When Parents Can Spare Time: Paid Sick Leave and Child Mental Healt[*]

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Abstract

Children's mental health challenges have risen sharply in the United States, yet structural barriers such as parental work constraints continue to limit access to timely care. This paper provides new causal evidence that Paid Sick Leave (PSL) mandates improve children's and adolescents' mental health. Following the adoption of PSL laws, the likelihood that a child receives any mental health care increases by 1.2 percentage points (a 10% rise relative to the baseline mean), while parent-reported depression diagnoses increase by 0.4 percentage points (7%). Complementary evidence shows that PSL mandates reduce youth depressive symptoms by 1.6 percentage points (5.3%) and suicidal ideation by 1.1–1.4 percentage points (7–10%). Mechanism analyses suggest that these improvements operate primarily through enhanced parental time flexibility. Overall, the findings highlight the broader public health benefits of labor protections that enable working parents to support their children's mental health.

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1 Introduction

Children and adolescents in the United States face a growing mental health crisis, with rising rates of depression, anxiety, and suicidality over the past decade (Centers for Disease Control and Prevention, 2024; Xiang et al., 2024; Warnick and Kolade, 2024). Unmet mental health needs among youth remain widespread, particularly for conditions such as depression and behavioral disorders, which are often underdiagnosed and untreated until symptoms escalate (Lu, 2019; The Pew Charitable Trusts, 2024). These gaps in care have long-term consequences for educational attainment, employment, and health over the life course (Bubonya et al., 2017; Kondirolli and Sunder, 2022; Frijters et al., 2014; Bryan et al., 2022; Fletcher, 2013; Currie, 2024). One frequently overlooked structural barrier to timely detection and treatment is *time constraints faced by parents*. Mental health appointments, counseling sessions, and follow-ups typically occur during standard working hours, making access difficult for working families without flexible or protected leave. Limited time flexibility can delay early intervention, reduce treatment adherence, and exacerbate the severity of mental health conditions among children (Mitchell and Selmes, 2007; Hansen et al., 2021).

Labor market policies that expand parents' ability to take time off for caregiving have the potential to alleviate these constraints. Among such policies, *paid sick leave (PSL)* mandates have emerged as a key instrument to balance work and family responsibilities. PSL laws allow workers to take protected, paid time off for personal or family health needs without risking income loss or job security (Eisenberg et al., 2025; Seixas and Macinko, 2020; Callison et al., 2025). By increasing the availability of short-term, protected time away from work, PSL mandates may facilitate earlier health-seeking behavior, improve continuity of care, and strengthen family well-being. Prior studies suggest PSL mandates increase parental childcare time and improve family stability (Deza et al., 2025; Maclean and Pabilonia, 2025; Guo and Peng, 2025), yet their implications for children's health—particularly mental health—remain largely unexplored.

Unlike most high-income countries, the United States lacks a federal PSL policy, leaving access to this benefit to state and local governments or voluntary employer provision (Pichler and Ziebarth, 2024). As of 2024, 18 states and the District of Columbia have enacted PSL mandates, and numerous localities have adopted similar ordinances (Mitchell, 2024). These laws typically guarantee 5–7 paid days per year and, crucially, allow employees to use this time for family care—such as taking a child to medical appointments or staying home when a child is ill. This feature makes PSL an especially relevant policy for examining child health spillovers. The staggered timing of state and local adoptions provides quasi-experimental variation that can be exploited using a difference-in-differences (DiD) and event-study framework. Beyond the U.S., international evidence links PSL to higher healthcare utilization and improved health outcomes (Pichler and Ziebarth, 2019). However, in the U.S., access remains highly unequal: low-wage, part-time, and service-sector workers are least likely to have PSL voluntarily provided (Bureau of Labor Statistics, 2024). Given that these groups disproportionately face barriers to child mental health care, PSL mandates may generate the largest benefits for disadvantaged families.

This paper provides the first causal evidence on the relationship between state PSL mandates and children's mental health outcomes. We link the timing and location of PSL adoption to child-level survey data from the National Survey of Children's Health (NSCH)

and the Youth Risk Behavior Surveillance System (YRBSS) to assess impacts on (1) use of any mental health services, (2) unmet mental health care need, (3) parent-reported depression diagnoses, and (4) self-reported depressive and suicidal symptoms. Our empirical approach employs a difference-in-differences design with state and year fixed effects and clustered standard errors at the state level, supplemented by event-study estimates to test for pre-trends and dynamic effects.

Our findings indicate that paid sick leave (PSL) mandates significantly improve children's access to mental health care and contribute to measurable reductions in psychological distress. Using the National Survey of Children's Health (NSCH), we estimate that PSL mandates increase the probability that a child received any mental health care in the past year by approximately 1.2 percentage points—a 10 percent increase relative to the pre-policy mean of 12 percent. We also find a 0.4 percentage-point rise in parent-reported depression diagnoses (a 7 percent increase), suggesting improved detection and engagement with care rather than worsening underlying conditions. Complementary analysis of adolescent data from the Youth Risk Behavior Surveillance System (YRBSS) reveals consistent downstream benefits: the prevalence of self-reported depressive symptoms declines by 1.6 percentage points, while passive and active suicidal ideation decrease by 1.1 and 1.4 percentage points, respectively. These effects correspond to 5–10 percent relative reductions from pre-policy baselines and are statistically significant at conventional levels. Together, these findings provide robust evidence that PSL mandates alleviate time-related barriers to care, enabling earlier intervention and improved mental well-being among children and adolescents.

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

2   Institutional Background

Paid sick leave (PSL) mandates have become an important feature of U.S. labor and health policy over the past two decades. The first ordinance was enacted in San Francisco in 2007, and since then, adoption has expanded across multiple cities and states, creating a patchwork of laws that vary substantially in scope and generosity (Ober, 2006; Gilliam and Ben-Ishai, 2012). As of 2024, eighteen states and the District of Columbia have statewide PSL mandates, and more than forty localities enforce their own ordinances. This staggered and decentralized expansion produces meaningful temporal and geographic variation that can be leveraged for quasi-experimental analysis.

Although PSL statutes differ across jurisdictions, most share several key characteristics. Workers typically accrue one hour of paid leave for every 30–40 hours worked, capped between 24 and 56 hours annually—equivalent to roughly 3–7 paid days per year (U.S. Department of Labor, 2023; Paycor, Inc., 2025). Employees may use this time for their own illness or preventive care, to care for a family member, or for school- and childcare-related health appointments. All state-level laws include "safe time" provisions that allow workers to address domestic violence, sexual assault, or stalking. Mandates also vary in employer size thresholds, accrual rates, and enforcement mechanisms; some states exempt small firms or preempt local ordinances altogether. These differences generate heterogeneity in policy intensity that may influence the magnitude of observed effects.

Despite such legislative progress, many U.S. families still face persistent barriers to timely mental health care for children and adolescents. National data indicate that only about half of children with a diagnosable mental, behavioral, or developmental disorder receive any treatment in a given year (Leeb et al., 2024; Centers for Disease Control and Prevention, 2024). Access challenges are especially pronounced among low-income households, racial and ethnic minority families, and single-parent homes. Parental work obligations remain a major impediment: mental health appointments and counseling sessions are often scheduled during standard work hours, forcing caregivers to choose between job security and their child's care. Families without paid leave report forgoing appointments or delaying treatment due to financial and scheduling constraints (Asfaw and Colopy, 2017). These barriers contribute to delayed diagnoses, poorer adherence to therapy, and higher symptom severity among children. By allowing parents protected, compensated time off to attend to their children's needs, PSL policies can directly reduce these logistical obstacles and promote earlier detection and continuous treatment engagement.

The United States remains an international outlier in its lack of a federal PSL policy (Pichler and Ziebarth, 2019). While most high-income countries guarantee paid sick or caregiving leave nationally, U.S. access depends on state and local statutes or voluntary employer provision. Coverage disparities are substantial: roughly 95% of public-sector workers have access to PSL, compared to only 61% of private-sector workers and fewer than 45% of part-time employees (U.S. Bureau of Labor Statistics, 2024). Low-wage and service-sector workers—groups least likely to receive employer-provided PSL—are also those most at risk of child health and developmental disadvantages. Consequently, state and local mandates disproportionately expand coverage among the very populations facing the steepest barriers to child mental health care.

The diffusion of PSL mandates across states reflects a combination of political, economic, and institutional factors. Adoption has been more common in states with stronger labor unions, higher female labor force participation, and Democratic-leaning legislatures (Callison and Pesko, 2022). By contrast, states with business-friendly policy environments or explicit preemption laws have been slower to adopt. These underlying determinants raise potential concerns about confounding from correlated state characteristics, which we address in our empirical analysis by including state and year fixed effects, adjusting for contemporaneous policy changes, and testing for pre-trends in event-study models.

PSL laws also interact with other state-level programs that shape children's access to behavioral health care. Medicaid expansions under the Affordable Care Act, for example, have improved financial access but do not directly alleviate parents' time constraints. Similarly,

school-based mental health programs increase availability but depend on parental consent and follow-up. PSL complements these efforts by addressing a distinct and pervasive barrier—time flexibility—that determines whether children actually receive available care.

Taken together, these institutional features underscore the relevance of PSL mandates as a potential upstream determinant of children's mental health. The decentralized rollout of mandates, combined with variation in policy design and enforcement, provides a rich setting for causal evaluation. In the next section, we build on this context to outline the conceptual mechanisms linking PSL to children's mental health outcomes and describe our empirical strategy that exploits the staggered implementation of PSL mandates across states and years.

3 Data

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

(Table 1 here)

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

For this study, we pool data from the 2016–2022 survey waves, the period following the NSCH redesign that introduced consistent sampling methodology, weighting, and question wording across years. We use the publicly available state identifiers in the NSCH to merge child-level outcomes with a state–year panel of paid sick leave (PSL) mandates and other policy variables. All analyses apply the appropriate sampling weights and replicate weights

provided by the Census Bureau to ensure national representativeness and to account for complex survey design.

The NSCH offers a unique advantage for evaluating the effects of PSL mandates on children's mental health. It includes multiple indicators of mental health care utilization and diagnostic outcomes, as well as measures of family functioning and parental well-being. Key outcome variables capture whether the child received any mental or behavioral health services in the past 12 months, whether the child needed but did not receive mental health care (unmet need), and whether the child currently takes medication for emotional or behavioral conditions. Additional outcomes include parent-reported diagnoses of depression, anxiety, and attention-deficit/hyperactivity disorder (ADHD). These indicators allow for a comprehensive assessment of both access to care and underlying mental health conditions.

Table 2 presents summary statistics for the analytic sample from the 2016–2022 NSCH, pooled across all survey years. The table reports weighted means of key outcome variables, demographic characteristics, and state-level contextual factors for the full sample and separately for states with and without paid sick leave (PSL) mandates in effect during the survey year. Approximately 13 percent of children received any mental health care in the past 12 months, while 1 percent had an unmet need for care. Around 6 percent and 12 percent of children were reported to have depression and anxiety diagnoses, respectively. Families in PSL mandate states are, on average, slightly more educated and have higher income-to-poverty ratios. State-level indicators show that PSL mandate states tend to have higher provider availability, higher minimum wages, and greater Medicaid eligibility thresholds for both parents and non-parents. These descriptive patterns provide preliminary evidence consistent with improved access to care and stronger social safety nets in PSL mandate states.

(Table 2 here)

The data on self-reported depression and suicidal ideation among youth are taken from the Youth Risk Behavior Surveillance System (YRBSS), a survey conducted by the U.S. Centers for Disease Control and Prevention (CDC) every alternate year since 1991. The YRBSS High School Survey is administered to high school students, typically aged 14 to 18 years, and serves as a nationally representative sample for monitoring Youth health and risk behaviors. We used three distinct measures of mental health derived from YRBSS questions. The first is the self-reported depression which is captured by the youth response to the question: "During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?". The second is Passive Suicidal Ideation which measures the binary response if the individual seriously consider attempting suicide in the last twelve months. The third measure is the active suicidal ideation which is measure by the response of YRBSS question "During the past 12 months, did you make a plan about how you would attempt suicide?".

These three measures were selected because the phrasing of these specific questions has remained consistent across all survey waves dating back to 1999. This consistency is critical for the analysis, as it pre-dates the implementation of the first state-level Paid Sick Leave (PSL) mandate in Connecticut in 2012. Although the additional questions were introduced regarding mental health in recent YRBS survey, we limit our analysis to these three variables, as they are the only ones with pre-intervention time period. In addition to these outcome

variables, we incorporate individual-level covariates from the survey, specifically race, age, and gender. We construct a binary indicator for age, comparing those less than 16 years to those 16 years and older, to proxy for potential labor market eligibility or exposure. These covariates also serve as sub-groups for analyzing heterogeneous treatment effects.

4 Empirical Strategy

To estimate the causal effect of state-level Paid Sick Leave (PSL) mandates on youth mental health outcomes, we exploit the staggered adoption of the mandates across US states using difference-in-difference with two-way fixed effects (TWFE). The treatment group dynamically consists of states who adopted the PSL mandate after the mandate is in effect whereas the control group includes states that have not yet or never adopted the mandate.

$$y_{ist} = \alpha + \beta \times PSL_{st} + \sum_m \gamma_m X_{st} + \sum_n \omega_n I_{ist} + \delta_s + \lambda_t + \epsilon_{ist} \tag{I}$$

In this specification, y_{ist} represents the respective health outcomes for individual i in state s at time t. The policy variable, PSL_{st}, is a binary indicator equal to one if state s has implemented a paid sick leave mandate in year t, and zero otherwise. The coefficient of interest, β, captures the average treatment effect of the PSL mandate on the outcome. The model includes state-level covariates (X_{st}) to control for state-specific, time-varying confounders, and individual-level covariates (I_{ist}) such as gender, age, and race. Identification relies critically on the inclusion of state fixed effects (δ_s), which absorb all unobserved time-invariant differences across states, and time (year) fixed effects (λ_t), which account for common temporal shocks affecting all states simultaneously. Finally, ϵ_{ist} is the idiosyncratic error term, and all standard errors are clustered at the state level to allow for arbitrary serial correlation within states over time. In addition to that, we also estimated equation 1 for the relevant subgroups (gender, age, race etc) to explore which subgroups are driving the effects.

Furthermore, the validity of the TWFE Difference-in-Differences estimator rests on the parallel trends assumption: that in the absence of the PSL mandate, outcomes in the treatment states would have followed the same trend as outcomes in the control states. To formally test this and explore the dynamics of the policy's effect over time, we employed an event-study methodology. This involves replacing the single PSL_{st} indicator in Equation (I) with a series of lead and lag indicators centered on the policy implementation date. The dynamic model is specified as:

$$y_{ist} = \alpha + \sum_{k \neq -1} \beta_k \times D_{s,t}^k + \sum_m \gamma_m X_{st} + \sum_n \omega_n I_{nist} + \delta_s + \lambda_t + \epsilon_{ist} \tag{II}$$

Here, $D_{s,t}^k$ is a dummy variable indicating that state s is k years from the adoption of the PSL mandate in year t. The average outcome in two periods immediately preceding the policy implementation ($k = -1, -2$) is used as the reference point.

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5 Results

Table 3 presents the estimated effects of Paid Sick Leave (PSL) mandates on children's mental health care utilization and diagnostic outcomes, estimated using a two-way fixed-effects Difference-in-Differences (DiD) specification that accounts for staggered policy adoption across states. The estimated coefficients indicate that PSL mandates substantially improve children's access to mental health services. Following adoption of a PSL mandate, the probability that a child received any mental or behavioral health care during the past 12 months increases by approximately 1.23 percentage points ($p < 0.01$). Relative to the pre-policy baseline mean of 12.3 percent, this translates into a 10 percent increase in mental health service utilization. We also find a 0.43 percentage-point increase ($p < 0.10$) in the likelihood of a parent-reported depression diagnosis, corresponding to a 7 percent increase relative to the pre-treatment mean of 5.8 percent. These estimates are consistent with the hypothesis that greater parental time flexibility enables earlier detection and evaluation of emotional or behavioral health concerns.

(Table 3 here)

The estimated effects on medication use for emotional or behavioral conditions and anxiety diagnoses are positive but statistically imprecise, suggesting that PSL may facilitate entry into care rather than directly influencing pharmacologic treatment patterns. Likewise, coefficients on ADHD diagnosis are small and statistically insignificant, consistent with the notion that PSL affects access pathways for episodic mental health services rather than chronic, school-mediated diagnoses. Taken together, the results point toward a mechanism of enhanced care access and earlier identification rather than changes in underlying prevalence.

Similarly, table 4 presents the Difference-in-Differences (DiD) estimates with two-way fixed effects (TWFE) model specified in Equation (I). The model incorporates individual-level covariates (age, race, and gender) and is weighted using the sample weights provided by the Youth Risk Behavior Surveillance System (YRBSS). The estimated coefficient for the Paid Sick Leave (PSL) mandate is negative and statistically significant across all three adverse mental health outcomes, suggesting a conducive effect of the policy. We estimated a reduction in the reported rate of Depression of 1.62 percentage points, which is statistically significant at the 10% level. Relative to the pre-treatment baseline mean of 30.3%, this estimated coefficient corresponds to a 5.3% decrease in the probability of reported depression.

In addition to that, we observe statistically significant negative treatment effects on both measures of suicidal ideation. The probability of reporting Passive Suicidal Ideation decreases by 1.15 percentage points, which is significant at the 10% level ($p < 0.10$). Given the baseline mean of 16.5%, this represents an approximate 7%reduction. The largest magnitude is estimated for Active Suicidal Ideation, with an estimated decrease of 1.38 percentage points. This effect is highly significant ($p < 0.01$) and constitutes a substantial 10% reduction relative to the baseline mean of 13.5%. The robust and consistent negative estimates across all three outcomes demonstrate that the paid sick leave mandate significantly improves youth reported mental health, representing a quantifiable positive policy externality in adopting states.

(Table 4 here)

The validity of the DiD design requires the parallel trends assumption. We ideally want the outcomes without the PSL mandate in treatment and control states to follow identical trends. To formally test this assumption and assess the dynamic effects, we estimate a standard event-study model using Equation II. Figure 1 displays the event-study estimates of dynamic treatment effects and provides visual support for the identifying assumptions. The coefficients for the pre-treatment years are close to zero and statistically indistinguishable from zero, suggesting the absence of differential pre-trends between PSL and non-PSL states prior to mandate adoption. Beginning in the first year after implementation, we observe positive and statistically significant increases in children's receipt of mental health care, which persist and slightly grow over the following years. The path of coefficients for depression diagnoses follows a similar temporal pattern, with statistically significant effects emerging two to three years post-implementation, consistent with a lag between increased service access and clinical detection or diagnosis. The magnitude and persistence of these post-policy effects provide compelling evidence that PSL mandates generate sustained improvements in children's mental health care engagement.

(Figure 1 here)

Similarly, Figure 2 displays the leads and lag coefficients for the youth self reported mental health outcomes. In this estimation, the coefficients are normalized relative to the average of the two immediate pre-treatment periods ($t = -1, -2$). The pre-treatment coefficients (for periods $t < 0$) are small in magnitude and generally statistically insignificant across all three outcomes. Examining the post-treatment coefficients (lags) for $t \geq 0$, we find that the negative policy effect emerges clearly one period after the mandate and the point estimates generally persists after that, although with varying precision. Importantly, the statistical insignificance of the pre-treatment coefficients supports the validity of the parallel trends assumption for our identification strategy. Lastly, the general negative point estimates with some degree of precision supports the presence of negative treatment effects.

(Figure 2 here)

The aggregate estimates of health measures may mask significant heterogeneity across demographic subgroups. To examine potential heterogeneity in these effects, Table ?? reports subgroup analyses by age, sex, parental education, and race/ethnicity. The results reveal that the largest and most precisely estimated effects occur among adolescents aged 12–17 years, for whom PSL mandates increase the likelihood of receiving any mental health care by 1.94 percentage points ($p < 0.01$). The effect is also statistically significant and of comparable magnitude among female children (+1.80 p.p., $p < 0.01$), who tend to have higher baseline rates of reported emotional distress and care utilization. For children whose parents hold a college degree, the estimated effect is +1.84 p.p. ($p < 0.01$), indicating that information or resource advantages may amplify responsiveness to greater time flexibility. Effects for younger children and those from households without a college-educated parent are smaller in magnitude and statistically insignificant. This heterogeneity pattern aligns with a time-constraint mechanism: working parents with limited job flexibility are more likely to benefit

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from PSL when coordinating appointments for older children or those requiring specialized care.

(Table 5 here)

Similarly, we also explore the treatment effect heterogeneity along three dimensions: gender, age, and race, by estimating Equation (1) separately for each subgroup. The full set of subgroup estimates is presented in Table 6. For females, the PSL mandate is associated with a statistically significant 2.03 percentage point (p.p.) reduction in self-reported depression ($p < 0.10$). Relative to the female baseline self-reported depression of 38.7%, this constitutes a 5.25% reduction. The effect for males, while statistically insignificant, is similar at 1.2 p.p. (baseline mean 22.2%), corresponding to a 5.4% relative reduction. Similarly, the point estimates of self-reported passive suicidal ideation show reductions of 1.36 p.p. for females (baseline mean 21%), representing a 6.5% relative reduction, and 0.91 p.p. for males (baseline mean 12%), representing a 7.4% relative reduction. However, these effects are statistically insignificant. Further, we observed negative effects for self-reported active suicidal ideation as well. For females, the reduction is 1.29 p.p. (baseline mean 16.5%), which is statistically significant ($p < 0.05$) and represents a 7.82% relative reduction. For males, the reduction is 1.44 p.p. (baseline mean 10.5%), significant at the 90 percent level ($p < 0.10$), representing a 13.71% relative reduction. The consistently negative signs and the narrow range of relative magnitudes observed across genders suggest that the insignificant findings for the male subgroup might be attributable to limitations in statistical power (Type II error) rather than evidence of a true absence of effect.

We further explore differential impacts by dividing the sample into two age groups: youth below 16 and youth aged 16 or older. The estimated effects are concentrated in the older cohort (age ≥ 16). For this older group, the PSL mandate is associated with a statistically significant 1.79 percentage point (p.p.) reduction in self-reported depression ($p < 0.05$). Relative to their baseline prevalence of 30.9%, this represents a 5.79% decrease. The effect on self-reported passive suicidal ideation is also statistically significant for the older cohort, showing a 1.79 p.p. reduction ($p < 0.05$) from a baseline of 16.1% (a 11.12% relative decrease). Most strongly, the self-reported active suicidal ideation decreases by 1.81 p.p. ($p < 0.01$) from a 13.0% baseline, a 13.92% relative reduction. In contrast, the point estimates for the younger cohort (age < 16) are consistently negative but statistically insignificant across all outcomes: depression (1.33 p.p. reduction from 29.3% baseline), passive suicidal ideation (0.929 p.p. reduction from 17.2% baseline), and active suicidal ideation (0.633 p.p. reduction from 14.3% baseline).

Finally, we explore the heterogeneity based on the race. The reported mental health benefits of the PSL mandate are largely driven by the Black youth subpopulation. For Black youth, the policy is associated with a highly significant 3.65 p.p. reduction in self-reported depression ($p < 0.01$), representing a substantial 12.46% decrease relative to their 29.3% baseline prevalence. Consistent and significant reductions are also found for passive suicidal ideation, which decreases by 1.69 p.p. ($p < 0.05$) from a 14.7% baseline (a 11.49% reduction), and active suicidal ideation, which decreases by 2.49 p.p. ($p < 0.01$) from a 12.7% baseline (a 19.61% reduction). While estimates for other racial groups are generally negative, the Hispanic subgroup also displays a strong, statistically significant reduction in active suicidal

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ideation of 3.87 p.p. ($p < 0.05$), equating to a staggering 25.97% relative reduction from their 14.9% baseline prevalence. This concentration of effects suggests that the benefits of PSL disproportionately accrue to Black and Hispanic youth.

(Table 6 here)

Some connecting lines to show we are writing the mechanism Table 7 explores potential pathways through which PSL mandates influence child and family well-being. We estimate effects on six potential mediators—insurance coverage, coverage gaps, problems obtaining care, parental mental health, family resilience, and parental aggravation. The results show no measurable impact of PSL mandates on health insurance status or parental aggravation, suggesting that financial protection and stress reduction are not the primary channels. However, we observe modest improvements in parental mental health and small reductions in reported difficulties obtaining mental health care, although these coefficients are imprecisely estimated and fall short of conventional significance thresholds. Collectively, the pattern of results supports the interpretation that PSL policies operate mainly by relaxing time-related barriers to care rather than altering financial or coverage constraints.

(Table 7 here)

Overall, the evidence from both the NSCH and YRBSS analyses indicates that Paid Sick Leave (PSL) mandates significantly improve children's and adolescents' mental health outcomes. The policies increase access to mental health care, raise detection of depressive disorders, and reduce self-reported depressive and suicidal symptoms among youth. These effects are most pronounced among adolescents, females, and minority groups, suggesting PSL helps narrow disparities in access to care. Mechanism analyses point to time flexibility—rather than changes in insurance or financial strain—as the primary pathway. Together, the findings highlight that labor protections designed for workers can yield meaningful public health benefits for families and children.

6   Discussion and Conclusion

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

The evidence from this study indicates that the effects of Paid Sick Leave (PSL) mandates operate primarily through improved time flexibility for working parents rather than changes in insurance or financial strain. By enabling caregivers to attend appointments and support children's mental health needs, PSL laws reduce time-related barriers to care. These findings align with prior work showing that PSL increases parental caregiving time and family stability, but they extend the literature by documenting downstream mental health benefits for children and adolescents.

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

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

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

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

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

In conclusion, our results highlight that Paid Sick Leave mandates, while designed as worker protections, deliver measurable mental health benefits for children and adolescents. By easing time constraints on working parents, these policies promote earlier care-seeking and emotional well-being, particularly among disadvantaged families. As the United States

confronts widening disparities in youth mental health, integrating labor-based policies like PSL into public health and family policy frameworks represents a promising and underutilized avenue for prevention.

References

Asfaw, A. and Colopy, M. (2017). Association between parental access to paid sick leave and children's access to and use of healthcare services. *American journal of industrial medicine*, 60(3):276–284.

Baker, M. and Milligan, K. (2008). Maternal employment, breastfeeding, and health: Evidence from maternity leave mandates. *Journal of health economics*, 27(4):871–887.

Bryan, M. L., Rice, N., Roberts, J., and Sechel, C. (2022). Mental health and employment: a bounding approach using panel data. *Oxford Bulletin of Economics and Statistics*, 84(5):1018–1051.

Bubonya, M., Cobb-Clark, D. A., and Wooden, M. (2017). Mental health and productivity at work: Does what you do matter? *Labour economics*, 46:150–165.

Bureau of Labor Statistics (2024). Employee benefits in the united states. U.S. Bureau of Labor Statistics Report.

Callison, K. and Pesko, M. F. (2022). The effect of paid sick leave mandates on coverage, work absences, and presenteeism. *Journal of Human Resources*, 57(4):1178–1208.

Callison, K., Pesko, M. F., Phillips, S., and Sosa, J. A. (2025). Health care utilization following the adoption of us paid sick leave mandates: a cohort study using health insurance claims data. *The Lancet Regional Health–Americas*, 49.

Centers for Disease Control and Prevention (2024). Data and statistics on children's mental health. https://www.cdc.gov/children-mental-health/data-research/index.html. Accessed: 2025-10-30.

Chen, J., Meyerhoefer, C. D., and Peng, L. (2020). The effects of paid sick leave on worker absenteeism and health care utilization. *Health Economics*, 29(9):1062–1070.

Currie, J. (2024). The economics of child mental health: Introducing the causes and consequences of child mental health special issue. *Journal of Human Resources*, 59(S):S1–S13.

Dahl, G. B., Løken, K. V., Mogstad, M., and Salvanes, K. V. (2016). What is the case for paid maternity leave? *Review of Economics and Statistics*, 98(4):655–670.

Deza, M., Maclean, J. C., and Ortega, A. (2025). Paid sick leave and child maltreatment. *NBER Working Paper No. 33758*. Revised October 2025.

Eisenberg, M., Ge, Y., Golberstein, E., and Maclean, J. C. (2025). Time for mental healthcare: Evidence from paid sick leave mandates. Technical report, National Bureau of Economic Research.

Fletcher, J. (2013). Adolescent depression and adult labor market outcomes. *Southern Economic Journal*, 80(1):26–49.

Frijters, P., Johnston, D. W., and Shields, M. A. (2014). The effect of mental health on employment: evidence from australian panel data. *Health economics*, 23(9):1058–1071.

Gilliam, A. L. and Ben-Ishai, L. (2012). First out of the gate: San francisco's sick days law. Technical report, Center for Law and Social Policy (CLASP), Washington, DC. Accessed October 2025.

Guo, X. and Peng, L. (2025). The effects of paid-sick-leave mandates on care provision. *Health Economics*.

Guo, Y. (2025). The effects of paid-sick-leave mandates on care provision. *Health Economics*. Forthcoming.

Hansen, A. S., Telléus, G. K., Mohr-Jensen, C., and Lauritsen, M. B. (2021). Parent-perceived barriers to accessing services for their child's mental health problems. *Child and Adolescent Psychiatry and Mental Health*, 15(1):4.

Kondirolli, F. and Sunder, N. (2022). Mental health effects of education. *Health economics*, 31:22–39.

Leeb, R. T., Danielson, M. L., Claussen, A. H., Robinson, L. R., Lebrun-Harris, L. A., Ghandour, R., Bitsko, R. H., Katz, S. M., Kaminski, J. W., and Brown, J. (2024). Trends in mental, behavioral, and developmental disorders among children and adolescents in the us, 2016–2021. *Preventing Chronic Disease*, 21:E96.

Lu, W. (2019). Adolescent depression: national trends, risk factors, and healthcare disparities. *American journal of health behavior*, 43(1):181–194.

Maclean, J. C. and Pabilonia, S. W. (2025). The effects of state paid sick leave mandates on parental childcare time. *NBER Working Paper No. 32710*. Revised April 2025.

Mitchell, A. J. and Selmes, T. (2007). Why don't patients attend their appointments? maintaining engagement with psychiatric services. *Advances in psychiatric treatment*, 13(6):423–434.

Mitchell, S. M. (2024). State paid sick leave laws. *Washington, DC: Women's Bureau, US Department of Labor*.

Ober, N. L. (2006). Employers' new headache: Sf's paid sick leave law. Littler Mendelson Insight. Accessed October 2025.

Paycor, Inc. (2025). Paid sick leave laws by state. `https://www.paycor.com/resource-center/articles/paid-sick-leave-laws-by-state/`. Accessed October 2025.

Pichler, S. and Ziebarth, N. R. (2017). Labor market effects of u.s. sick pay mandates. *Journal of Human Resources*, 52(2):1–36.

Pichler, S. and Ziebarth, N. R. (2019). Reprint of: The pros and cons of sick pay schemes: Testing for contagious presenteeism and noncontagious absenteeism behavior. *Journal of Public Economics*, 171:86–104.

Pichler, S. and Ziebarth, N. R. (2024). Sick leave and medical leave in the united states: a categorization and recent trends.

Seixas, B. V. and Macinko, J. (2020). Unavailability of paid sick leave among parents is a barrier for children's utilization of nonemergency health services: evidence from the national health interview survey. *The International Journal of Health Planning and Management*, 35(5):1083–1097.

The Pew Charitable Trusts (2024). Behavioral health needs are largely unmet across the u.s. `https://www.pew.org/en/research-and-analysis/data-visualizations/2024/behavioral-health-needs-are-largely-unmet-across-the-us`. Data visualization; accessed: 2025-10-30.

U.S. Bureau of Labor Statistics (2024). National compensation survey: Employee benefits in the united states, march 2024. Technical report, U.S. Department of Labor. Accessed October 2025.

U.S. Census Bureau (2023). National survey of children's health (nsch) data resource guide. Technical report, Health Resources and Services Administration, Maternal and Child Health Bureau, Rockville, MD. Accessed October 2025.

U.S. Department of Labor (2023). Paid sick leave for federal contractors: Frequently asked questions. `https://www.dol.gov/agencies/whd/government-contracts/sick-leave/faq`. Accessed October 2025.

Warnick, E. and Kolade, V. O. (2024). Mental health and suicide among adolescents in the united states in the wake of the covid-19 pandemic: a narrative review. *Journal of Public Health and Emergency*, 8.

Xiang, A. H., Martinez, M. P., Chow, T., Carter, S. A., Negriff, S., Velasquez, B., Spitzer, J., Zuberbuhler, J. C., Zucker, A., and Kumar, S. (2024). Depression and anxiety among us children and young adults. *JAMA network open*, 7(10):e2436906–e2436906.

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

(a) Received Any Mental Health Care

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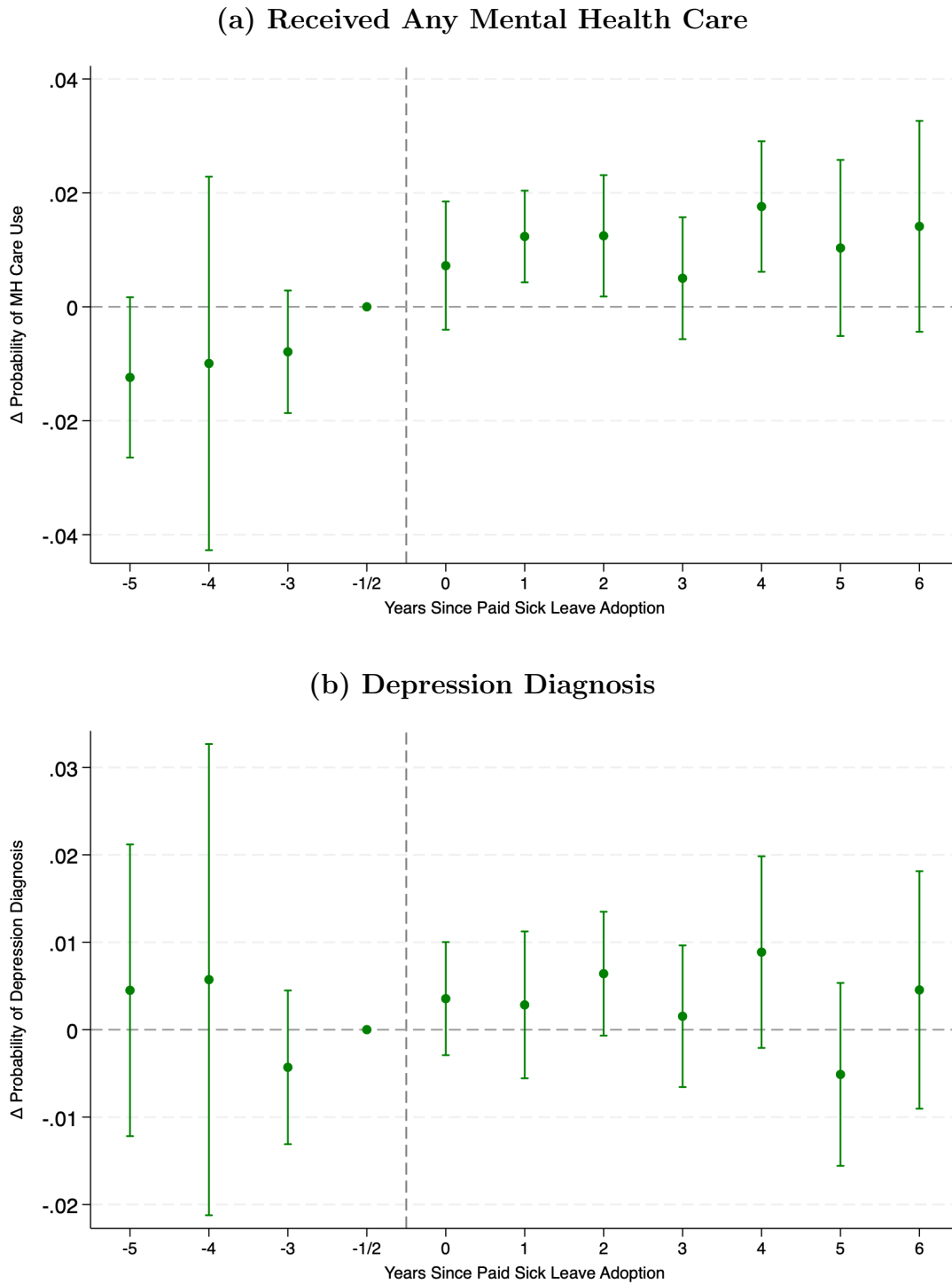
Notes: This figure presents event-study estimates of the effects of state and local paid sick leave (PSL) mandates on two key child mental health outcomes. Panel (a) plots coefficients for receipt of any mental health care, and Panel (b) plots coefficients for parent-reported depression diagnosis. Coefficients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

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

(a) Depression
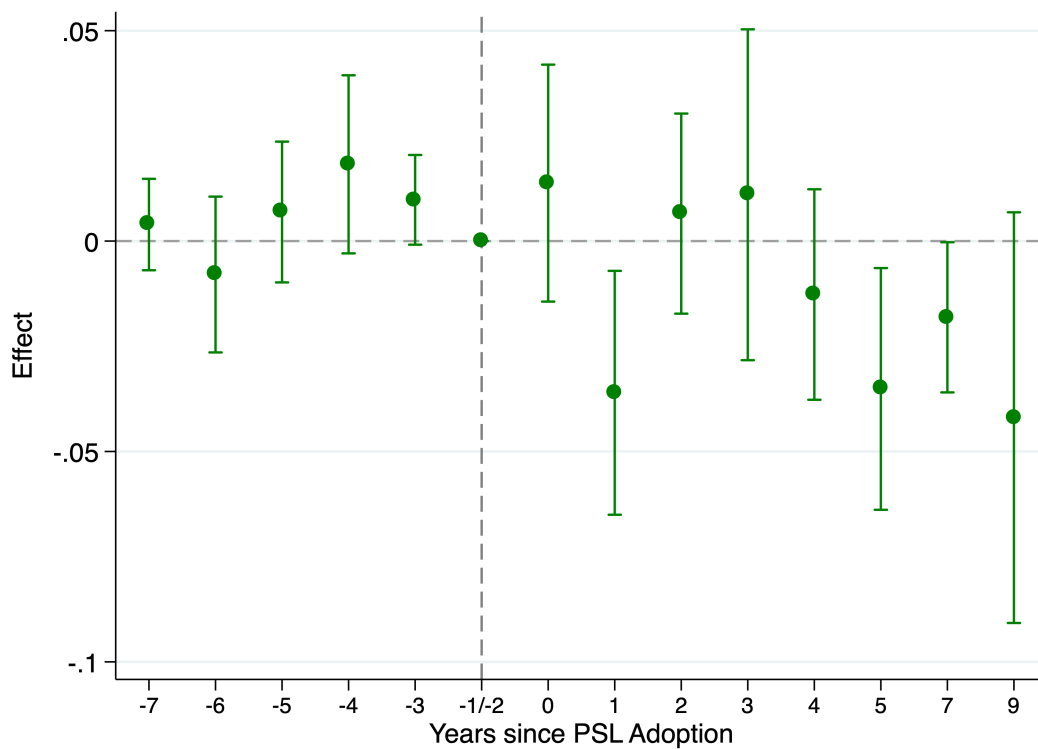
(b) Passive Suicidal Ideation
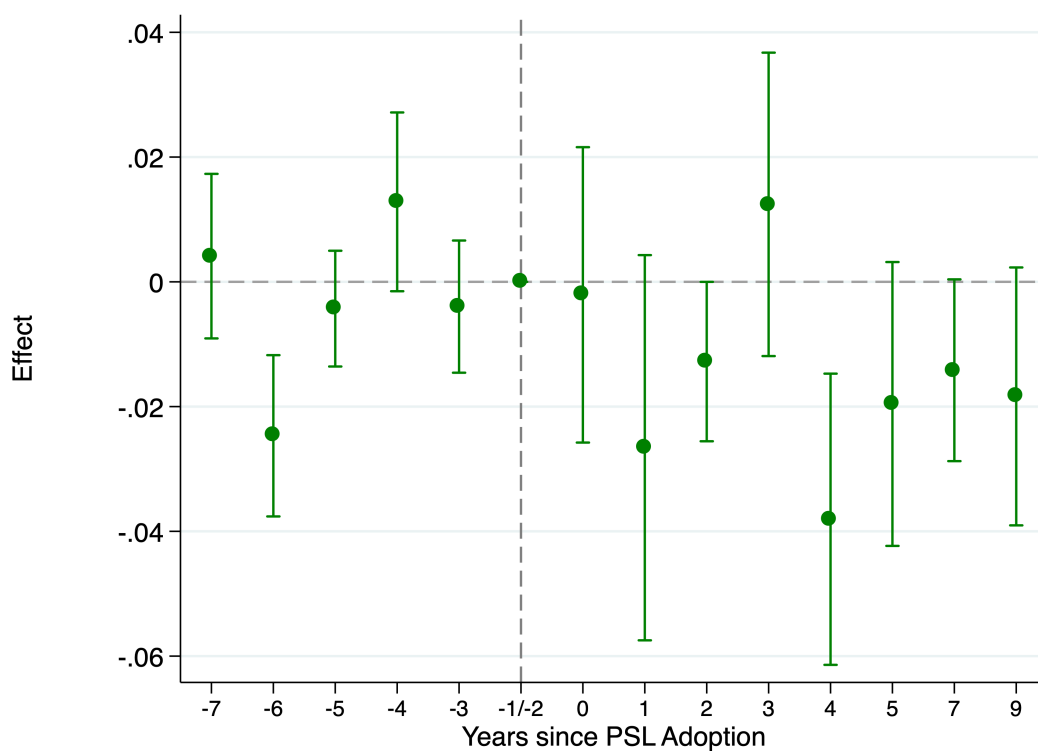
(c) Active Suicidal Ideation
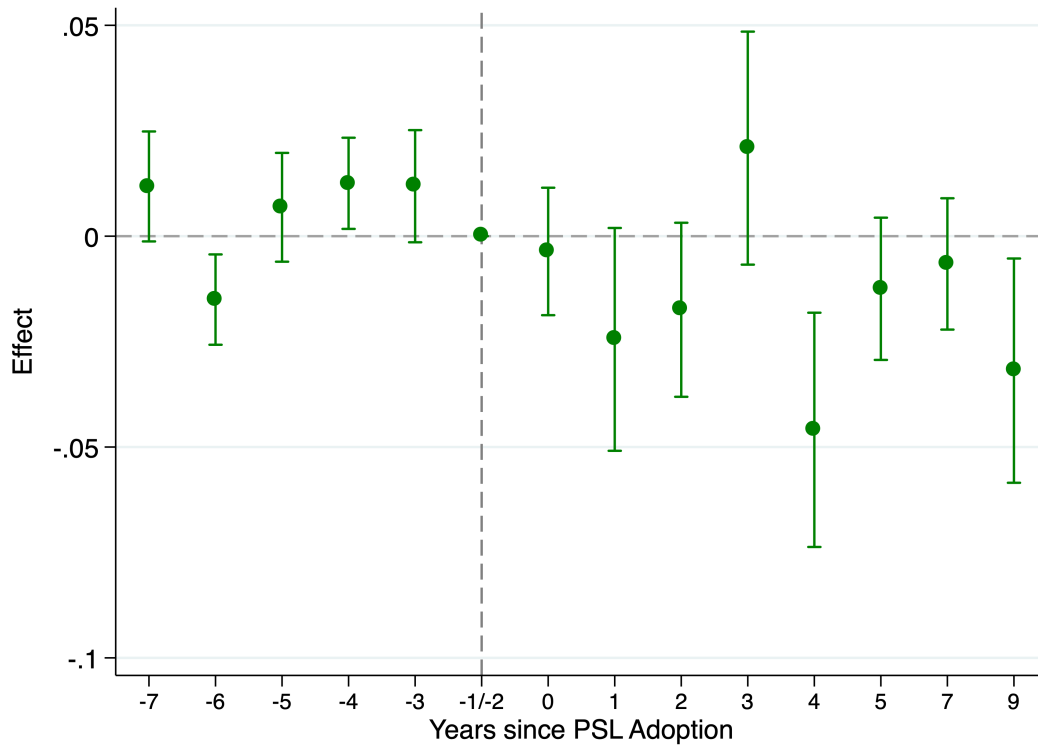
Notes: Figure plots dynamic treatment effects from event-study specifications for Self-Reported Depression, Active Suicidal Ideation, and Passive Suicidal Ideation from YRBSS. Coefficients are relative to the mean outcome in the two years before the mandate. Models include the same controls and fixed effects as described in Table 4.

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

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

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

Table 2: Descriptive Statistics (NSCH 2016–2022)

	Full Sample	Untreated States	Treated States
Outcomes			
Received Any Mental Health Care	0.127	0.124	0.137
Unmet Mental Health Need	0.013	0.012	0.015
Takes Medication for MH Issues	0.104	0.11	0.09
Depression Diagnosis	0.059	0.059	0.059
Anxiety Diagnosis	0.123	0.119	0.13
ADHD Diagnosis	0.113	0.117	0.102
Demographics			
Female (=1)	0.517	0.518	0.515
Child Age (Years)	9.046	9.036	9.072
Federal Poverty Level Ratio	288.077	282.486	301.556
Number of Adults in Household	2.164	2.148	2.202
Number of Children in Household	1.857	1.884	1.794
Parent Married	0.754	0.753	0.756
Parent Never Married	0.05	0.05	0.051
Parent Divorced	0.082	0.084	0.078
Parent Separated	0.018	0.017	0.019
Parent Unmarried, Partnered	0.052	0.051	0.053
Parent Widowed	0.015	0.016	0.013
Parental Education: College Degree or Higher	0.62	0.597	0.676
Race/Ethnicity: Black, non-Hispanic	0.063	0.065	0.057
Race/Ethnicity: Hispanic	0.13	0.109	0.178
Race/Ethnicity: Other/Multi-racial	0.08	0.079	0.081
Race/Ethnicity: White, non-Hispanic	0.673	0.701	0.606
Private Insurance	0.247	0.25	0.239
Public Insurance	0.709	0.705	0.721
Unspecified Insurance	0.016	0.015	0.018
Other Insurance	0.028	0.031	0.023
State Controls			
Share of White Population (State)	78.076	78.7	76.569
Share of Population Ages 20–64 (State)	58.04	57.394	59.599
COVID-19 Cumulative Case Rate	0.074	0.07	0.082
COVID-19 Cumulative Death Rate	0.001	0.001	0.001
Medicaid Eligibility: Non-Parents	0.994	0.814	1.426
Medicaid Eligibility: Parents	1.123	0.991	1.441
Community Health Centers per 100k	5.88	6.538	4.295
Primary Care Physicians per 10k	6.378	5.889	7.557
Government COVID Response Index	24.167	22.668	27.78
Housing Price Index	204.792	191.781	236.157
Log Per Capita Income	11.045	10.985	11.189
Minimum Wage (Average)	0.474	0.438	0.561

Notes: This table presents descriptive statistics for the analytic sample drawn from the 2016–2022 waves of the National Survey of Children's Health (NSCH). All estimates are weighted using the NSCH survey sampling weights to produce nationally representative averages of children aged 0–17 years. Variables capture measures of child mental health outcomes, demographic characteristics, and state-level contextual factors. Mental health outcomes include parent-reported indicators such as depression and anxiety diagnoses. Demographic variables describe household composition, parental education, marital status, and income-to-poverty ratios. State-level controls include measures of Medicaid eligibility thresholds, provider availability, minimum wage, income, and housing prices. Treated states are defined as those that had an active paid sick leave (PSL) mandate in effect during the survey year.

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

	Any MH Care	Unmet MH Need	Medication for MH Issues	Depression Diagnosis	Anxiety Diagnosis	ADHD Diagnosis
PSL_Mandate	0.0123***	-0.000840	0.00399	0.00428*	0.00519	0.00248
	(0.00377)	(0.00156)	(0.00357)	(0.00220)	(0.00483)	(0.00357)
Baseline Mean	0.123	0.012	0.108	0.058	0.119	0.116
Observations	227337	227541	225279	227064	226530	226286
R-squared	0.059	0.009	0.061	0.068	0.066	0.061

Notes: This table reports estimates of the effect of state and local paid sick leave (PSL) mandates on children's mental health care utilization and diagnostic outcomes. Each column presents results from a separate regression estimated using a two-way fixed effects difference-in-differences framework that accounts for staggered policy adoption across states and years. Covariates include child age, sex, race/ethnicity, insurance status, parental education, marital status, household income, and family size, as well as state-level controls such as unemployment rate, median income, health provider availability, and COVID-19 indicators. All models include state and year fixed effects, and standard errors are clustered at the state level. Statistical significance is denoted by *** $p < 0.01$, ** $p < 0.05$, and * $p < 0.1$.

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

	Depression	Passive Suicidal Ideation	Active Suicidal Ideation
Paid Sick Leave Mandate	-0.0162*	-0.0115*	-0.0138***
	(0.00830)	(0.00575)	(0.00489)
Baseline Mean	0.303	0.165	0.135
Observations	1064699	957730	1038576
R-squared	0.052	0.022	0.016

*T*able reports coefficients from regressions of youth mental health outcomes on indicators for state paid sick leave (PSL) mandates. All regressions include Youth age, race, gender, state-level time-varying controls, and fixed effects for state and survey year. Standard errors, clustered at the state level, are reported in parentheses. Baseline means are calculated from non-PSL states/years. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

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

	Age			Race					Sex		Education	
	0–5	6–11	12–17	Asian	Black	Hispanic	Other/Multi	White	Male	Female	No College Degree	College+
Panel A: Received Any Mental Health Care												
PSL_Mandate	-0.000413	0.00950	0.0194***	0.0177*	0.0115	0.00159	0.0153	0.0122***	0.0180***	0.00483	-0.00346	0.0184***
	(0.00533)	(0.00690)	(0.00409)	(0.00988)	(0.00867)	(0.00767)	(0.0207)	(0.00448)	(0.00413)	(0.00548)	(0.00641)	(0.00384)
Obs.	48152	79106	103102	12608	14396	29362	17936	156058	111240	119120	87907	142453
R-sq	0.015	0.030	0.031	0.041	0.034	0.050	0.054	0.051	0.076	0.031	0.041	0.058
Panel B: Depression Diagnosis												
PSL_Mandate	0.00159	0.00470	0.00405	0.0118	0.0113	-0.00337	0.00940	0.00370	0.00476	0.00263	-0.00476	0.00833**
	(0.00135)	(0.00368)	(0.00372)	(0.00715)	(0.00804)	(0.00420)	(0.00885)	(0.00261)	(0.00438)	(0.00343)	(0.00513)	(0.00314)
Obs.	48125	79126	102924	12624	14374	29349	17924	155904	111142	119033	87746	142429
R-sq	0.005	0.019	0.039	0.042	0.045	0.064	0.080	0.065	0.082	0.043	0.065	0.060

Notes: Each column reports the estimated effect of state and local paid sick leave (PSL) mandates on the specified outcome for a given subgroup. Panel (A) shows effects on whether the child received any mental health care in the past year; Panel (B) shows effects on parent-reported depression diagnosis. Subgroups are defined by child age group, race/ethnicity, sex, and parental education. All models are estimated using a two-way fixed effects difference-in-differences framework that accounts for staggered policy adoption across states and years. Covariates include child demographics, family socioeconomic characteristics, insurance status, and state-level controls such as income, unemployment, and health provider availability. State and year fixed effects are included, and standard errors are clustered at the state level. Estimates are suppressed for subgroup cells with fewer than 50 observations. Statistical significance is denoted by *** $p < 0.01$, ** $p < 0.05$, and * $p < 0.10$.

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

	Sex		Age		Race				
	Female	Male	Younger than 16	16 or Older	White	Black	Asian	Hispanics	Others
Panel A: Depression									
Paid Sick Leave Mandate	-0.0203**	-0.0120	-0.0133	-0.0179**	-0.0118	-0.0365***	0.0186	-0.0198	0.00693
	(0.00892)	(0.00986)	(0.0134)	(0.00673)	(0.0117)	(0.0109)	(0.0371)	(0.0166)	(0.0161)
Baseline Mean	0.387	0.222	0.293	0.309	0.284	0.293	0.285	0.354	0.364
Observations	539492	525207	443957	620742	609856	136873	43857	178626	95487
R-squared	0.026	0.014	0.060	0.048	0.049	0.041	0.039	0.055	0.056
Panel B: Passive Suicidal Ideation									
Paid Sick Leave Mandate	-0.0136	-0.00908	-0.00929	-0.0127**	-0.00820	-0.0169**	0.0143	-0.0205	-0.00697
	(0.00805)	(0.00577)	(0.00905)	(0.00522)	(0.00964)	(0.00787)	(0.0223)	(0.0155)	(0.0183)
Baseline Mean	0.209	0.122	0.172	0.161	0.161	0.147	0.156	0.173	0.223
Observations	486299	471431	398999	558731	518483	134473	40404	174621	89749
R-squared	0.012	0.005	0.028	0.019	0.020	0.022	0.019	0.025	0.033
Panel C: Active Suicidal Ideation									
Paid Sick Leave Mandate	-0.0129**	-0.0144*	-0.00633	-0.0181***	-0.00430	-0.0249***	0.00573	-0.0387**	-0.00662
	(0.00621)	(0.00826)	(0.00574)	(0.00566)	(0.00648)	(0.00865)	(0.00953)	(0.0175)	(0.0187)
Baseline Mean	0.165	0.105	0.143	0.130	0.127	0.127	0.136	0.149	0.186
Observations	526392	512184	434134	604442	587211	136397	43171	177495	94302
R-squared	0.013	0.005	0.021	0.013	0.013	0.018	0.012	0.022	0.019

Table reports coefficients from regressions of child health outcomes on indicators for state paid sick leave (PSL) mandates. All regressions include Youth age, race, gender, state-level time-varying controls, and fixed effects for state and survey year.
Standard errors, clustered at the state level, are reported in parentheses.
Baseline means are calculated from non-PSL states/years. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.

Table 7: Estimated Effects of Paid Sick Leave Mandates on Child and Family Health Outcomes

	Current Insurance Coverage	Insurance Coverage Gaps	Problems Obtaining Mental Health Care	Parental Mental Health	Family Resilience	Parental Aggravation
PSL_Mandate	-0.000862	-0.00209	0.0230	0.00269	-0.000938	0.00357
	(0.00291)	(0.00283)	(0.0160)	(0.00250)	(0.00274)	(0.00218)
Baseline Mean	0.954	0.941	0.529	0.941	0.838	0.051
Observations	269110	267882	34493	246353	268214	268695
R-squared	0.030	0.031	0.035	0.024	0.025	0.007

Notes: This table reports estimates of the effect of state and local paid sick leave (PSL) mandates on indicators of child and family health and well-being. Each column presents results from a separate regression estimated using a two-way fixed effects difference-in-differences framework that accounts for staggered policy adoption across states and years. Covariates include child age, sex, race/ethnicity, insurance status, parental education, marital status, household income, and family size, as well as state-level controls such as unemployment rate, median income, health provider availability, and COVID-19 indicators. All models include state and year fixed effects, and standard errors are clustered at the state level. Statistical significance is denoted by *** $p < 0.01$, ** $p < 0.05$, and * $p < 0.10$.

Appendix Figures and Tables

Table A.1: YRBSS Descriptive Statistics

Variable	Full Sample Mean (Std. Dev.)	Untreated States Mean (Std. Dev.)	Treated States Mean (Std. Dev.)
Panel A: Outcomes			
Self-Reported Depression	0.308	0.307	0.312
	(0.462)	(0.461)	(0.463)
Self-Reported Passive Suicidal Ideation	0.168	0.167	0.169
	(0.373)	(0.373)	(0.375)
Self-Reported Active Suicidal Ideation	0.137	0.137	0.139
	(0.344)	(0.343)	(0.346)
Panel B: Individual Controls			
Gender			
Male	0.512	0.511	0.512
	(0.500)	(0.500)	(0.500)
Female	0.488	0.488	0.489
	(0.500)	(0.500)	(0.500)
Age			
Less than 16 years old	0.374	0.374	0.376
	(0.484)	(0.484)	(0.484)
16 or older	0.626	0.626	0.624
	(0.484)	(0.484)	(0.484)
Race			
White	0.546	0.511	0.578
	(0.498)	(0.494)	(0.500)
Black	0.164	0.157	0.182
	(0.371)	(0.363)	(0.386)
Asian	0.031	0.029	0.347
	(0.172)	(0.167)	(0.183)
Hispanic	0.210	0.188	0.260
	(0.408)	(0.391)	(0.434)
Other	0.048	0.048	0.050
	(0.214)	(0.213)	(0.218)

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