**The Minimum Wage and Children’s Mental Health**

Nolan M. Kavanagh, M.P.H.1,2, Margaret McConnell, Ph.D.,3 Natalie Slopen, Sc.D., M.A.3

1 Program in Health Policy, Harvard University, Cambridge, Massachusetts

2 Perelman School of Medicine, University of Pennsylvania, Philadelphia, Pennsylvania

3 T.H. Chan School of Public Health, Harvard University, Boston, Massachusetts

**Structured abstract**

**Introduction**

Children and adolescents in the U.S. are facing a mental health crisis.1–6 Mood and anxiety disorders are on the rise in this population, with 3% of children aged 3–17 having depression and 9% having anxiety in 2016–2019.7 The COVID-19 pandemic has only accelerated the crisis.8 Poor mental health worsens children’s quality of life, XXXX, and academic performance.9 It even has consequences lasting into adulthood, as adolescent depression has been associated with lower educational attainment, higher rates of unemployment, and earlier parenthood.10

Structural changes, such as raising the minimum wage, have the potential to improve children’s mental health.11 Children living in poverty are especially burdened by poor mental health, with higher rates of depression, anxiety, and behavioral disorders than children in higher-income households.12 Raising the minimum wage has been associated with improvements in children’s physical health, including birth weights,13 infant mortality,13,14 school absenteeism,15 and indexes of overall health,15 with heterogeneous results by demographic group.16,17 However, no studies have examined the effect of raising the minimum wage on children’s mental health.

Children’s mental health may be especially responsive to changes in a family’s income. For example, children’s emotional and behavioral problems tend to worsen with household economic stress.12,18 And when families’ incomes rise, they disproportionately dedicate those resources to their children.19 Consequently, raising the minimum wage could meaningfully improve children’s mental health, whether by reducing household financial stress,18,20 meeting a child’s need for mental health care,12,21 or granting access to other resources that could improve mental health, such as higher-quality housing, time for exercise and leisure, or better education.22,23

In this study, we use two nationally representative samples of over 1.4 million children and adolescents, aged 3 to 18, in the U.S. from 2001 to 2020 to estimate the effect of raising the minimum wage on children’s mental health. We examine several outcomes, including diagnoses, symptoms, health care utilization, and impacts on school and social life. This study has important implications for the design of economic policy to improve the mental health of children, as well as the use of structural interventions to benefit vulnerable populations more generally.

**Materials and Methods**

***Study Populations***

We use two nationally representative surveys of children in the U.S.: the National Survey of Children’s Health (NSCH) and the Youth Risk Behavior Surveillance System (YRBSS). Each captures a different time, population, and outcomes of interest. Together, they allow us to broadly characterize the relationship between the minimum wage and children’s mental health.

We used the 2016 to 2020 waves of the NSCH, a yearly, national study of children’s physical and emotional well-being in the U.S. It samples households known to have a child based on Census data and those projected to have one based on demographic characteristics. Then, parents and guardians report on one of their children. All analyses using the NSCH are weighted to be representative of all children in all state-years. Consistent with surveillance studies that estimate the prevalence of mood disorders starting at age 3,7 we include all children aged 3–17 whose parent or guardian provided information on at least one of our outcomes, for a sample of 141,427.

Next, we used the 2001 to 2019 waves of the state-level YRBSS, a set of biennial, state-level surveys of mental health and risk behaviors in adolescents. As a school-based study, it samples classrooms within randomly selected schools. Then, adolescents directly respond to the surveys. All analyses using the YRBSS are weighted to be representative of all students in grades 9–12 in each state-year, although not all states participate in all years. We include all adolescents who provided information on at least one of our outcomes, for a sample of 1,246,623. The demographic characteristics of respondents to the NSCH and YRBSS are provided in **Tables 1** and **2**.

***Exposure and Outcome Measures***

Our primary exposure is a state’s effective minimum wage per year in U.S. dollars. Based on wage data from the Bureau of Labor Statistics, we use the higher of a state’s minimum wage or the federal minimum wage. Descriptive statistics for the wages are provided in **Figure 1**. Our results are not sensitive to adjusting wages for inflation in 2020 dollars (see appendix).

We examine 15 mental health outcomes for children and adolescents, including self-reported diagnoses, symptoms, health care utilization, and impacts on school and work. Together, they capture the clinical, behavioral, and social facets of a child’s mental well-being.

For the NSCH, we evaluate whether a child (1) has depression as diagnosed by a doctor or other health care provider; (2) has diagnosed anxiety; (3) has diagnosed ADD or ADHD; (4) has behavioral problems as identified by a health care provider or educator; (5) has had chronic difficulty digesting food (e.g. stomach or intestinal problems, constipation, or diarrhea) in the past calendar year, a common manifestation of anxiety in children; (6) has not received necessary health care of any kind in the past year; (7) has not received necessary mental health services in the past year; (8) has missed 7 or more days of school in the past year, which can result if a child has debilitating mental health problems; and (9) has participated in any formal or informal paid employment in the past year. All outcomes in the NSCH are reported by parents or guardians.

For the YRBSS, we evaluate whether an adolescent (1) has felt incapacitating sadness or hopelessness for two weeks or longer in the past calendar year, which is a diagnostic criterion for depression; (2) has considered suicide in the past year; (3) has attempted suicide in the past year; (4) has used alcohol in the past month; (5) has used marijuana in the past month; and (6) has been in a physical fight in the past year. All outcomes in the YRBSS are directly reported by adolescents. The exact wording and coding of all survey questions are provided in the appendix.

***Statistical Analyses***

We test the effect of raising a state’s minimum wage on children’s mental health using two approaches: two-way fixed effects (TWFE) regressions and event studies. TWFE models capture the descriptive association between a state’s minimum wage and children’s mental health, while the event studies estimate the causal effect of raising the minimum wage on mental health.

First, our TWFE models estimate the association between a $1 increase in the minimum wage and the percentage-point change in the prevalence of each outcome. They are akin to a difference-in-differences model when the treatment variable is continuous, and they allow us to use all states-years of available data. As such, they are the most generalizable approach to understanding how the minimum wage shapes children’s mental health. The TWFE models include state fixed effects to account for time-invariant statewide sociodemographic and policy characteristics, as well as year fixed effects to account for time-variant national economic and other trends.

We also adjust for competing time-variant state policies that might affect low-income families: (1) the state’s Medicaid income eligibility limits for children aged 1–5 and (2) 6–18; (3) whether the state has an earned-income tax credit (EITC); (4) the state’s EITC as a percent of the federal EITC, (5) whether the state’s EITC is refundable; and (6) the state’s maximum Temporary Assistance for Needy Families (TANF) benefits for a family of three. On the respondent level, the NSCH models are adjusted for each child’s age, sex, race/ethnicity, family structure, the highest level of educational attainment by any adult in the household, and family nativity. The YRBSS models have fewer available covariates and are adjusted for age-by-year (to account for generational differences in the longer study period), sex, race/ethnicity, and grade in school.

Of note, our main models include children of all income levels. This design is analogous to intention-to-treat, as a change in the minimum wage may affect any or all households in a state. Households earning near the minimum wage are mostly likely to see their take-home pay rise, but those earning above the minimum wage may experience spillover wage growth.24 Even so, we also estimate the associations for vulnerable sub-populations of children who are more likely to benefit: in the NSCH, (1) households earning less than 200% of the federal poverty level; (2) households whose adults have a high school education or less; (3) Black and Hispanic/Latino children; (4) first- or second-generation children; and (5) adolescents (age 13–17), many of whom work minimum wage jobs; and in the YRBSS, Black and Hispanic/Latino adolescents. To do so, we used interacted TWFE models, which interact the minimum wage variable with a dummy variable for the demographic group of interest. These analyses are all provided in the appendix.

We also examine the sensitivity of our results using models with (1) inflation-adjusted minimum wages (in 2020 dollars); (2) wages lagged by 1 year, in case gains in children’s mental health take time to manifest; (3) estimations by logistic regression, which provide the odds ratio for each outcome given a $1 increase in the minimum wage; and (4) the average minimum wage to which a child is exposed throughout their entire life. All are provided in the appendix.

Second, we use event studies to estimate the causal effect of raising the minimum wage on adolescents’ mental health. For these models, we use the period from 2011–2019 and code 10 states that raised their minimum wage above the federal minimum as the treatment group, and the 21 states that remained at the federal minimum as the control group. Then, we test how raising the minimum wage affects the YRBSS outcomes. Given the limited states and study period, the event studies are less generalizable than the TWFE models. However, since TWFE models can be biased when policies are implemented at different times, event studies allow us to identify an unbiased, causal effect.25–27 A full description of the event studies is provided in the appendix.

All analyses use the NSCH or YRBSS weights to produce state-representative estimates, and all standard errors are clustered by state since the treatment is assigned at that level. Estimates using the survey’s nested clustered errors are provided in the appendix. We use the “lfe” package (v. 2.8) in R to estimate our models. This study did not require institutional review board approval as it used public, de-identified data. All replication materials are available at XXXXXXX.

**Results**

***National Survey of Children’s Health***

Between 2016 and 2020, 141,427 children aged 3–17 were surveyed by the National Survey of Children’s Health (NSCH) and included in our analyses. Their demographic and socioeconomic characteristics are presented in **Table 1**. In cross-sectional analyses, a weighted 3% of children had depression, 8% had anxiety, 9% had ADD/ADHD, 7% had behavioral problems, and 8% had chronic digestive issues. In the past year, 4% had not received necessary medical care of any kind, and 1% had not received necessary mental health services. Meanwhile, 10% had missed 7 or more days of school, and 22% had a job or some form of employment in the past year.

However, there were deep inequities in children’s mental health by household income. Children living in poverty had a rate of depression that was 3 percentage points (pp) higher than that of children living above 400% FPL, after adjusting for age, sex, race/ethnicity, family structure, the highest education of any adult in the household, nativity, state, and year (**Figure AX**). The inequities were similarly stark for all outcomes. Meanwhile, children in poverty had less access to economic opportunities, being less likely to have jobs than wealthier children.

Despite economic inequities, there was little evidence that rising minimum wages between 2016 and 2020 were associated with improvements in children’s mental health. During this period, the effective minimum wages ranged from $7.25 to $14 across states and Washington, D.C., with many states aggressively raising their wages (**Figure 1**). Even so, for all outcomes except absenteeism, TWFE models allowed us to rule out an improvement of 1 pp or less per $1 increase in the minimum wage. For absenteeism, we could rule out an improvement greater than 1.4 pp.

Similarly, there was minimal evidence of an association when we examined several vulnerable sub-populations, including children in households living under 200% FPL, households whose adults have a high school education or less; Black and Hispanic/Latino children; first- or second-generation children; and adolescents (aged 13–17) (see appendix). Nor was there evidence of an association with several alternative specifications (also provided in the appendix).

***Youth Risk Behavior Surveillance System (YRBSS)***

Given that the NSCH is limited to parent- or guardian-reported outcomes over a narrow range of years, we turned to the Youth Risk Behavior Surveillance System (YRBSS). Adolescents have directly reported symptoms and risk behaviors to the YRBSS for many decades. Between 2001 and 2019, 1,246,623 adolescents were surveyed and included in our analyses (**Table 1**). Their demographic characteristics are presented in **Table 1**. In cross-sectional analyses, a weighted 29% reported being sad or hopeless, 16% considered suicide, 9% attempted suicide, 35% had recently used alcohol, 20% had recently used marijuana, and 27% had been in a physical fight.

Between 2001 and 2019, the effective minimum wage ranged from $5.15 to $14 across states and D.C., and the federal minimum wage rose from $5.15 to $7.25 between 2008 and 2010. Even so, there was little evidence that rising minimum wages during this period were associated with improvements in adolescents’ mental health (**Figure 3**). For all 6 outcomes, TWFE models ruled out an improvement of 1 pp or less per $1 increase in the minimum wage. Similarly, there was minimal evidence of improving mental health for Black and Hispanic/Latino children, specifically, nor in models that tested several alternative specifications (see appendix).

Lastly, we used difference-in-differences models to evaluate the causal effect of raising the minimum wage on adolescents’ mental health since the last raise in the federal minimum wage, i.e. 2011 to 2019. For all 6 outcomes, we saw little evidence of a causal improvement, even when we evaluated the effects up to 5 years later, and when the mean treated child was exposed to a wage increase of $3.63 over control children. These models are described in the appendix.

**Discussion**

In this national study, we find little to no evidence that minimum wage increases over the past two decades have improved the mental health of children and adolescents in the U.S. We rule out meaningfully large effects using two national surveys, 15 outcomes capturing multiple facets of mental well-being, and both descriptive and causal approaches. We also fail to find evidence of benefit for several vulnerable populations, including lower-income and minoritized children.

Existing work on the minimum wage and mental health has found mixed results but focused exclusively on adults.28 A longitudinal study on minimum wages in the United Kingdom from 1994 to 2001 found substantial improvements in the mental health of lower-wage workers, relative to higher-wage ones.29 However, a subsequent study suggested that any improvements were short-lived.30 In the U.S., a repeated cross-sectional study on the minimum wage from 1993 to 2014 identified improvements in the mental health of less-educated women but not men.31 Another study in the U.S. identified null effects for less-educated adults.32 Despite mixed evidence that rising minimum wages improve the mental health of vulnerable adults, our study suggests that similar benefits have not accrued to children and adolescents in the U.S. in recent decades.

Our results also contrast with mixed but generally positive evidence for the effect of rising minimum wages on children’s physical health. Increases in the minimum wage have been associated with improvements in birth weights,13 infant mortality,13,14 school absenteeism,15 and indexes of children’s overall health.15 Mixed results have been identified for the self-reported general health of working teens, with only some demographic groups seeing improvements,17 and null results with various outcomes for the children of immigrants.16 However, all these studies predate econometric advancements that have identified biases in TWFE models.25–27 As such, it may be necessary to update studies on the minimum wage and children’s physical health with newer causal approaches. Our study uses both descriptive and causal approaches to identify its null results.

Our study has several limitations. First, it is based on survey data, which is vulnerable to sampling, response, and weighting biases. That said, we use two surveys with different sampling schemes, and our outcomes include both parent- or guardian and child-reported outcomes. Second, XXXXX

While the minimum wage might improve the mental health of children and adolescents to a smaller degree than we can rule out, it is unlikely that minimum wage increases alone would be sufficient to move the needle.

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**Table 1. Characteristics of children in the National Survey of Children’s Health.**

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|  | | **Unweighted**  N=141,427 | | | **Wt.** | |
| **National Survey of Children’s Health (2016–2020)** | |  | |  |  | |
| **Child’s age**  Mean (SD) | | 11.7 (4.4) | |  | 11.1 (4.3) | |
| **Child’s sex**  Male  Female | | 72,965  68,462 | | 52%  48% | 51%  49% | |
| **Child’s race/ethnicity**  White, non-Hispanic/Latino  Black, non-Hispanic/Latino  Hispanic/Latino  American Indian or Alaska Native  Asian, Native Hawaiian, or Pacific Islander  Other or mixed race | | 98,521  8,233  16,601  754  7,823  9,495 | | 70%  6%  12%  1%  6%  7% | 52%  12%  25%  <1%  5%  5% | |
| **Family structure**  Two parents, married  Two parents, not married  Single parent  Another family structure | | 104,553  8,888  27,664  322 | | 74%  6%  20%  <1% | 69%  8%  23%  <1% | |
| **Highest education of any adult in household**  Less than high school  High school (including vocational or similar)  Some college or associate degree  College degree or higher | | 3,144  17,225  32,379  88,679 | | 2%  12%  23%  63% | 9%  19%  22%  51% | |
| **Household nativity**  First-generation household  Second-generation household  Third-generation household or higher | | 2,742  22,770  115,915 | | 2%  16%  82% | 3%  25%  72% | |
| **Federal poverty level of household**  Less than 100%  100% to 199%  200% to 299%  300% to 399%  400% or greater | | 12,976  22,763  25,217  23,606  56,865 | | 9%  16%  18%  17%  40% | 17%  22%  18%  14%  30% | |
| **Youth Risk Behavior Surveillance System (2001–2019)** | |  | |  |  | |
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**Notes:** Based on author’s analysis of the National Survey of Children’s Health, 2016–2020.



**Figure 1. Effective minimum wages for each state from 2001 to 2020.**

**Notes:** We show the higher of a state’s minimum wage or the federal minimum wage, not adjusted for inflation, based on data from the Bureau of Labor Statistics. The range is $5.15 to $14.