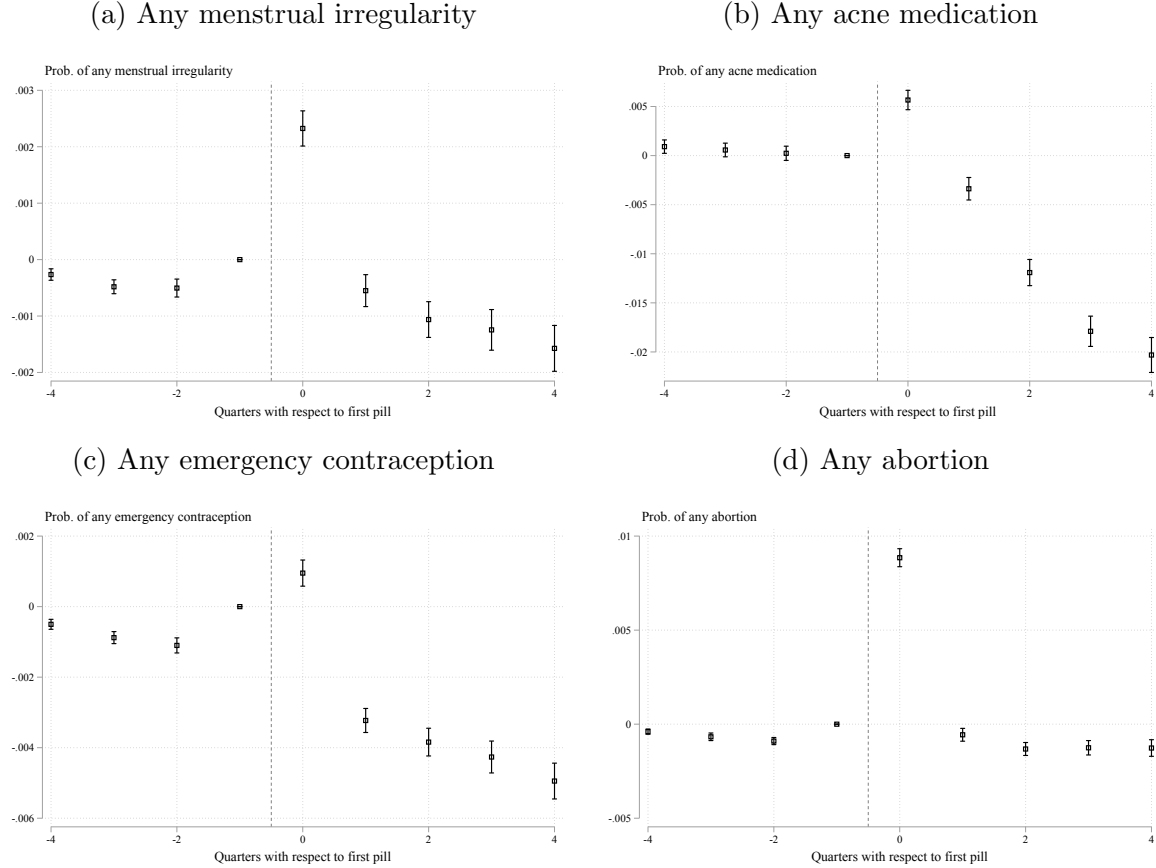
Notes: This figure plots the cumulative distribution of first pill use by age for the whole sample in the left panel and by GP's tendency to prescribe in the right one. In the right panel, we divide the sample into two groups: girls assigned a GP with a high tendency to prescribe the pill (above the 75th percentile) and those with a low-prescribing GP (below the 25th percentile). We use our GP sample from Table A1, which includes girls born from 1986 to 2002 (first-borns, and from non-immigrant backgrounds).

Figure A2: Pill discontinuation



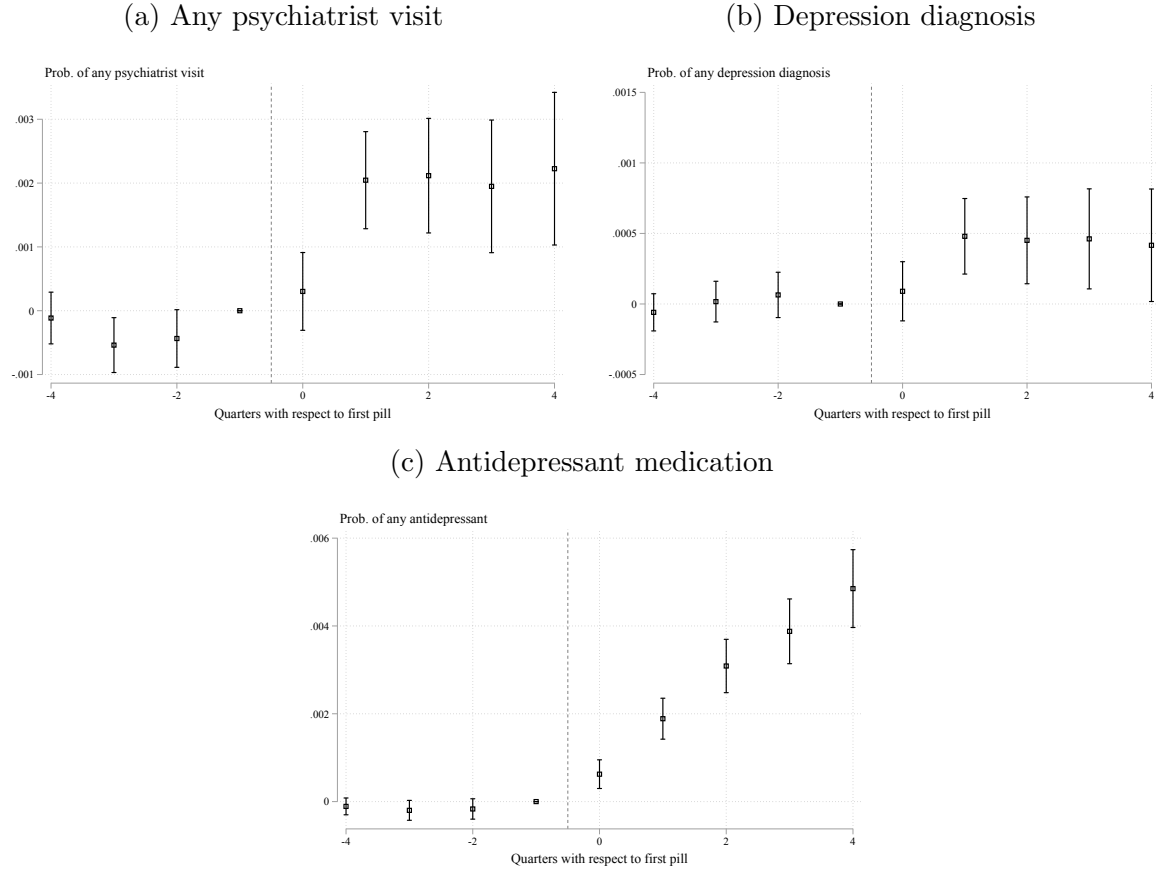
Notes: This figure plots the percentage of girls who discontinue using the combined hormonal contraceptive pill in each quarter after pill initiation. A girl is classified as discontinuing the pill in a given quarter after pill initiation if, starting in that quarter, she does not refill any pill prescription for one year. Panel (a) plots the share of girls discontinuing in each quarter relative to the entire sample of girls starting pill use. Panel (b) plots the share of girls discontinuing in each quarter relative to those who discontinue the pill within one and a half years of starting to use it. Our sample consists of a balanced panel of girls born from 1986 to 2002 who started taking the pill between the ages of 12 to 17 (event study sample in Table A1).

Figure A3: Potential Reasons for Contraceptive Use



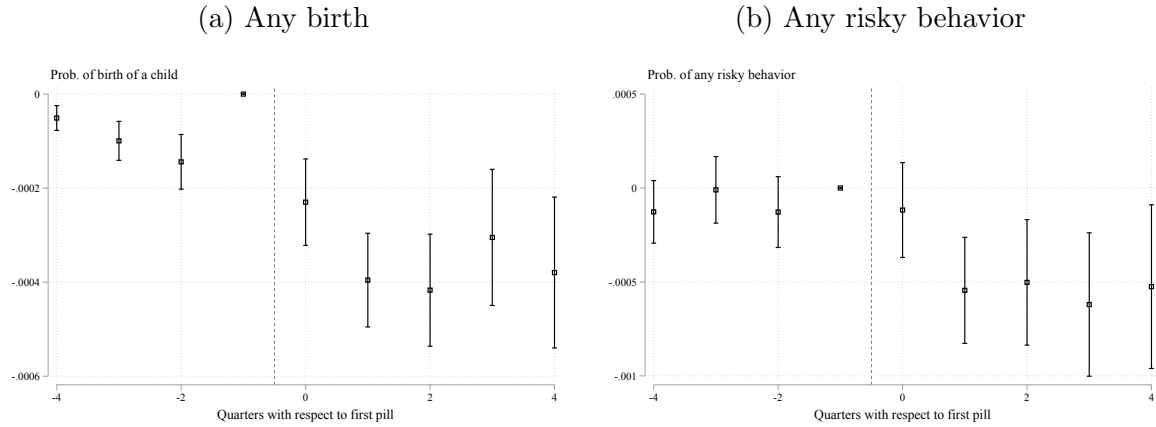
Notes: This figure plots the event time dummies' coefficients for the probability of having any menstrual irregularity (in panel (a)), any acne prescription (in panel (b)), having emergency contraception (in panel (c)) and of having an abortion (in panel (d)), estimated using Sun and Abraham (2020)'s IW estimator (see equation (1) for details). Our sample consists of a balanced panel of girls born from 1986 to 2002 who started taking the pill between the ages of 12 to 17 (event study sample in Table A1). Standard errors are clustered at the individual level.

Figure A4: Excluding Those with Other Shocks at $t=0$



Notes: This figure plots the event time dummies' coefficients for the probability of having any psychiatrist visit (in panel (a)), any depression diagnosis (panel (b)), and of redeeming any prescription for antidepressant medication (in panel (c)), estimated using Sun and Abraham (2020)'s IW estimator (see equation (1) for details). Our sample consists of a balanced panel of girls born from 1986 to 2002 who started taking the pill between the ages of 12 to 17 (event study sample in Table A1). We exclude girls who, in the same quarter of pill start, have a diagnosis for any menstrual irregularity, have any acne prescription, have an abortion, or use emergency contraception. Standard errors are clustered at the individual level.

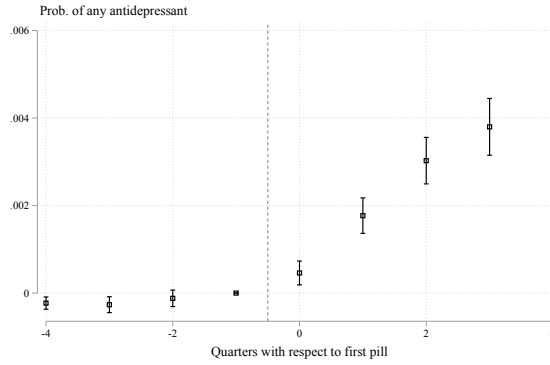
Figure A5: Evolution of Risky Behaviors



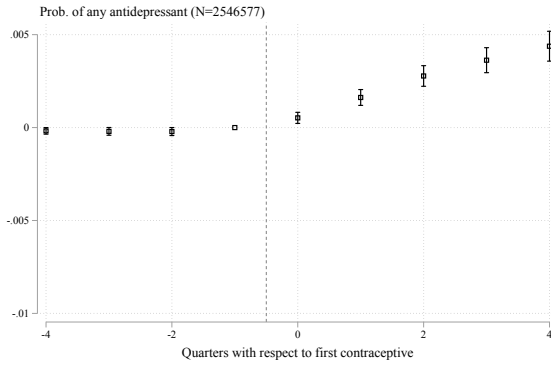
Notes: This figure plots the event time dummies' coefficients for the probability of giving birth (panel (a)) and having a hospital visit due to alcohol abuse or sexually-transmitted diseases (panel (b)). Our sample consists of a balanced panel of girls born from 1986 to 2002 who started taking the pill between the ages of 12 to 17 (event study sample in Table A1). Standard errors are clustered at the individual level.

Figure A6: The Role of Biology: Antidepressant Prescriptions

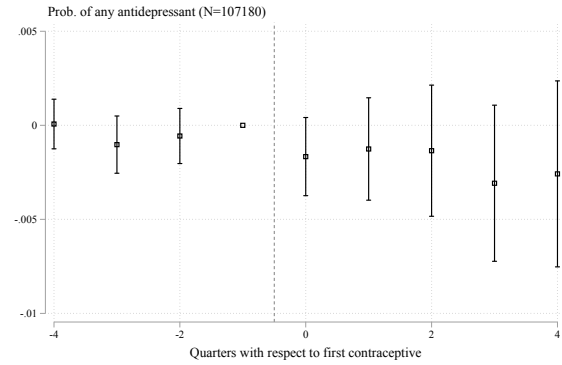
(a) Excluding girls with a previous mental health history



(b) Combined pills

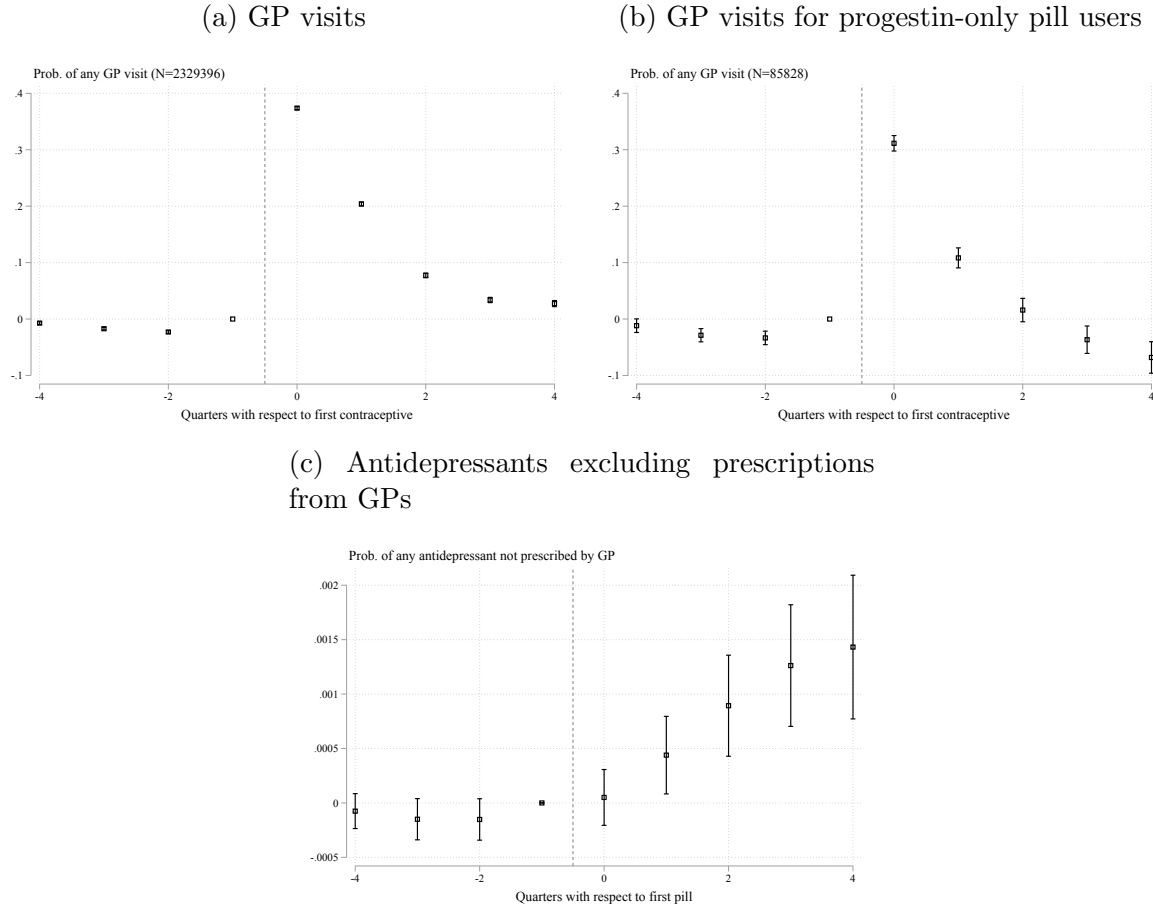


(c) Progestin-only contraceptives



Notes: This figure plots the event time dummies' coefficients for the probability of filling an antidepressant prescription around the time of first pill use: for girls with no previous history of mental health diagnosis in panel (a); in panel (b), for girls who start on the combined oral contraceptive pill (as in Figure 1c) and, in panel (c), for girls who start on a progestin-only pill or implant. Panel (a) is estimated with Sun and Abraham (2020)'s IW estimator, while panels (b) and (c) are estimated with a two-way-fixed effect estimator (see equation (1) for details). Across all panels, the samples are part of a balanced panel of girls born from 1986 to 2002 who started taking the corresponding pill between the ages of 12 to 17. Standard errors are clustered at the individual level.

Figure A7: The Role of GPs



Notes: This figure plots the event time dummies' coefficients for the probability of visiting a GP for girls starting on the combined oral pill (panel (a)) and those starting on progestin-only contraceptives (panel (b)), and for the probability of filling an antidepressant medication issued by a specialist around the time of the first combined oral contraceptive pill use (panel (c)). Panels (a) and (b) are estimated with a two-way-fixed effect estimator, while panel (c) is estimated with Sun and Abraham (2020)'s IW estimator (see equation (1) for details). Our sample consists of a balanced panel of girls born from 1986 to 2002 who started taking the pill between the ages of 12 to 17. Standard errors are clustered at the individual level.

Table A1: Summary statistics

| | Full sample | | Event study sample | | GP sample | |
|---|-------------|----------|--------------------|----------|-----------|----------|
| | Mean | SD | Mean | SD | Mean | SD |
| <i>Contraceptive use</i> | | | | | | |
| Any pill by age 15 | 0.206 | 0.404 | 0.596 | 0.491 | 0.234 | 0.424 |
| Any pill by age 16 | 0.397 | 0.489 | 0.973 | 0.162 | 0.440 | 0.496 |
| <i>Child characteristics</i> | | | | | | |
| Eldest sibling | 0.522 | 0.500 | 0.538 | 0.499 | 1.000 | 0.000 |
| No. of siblings | 1.353 | 1.126 | 1.192 | 0.976 | 0.848 | 0.754 |
| Immigrant background | 0.089 | 0.284 | 0.025 | 0.155 | 0.000 | 0.000 |
| No. GP visits at 11 | 2.134 | 2.310 | 2.275 | 2.361 | 2.346 | 2.418 |
| <i>Family characteristics (at age 11)</i> | | | | | | |
| Parents are married/cohabiting | 0.661 | 0.474 | 0.615 | 0.487 | 0.603 | 0.489 |
| Mean family income | 332017.8 | 394626.1 | 326160.5 | 387916.3 | 339116.4 | 328754.3 |
| Missing information of family income | 0.103 | 0.304 | 0.107 | 0.309 | 0.054 | 0.227 |
| Missing information on mother | 0.016 | 0.126 | 0.014 | 0.116 | 0.006 | 0.075 |
| Mother's age | 40.066 | 4.870 | 39.113 | 6.618 | 38.847 | 4.759 |
| Mother's years of schooling | 13.737 | 2.619 | 13.358 | 2.830 | 13.854 | 2.391 |
| Mother has college degree | 0.306 | 0.461 | 0.249 | 0.432 | 0.306 | 0.461 |
| Mother has at most compulsory education | 0.039 | 0.194 | 0.026 | 0.160 | 0.020 | 0.139 |
| Mother is employed | 0.809 | 0.393 | 0.820 | 0.384 | 0.829 | 0.376 |
| Mother uses oral contraceptive | 0.192 | 0.394 | 0.346 | 0.476 | 0.227 | 0.419 |
| Mother uses antidepressants | 0.087 | 0.282 | 0.094 | 0.291 | 0.087 | 0.282 |
| Missing information on father | 0.047 | 0.211 | 0.045 | 0.207 | 0.038 | 0.191 |
| Father's age | 42.849 | 5.757 | 40.463 | 10.363 | 41.396 | 5.722 |
| Father's years of schooling | 13.901 | 2.651 | 13.035 | 3.755 | 13.913 | 2.529 |
| Father has college degree | 0.292 | 0.455 | 0.226 | 0.418 | 0.281 | 0.450 |
| Father has at most compulsory education | 0.057 | 0.232 | 0.054 | 0.227 | 0.044 | 0.205 |
| Father is employed | 0.858 | 0.349 | 0.850 | 0.357 | 0.874 | 0.331 |
| Father uses antidepressants | 0.050 | 0.217 | 0.050 | 0.218 | 0.047 | 0.212 |
| <i>Mental health outcomes (ages 16-18)</i> | | | | | | |
| Any psychiatrist visit | 0.073 | 0.260 | 0.089 | 0.285 | 0.083 | 0.275 |
| Any depression diagnosis | 0.012 | 0.108 | 0.015 | 0.122 | 0.013 | 0.113 |
| Any antidepressant prescription | 0.048 | 0.214 | 0.062 | 0.241 | 0.054 | 0.226 |
| Any antidepressant prescription (specialist) | 0.027 | 0.162 | 0.032 | 0.175 | 0.030 | 0.171 |
| <i>Provider characteristics (at age 12)</i> | | | | | | |
| GP's propensity to prescribe the pill to 12-18-y-o | | | | | 0.200 | 0.074 |
| Number of 12-18-y-o girls treated during year | | | | | 248 | 188 |
| Clinic with multiple physicians | | | | | 0.679 | 0.470 |
| Share of female physicians | | | | | 0.369 | 0.344 |
| Share of immigrant physicians | | | | | 0.045 | 0.163 |
| Average age of physicians | | | | | 51.558 | 6.519 |
| Average tenure | | | | | 12.411 | 6.804 |
| Missing clinic characteristics | | | | | 0.002 | 0.044 |
| Mean family income among patients | | | | | 339557.8 | 101636.6 |
| Patient share with married parents | | | | | 0.656 | 0.157 |
| Patient share whose mother has a college degree | | | | | 0.310 | 0.182 |
| Patient share whose father has a college degree | | | | | 0.280 | 0.175 |
| Patient share whose mother has only mandatory ed. | | | | | 0.020 | 0.045 |
| Patient share whose father has only mandatory ed. | | | | | 0.044 | 0.066 |
| Patient share whose mother uses oral contraceptives | | | | | 0.201 | 0.122 |
| Patient share whose mother uses antidepressants | | | | | 0.083 | 0.085 |
| Patient share whose father uses antidepressants | | | | | 0.046 | 0.062 |
| Observations | 539247 | | 266344 | | 238006 | |

This table presents descriptive statistics for the full sample, the event study sample, and the GP sample. The full sample comprises girls born from 1986 to 2002 that are observed in the data every year from age 11 to 18. The event study sample consists of girls from those cohorts who start using the pill at some point between ages 12 to 17. The GP sample consists of girls from those cohorts who can be linked to their general practitioner (GP) clinic at age 12, whose GP clinic attended more than 25 patients aged 12 to 18 in that year, and who are first-born children from non-immigrant backgrounds. Income variables are expressed in nominal Danish kroner (DKK).

Table A2: Association of contraceptive pill use with mental health disorders (ages 16-18)

| | Psychiatrist visit | | Depression diagnosis | | Antidepressant | |
|-------------------------|---------------------|---------------------|----------------------|---------------------|---------------------|---------------------|
| | (1) | (2) | (3) | (4) | (5) | (6) |
| Pill by 16 | 4.125*** (0.077) | 2.904*** (0.079) | 0.802*** (0.034) | 0.625*** (0.035) | 3.100*** (0.064) | 2.363*** (0.066) |
| N | 539210 | 539210 | 508201 | 508201 | 539210 | 539210 |
| Adjusted R ² | 0.016 | 0.032 | 0.006 | 0.006 | 0.010 | 0.020 |
| Outcome mean (x 100) | 7.321 | 7.321 | 1.176 | 1.176 | 4.815 | 4.815 |
| Municipality x YOB FE | Yes | Yes | Yes | Yes | Yes | Yes |
| Family controls | | Yes | | Yes | | Yes |

This table shows the results of regressions of mental health outcomes at ages 16-18 on an indicator for having taken the pill by age 16. We use our full sample from Table A1, which includes girls born from 1986 to 2002. Family controls consist of parental age, parental absence, parental employment status, education of each parent (college degree, at most comprehensive schooling, missing information on education), parental use of antidepressants, maternal contraceptive pill use, married parents indicator, average parental income, number of siblings, immigrant background, GP utilization at age 11, and birth order and month of birth fixed effects. Robust standard errors in parentheses. * p<0.1, ** <0.05, *** p<0.01