2019 data

HARC
HEALTH ASSESSMENT AND RESEARCH FOR COMMUNITIES

Child Health
IN THE COACHELLA VALLEY: A SPECIAL REPORT
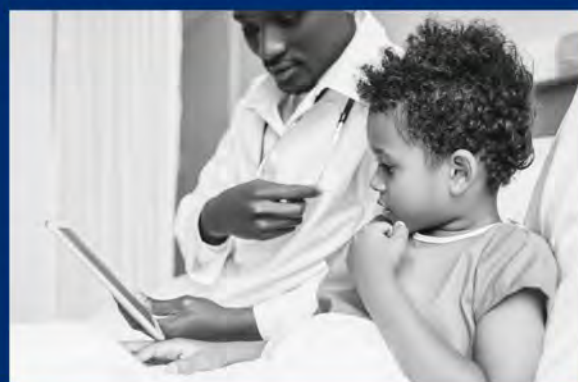
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Executive Summary

Introduction

The Coachella Valley is a unique community located within Riverside County in Inland Southern California. HARC, Inc. (Health Assessment and Research for Communities) is a nonprofit research organization that was founded in 2006 to provide objective, reliable data pertaining to this unique portion of the County. Since then, every three years, HARC conducts a massive random-digit-dial telephone survey of the Coachella Valley community and provides this data back to the community free of charge. The survey is conducted in English and Spanish, on cell phones and landlines, with adults and adult proxies to provide data for children, and includes more than 2,500 completed surveys to represent the 430,000+ people who live in the Coachella Valley. To date, the survey has been conducted five times: 2007, 2010, 2013, 2016, and 2019.

HARC applied for a grant from the Anderson Children's Foundation to create this special report on the health of children in the Coachella Valley, based on the 2019 survey results. Anderson Children's Foundation funded the project in July 2020. Specifically, this report drills down the child data into three age groups: 0 to 5, 6 to 11, and 12 to 17. Topics captured in this report include adverse childhood experiences (ACEs), healthcare access, utilization of healthcare, oral health, safety, asthma, mental health, obesity, physical activity, nutrition, food insecurity, sleep, and learning and socialization.

Methods

HARC contracted with the Kent State University Survey Research Lab to conduct the 2019 survey via telephone (cell phones and landlines). In homes where children were present, an adult proxy completed the interview on behalf of a randomly selected child in the home. Thus, responses come from adults, but are relevant to the child. The respondents are called "parents/guardians", although in a few cases it may be another adult that lives in the home that is knowledgeable about the child. The total sample size was 502 children. The data is then weighted (using U.S. Census data for weights) to extrapolate from these 502 children to the entire population under the age of 18 residing in the Coachella Valley.

Results

There are approximately 88,360 children under the age of 18 living in the Coachella Valley. This number of children equates to 20.6% of the Coachella Valley population (429,880 people overall). The three age groups (0 to 5, 6 to 11, 12 to 17) represent roughly a third each of the total population of children. Overall, approximately 51.9% of Coachella Valley children are Hispanic/Latino. Approximately 18.6% of Coachella Valley children live in homes where the total annual household income is less than $20,000.

Healthcare Access and Utilization

Approximately 4.6% of local children are uninsured. Most of the children who are insured (66.5%) are covered by government or public coverage instead of private coverage. Younger children are especially likely to be covered by government coverage; 77.4% of insured children 0 to 5 are covered by public insurance. Low-income children are also more likely to have public health insurance rather than private insurance, and Hispanic/Latino children are more likely than non-Hispanic/Latino children to have public coverage.

Most local children (74.8%) have been to a healthcare provider in the past six months. The most common usual sources of care for local children include the doctor's office (34.5%) and urgent care (33.8%). Unfortunately, approximately 8.0% of local children use the hospital or emergency room as their usual source of care and are likely not receiving proper continuity of care.

The most common barriers to healthcare that parents/guardians of local children experience are language barriers, taking time off work, and understanding what is covered by their insurance. Approximately 5.7% of local children had to delay or forgo a test or treatment ordered by a healthcare provider in the past year. Common reasons for this delay or denial include the cost, lack of insurance, and/or inability of the parent/guardian to take time off work to bring the child to the provider.

Oral Health

Results show that 39.0% of children ages 0 to 5 have never been to see the dentist, in contrast to recommendations that all children visit a dentist by their first birthday. Additionally, 5.8% of 6 to 11-year-olds have never been to the dentist and are long overdue. When asked why their children had not been to the dentist recently, the most common reason given by parents/guardians was that the child does not have any dental problems. Thus, there appears to be a misunderstanding of the importance of general preventative dental care.

Water Safety – Ages 2+

Overall, the majority of Coachella Valley children ages 2 and older do know how to swim (73.9%) which is fortunate, given how common swimming pools are in the Coachella Valley. However, more than half of young children (ages 2 to 5) do not know how to swim and are at high risk for drowning. Parents/guardians may not be aware that children as young as six months old can learn water safety. Additionally, 20.4% of children 6 to 11 do not know how to swim—that is 1 in 5 who cannot swim and are at high risk for drowning. Swimming ability is related to income—children who live in lower-income households are less likely to know how to swim than children who live in wealthier homes. Hispanic/Latino children are also significantly less likely to know how to swim when compared to non-Hispanic/Latino children (65.8% versus 81.8%, respectively).

Asthma

Approximately 12.1% of local children have been diagnosed with asthma. Diagnoses increase with age; for example, only 5.1% of children 0 to 5 have been diagnosed with asthma, compared to 23.3% of children 12 to 17. Male children are more than twice as likely to have been diagnosed with asthma when compared to their female counterparts (17.1% versus 7.6%, respectively).

Mental Health – Ages 3+

Approximately a quarter of local children ages 3 and older struggle with emotions, concentration, behavior, and/or getting along with others. Male children are twice as likely to struggle with these issues than females (32.2% versus 16.9%, respectively). Additionally, non-Hispanic/Latino children are significantly more likely to have difficulties with emotions, concentration, behavior, and/or getting along with others than Hispanic/Latino children.

Approximately 18.5% of children ages 3 and older have been diagnosed with a mental health disorder. The likelihood that a child has been diagnosed with one or more mental health disorders increases as the child gets older. Non-Hispanic/Latino children are significantly more likely than their Hispanic/Latino counterparts to have been diagnosed with a mental health disorder. Specifically, 24.3% of non-Hispanic/Latino children ages 3 and older have been diagnosed with a mental health disorder, compared to only 12.7% of Hispanic/Latino children ages 3 and older.

Attention deficit disorder/attention deficit-hyperactivity disorder (ADD/ADHD) is the most commonly diagnosed mental health disorder among local children ages 3 and older. Male children are four times more likely to have been diagnosed with ADD/ADHD than female children (12.0% versus 3.1%, respectively).

Obesity – Ages 2+

Approximately 46.1% of children ages 2 and older have a body mass index (BMI) percentile that places them in the "overweight" or "obese" category. The majority of children ages 12 to 17 have a BMI percentile that places them in the "healthy" category, but young children ages 2 to 5 are most likely to be in the "obese" category. Lower-income children are significantly more likely to be obese than higher-income children.

Despite the fact that nearly half of local children ages 2 and older are likely overweight or obese, only 14.4% of their parents/guardians believe their child is overweight; the majority believe their child is "about the right weight". This misperception is especially pronounced in parents/guardians of young children: more than two-thirds of children ages 2 to 5 have a BMI percentile that puts them in the "overweight" or "obese" category, but only 1.0% of their parents/guardians believe that their child is overweight. This disconnect indicates that the child is unlikely to become a healthy weight unless the parents/guardians are educated about what obesity truly looks like in a young child. Boys are more likely to be considered to be overweight by their parents/guardians in comparison to girls.

Physical Activity – Ages 6+

About a third of local children ages six and older (31.0%) are physically active for at least an hour a day outside of school every day of the week, as is recommended. The remainder of children are likely not getting as much exercise as they truly need. Male children are significantly more likely to exercise daily than female children, who are more likely to be sedentary outside of school. Lower income children are more likely to be sedentary than higher income children. For example, 22.0% of children in the lowest household income bracket ($0 to $19,999) are not active for an hour outside of school for even a single day of the week. In contrast, only 5.0% of children in the $100,000 or more income bracket fall into that category.

Nutrition

About half of Coachella Valley children ages 2 and older consume fast food once a week or less. However, 12.9% of children ages 2 and older consumed fast food four or more times per week, which is likely connected to obesity. Older children (12 to 17) eat significantly more fast food than younger children. Children living in wealthier homes are more likely to completely abstain from fast food than children living in lower-income homes.

The majority of children ages 0 to 5 (82.9%) were breastfed during infancy; however, female children were significantly more likely to be breastfed than male children. In fact, only 8.3% of female children 0 to 5 were not breastfed, compared to 25.4% of male children 0 to 5.

Food Insecurity

Approximately 16.7% of local children live in households where their parents/guardians were "often" or "sometimes" worries about food running out before they had money to buy more. About 11.0% of children live in households where their parents/guardians "often" or "sometimes" ran out of food and did not have money to buy more. Approximately 14.0% of children live in homes where they had to cut back on food spending in order to prioritize other basic needs. Finally, 4.1% of children had to cut the size of their meals or skip meals due to lack of money for food. Naturally, children living in lower-income households were significantly more likely to experience these food insecurity issues than children living in higher-income households. Hispanic/Latino children are more likely to experience food insecurity as measured by some of these indicators than non-Hispanic/Latino children.

Fortunately, there are resources available to support food insecure families. Approximately 17.0% of local children live in homes that are utilizing the CalFresh program (also known as SNAP or food stamps); younger children (0 to 5) are more likely to live in homes that tap into this resource than older children.

Approximately 14.7% of children live in homes that utilize the Special Supplemental Nutrition Program for Women, Infants, and Children (commonly known as WIC). This is again more common for children in the 0 to 5 age group than older children; it is also more common for Hispanic/Latino children than non-Hispanic/Latino children.

Sleep

Fortunately, most Coachella Valley children are getting sufficient sleep per the recommendations from the National Sleep Foundation. Only 5.3% of local children are sleep deprived. Young children sleep longer hours that older children, as is recommended.

School Absenteeism – Ages 6+

Approximately one quarter of children ages 6 and older have not missed any days of school in the past year. In contrast, 7.5% of students missed 11 or more days of school, and are likely struggling to keep up. The most common reason for missing school was absence due to illness.

Reading to Child – Ages 0 to 5

The majority of young children 0 to 5 (69.3%) are read to in their home five or more times per week. Young girls are more likely to be read to in the home than young boys (75.0% versus 64.2%, respectively). Additionally, Hispanic/Latino children are less likely to read with their parents/guardians five or more times a week than non-Hispanic/Latino children. Specifically, 84.2% of non-Hispanic/Latino children 0 to 5 read with their parents/guardians five or more times per week, but only 56.7% of Hispanic/Latino children 0 to 5 read this frequently.

Discussions with Children – Ages 6+

Parents/guardians were asked whether they or another adult in the home discussed important topics with their child in the past year. The majority of children ages 6 to 17 have had parent-child discussions about topics like tobacco use, drugs, alcohol, racism, social media/sharing of private photos, and dealing with anger. In contrast, less than a third of local children ages 6 to 17 have had parent-child discussions on topics such as self-harm, eating disorders, domestic violence, and suicide. Overall, parents/guardians are significantly more likely to discuss all topics with older children (12 to 17) than younger children (6 to 11).

Parents/guardians of children 6 to 17 are more likely to discuss racism with their daughters (72.3%) than their sons (59.6%). They are also more likely to discuss social media/sharing of private photos online with their daughters (69.9%) than their sons (54.8%). Parents/guardians of Hispanic/Latino children are significantly more likely to have talked about gangs and violence than parents/guardians of non-Hispanic/Latino children (54.1% versus 37.5%, respectively).

Conclusion

This report outlines some of the strengths and the needs that our local children are experiencing, along with some local resources to address them. It is HARC's hope that health and human services organizations can use this information to better serve local children and support their prospects for a successful and healthy life.

About HARC

HARC, Inc. is a 501(c)(3) nonprofit organization that specializes in research and evaluation services. HARC was founded to help tell the story of the Coachella Valley through a quantitative lens, as the only data available to our region was at the county-level. Having a local research firm enables health leaders and service providers to identify health disparities, inequities, unhealthy behaviors, and trends.

HARC has since expanded to not only continue the survey, but to provide other research and evaluation-based services. These services include, but are not limited to needs assessments, program evaluations, analyses of existing data, and much more. HARC provides customized analytical consulting services, tailored to the needs of its clients to help them answer important questions regarding those they serve. Doing so enables our clients to evaluate the great work that they do and to make the Inland Empire a healthier, and ultimately, happier place to live.

The Coachella Valley Community Health Survey

The Coachella Valley is a unique community located within Riverside County in Inland Southern California. HARC was founded in 2006 to provide objective, reliable data pertaining to this unique portion of the County. Since then, every three years, HARC conducts a massive random-digit-dialing survey of the Coachella Valley community. Randomly sampling the community is an extraordinary effort to undertake, as it took an entire year to collect enough samples for the 2019 survey. However, this random sampling method enables HARC to reliably estimate the characteristics of our community.

The data acquired from this survey are used by nonprofit health and human services agencies, hospitals, federally qualified health centers, institutions of higher education, K-12 education, governmental agencies, and media organizations, among others. These organizations use the data to better understand the people who live in our region, and also to apply for funding, prioritize health needs, develop programs to address those needs, create presentations/lectures, write articles, design and conduct trainings, and make/change policy.

Most notable among these uses is how the data have strengthened local nonprofits' requests for funding. Dozens of nonprofits have used this data over the last decade to make compelling requests for funding and have successfully generated millions of dollars each survey cycle. These funds have provided support for critically important programs and services, such as mental health counseling for children, pregnancy prevention education for teens, medical care for uninsured adults, meal delivery for homebound seniors, and HIV testing for all.

HARC is hopeful that the findings from the present report will aid local organizations in identifying critical needs among children and making a case to develop specialized programs in their favor. This important survey has been conducted five times, as of this report: 2007, 2010, 2013, 2016, and now 2019.

This Report on Child Health in the Coachella Valley

The data collected across the Coachella Valley allows HARC to examine certain characteristics of the population more closely. For this report, the focus is on the child population of the Coachella Valley. Data pertaining to the health of children, split by ages 0 to 5, 6 to 11, and 12 to 17 across demographics, adverse childhood experiences (ACEs), healthcare access, utilization of healthcare, preventative health, safety and injury, major diseases, weight, activity, and nutrition, sleep, and learning and socialization.

Each variable includes a vertical column chart such as the example to the right. For these charts, the dark blue column represents the 0 to 5 age group, the teal column represents the age 6 to 11 group, and the grey column represents the 12 to 17 age group.
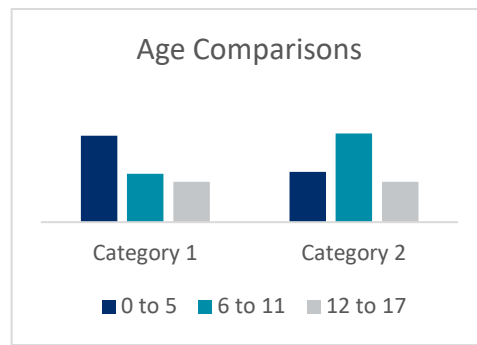
Age comparisons will be offered for all variables (except those that only target a small age group, such as questions on breastfeeding that are directed towards only the children ages 0 to 5). Other comparisons—based on gender, ethnicity, household income, and adverse childhood experiences (ACEs)—will be described only if they are statistically significant. This means that our statistical analyses provide evidence that a true difference exists. These differences are unlikely to be due to chance but likely reflect real differences in the populations, locations, or times being compared. When present, these additional demographic comparisons will be represented by horizontal bar graphs, as illustrated in the example to the right.
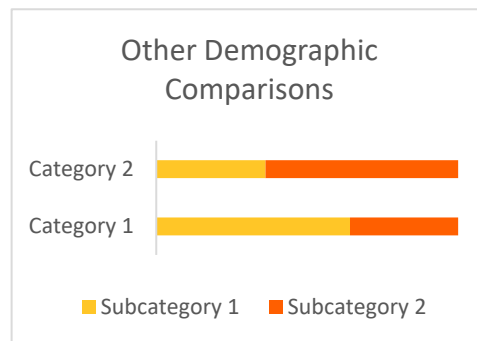
Finally, this report identifies many unmet needs among local children. It is likely that many community members reading this report will want to know where resources exist to obtain help. Thus, HARC has embedded in this report several resources pertaining to each of these topics. HARC does not vouch for or certify as to the quality of these resources, and these lists of resources are by no means comprehensive. They are meant merely as a starting point for those seeking to address these problems. For more local resources, please visit www.connectie.org.

Coachella Valley Geography

This report focuses on the health status of the Coachella Valley in Eastern Riverside County, California. Tribal areas within the Coachella Valley include the reservations of the Agua Caliente Band of Cahuilla Indians, the Augustine Band of Mission Indians, the Cahuilla Band of Mission Indians, and the Torres-Martinez Desert Cahuilla Indians. The Coachella Valley is made up of nine major cities (Cathedral City, Coachella, Desert Hot Springs, Indian Wells, Indio, La Quinta, Palm Desert, Palm Springs, and Rancho Mirage) as well as several unincorporated areas (such as Bermuda Dunes, Mecca, Thermal, and Thousand Palms, among others).
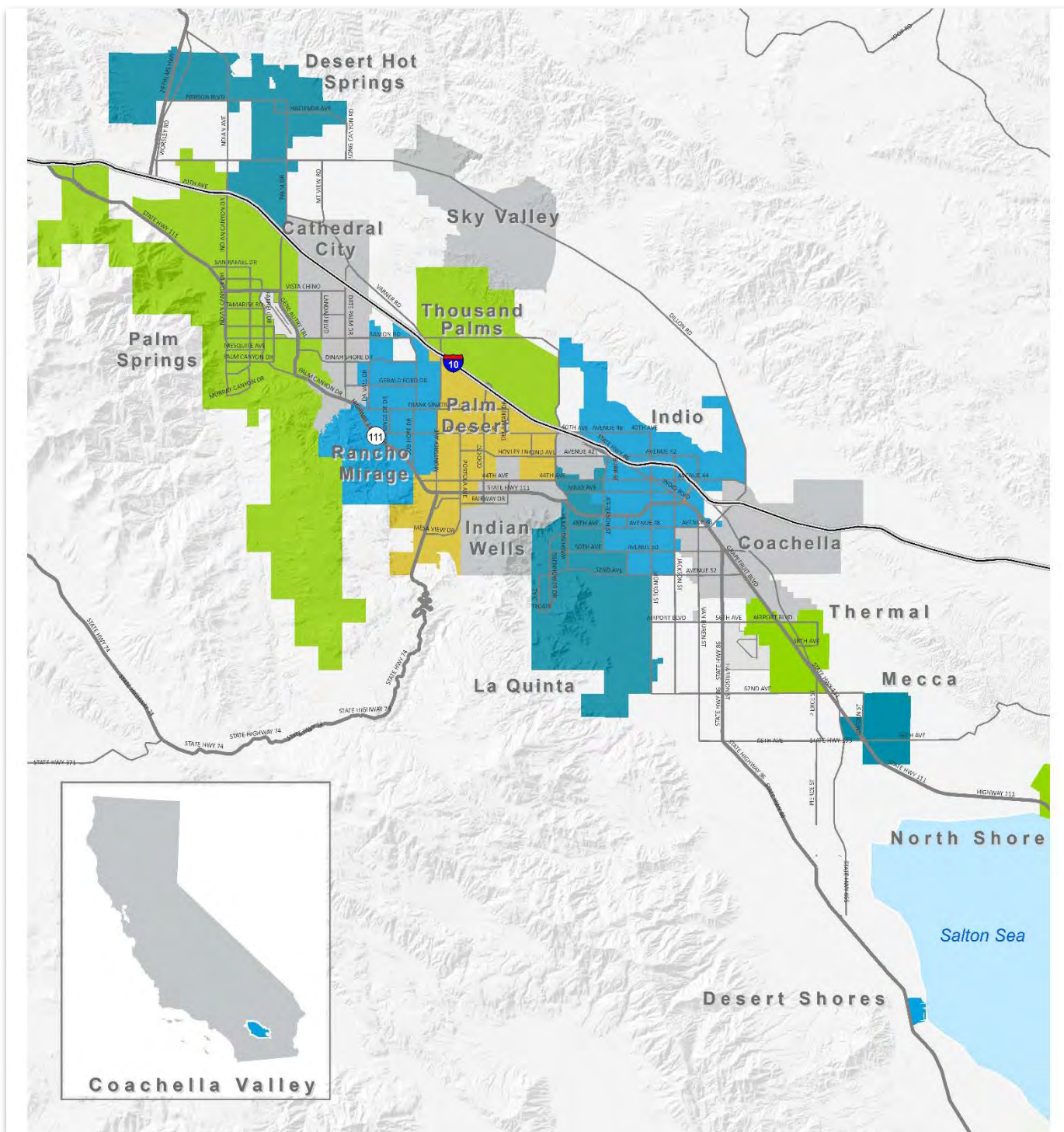
Methods

Data Collection

HARC contracted with the Kent State University Survey Research Lab to conduct the 2019 survey via telephone (cell phones and landlines). In homes where children were present, an adult proxy completed the interview on behalf of a randomly selected child in the home. Thus, responses come from adults, but are relevant to the child. The total sample size was 502 children.

The vast majority of survey respondents were parents, as illustrated in Figure 1. Thus, it is worth noting that throughout the report, respondents are referred to as parents/guardians, although in limited circumstances, these include adults who are not a parent/guardian of the child.

Figure 1. Respondent Relationship to Child
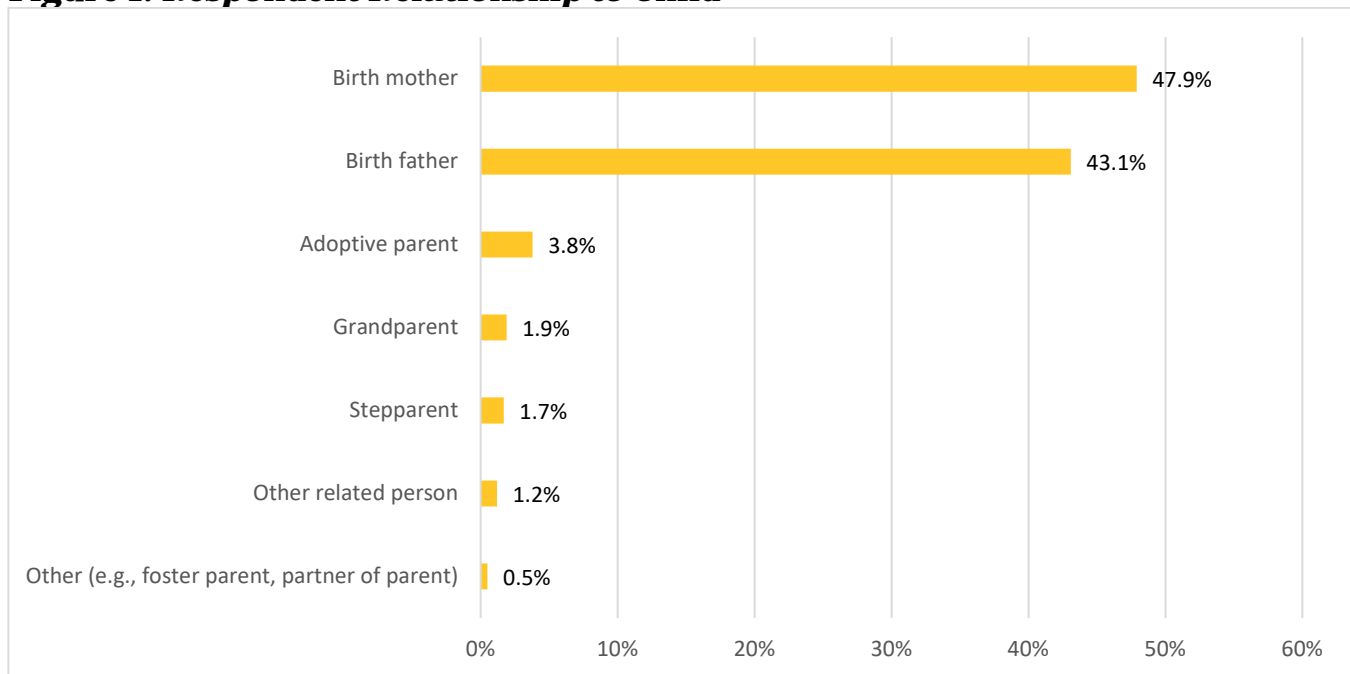
Note: Total sample size is 502.

Data collection began on January 29, 2019 and concluded on December 9, 2019. Surveys were restricted to private residences (such as apartments, houses, or mobile homes) within the geographic area of the Coachella Valley with landlines and/or cell phones. This survey does not include people who live in group home settings (such as nursing homes, assisted living facilities, jails, or prisons, etc.), or those who do not have a landline or a cell phone (which is an estimated 3.1% of U.S. households, according to the National Health Interview Survey).[1]

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[1] Blumberg, S.J., Luke, J.V. (June 2019). Wireless substitution: Early release of estimates from the National Health Interview Survey, July—December 2018. *National Center for Health Statistics.* Available online at https://www.cdc.gov/nchs/data/nhis/earlyrelease/wireless201906.pdf

Weighted Data

Once data collection was complete, statisticians weighted the sample data to most accurately represent the entire population living in the Coachella Valley. The post-stratification weighting used an iterative proportional fitting (or raking) algorithm. Missing data was imputed using a hot deck method.

The data was weighted based on the U.S. Census Bureau's American Community Survey's five-year estimates (2014 to 2018) for the nine incorporated cities in the Coachella Valley combined with the 12 census-designated areas (CDPs; Bermuda Dunes, Desert Edge, Desert Palms, Indio Hills, Garnet, Mecca, North Shore, Oasis, Sky Valley, Thermal, Thousand Palms, and Vista Santa Rosa) to capture the Coachella Valley population. The weights were raked to age, sex, race, ethnicity and telephone use.[2]

Thus, by taking the known population estimates of all these cities available in the U.S. Census Bureau and applying them to the randomly sampled 502 children in our survey, we can estimate the characteristics of the 88,000+ children living in the valley.

Throughout the report, term "significant" is often used. This means that our statistical analyses provide evidence that a true difference exists. These differences are unlikely to be due to chance but likely reflect real differences in the populations, locations, or times being compared.

Lastly, at times, charts and tables will include red font numbers. These red font numbers indicate that the estimate was statistically unstable, meaning it is not reliable as there was not enough data. Readers should interpret these red numbers with great caution.

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[2] Wireless Substitution: State-Level Estimates from the National Health Interview Survey, 2018

Results

Demographics

There are approximately 88,360 children under the age of 18 living in the Coachella Valley. This number of children equates to 20.6% of the Coachella Valley population (429,880 people).

Age

About a third of children are represented by each age group as illustrated in the figure below. That is, slightly over a third (37.6%) are ages 0 to 5, while another 31.7% are ages 6 to 11, and 30.7% are ages 12 to 17.
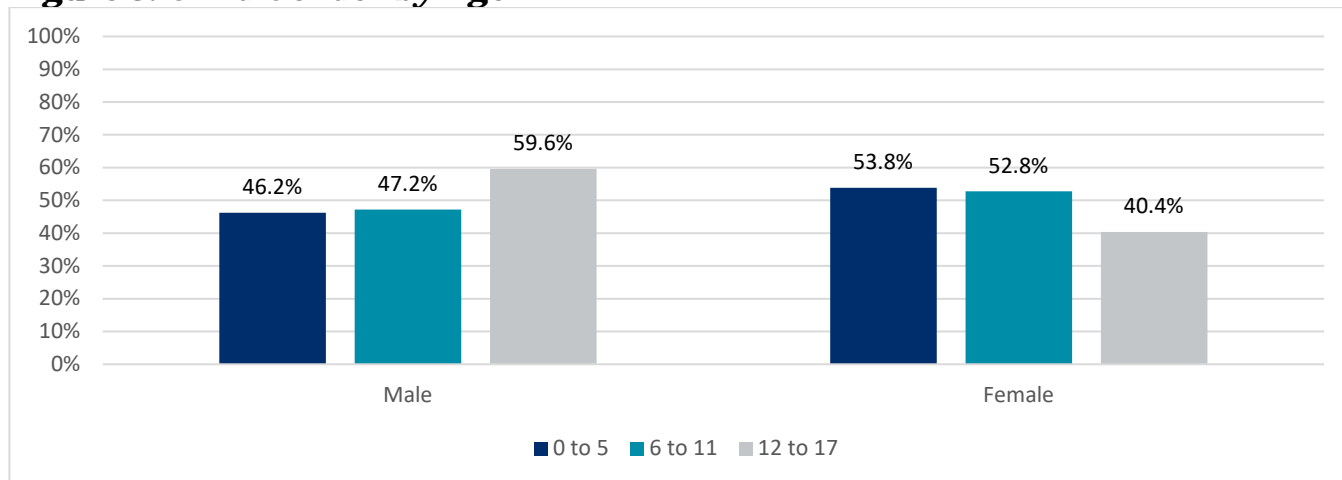
Figure 2. Child Age Groups
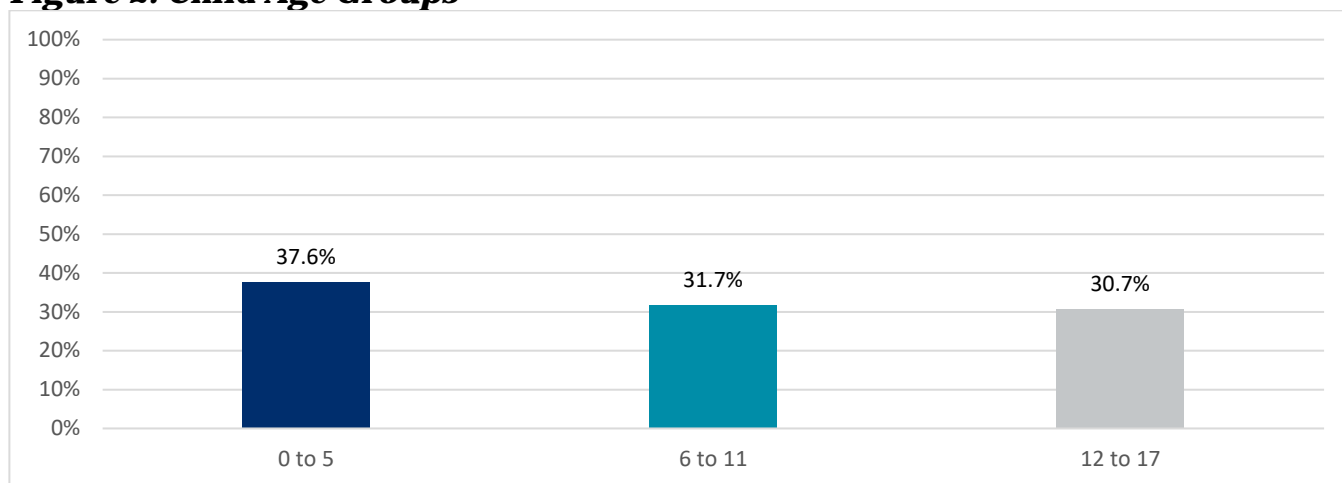
Note: Population estimate = 88,360.

Gender

The gender distribution of males and females is approximately similar across the children age groups, as illustrated below. However, there are substantially more teenage boys (ages 12 to 17) than teenage girls (12 to 17) living in the valley.

Figure 3. Child Gender by Age

Note: 0 to 5 population estimate = 32,910; 6 to 11 population estimate = 26,714; 12 to 17 population estimate = 26,888.

Race/Ethnicity

The majority of children are identified as being white for each age group and the second most common race category is "another race". Under "another race" most responses included identifying as Hispanic/Latino.

Figure 4. Child Race by Age
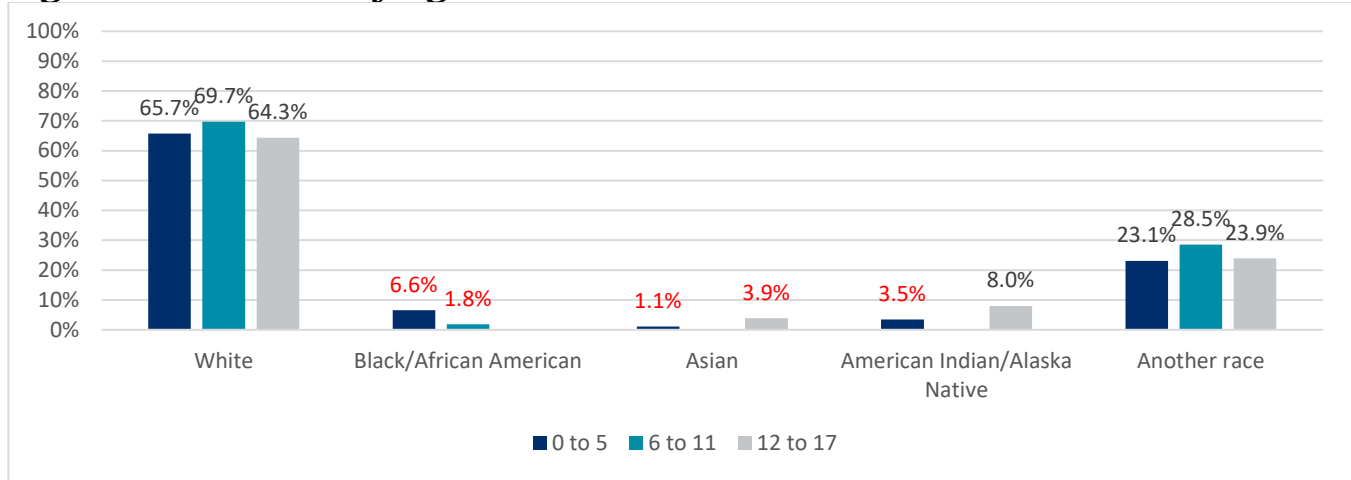
Note: 0 to 5 population estimate = 17,465; 6 to 11 population estimate = 14,537; 12 to 17 population estimate = 12,608. Red indicates statistically unstable estimates.

Overall, approximately 51.9% of Coachella Valley children are Hispanic/Latino. When examining specific age groups, the percentages of Hispanic/Latino children and non-Hispanic/Latino children are fairly evenly split, although there does appear to be slightly higher percentages of younger children (ages 0 to 5 and 6 to 11) who are Hispanic/Latino, as illustrated below.

Figure 5. Child Ethnicity by Age
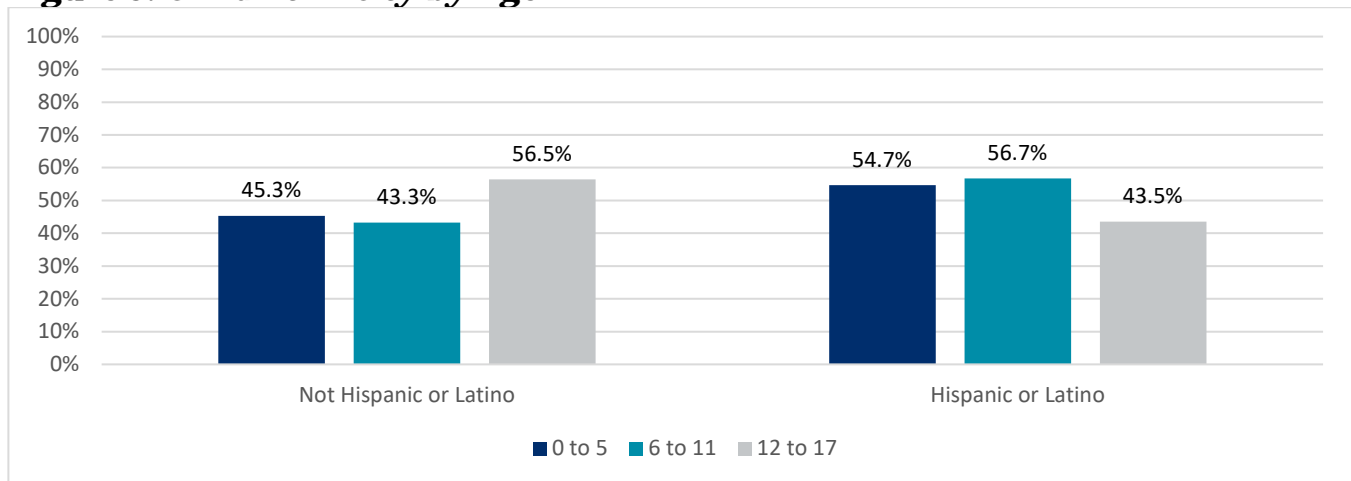
Note: 0 to 5 population estimate = 33,245; 6 to 11 population estimate = 27,978; 12 to 17 population estimate = 27,137.

Income and Poverty

Household income level does not appear to significantly vary based on age group, as illustrated in the chart below. There are over 13,600 children living in households with incomes under $20,000.

Figure 6. Household Income by Age
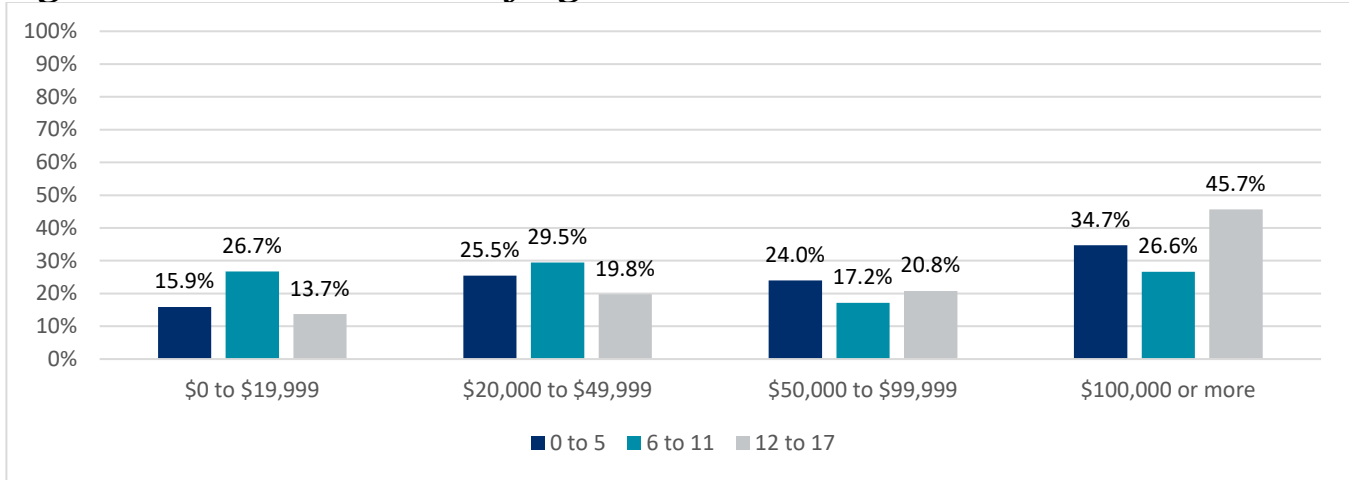
Note: 0 to 5 population estimate = 28,063; 6 to 11 population estimate = 23,020; 12 to 17 population estimate = 22,190.

Income level does significantly vary based on children's ethnicity. As illustrated in the figure below, significantly higher percentages of Hispanic/Latino children are living in households in the lowest income bracket ($0 to $19,999; 29.6%) compared to children who are not Hispanic/Latino (7.5%).

Figure 7. Household Income by Ethnicity
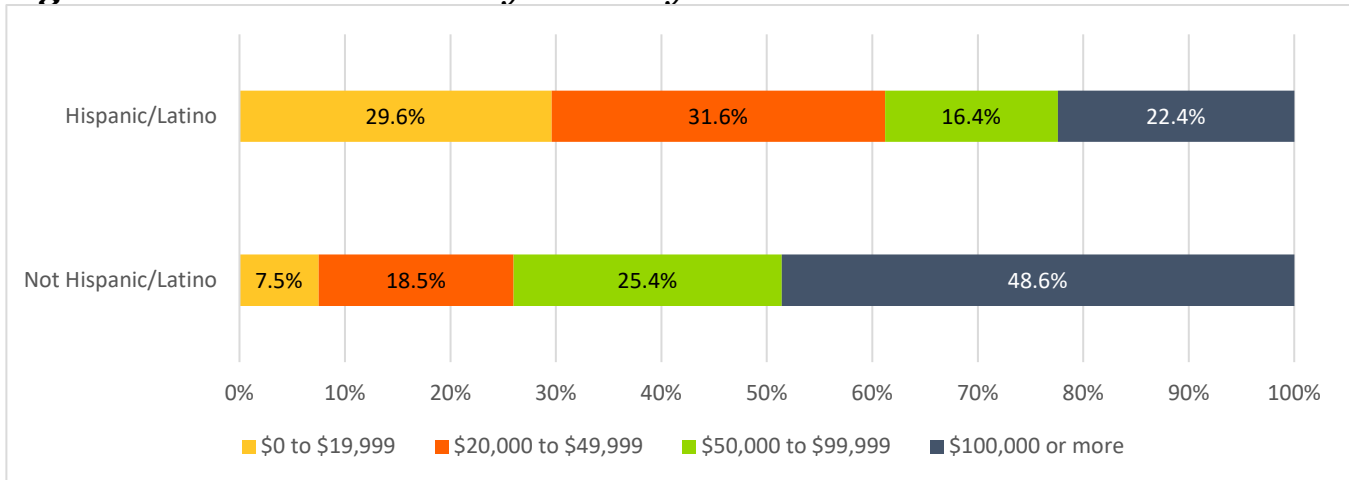
Note: Not Hispanic/Latino population estimate = 36,519; Hispanic/Latino population estimate = 36,755.

Children's parents/guardians were asked to report their household income and the number of people residing within their household. This information enabled HARC to calculate federal poverty levels (FPL) per the Department of Health and Human Service's guidelines for 2019. Overall, 29.1% of local children live below the poverty line. As illustrated in the figure below, FPL significantly varies based on age group.

Figure 8. Federal Poverty Level by Age
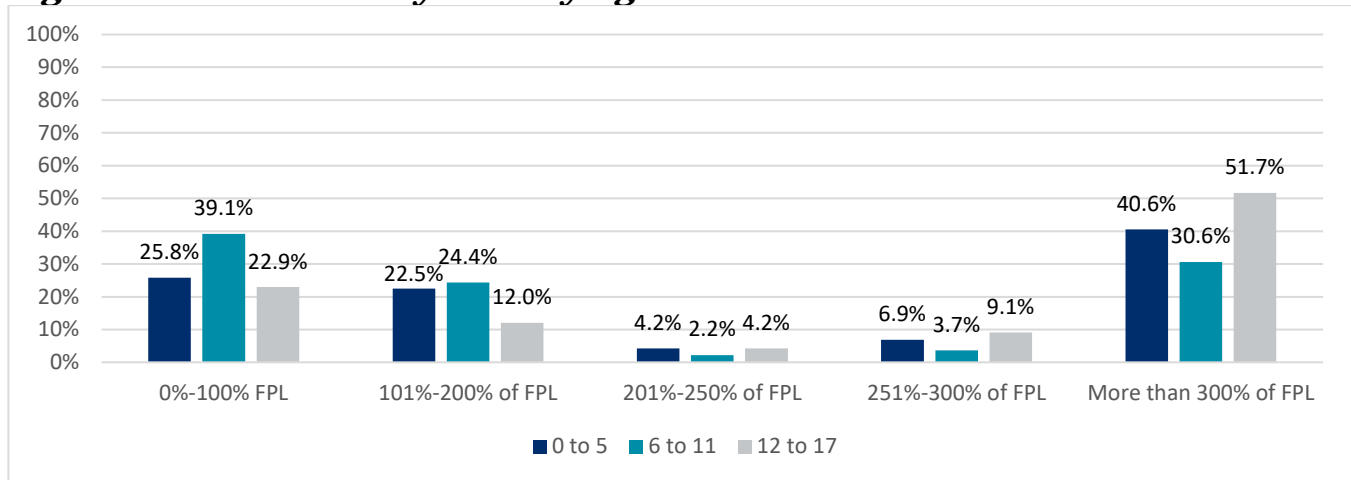
Note: 0 to 5 population estimate = 28,063; 6 to 11 population estimate = 23,020; 12 to 17 population estimate = 22,190.

FPL also significantly varies based on ethnicity. That is, Hispanic/Latino children are more likely to live in poverty (that is, below 100% of the FPL; 45.9%) compared to those who are not Hispanic/Latino (12.2%).

Figure 9. Federal Poverty Level by Ethnicity
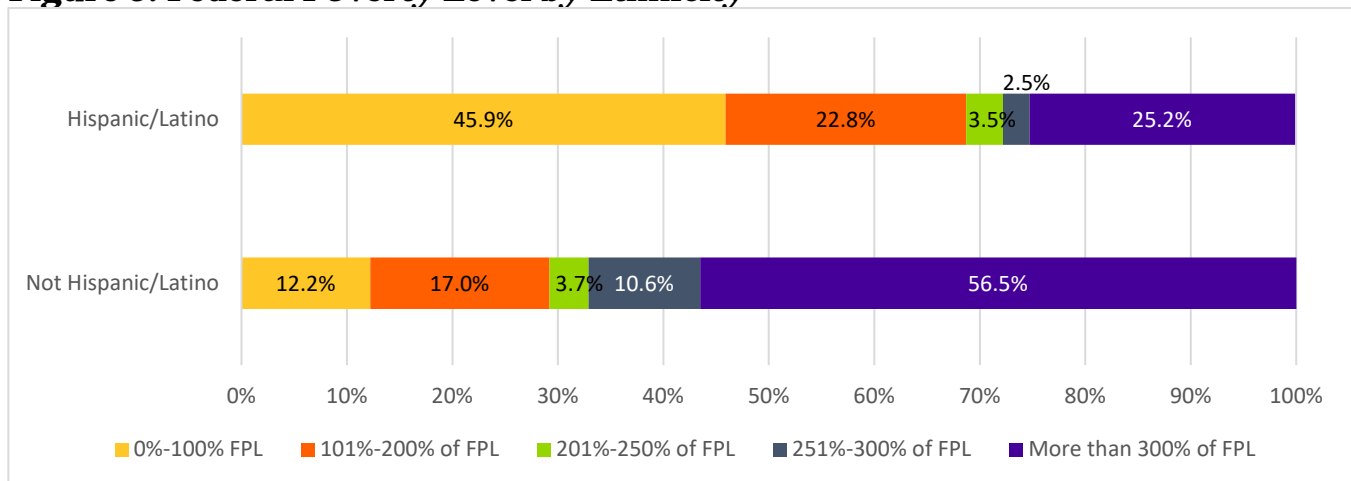
Note: Not Hispanic/Latino population estimate = 36,519; Hispanic/Latino population estimate = 36,755.

Adverse Childhood Experiences

Adverse childhood experiences (ACEs) are potentially traumatic events occurring during childhood, including abuse (emotional, physical, or sexual), neglect (emotional or physical), and household instability (witnessing violence against a parent, substance abuse in household, mental illness in household, parental separation or divorce, or incarcerated household member).[3] These experiences can have immediate health consequences, and also have long-term, negative effects for quality of life in adulthood.[4]

There are typically 10 ACEs; however, for this survey, HARC measured four ACEs, all within the "household instability" category:
1. Parental separation or divorce
2. Mental illness in the household
3. Incarceration of a household member
4. Substance abuse in the household

Because of the methods of this survey (i.e., interviewing parent/guardian proxies for the child), asking questions about child abuse or neglect is unlikely to yield solid information—that is, the parents may be unaware of the abuse/neglect or inclined not to disclose it. Thus, only four of the 10 ACEs were assessed, all of which the parent/guardian respondent can accurately report on.

Results show that **the majority of local children (58.6%) have not experienced any of these four ACEs. However, 41.4% of local children have experienced one or more of the four ACEs measured in this survey.**

As illustrated in the figure below, 33.8% of children ages 0 to 5, 47.9% of children ages 6 to 11, and 44.0% of children ages 12 to 17 have experienced an ACE.

Figure 10. Child Has Experienced ACEs by Age
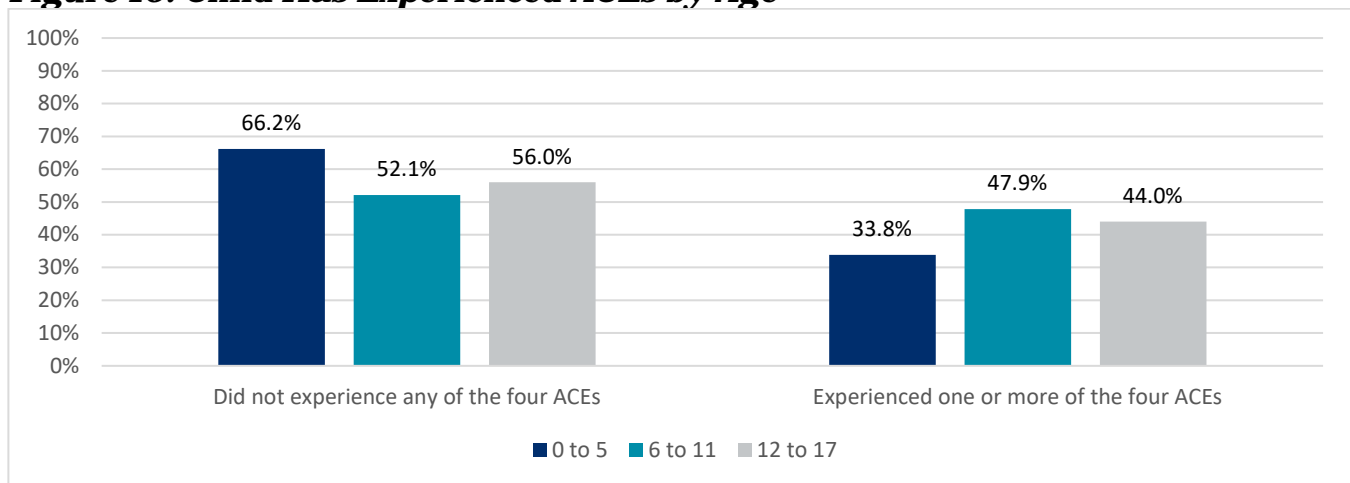
Note: 0 to 5 population estimate = 33,245; 6 to 11 population estimate = 27,978; 12 to 17 population estimate = 27,086.

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[3] Preventing Adverse Childhood Experiences. (2020). Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/acestudy/fastfact.html
[4] Ibid.

Household income is significantly related to whether children experience ACEs; children living in lower-income households are significantly more likely to have experienced one or more ACEs than children in high-income households.

Figure 11. Child Has Experienced ACEs by Income
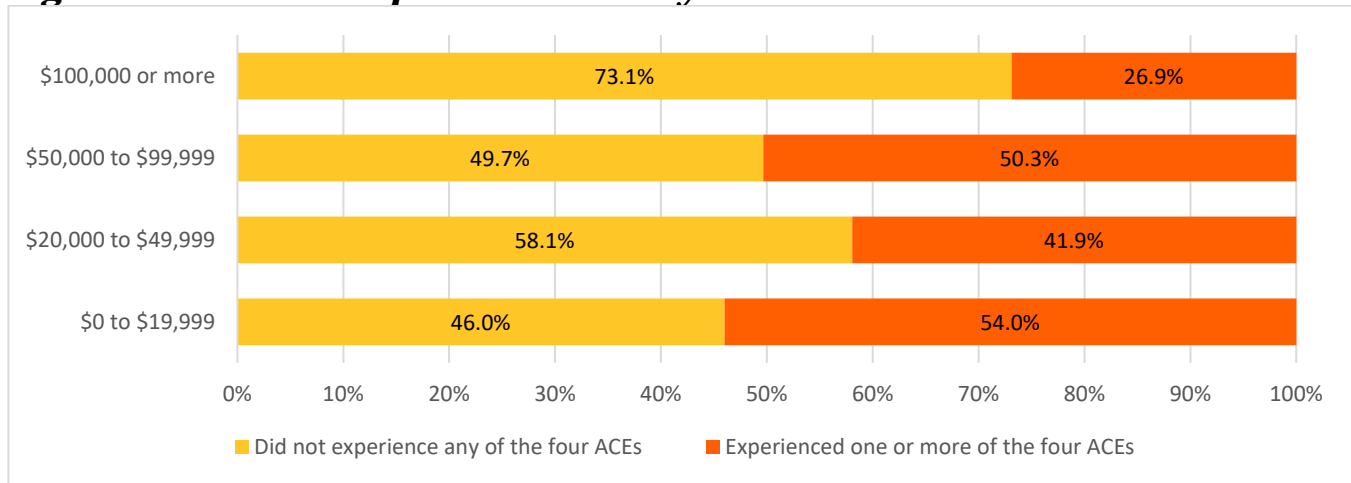
Note: $0 to $19,999 population estimate = 13,648; $20,000 to $49,999 population estimate = 18,340; $50,000 to $99,999 population estimate = 15,308; $100,000 or more population estimate = 25,978.

When looking at all four of the ACEs that HARC measured, it appears that experiencing divorce or separation and having someone in the household with mental health problems are more common than having someone in the household who has been to jail or someone who is a problem drinker/drug user, as illustrated in the chart below.

Figure 12. Breakdown of ACEs by Age
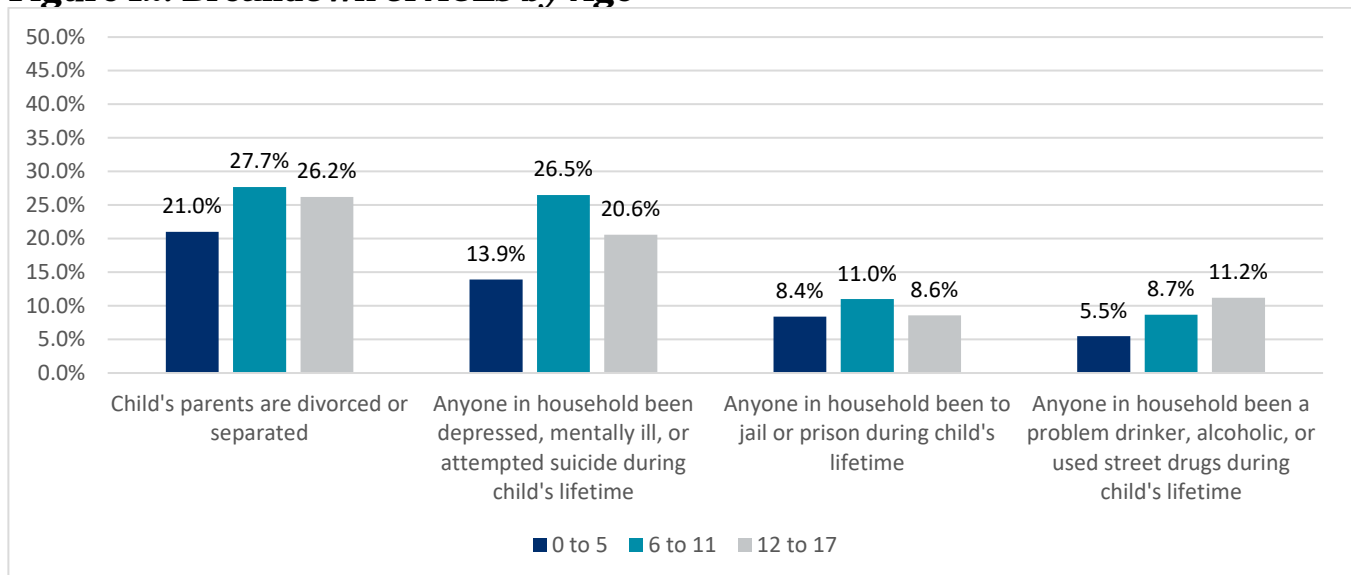
Note: Divorce or separation (0 to 5 population estimate = 32,9972; 6 to 11 population estimate = 27,768; 12 to 17 population estimate = 26,770). Jail/prison (0 to 5 population estimate = 32,305; 6 to 11 population estimate = 27,552; 12 to 17 population estimate = 27,086). Problem drinker/drugs (0 to 5 population estimate = 32,341; 6 to 11 population estimate = 27,911; 12 to 17 population estimate = 26,477). Mental health problems (0 to 5 population estimate = 32,518; 6 to 11 population estimate = 27,978; 12 to 17 population estimate = 26,737).

Healthcare Access

Access to healthcare is imperative for children to have appropriate medical and behavioral care as health concerns arise as well as responding to issues early on. Under Senate Bill (SB) 75, all low-income children under the age of 19 are eligible for Medi-Cal and its full range of benefits, including children who are unable to establish a satisfactory immigration status.[5] Thus, even those who are undocumented are eligible for health insurance.

Results show that 95.4% of local children have health insurance; 4.6% are uninsured. Lack of insurance does not vary based on age, as illustrated in the figure below. There are close to 4,000 uninsured children in the Coachella Valley.

Figure 13. Child Healthcare Coverage by Age
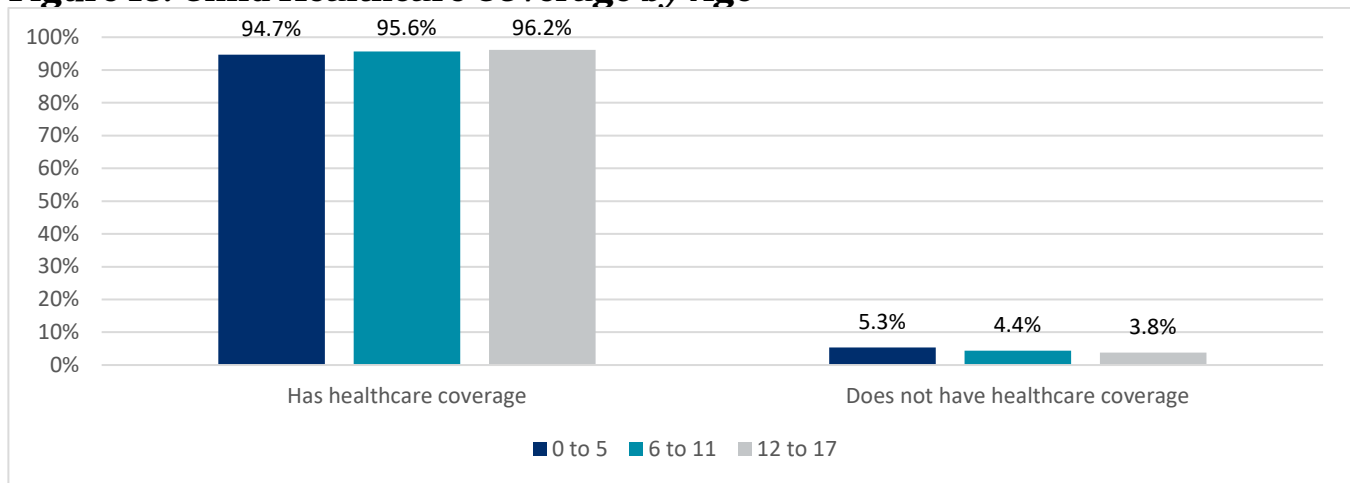
Note: 0 to 5 population estimate = 32,453; 6 to 11 population estimate = 27,911; 12 to 17 population estimate = 27,059.

Overall, **most local insured children (66.5%) are covered by public coverage**. This is especially true for younger children, as illustrated in the chart below.
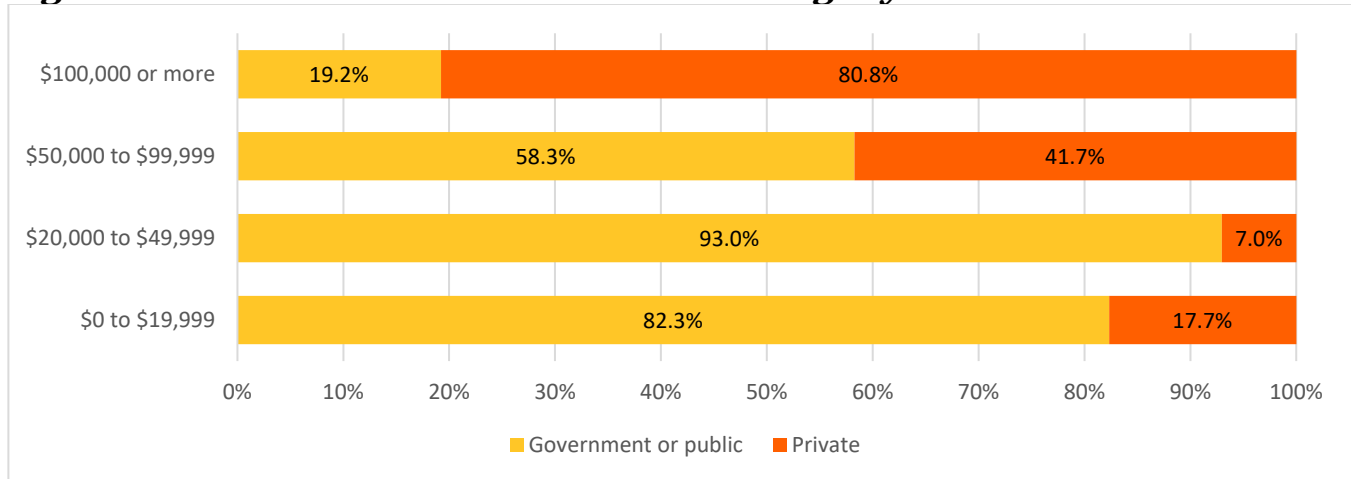
Figure 14. Government/Public or Private Coverage by Age
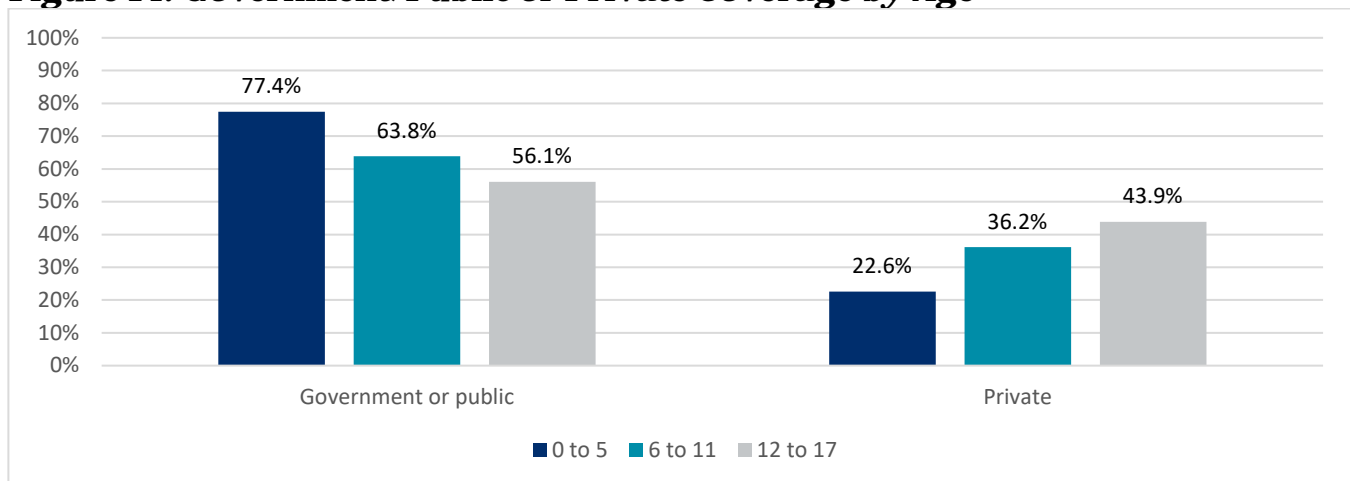
Note: Insured children only. 0 to 5 population estimate = 20,642; 6 to 11 population estimate = 20,456; 12 to 17 population estimate = 16,504.

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[5] SB 75 – Medi-Cal for All Children. (2019). California Department of Healthcare Services. https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/SB75Children.aspx

Government/public and private health insurance coverage also significantly varies according to household income. Children with household incomes of $0 to $19,999 are significantly more likely to be on government or public coverage (82.3%) when compared to children in homes with incomes of $100,000 or more (19.2%).

Figure 15. Government/Public or Private Coverage by Income

Note: Insured children only. $0 to $19,999 population estimate = 11,513; $20,000 to $49,999 population estimate = 14,783 $50,000 to $99,999 population estimate = 8,057; $100,000 or more population estimate = 12,496.

Public coverage significantly varies according to ethnicity. Children who are Hispanic/Latino (81.3%) are more likely to have government or public coverage compared to non-Hispanic/Latino children (48.0%).

*Figure 16. Government/Public or Private Coverage by Ethnicity*
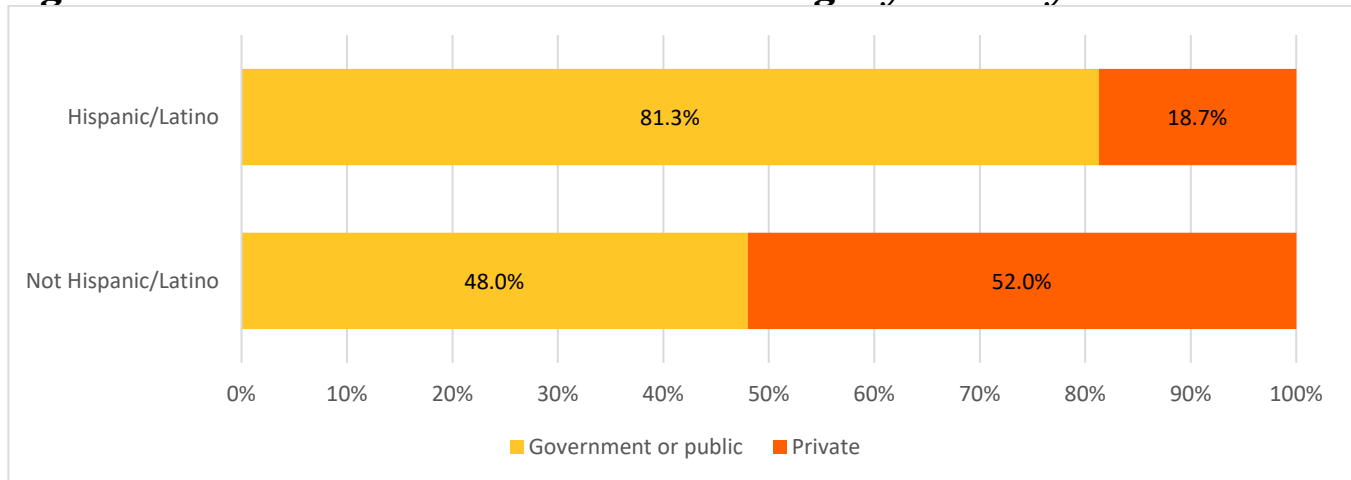
Note: Insured children only. Not Hispanic/Latino population estimate = 25,631 Hispanic/Latino population estimate = 31,971.

Parents/guardians were also asked whether their child had insurance that covered their dental, vision, and/or mental healthcare. Overall, **most local children have insurance that pays for their dental care, vision care, and/or mental healthcare**. Prescription coverage is the most widespread; virtually all local children have prescription insurance.

The rate of having dental, prescription, and vision coverage does not vary according to child age, as illustrated in the figure below.

Figure 17. Child Dental, Prescription, Vision Insurance by Age
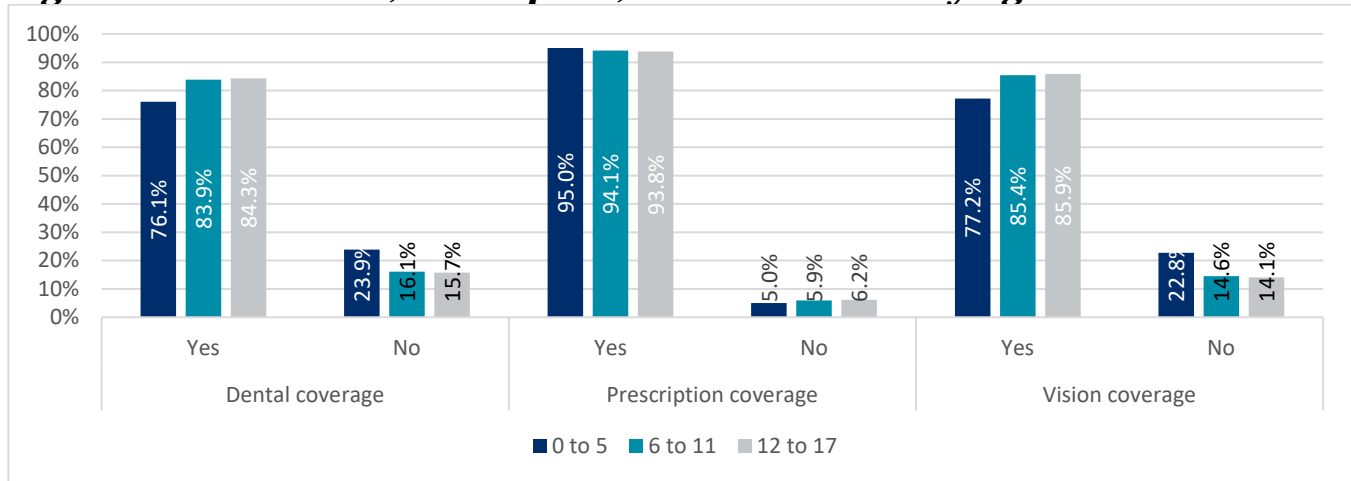
Note: Dental coverage (0 to 5 population estimate = 31,155; 6 to 11 population estimate = 27,209; 12 to 17 population estimate = 26,892). Prescription coverage (0 to 5 population estimate = 32,427; 6 to 11 population estimate = 27,696; 12 to 17 population estimate = 26,787). Vision coverage (0 to 5 population estimate = 30,126; 6 to 11 population estimate = 26,565; 12 to 17 population estimate = 25,762).

Parents/guardians were asked if their child has ever not obtained a needed prescription due to cost. Overall, **6.5% of local children did not get prescriptions they needed due to cost**. This did not differ significantly based on age, as illustrated in the chart below.

Figure 18. Did not Get Prescription for Child due to Cost by Age
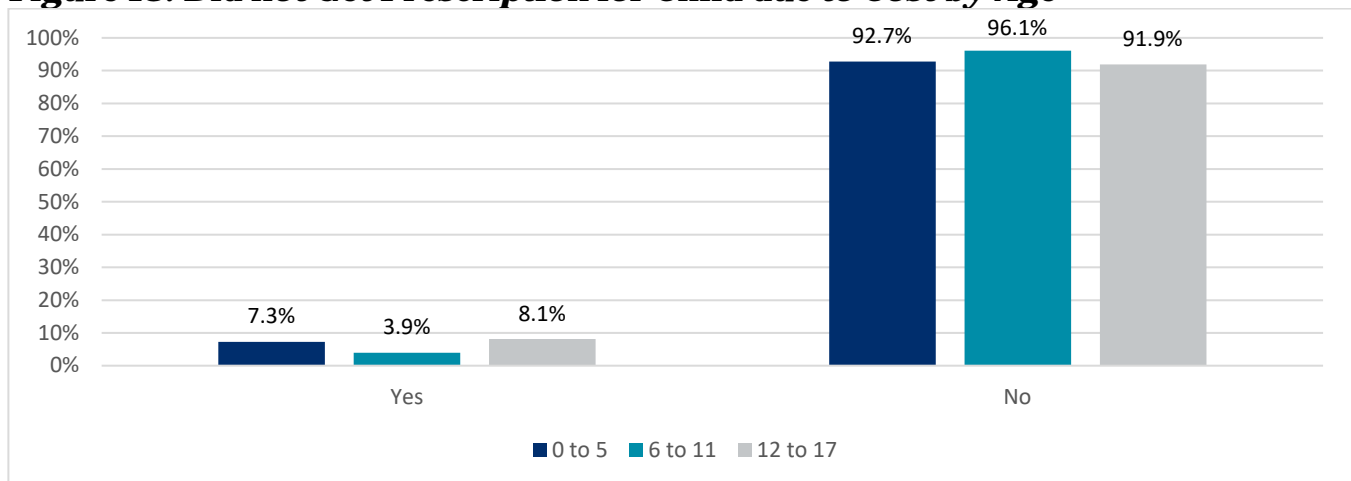
Note: 0 to 5 population estimate = 32,453; 6 to 11 population estimate = 27,978; 12 to 17 population estimate = 27,082.

Utilization

Regularly utilizing healthcare is important for children's health. Having regular visits with a healthcare provider increases the chances of identifying problems early on, thereby improving treatment outcomes.[6] Regular utilization also means getting services, screenings, and treatments when needed which will improve the chances of a higher quality of life.[7]

Recent Healthcare Utilization

Parents/guardians were asked, "About how long has it been since (child's name) last visited a doctor or other healthcare provider?" **Results show that most children (74.8%) have been to see a provider in the past six months.**

There are no significant differences in recent healthcare utilization based on age, however, the trend appears to show that younger children are generally more likely to have visited within the past year than older children.

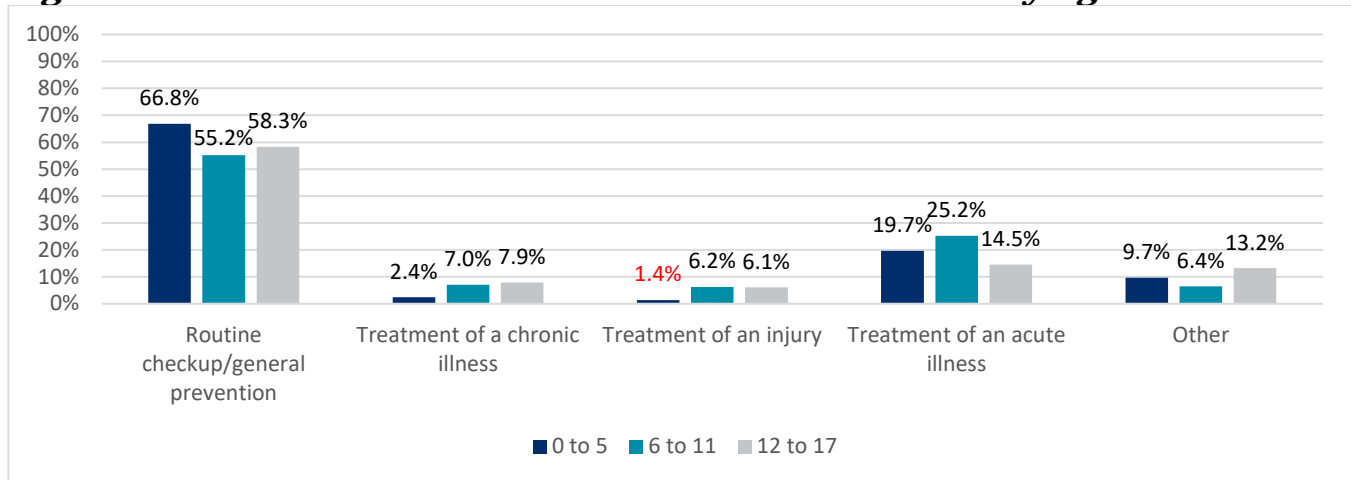*Figure 19. Time Since Last Healthcare Provider Visit by Age*
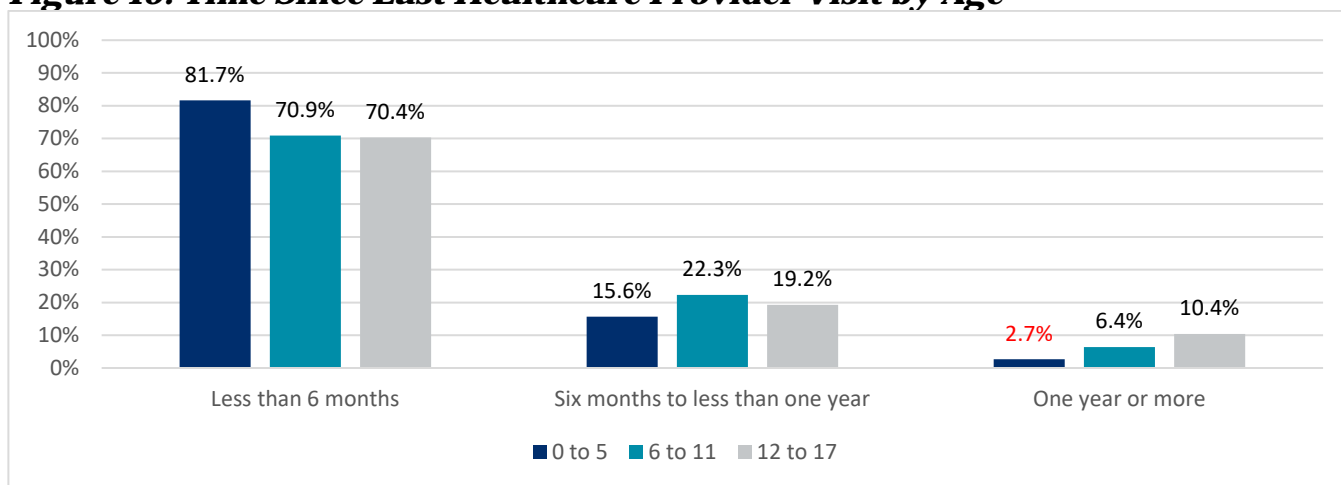
Note: 0 to 5 population estimate = 32,473; 6 to 11 population estimate = 27,734; 12 to 17 population estimate = 26,006. Red indicates statistically unstable estimates.

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[6] Regular Check-Ups are Important. (2017). Centers for Disease Control and Prevention. https://www.cdc.gov/family/checkup/index.htm
[7] Ibid.

Parents/guardians were then asked, "What was the reason for this visit?" **Results show that most recent visits to the healthcare provider were for a routine check-up/general prevention**, as illustrated below. The next most common reason among children was for treatment of an acute illness, such as the flu. Reasons for visiting a provider do not significantly vary based on age.
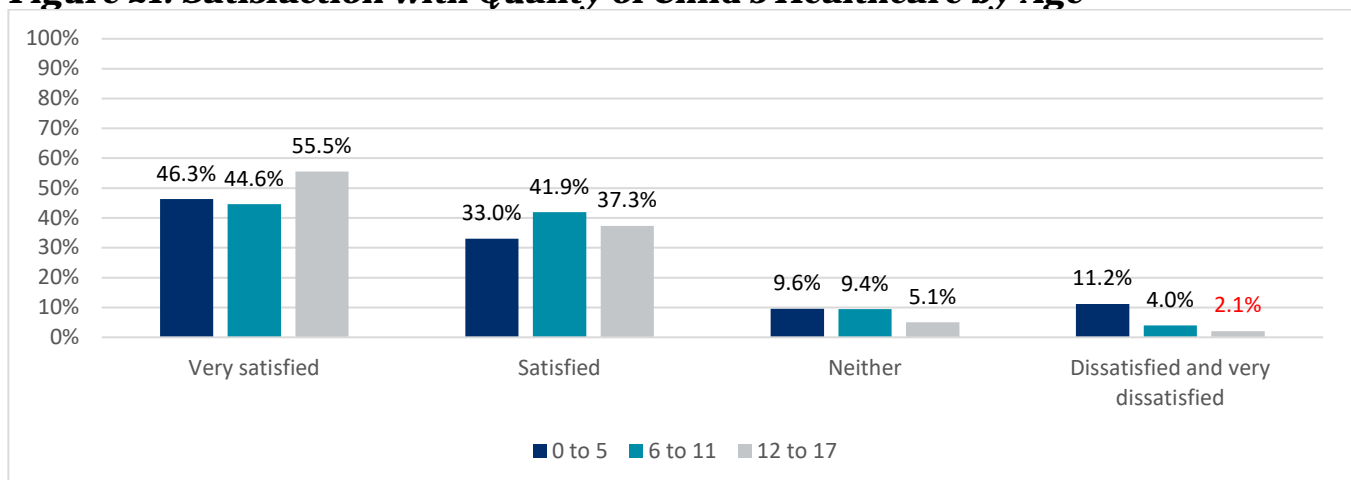
Figure 20. Reason for Child's Most Recent Healthcare Visit by Age

Note: 0 to 5 population estimate = 31,260; 6 to 11 population estimate = 25,870; 12 to 17 population estimate = 23,180. Red indicates statistically unstable estimates.
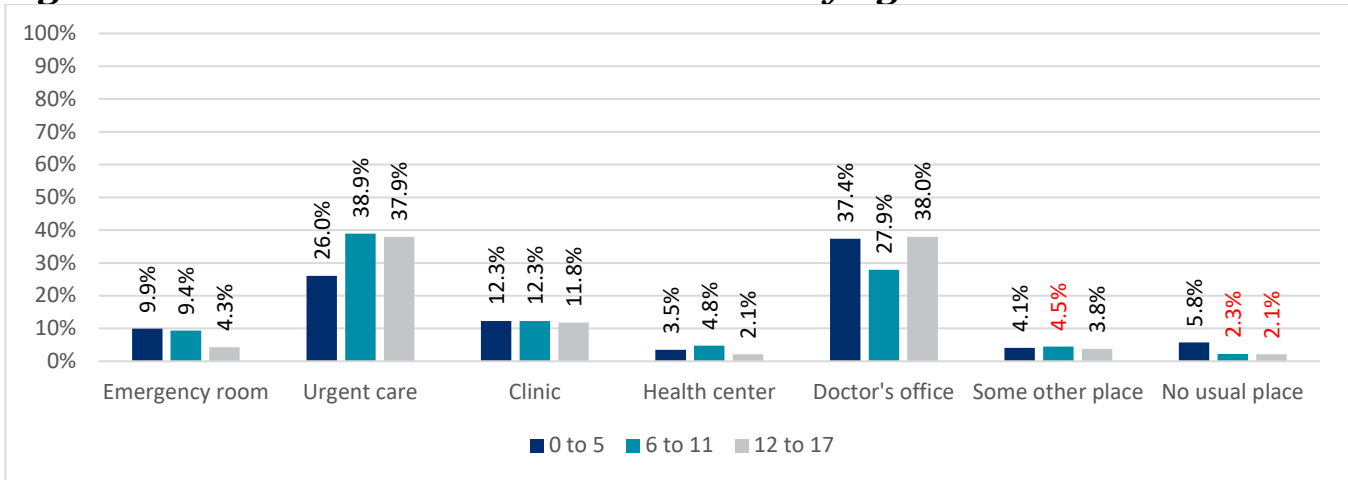
Parents/guardians were asked, "How satisfied are you with the quality of care your child received at their last visit to a healthcare provider?" Results show that satisfaction with quality of care does not seem to significantly vary with child age group, as illustrated in the chart below; **the majority of parents/guardians are "very satisfied" or "satisfied" with the quality of care their child received on their most recent visit**.

Figure 21. Satisfaction with Quality of Child's Healthcare by Age

Note: 0 to 5 population estimate = 31,605; 6 to 11 population estimate = 25,870; 12 to 17 population estimate = 23,000. Red indicates statistically unstable estimates.

Usual Source of Care

Parents/guardians were asked, "When your child is sick or in need of health care, where do you usually go? Would you say…", and then provided with a list of options from which to choose. **Results show that most local children either go to the doctor's office (34.5%) or urgent care (33.8%) when they are sick or in need of care.**

There are no significant differences in usual source of care based on age. Unfortunately, between 4% and 10% of children utilize the emergency room as their usual source of care, as illustrated in the figure below. This is not ideal as children will lack a continuity of care.

Figure 22. Usual Source of Healthcare for Child by Age

Note: 0 to 5 population estimate = 32,972; 6 to 11 population estimate = 27,978; 12 to 17 population estimate = 26,714. Red indicates statistically unstable estimates.

Next, parents/guardians were asked, "Does the child's usual healthcare provider have services available during evenings and weekends?" Weekend/evening availability does not vary by age, as illustrated below; it is concerning that **the majority of children of all ages do not have a provider available on the off-hours**, however.

Figure 23. Child's Provider Available on Evenings/Weekends by Age
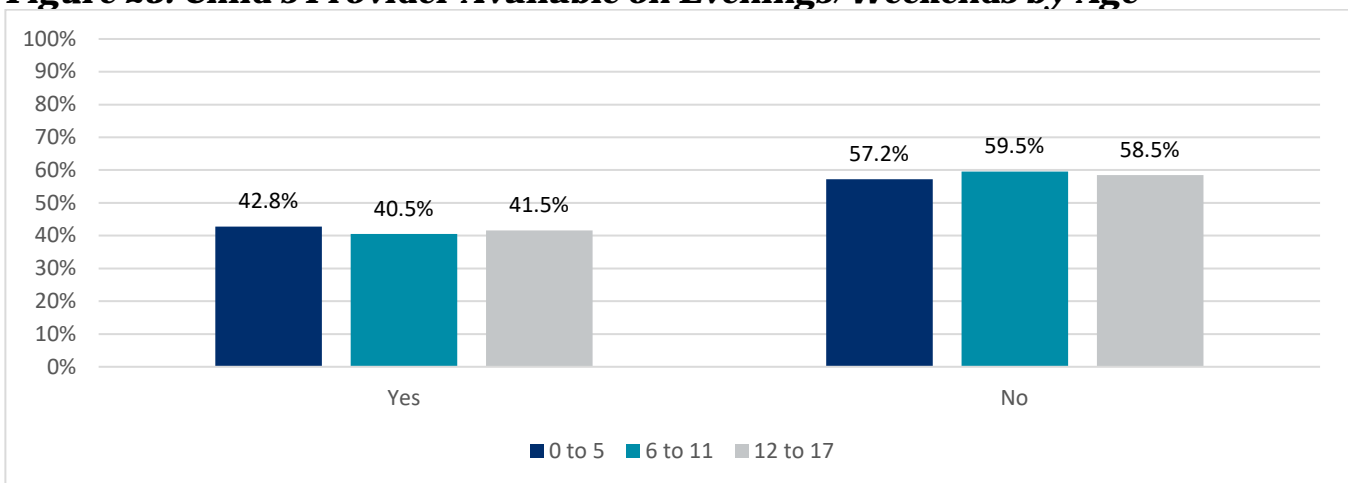
Note: 0 to 5 population estimate = 30,629; 6 to 11 population estimate = 23,365; 12 to 17 population estimate = 25,403.

Barriers to Care

Parents/guardians of children were asked, "Please tell me if any of the following has consistently made it very difficult or prevented you from getting (child's name) the health care he/she needs in the past 12 months", and then were provided with a list of options.

As illustrated in the figure below, language barriers/problems appear to be the top barrier for each child age group when trying to access healthcare. Other common barriers, regardless of child age group, include taking time off work to take the child to the appointment and understanding what is covered by the child's health insurance.

These findings illustrate a need for healthcare services that are bilingual and easily understood by parents. In addition, there is a need for flexible work time schedules among employers, or flexible healthcare service hours, especially for parents of young children.

Figure 24. Barriers to Child Receiving Healthcare by Age
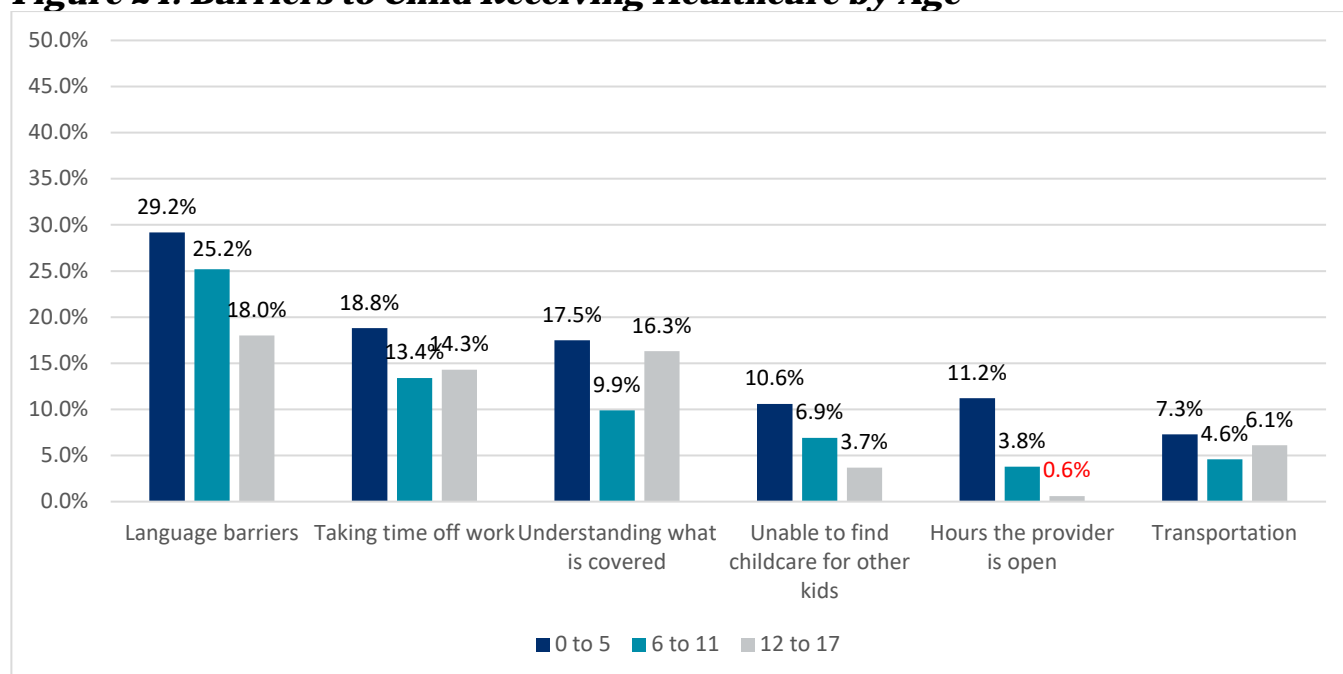
Note: Transportation (0 to 5 population estimate = 33,245; 6 to 11 population estimate = 27,978; 12 to 17 population estimate = 27,137), hours (0 to 5 population estimate = 33,245; 6 to 11 population estimate = 27,978; 12 to 17 population estimate = 27,137), language (0 to 5 population estimate = 33,245; 6 to 11 population estimate = 27,978; 12 to 17 population estimate = 27,137), taking time off work (0 to 5 population estimate = 33,245; 6 to 11 population estimate = 27,978; 12 to 17 population estimate = 27,137), understanding coverage (0 to 5 population estimate = 33,245; 6 to 11 population estimate = 27,978; 12 to 17 population estimate = 27,137), can't find childcare or homecare (0 to 5 population estimate = 33,245; 6 to 11 population estimate = 27,798; 12 to 17 population estimate = 27,137). Red indicates statistically unstable estimates.

Children who have experienced ACEs (33.6%) are significantly more likely to have a language barrier when seeking healthcare compared to children who have no ACEs (18.1%).

## *Figure 25. Language Barrier by ACEs*
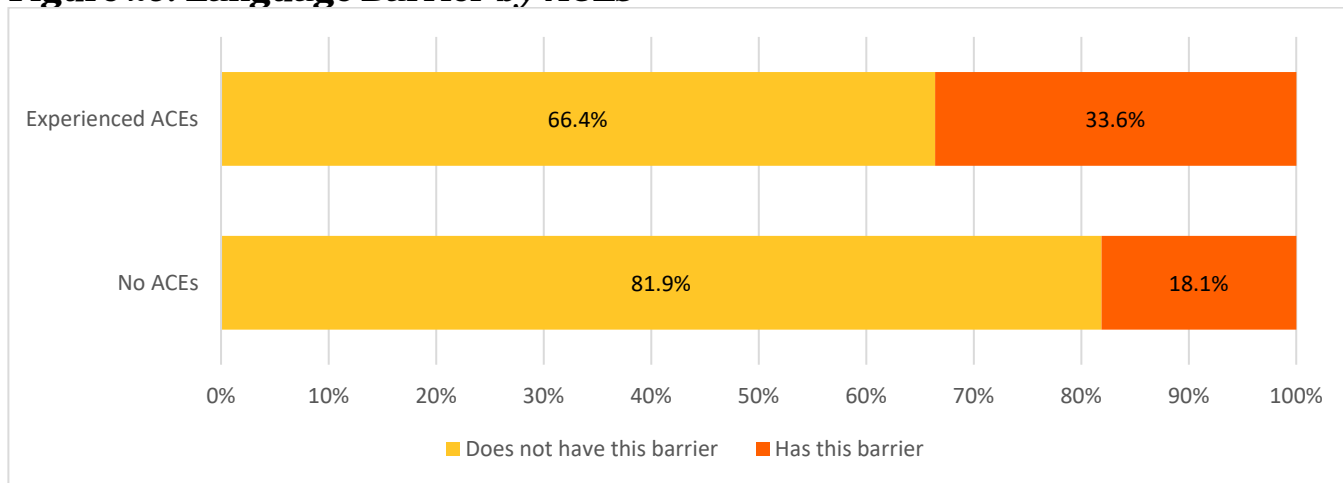
Note: No ACEs population estimate = 51,773; Experienced one or more ACEs population estimate = 36,536.

Sometimes barriers to care can make it so difficult that parents/guardians are not able to get the child the appropriate care. To measure this, parents/guardians were asked, "During the past 12 months, did you delay or not get a test or treatment that a health care provider ordered for (child's name)?"

Fortunately, results show that the vast majority of children, regardless of age group, did not have to delay or forego treatment in the past year. However, **approximately 5.7% of local children had to delay or forgo a test or treatment that a healthcare provider ordered in the past year**. Common reasons for the delay or denial of treatment included high cost, lack of insurance, or inability to take time off work to take the child to the treatment.

Figure 26. Delayed or Did not get Treatment in the Past Year by Age
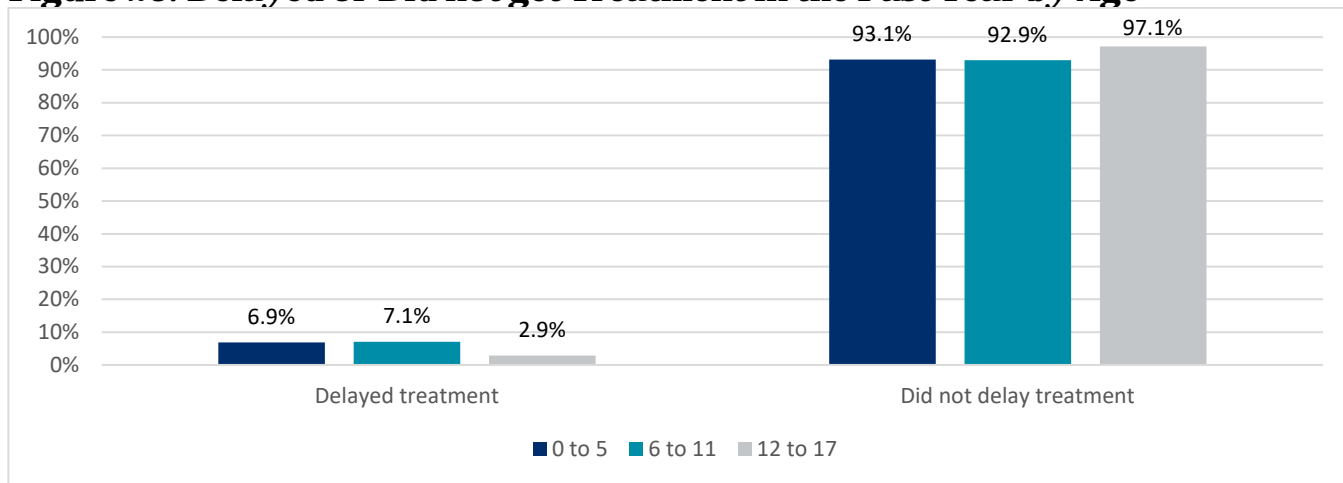
Note: 0 to 5 population estimate = 32,910; 6 to 11 population estimate = 27,905; 12 to 17 population estimate = 26,651.

Local Resources for Healthcare Access and Utilization

<u>Federally Qualified Health Centers</u>

Federally qualified health centers (FQHCs) are a key way for local children to get the care they need. All FQHCs accept Medi-Cal/Medicaid and all provide a sliding-scale fee structure for people who are uninsured. As a result, FQHCs are a way to provide healthcare for even the most impoverished. FQHCs provide primary care, and many also provide behavioral healthcare, dental care, and specialty care. The Coachella Valley is home to several FQHCs, including:

Borrego Health
Website: www.borregohealth.org
Clinic Locations: Cathedral City, Desert Hot Springs, Indio, Thermal, Palm Springs, Oasis
Services: Behavioral health, dental, family planning, family practice, gynecology, pediatrics, pharmacy, psychiatry, radiology, sexual health, urgent care

Central City Community Health Center
Website: www.centralcityhealth.org
Clinic Location: Indio
Services: Behavioral health, family practice

Clinicas de Salud del Pueblo
Website: www.cdsdp.org
Clinic Locations: Coachella, Mecca
Services: Behavioral health, dental, family planning, laboratory, obstetrics, pediatrics, pharmacy, psychiatry, radiology, women's health

Loma Linda University Children's Health Indio
Website: https://lluh.org/locations/loma-linda-university-childrens-health-indio
Clinic Location: Indio
Services: Pediatrics, pediatrics urgent care

Riverside University Health System – Community Health Centers (RUHS-CHC)
Website: https://www.rivco-familycarecenters.org/Home.aspx
Clinic Locations: Indio, Palm Springs
Services: Family planning, perinatal care, primary care,

Hospitals

Our three local hospitals also provide care at their main locations and their many satellite locations throughout the Valley.

Desert Care Network
DCN operates both Desert Regional Medical Center in Palm Springs and JFK Memorial Hospital in Indio, as well as several satellite locations, which include urgent cares, imaging centers, and cancer centers, among others.
Website: https://www.desertcarenetwork.com/home

Eisenhower Health
Eisenhower Health's main location in Rancho Mirage is supplemented by many others across the Valley, including health centers in Cathedral City, La Quinta, Palm Desert, and Palm Springs.
Website: https://eisenhowerhealth.org/

Medi-Cal Providers

As illustrated in the previous section, most local children are insured by Medi-Cal, California's Medicaid program. Any low-income children who are uninsured are eligible for Medi-Cal, even those who are undocumented.

Inland Empire Health Plan (IEHP)
About: IEHP is a nonprofit Medi-Cal health plan. They are the largest health plan in the Inland Empire, and they provide comprehensive managed health care coverage to those who are enrolled in Medi-Cal or Cal MediConnect (Medicare-Medicaid Plan).
Website: https://ww3.iehp.org/

Molina Healthcare
About: Molina Healthcare provides Medi-Cal and the State Children's Health Insurance Program (SCHIP) as well as integrated Medicaid/Medicare plans. They also provide coverage through Covered California.
Website: https://www.molinahealthcare.com/

Preventative Health

Preventative health is vitally important in early identification and treatment of health conditions/major diseases. Engaging in preventative health can be as simple as having regular screenings and checkups.

Dental Health

The American Academy of Pediatric Dentists recommends that all children have their first dentist visit by the age of one, and subsequently get a check-up every six months in order to prevent cavities and other dental problems.[8] Parents/guardians were first asked, "Has your child ever been to a dentist?"

Overall, 83.3% of local children ages 0 to 17 have been to the dentist at least once, while 16.7% have never visited.

Whether a child has ever been to see a dentist significantly varies with age, as illustrated in the figure below—younger children are significantly less likely to have been to the dentist than older children. In fact, 39.0% of children 0 to 5 have never been to see a dentist. However, the problem does not completely go away as the children get older—approximately 3.3% of children ages six an older have never been to see the dentist and are long overdue for their first appointment.

Figure 27. Child Ever Been to Dentist by Age
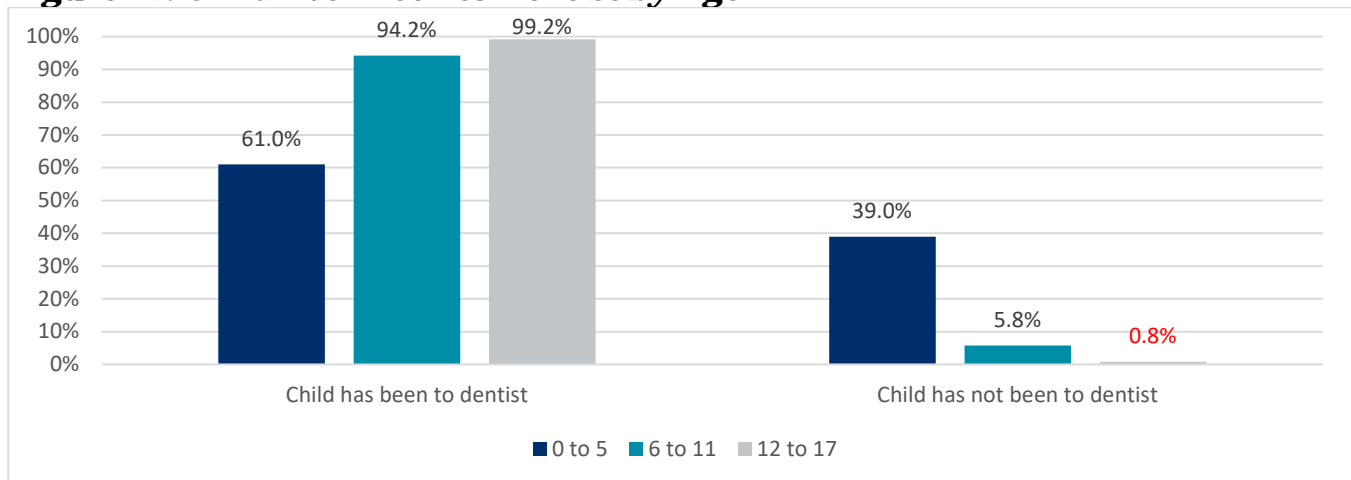
Note: 0 to 5 population estimate = 33,128; 6 to 11 population estimate = 27,978; 12 to 17 population estimate = 27,137. Red indicates statistically unstable estimates.

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[8] Frequently Asked Questions. (n.d.). America's Pediatric Dentists.
https://www.aapd.org/resources/parent/faq/#targetText=A%20check%2Dup%20every%20six,on%20their%20personal%20oral%20health.

Parents/guardians of children who had been to the dentist at least once were then asked, "At what age did (child's name) first visit the dentist?" Results show that **only 17.9% of children who had been to the dentist in their lifetime had that first visit before the age of one, as is recommended**. See the table below for more detail.

Child's Age at First Dental Visit *Children Who Have Ever Been to a Dentist*	Weighted Percent	Population Estimate
0 to 1 years old	17.9%	12,226
2 to 3 years old	42.8%	29,160
4 to 5 years old	28.4%	19,394
6 to 17 years old	10.9%	7,398
Total	**100.0%**	**68,178**

As illustrated in the figure below, the age at which children have first gone to the dentist varies by gender. For example, of those children who have ever been to the dentist, 25.1% of females had their first dental visit by age one, as recommended, but only 11.9% of males had had their first visit in that timeframe.

Figure 28. Child's Age at First Dental Visit by Gender
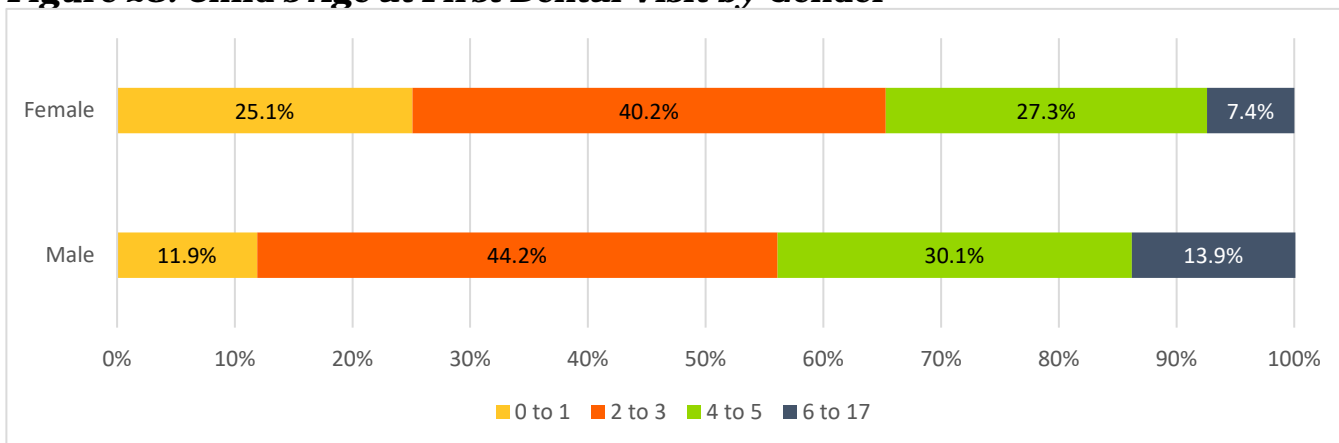
Note: This only includes children who have been to the dentist at least once in their lifetime. Male population estimate = 34,990; Female population estimate = 32,216.

Next, parents/guardians of children who had had at least one dental visit in their lifetime were asked, "About how long has it been since (child's name) last saw a dentist?" Results showed that **most children who have been to the dentist at least once (72.2%) have gone within the past six months, as is recommended**. There is no statistically significant difference in the recency of dental visits based on age.
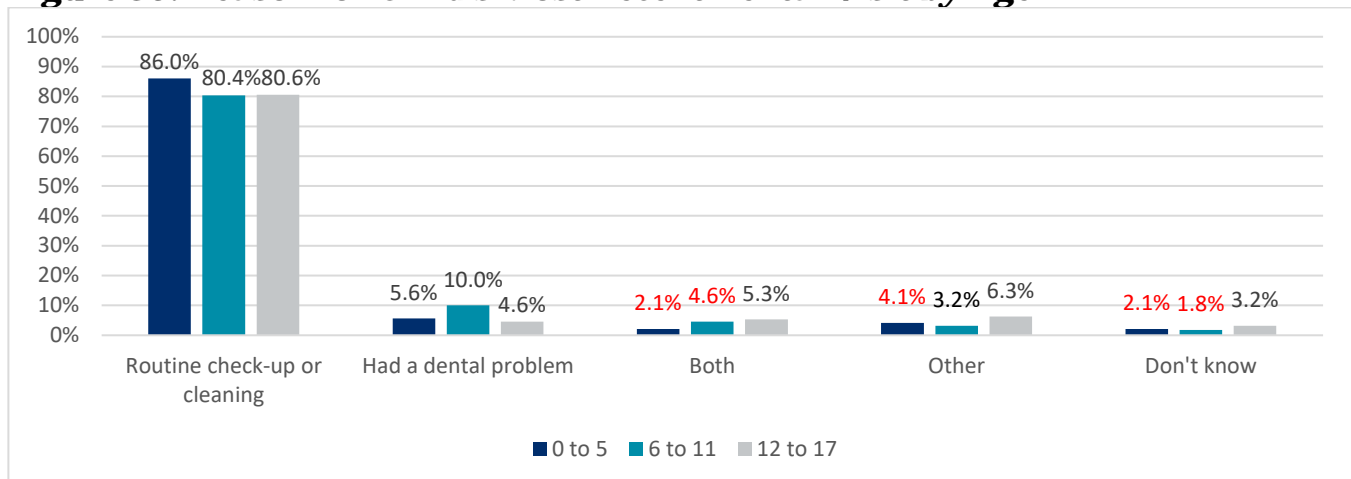
### Figure 29. Time Since Last Visited Dentist by Age
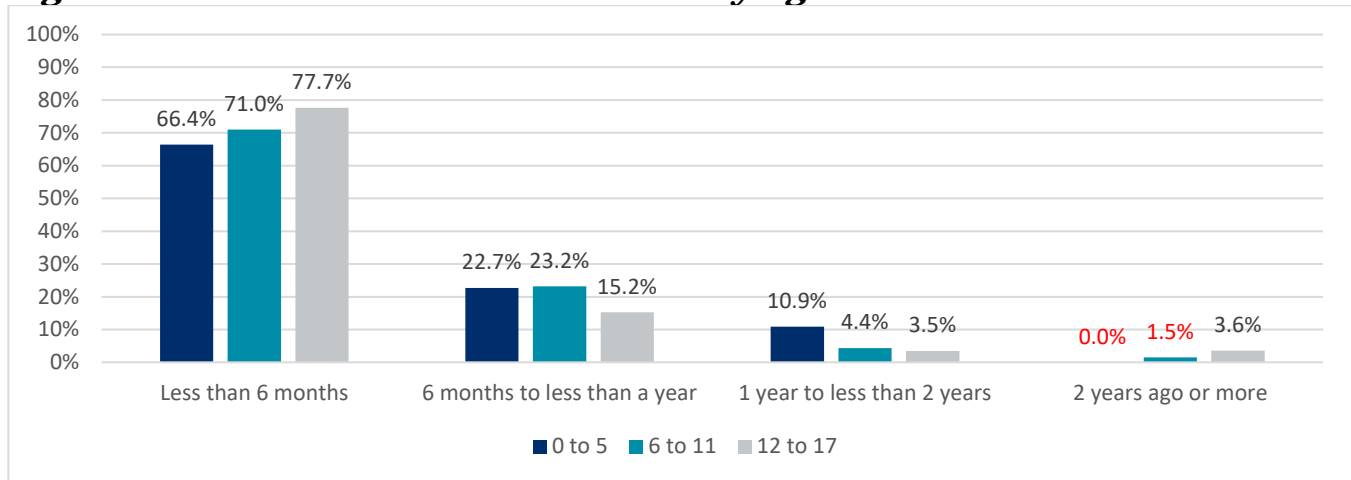
Note: This only includes children who have been to the dentist at least once in their lifetime. 0 to 5 population est. = 19,491; 6 to 11 population est. = 26,148; 12 to 17 population est. = 26,157. Red indicates statistically unstable est..

Parents/guardians of children who hadn't been to the dentist in the past year were asked, "What is the main reason (child's name) has not visited the dentist in the last year?" Results show that **the most common reason why children have not visited the dentist in the past year is because there are "no problems" with the child's teeth**. This illustrates a lack of understanding of the importance of preventative dental care.

Lastly, parents/guardians were asked whether their child's most recent visit was for a routine check-up/cleaning or because of a dental problem. As illustrated below, the majority of these visits are for a routine check-up or cleaning, regardless of the child's age.

Figure 30. Reason for Child's Most Recent Dental Visit by Age

Note: This only includes children who have been to the dentist at least once in their lifetime. 0 to 5 population est. = 20,221; 6 to 11 population est. = 26,354; 12 to 17 population est. = 26,919. Red indicates statistically unstable est.

Immunizations

Parents/guardians were asked, "How concerned are you about the potential risks associated with childhood vaccinations?" As illustrated in the figure below, **the majority of parents/guardians are not at all concerned about potential risks associated with immunizations**. This does not differ based on the age of the child.

Figure 31. Parent/Guardian Concern about Immunization Risks by Age
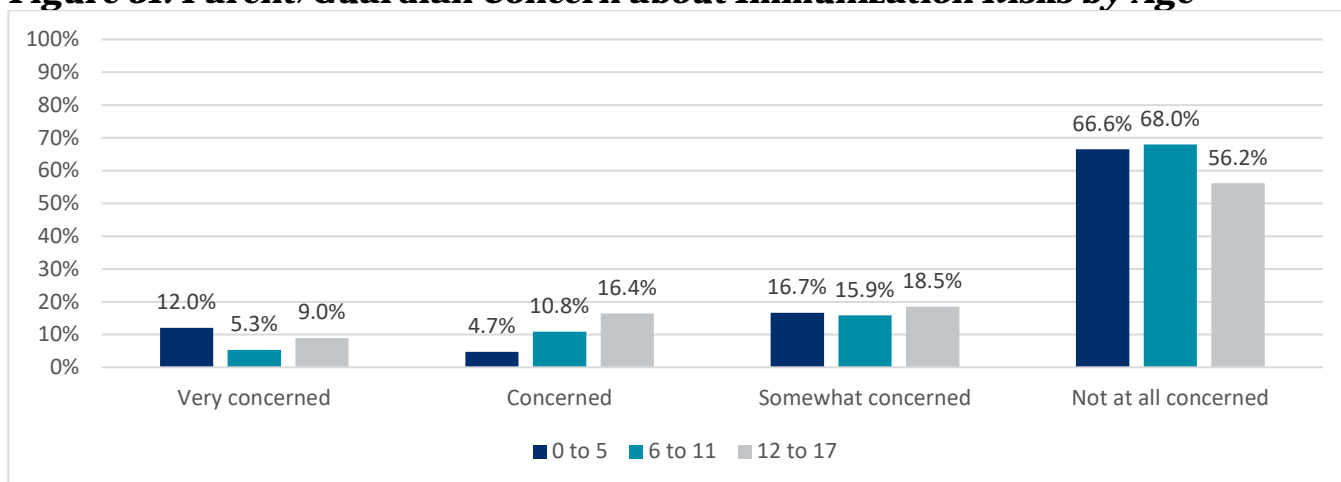
Note: 0 to 5 population estimate = 32,866; 6 to 11 population estimate = 27,632; 12 to 17 population estimate = 26,639.

Parents/guardians of children ages 0 to 5 were also asked, "Please answer the next statement as true or false: I need help using immunization services in my community." Results show that **5.9% of parents/guardians of children ages 0 to 5 need help with immunization services** in their community.

Human papillomavirus (HPV) is a very common virus that can lead to at least six types of cancers.[9] A vaccine known as Gardasil protects against HPV types that are associated with cancer of the cervix, anus, vulva/vagina, penis, and throat.[10] The vaccine is meant for children as early as age 9, and thus, parents/guardians of children ages 9 to 17 were asked, "A vaccine to prevent the human papillomavirus or HPV infection is available and is called cervical cancer vaccine, HPV shot, or GARDASIL®. Has your child ever had the HPV vaccination?"

Results show that **53.9% of children ages 9 to 17 have had the HPV vaccine as recommended**. However, this means that 46.1% of children ages 9 to 17 have *not* had the HPV vaccine, and therefore should be vaccinated as soon as possible.

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[9] About HPV (2019). Centers for Disease Control and Prevention. https://www.cdc.gov/hpv/parents/about-hpv.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fhpv%2Fparents%2Fwhatishpv.html
[10] Should I get the HPV Vaccine? (n.d.). Planned Parenthood. Available online at: https://www.plannedparenthood.org/learn/stds-hiv-safer-sex/hpv/should-i-get-hpv-vaccine

Safety and Injury

Unintentional injury is the leading cause of death among children under the age of 18.[11] Therefore, taking precaution during certain activities is critical for children's health and safety.

Helmet Safety

Helmets are of paramount importance for the prevention of brain and head injuries. Additionally, it is California law that all children under the age of 18 wear a helmet while operating a bicycle.[12]

To assess helmet use, parents of children who are at least age 2 or older are asked, "During the past 12 months, how often has your child worn a helmet when riding a bicycle, scooter, skateboard or skates? Would you say…" As illustrated in the table below, **only about a third of local children ages 2 and older wear a helmet "always"**.

Frequency of Helmet Use *Children Age 2+*	Weighted Percent	Population Estimate
Always	34.8%	27,846
Nearly always	10.9%	8,741
Sometimes	8.1%	6,439
Seldom	3.7%	2,996
Never	12.3%	9,835
Does not ride a bicycle/skateboard/scooter/skates	30.2%	24,118
Total	**100.0%**	**79,975**

Helmet use does not differ based on age, as illustrated in the chart below.

Figure 32. Helmet Usage by Age
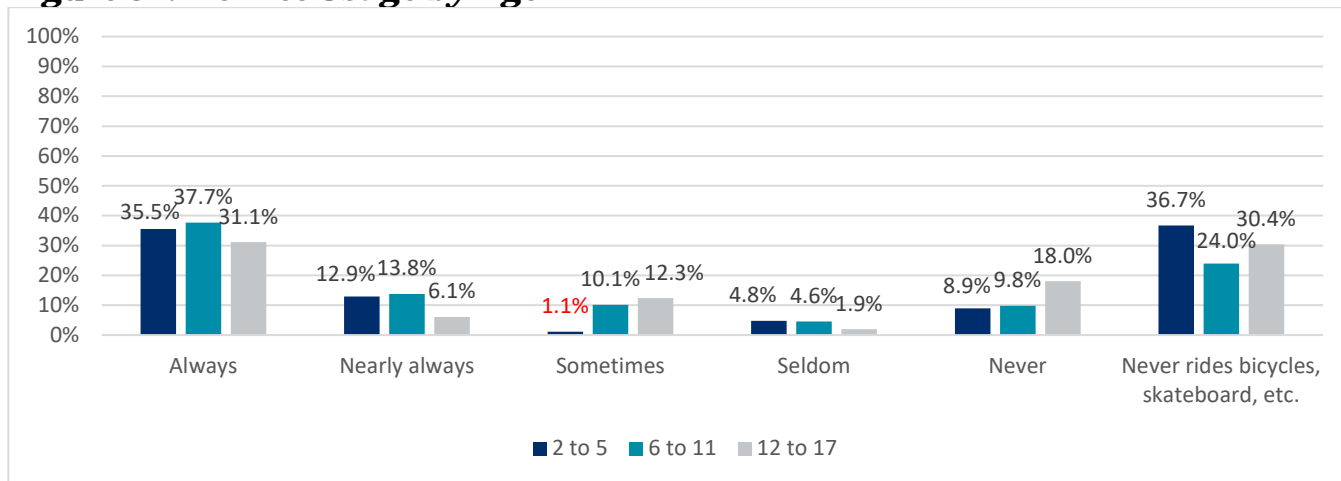
Note: Ages 2+. 2 to 5 population estimate = 25,087; 6 to 11 population estimate = 27,978; 12 to 17 population estimate = 26,911. Red indicates statistically unstable estimates.

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[11] Ten Leading Causes of Death by Age Group -2017. (2019). Centers for Disease Control and Prevention. https://www.cdc.gov/injury/images/lc-charts/leading_causes_of_death_by_age_group_2017_1100w850h.jpg

[12] Article 4. Operation of Bicycles [21200 - 21213]. California Legislative Information. http://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=VEH&division=11.&title=&part=&chapter=1.&article=4.
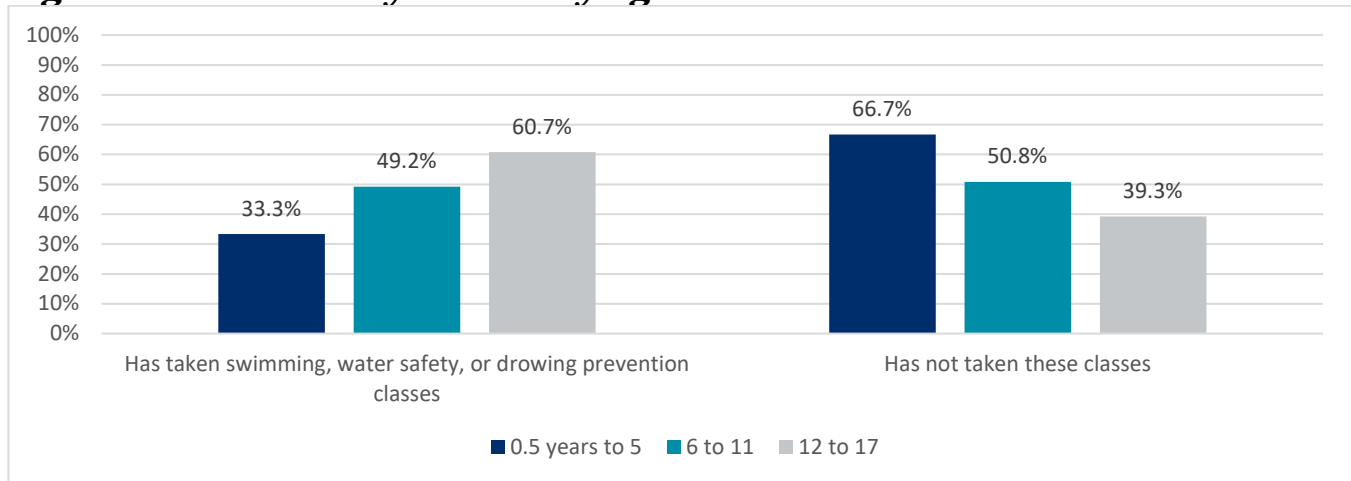
Water Safety

Drownings are the leading cause of injury death for those aged one to 14.[13] Given the Coachella Valley's warm weather, many homes, housing complexes, and apartment buildings have pools, and the opportunities for drowning are high.

Children as young as six months old can take water safety lessons, also known as "self-rescue swim lessons".[14] In these classes, young children are taught how to rotate from an underwater position into a back float and breathe until help arrives, while older children are actively taught how to swim. Thus, parent/guardian respondents of children age six months and older were asked, "Has your child ever taken any swimming, water safety classes, or other drowning prevention classes?"

Results show that 47.0% of Coachella Valley children six months and older have taken one or more water safety classes. This means the other **53.0% of children age six months and older (45,790 children) have _never_ taken any swimming or water safety classes**.

As illustrated below, whether the child has ever taken a water safety courses varies significantly by age. Children of younger ages (0.5 years to 5) are less likely to have taken swimming safety courses compared to teenagers (12 to 17). This may be partially because many parents/guardians are not aware that water safety courses are available for very young children.

Figure 33. Water Safety Courses by Age

Note: Ages 6 months +. 0.5 to 5 population estimate = 31,422; 6 to 11 population estimate = 27,978; 12 to 17 population estimate = 27,069.

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[13] Drowning Prevention. (2019). Centers for Disease Control and Prevention. https://www.cdc.gov/safechild/drowning/index.html
[14] First 5 Riverside. (2019). Water safety lessons save lives. https://www.rccfc.org/wp-content/uploads/2019/04/Drowning-Prevention.pdf

Taking swimming safety courses also varies significantly by household income level. As illustrated in the figure below, children in the higher income brackets ($50,000 to $99,999 and $100,000 or more) are significantly more likely to have taken water safety classes than children in the lower income brackets.

Figure 34. Water Safety Courses by Household Income
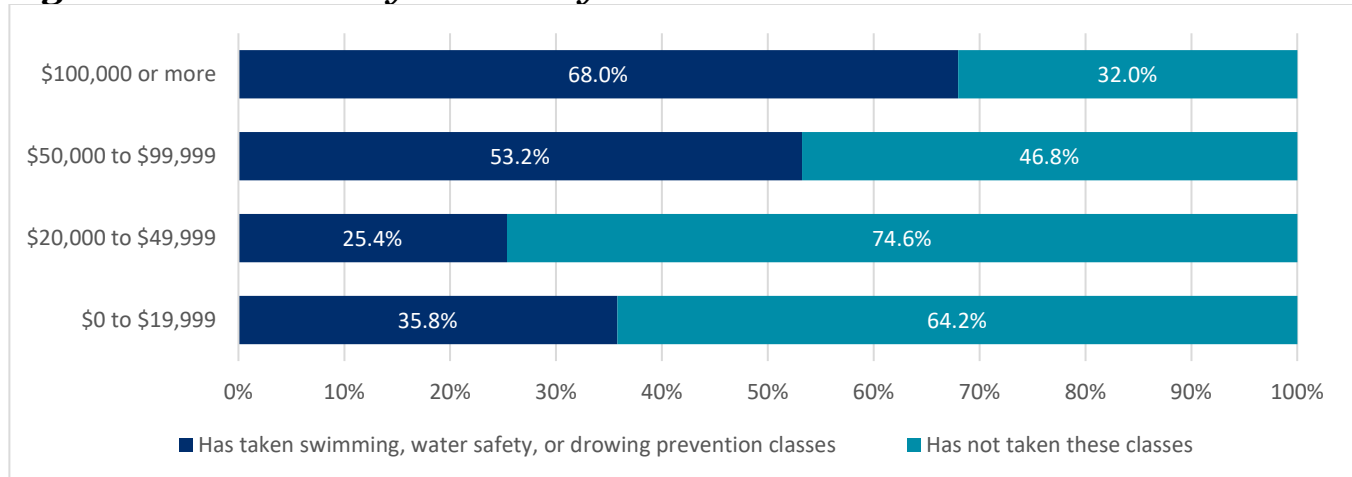
Note: Ages 6 months+. $0 to $19,999 population estimate = 13,507; $20,000 to $49,999 population estimate = 18,082; $50,000 to $99,999 population estimate = 14,655; $100,000 or more population estimate = 25,454.

Ethnicity is also a factor differentiating whether children have taken swimming safety courses. Non-Hispanic/Latino children (55.6%) are significantly more likely to have taken these courses compared to Hispanic/Latino children (38.9%).

Figure 35. Water Safety Courses by Ethnicity
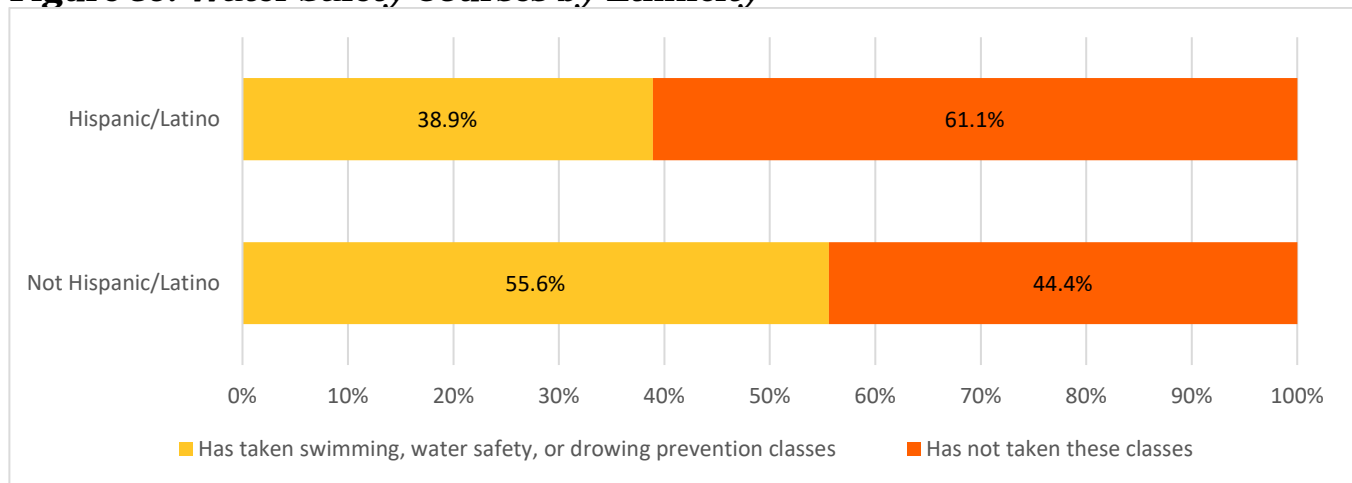
Note: Ages 6 months+. Not Hispanic/Latino population estimate = 42,155; Hispanic/Latino population estimate = 44,315.

Next, parents/guardians of children ages 2 and older were asked, "Does (child's name) know how to swim?" Results show that even though many children have not taken any classes, **the majority of Coachella Valley children ages 2 and older do indeed know how to swim (73.9%)**.

As illustrated in the figure below, swimming ability varies significantly with age; overall, younger children are significantly less likely to know how to swim than older children. However, is worth noting that there are still many older children in the age groups of 6 to 11(20.4%) and 12 to 17 (8.5%) who cannot swim.

Figure 36. Child's Swimming Ability by Age
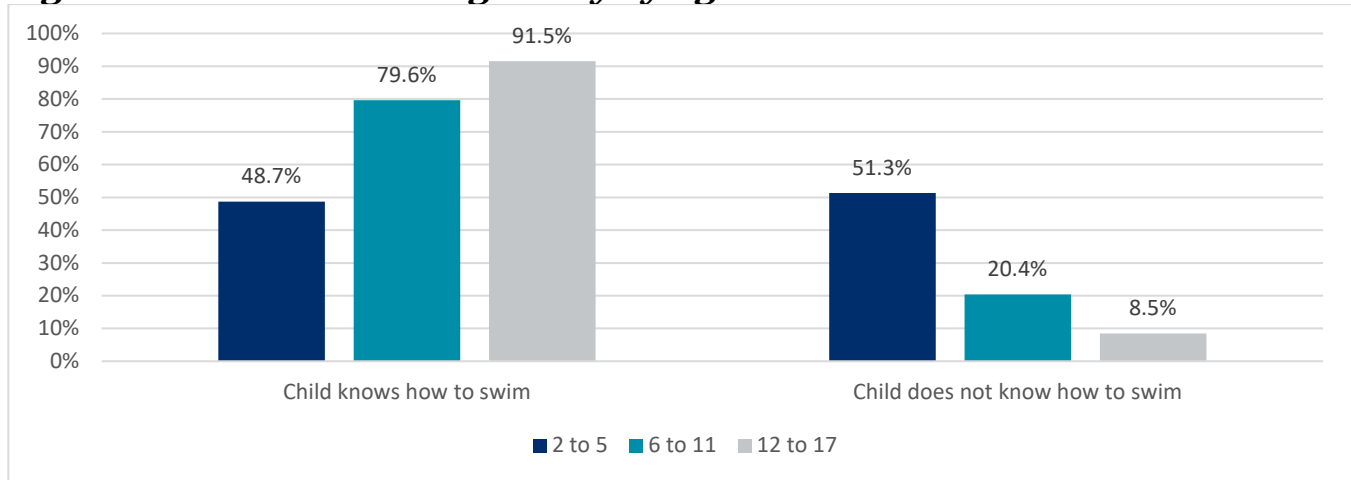
Note: Ages 2+. 2 to 5 population estimate = 25,087; 6 to 11 population estimate = 27,533; 12 to 17 population estimate = 26,877.

Swimming ability of children significantly varies according to household income. As illustrated in the figure below, children living in homes with lower household incomes are less likely to know how to swim compared to children living in homes of greater household incomes.

Figure 37. Child's Swimming Ability by Household Income
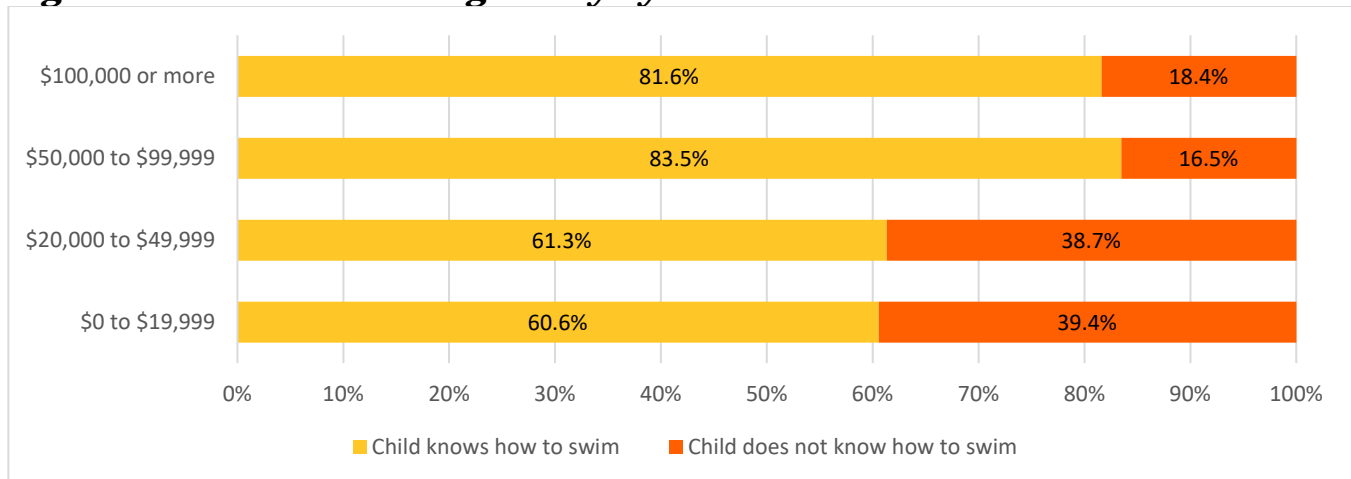
Note: Ages 2+. $0 to $19,999 population estimate = 12,357; $20,000 to $49,999 population estimate = 15,737; $50,000 to $99,999 population estimate = 14,268; $100,000 or more population estimate = 24,176.

Swimming ability also significantly varies by ethnicity; non-Hispanic/Latino children (81.8%) are more likely to be able to swim than Hispanic/Latino children (65.8%).

Figure 38. Swimming Ability by Ethnicity
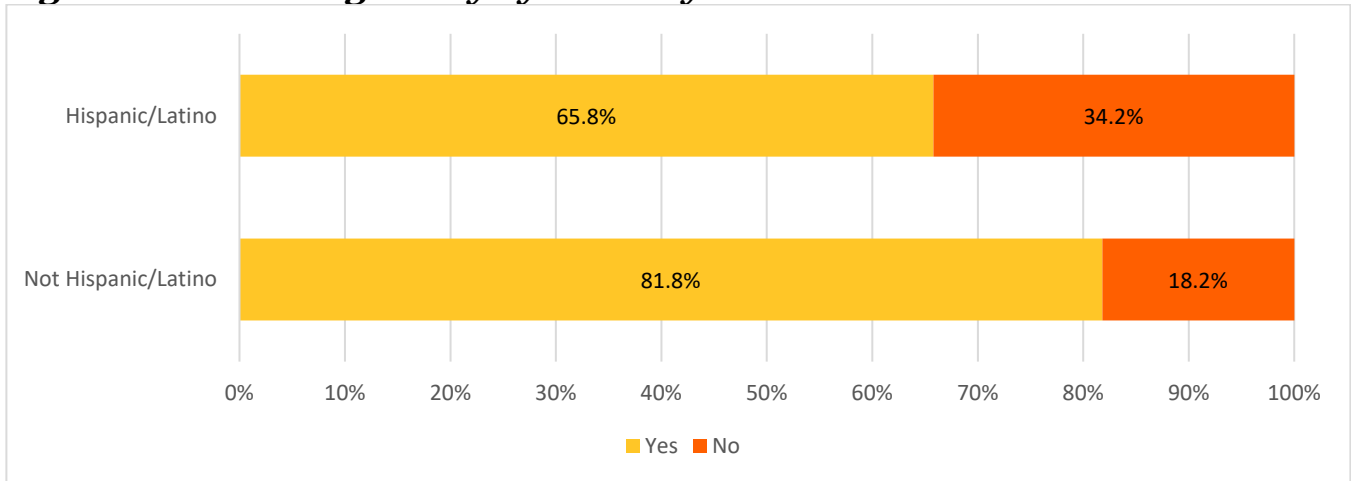
Note: Ages 2+. Not Hispanic/Latino population estimate = 40,328; Hispanic/Latino population estimate = 39,168.

Overall Health

Parents/guardians were asked to categorize the child's health as "excellent", "very good", "good", "fair", or "poor". As illustrated below, most parents think their children are in good or better health. Only a small percent of parents believe their children have "fair" or "poor" health; due to the very small sample sizes, these two categories have been combined. Perception of overall health does not differ based on age.

Figure 39. General Health by Age
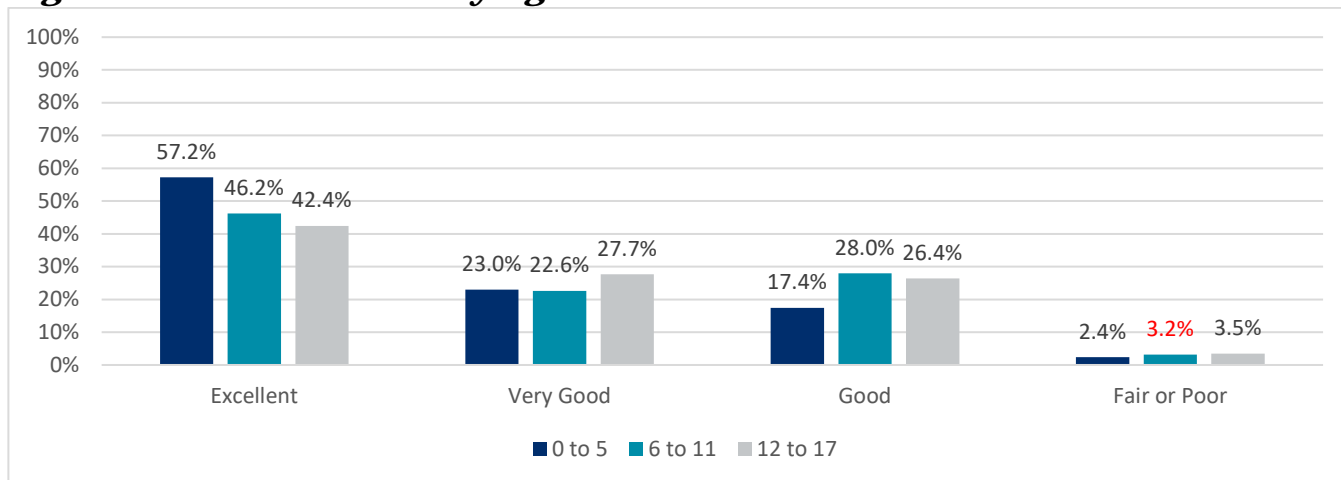
Note: 0 to 5 population estimate = 33,150; 6 to 11 population estimate = 27,978; 12 to 17 population estimate = 27,137. Red indicates statistically unstable estimates.

Parent/guardian perceptions of overall health do differ significantly based on household income, such that children in homes with higher household incomes are more likely to have "excellent" health than those in homes with lower household incomes. For example, approximately 58.3% of children in homes with a household income $100,000 or more have "excellent" health, compared to only 23.8% of children in homes with a household income of less than $20,000.
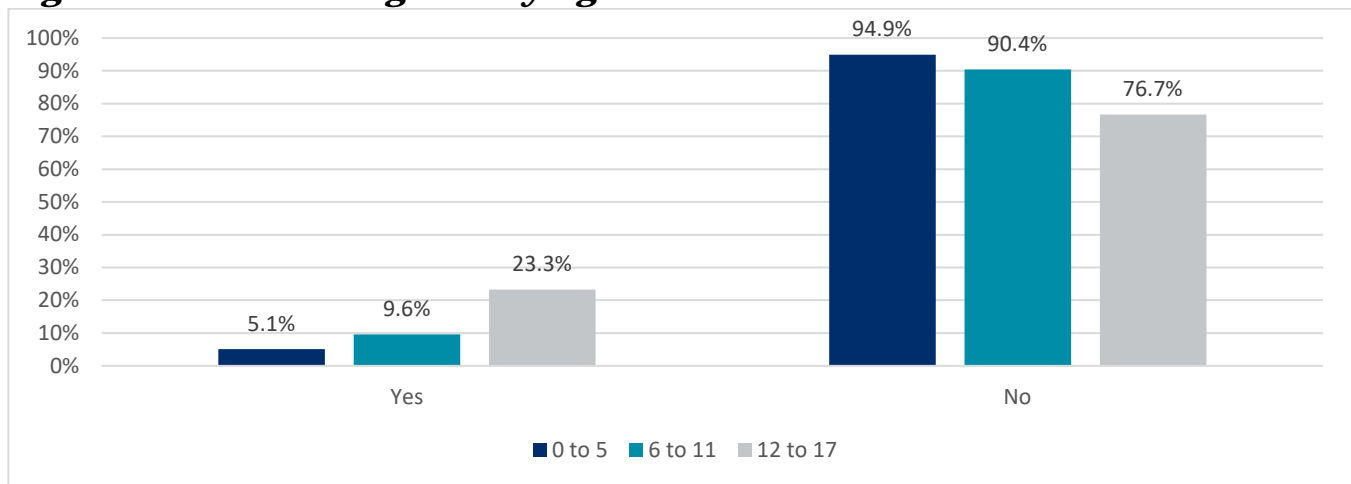
Asthma

Asthma is a chronic condition in which the airways of the body's lungs inflame and narrow, thereby making it difficult to breathe.[15] Symptoms of asthma depend on the severity of the condition, but can include chest tightness, coughing, shortness of breath, and wheezing. Fortunately, asthma can be properly managed by taking medicine and identifying and avoiding triggers in the environment that can cause an asthma attack.[16]

Parents/guardians were asked if any doctor or health professional has ever told them that the child has asthma. Results show that **12.1% of local children have been diagnosed with asthma**.

Asthma diagnoses differ based on the child's age; older children are significantly more likely to have been diagnosed with asthma than their younger counterparts, as illustrated in the figure below.

Figure 40. Asthma Diagnosis by Age

Note: 0 to 5 population estimate = 32,810; 6 to 11 population estimate = 27,978; 12 to 17 population estimate = 27,086.

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[15] Asthma. (n.d.). National Heart, Lung, and Blood Institute. https://www.nhlbi.nih.gov/health-topics/asthma
[16] Asthma. (2018). Centers for Disease Control and Prevention. https://www.cdc.gov/asthma/default.htm

Asthma diagnosis significantly varied by gender. The prevalence of asthma diagnoses is more than twice as high for boys (17.1%) than for girls (7.6%), as illustrated in the figure below.

Figure 41. Asthma Diagnosis by Gender
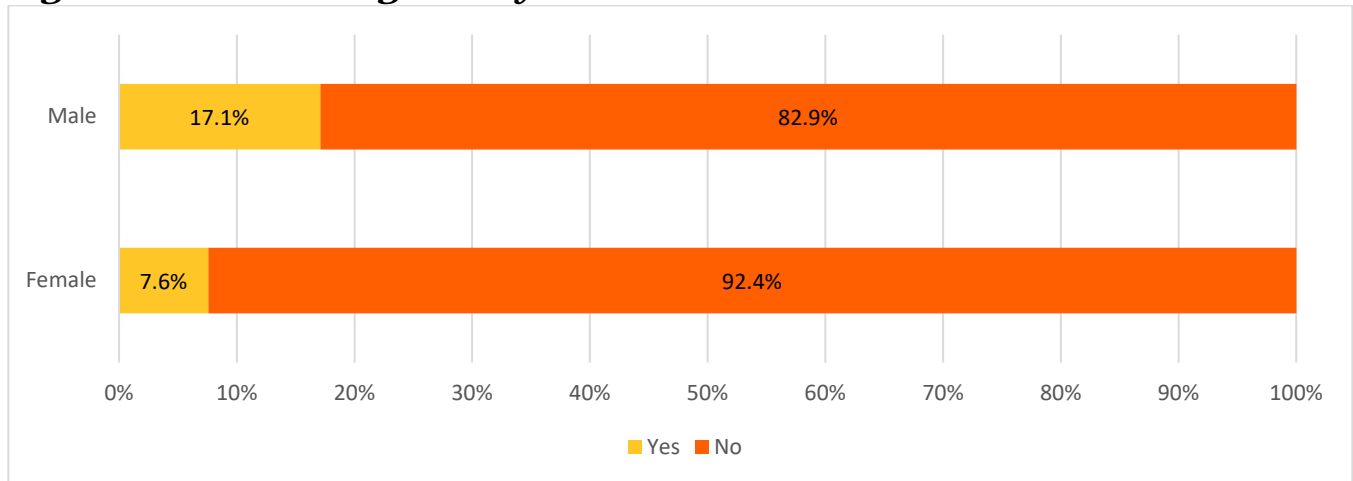
Note: Male population estimate = 43,683; Female population estimate = 42,343.

Parents/guardians of children with an asthma diagnosis were asked if their child had to miss any days of school/daycare due to their asthma. More than half of 6 to 11-year-olds with asthma missed at least one day of school due to asthma, as illustrated in the figure below.

Figure 42. Children with Asthma - Missed School Due to Asthma by Age
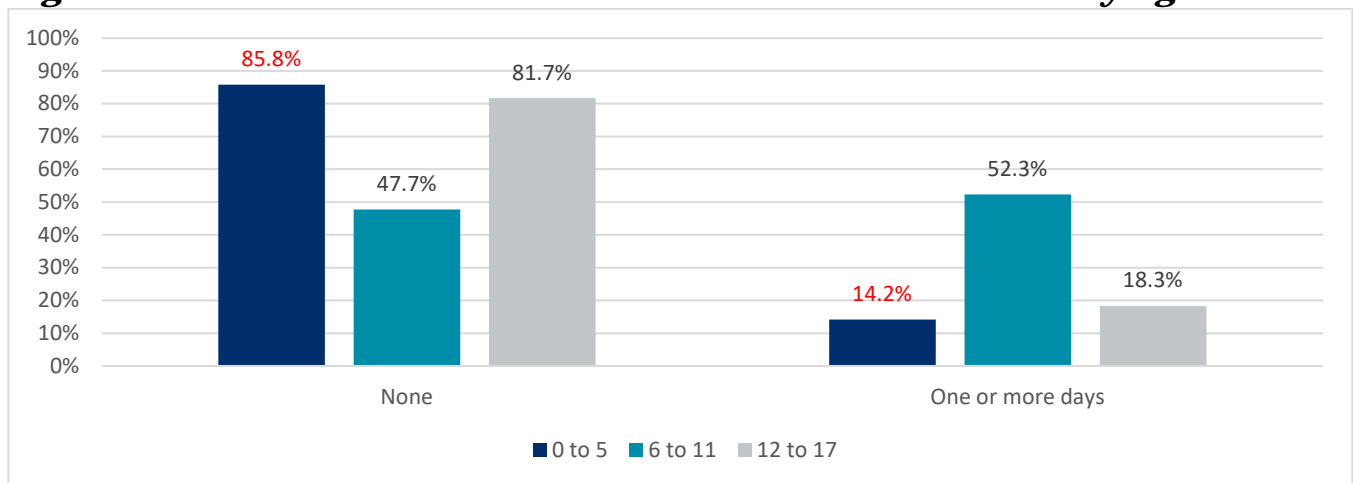
Note: Children with asthma only. 0 to 5 population estimate = 1,312; 6 to 11 population estimate = 2,625; 12 to 17 population estimate = 6,311. Red indicates statistically unstable estimates.

Mental Health

Mental health disorders in children can be defined as issues or changes in the way children learn, behave, or handle their emotions.[17] Common mental health disorders among children are attention-deficit/hyperactivity disorder (ADHD), anxiety, and behavior disorders.[18] Since it can be difficult to diagnose an infant or very young child with a mental health disorder, this section is limited to children age 3 years or older.

Mental or Behavioral Difficulties

Parents/guardians of children ages 3 and older were asked, "Overall, do you think that (child's name) has difficulties in any of the following areas: emotions, concentration, behavior, or being able to get along with other people?" Results show that **25.3% of children ages 3 and older have difficulties with emotions, concentration, behavior, and/or getting along with others**. There were no significant differences based on age, as illustrated in the figure below.
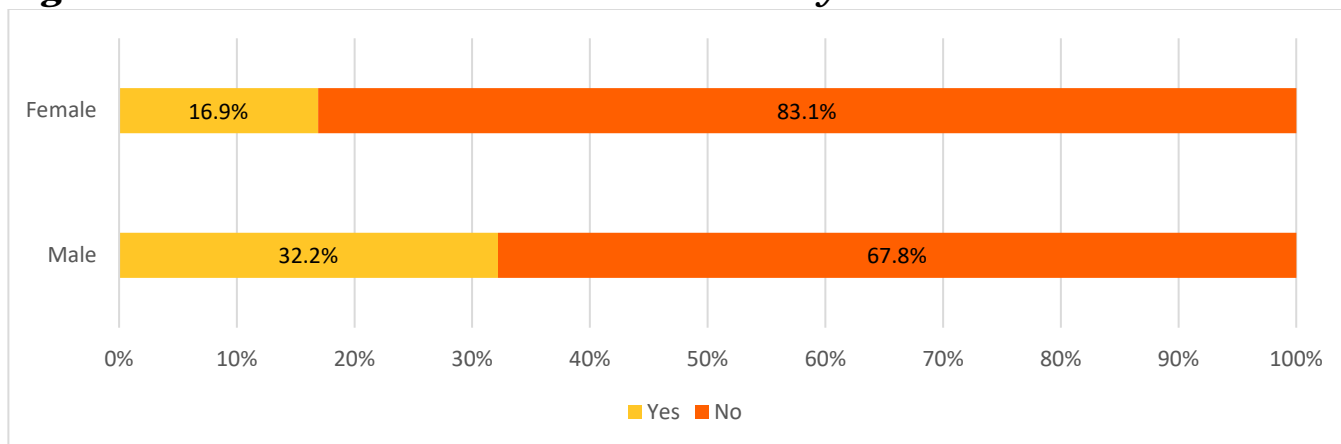
Figure 43. Child has Difficulties with Emotions by Age
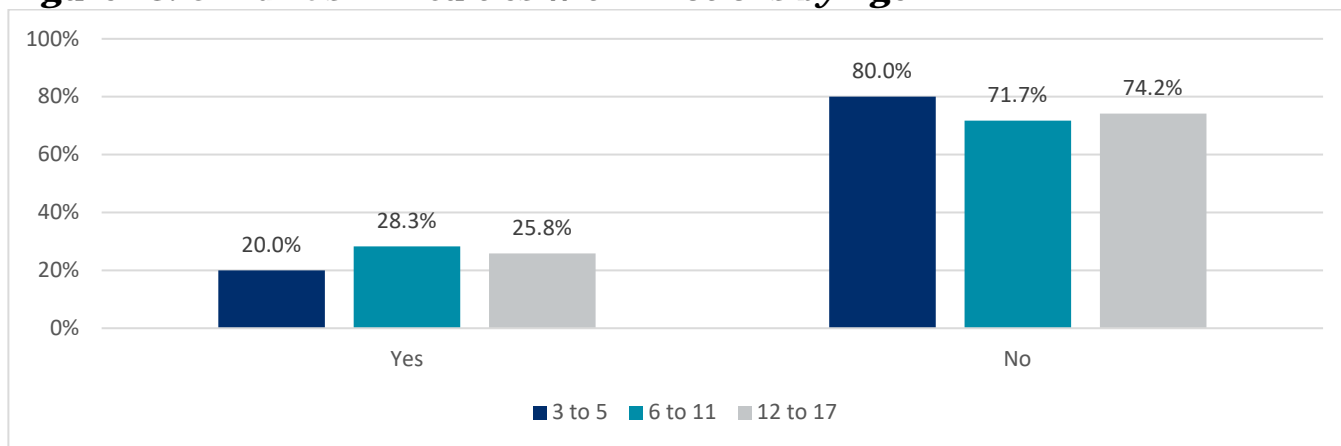
Note: Ages 3+. 3 to 5 population estimate = 17,915; 6 to 11 population estimate = 27,978; 12 to 17 population estimate = 27,137.

However, there were significant differences based on gender; as illustrated below, male children were twice as likely to struggle with emotions, concentration, etc. than female children.

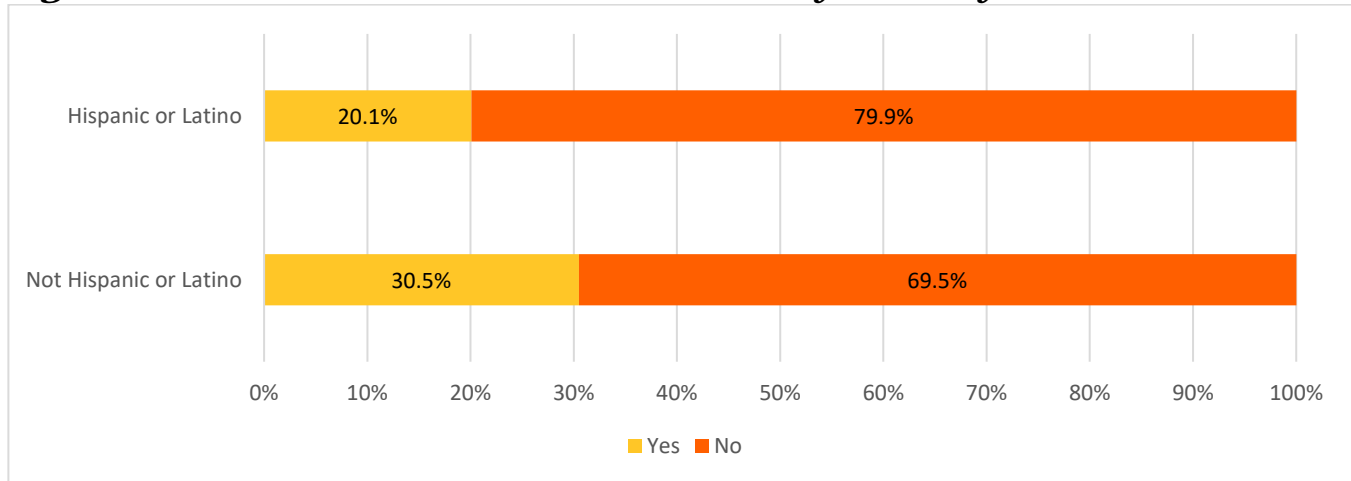**Figure 44. Child has Difficulties with Emotions by Gender**

Note: Ages 3+. Male population estimate = 36,410; Female population estimate = 34,772.

[17] https://www.cdc.gov/childrensmentalhealth/features/kf-childrens-mental-health-report.html
[18] https://www.cdc.gov/childrensmentalhealth/data.html#ref

These difficulties also vary by ethnicity; non-Hispanic/Latino children are significantly more likely to struggle with emotions, concentration, behavior, and/or getting along with others when compared to Hispanic/Latino children.
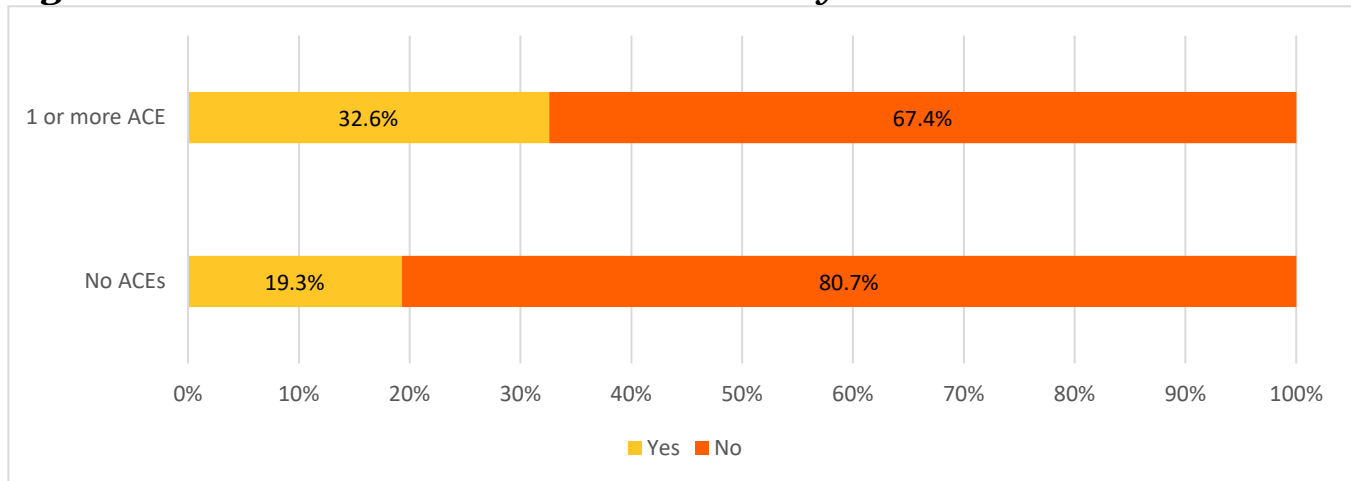
Figure 45. Child has Difficulties with Emotions by Ethnicity

Note: Ages 3+. Hispanic or Latino population estimate = 36,580; Not Hispanic or Latino population estimate = 36,450.

Children that have experienced one or more ACE also show higher rates of difficulties with emotions, concentration, etc. (32.6%) when compared to children with no ACEs (19.3%), as illustrated in the figure below.

*Figure 46. Child has Difficulties with Emotions by ACEs*

Note: Ages 3+. No ACEs population estimate = 40,005; 1 or more ACEs population estimate = 32,974.

Parents/guardians of children who had difficulties with emotions, concentration, behavior, and/or getting along with others were then asked, "Are these difficulties minor or severe?"

Results show that the majority of these issues—72.3%—are minor. Nonetheless, about one quarter of children who experience such difficulties experience severe difficulties, and may need treatment. The severity of emotional/behavioral difficulties does not vary based on age, as illustrated below.
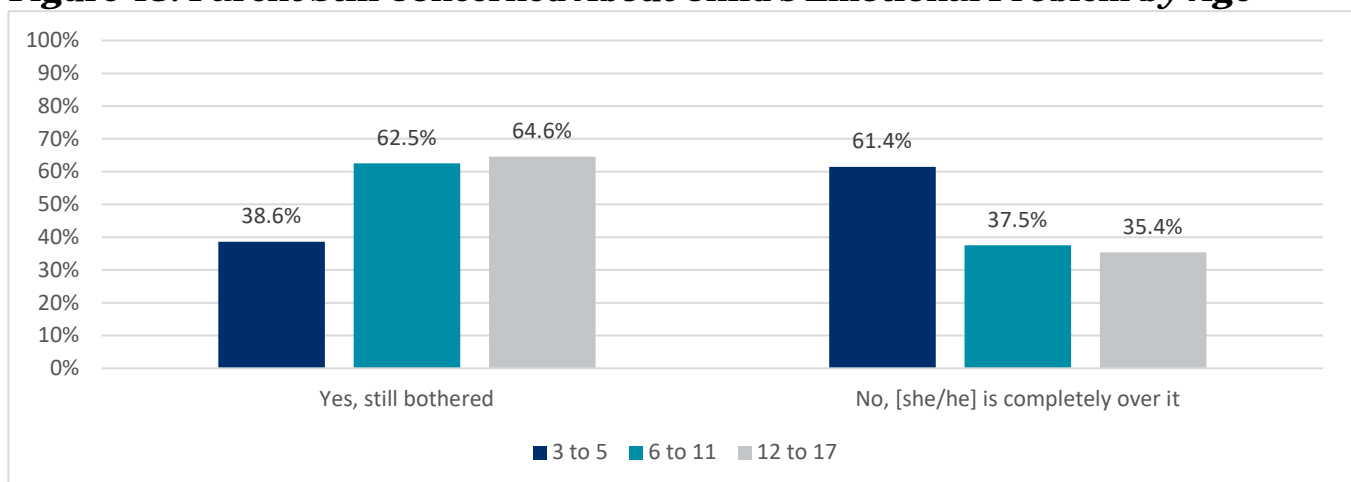
Figure 47. Difficulties are Minor or Severe by Age
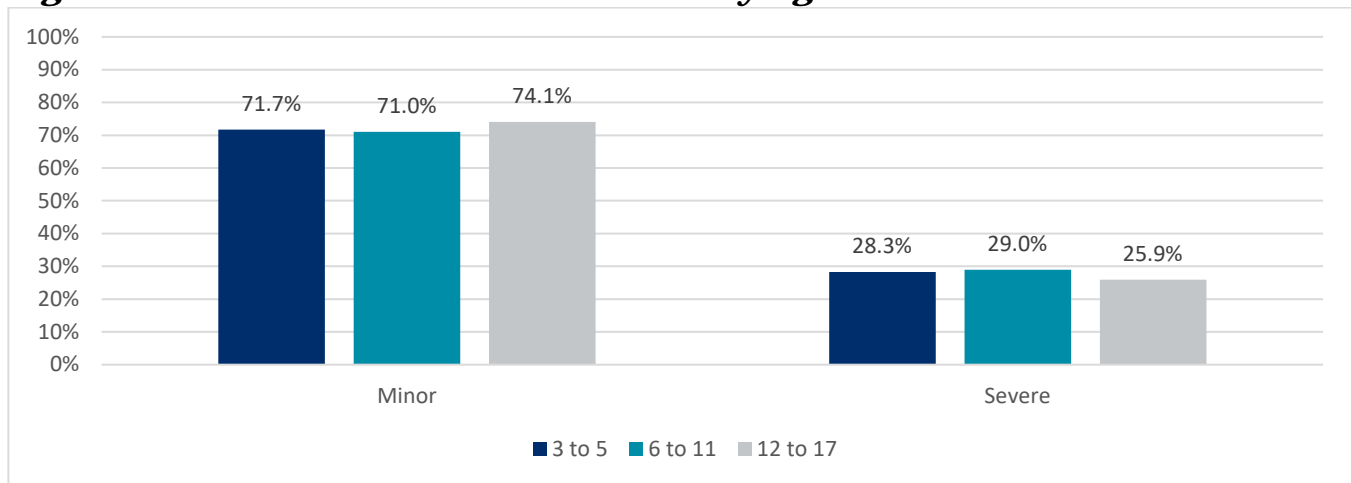
Note: Ages 3+, restricted to only those children who experienced a difficulty with emotions, concentration, behavior and/or getting along with others. 3 to 5 population estimate = 3,576; 6 to 11 population estimate = 7,368; 12 to 17 population estimate = 6,675.

Parents/guardians of children with difficulties were then asked, "Are you still concerned about your child's emotional, mental and behavioral problem?" Most of the parents of children ages 3 to 5 are no longer concerned (61.4%). However, for the older children, ages 6-17, most parents are still concerned.

Figure 48. Parent Still Concerned About Child's Emotional Problem by Age


Note: Ages 3+, restricted to only those children who experienced a difficulty with emotions, concentration, behavior and/or getting along with others. 3 to 5 population estimate = 3,576; 6 to 11 population estimate = 7,925; 12 to 17 population estimate = 6,995.

Mental Health Diagnoses

To assess how many children had been diagnosed with various mental health disorder, parents/guardians were asked, "Has a doctor or health professional ever told you that (child's name) had… (list of specific mental health disorders)". The list included seven specific disorders: attention deficit disorder/attention deficit/hyperactivity disorder (ADD/ADHD), anxiety disorders, developmental delay, autism, mood disorders, suicidal thoughts, and eating disorders.

Overall, **18.5% of local children ages 3 and over have been diagnosed with one or more of these mental health disorders**. The likelihood that a child has been diagnosed with one or more mental health disorders increases as the child gets older, as illustrated in the figure below.

Figure 49. Diagnosed with Any Mental Health Disorder by Age
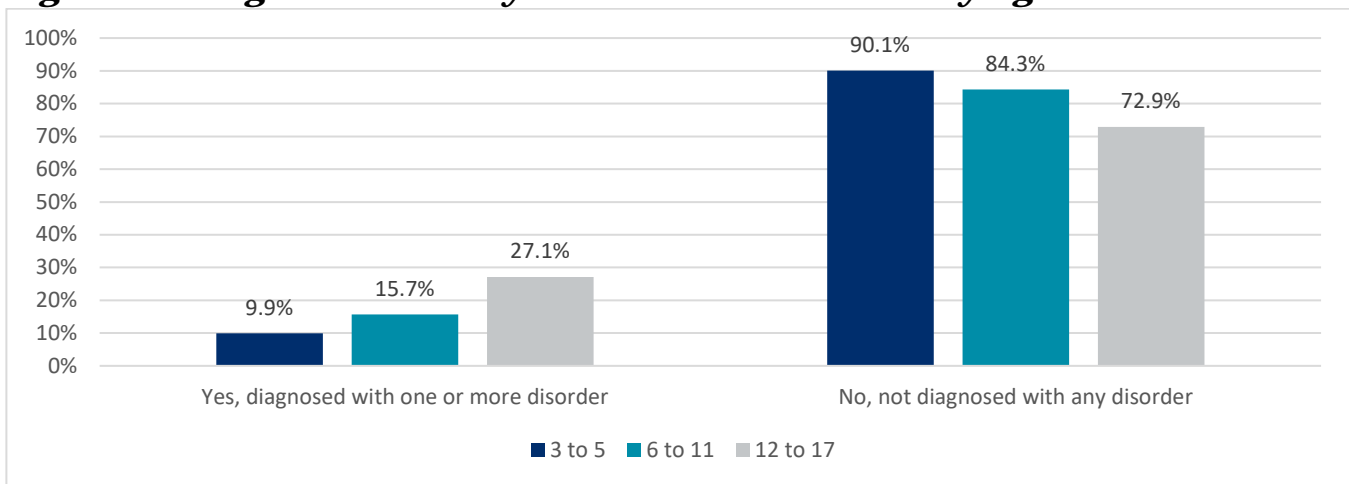
Note: Ages 3+. 3 to 5 population estimate =17,915; 6 to 11 population estimate = 27,978; 12 to 17 population estimate = 27,137.

Non-Hispanic/Latino children are significantly more likely to have been diagnosed with one or more mental health disorders when compared to Hispanic/Latino children, as illustrated in the figure below.

Figure 50. Diagnosed with Any Mental Health Disorder by Ethnicity
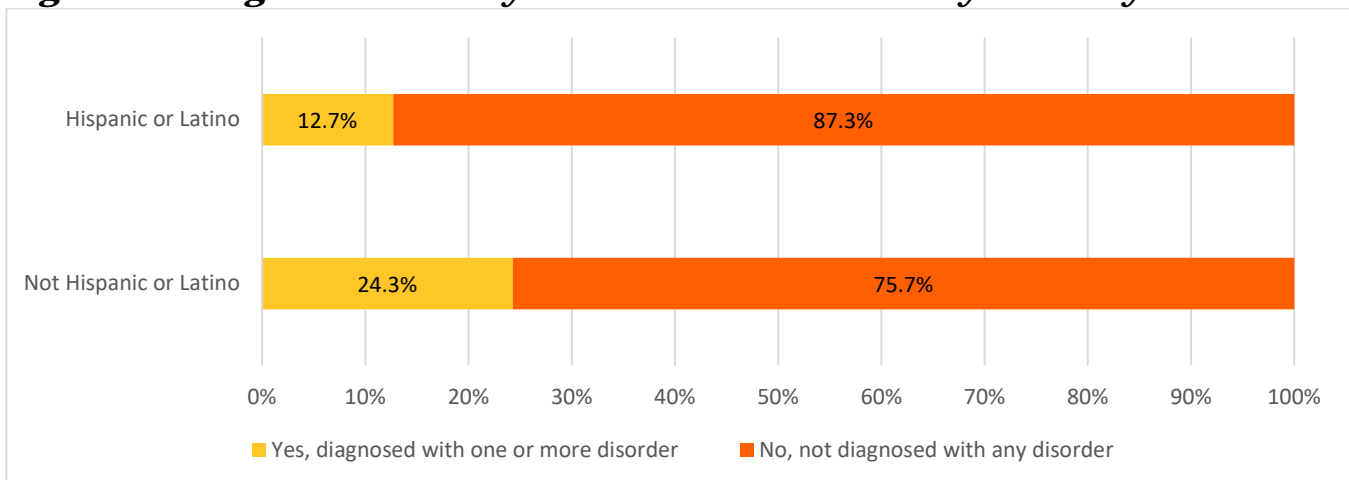
Note: Ages 3+. Hispanic or Latino population estimate = 26,580; Not Hispanic or Latino population estimate = 36,450.

Of the seven specified mental health disorders, attention deficit disorder/attention deficit/hyperactivity disorder (ADD/ADHD) is the most common among local children, as illustrated in the table below.

Mental Health Diagnosis Children Age 3+	Weighted Percent	Population Estimate
ADD/ADHD	7.4%	5,433
Anxiety disorder	5.8%	4,210
Developmental delay	5.3%	3,864
Autism	3.0%	2,168
Mood disorder (depressive or bipolar disorders)	2.3%	1,695
Suicidal thoughts	2.2%	1,575
Eating disorder	2.0%	1,492
Other mental health disorder	3.7%	2,733

Because of the small sample sizes, only the three most commonly diagnosed mental health disorders are examined further here: ADD/ADHD, anxiety disorder, and developmental delay.

Diagnoses of ADD/ADHD vary significantly by age. Virtually no children ages 3 to 5 have been diagnosed with ADD/ADHD, which then increases to 5.0% of children ages 6 to 11 and 14.5% of children 12 to 17, as illustrated in the figure below.
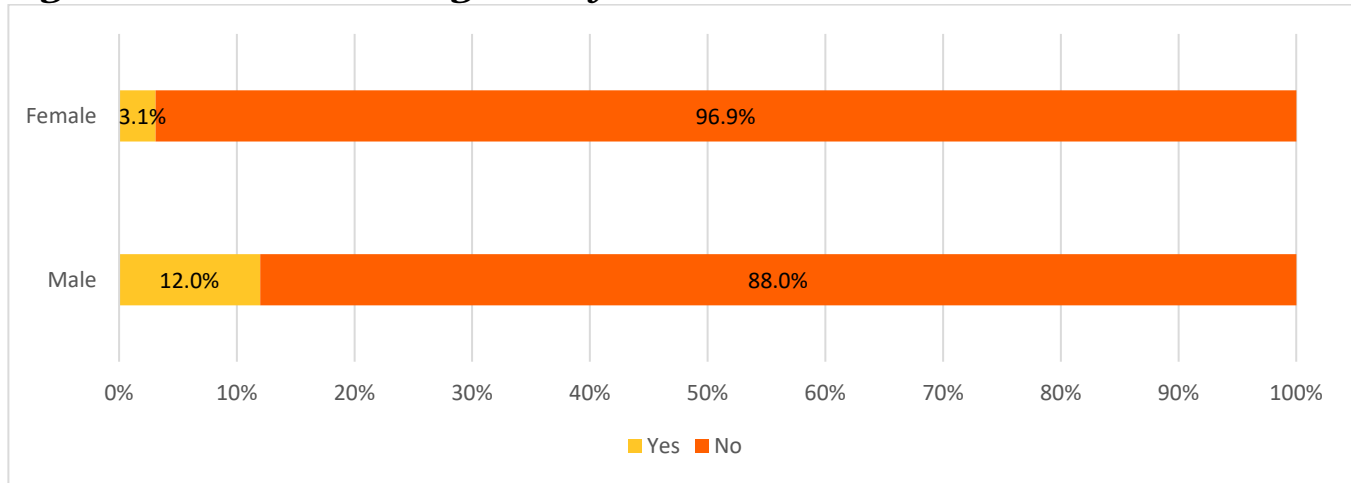
Figure 51. ADD/ADHD Diagnosis by Age
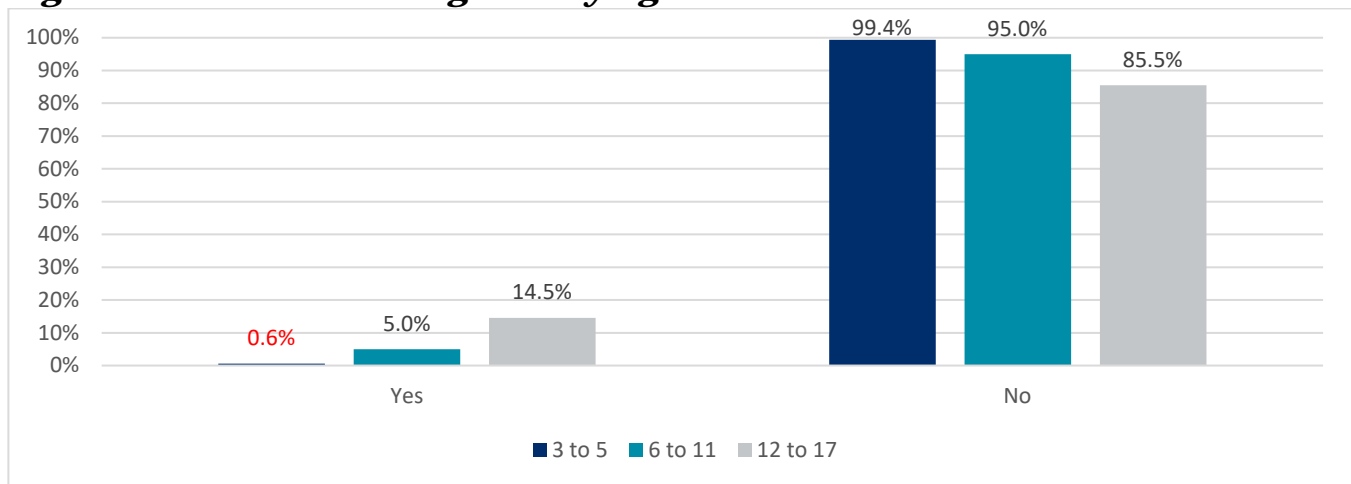
Note: Ages 3+. 3 to 5 population estimate = 17,915; 6 to 11 population estimate = 27,978; 12 to 17 population estimate = 27,137. Red indicates statistically unstable estimates.

In the United States, boys are more likely to be diagnosed with ADHD than girls.[19] This pattern holds true in the Coachella Valley as well: 12.0% of local boys have been diagnosed with ADD/ADHD, compared to only 3.1% of local girls.

Figure 52. ADD/ADHD Diagnosis by Gender

Note: Ages 3+. Male population estimate = 36,410; Female population estimate = 34,772.

Anxiety disorders may present in several forms such as fear or worry, irritability, and anger.[20] Once again, virtually no children in the 3 to 5 age group have been diagnosed with anxiety disorder; however, diagnosis rates among children in the 6 to 11 age group are roughly similar to those in the 12 to 17 age group, as illustrated in the figure below.

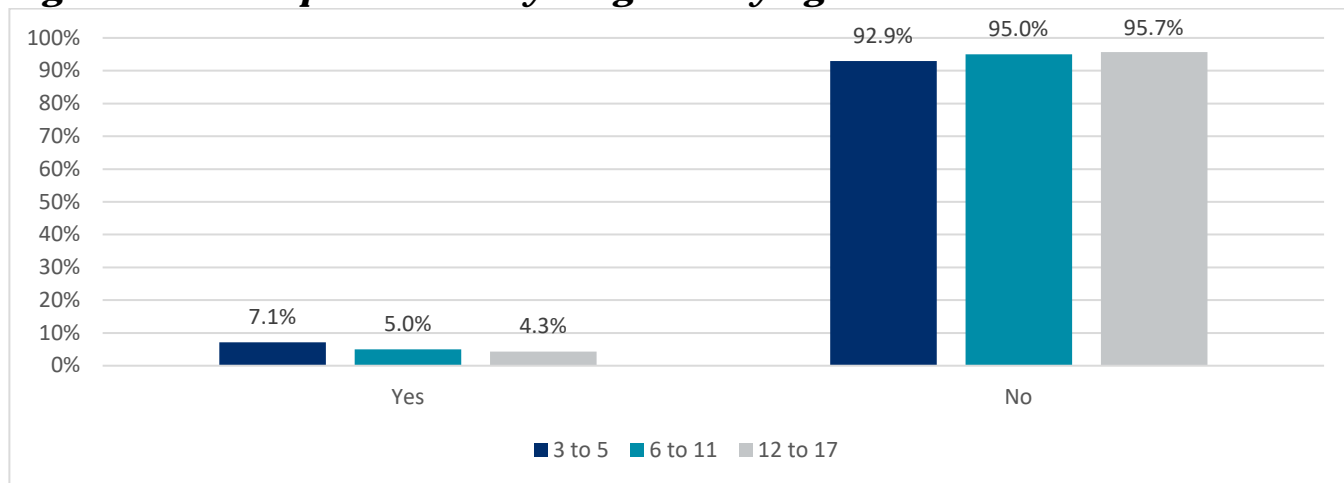*Figure 53. Anxiety Disorder Diagnosis by Age*
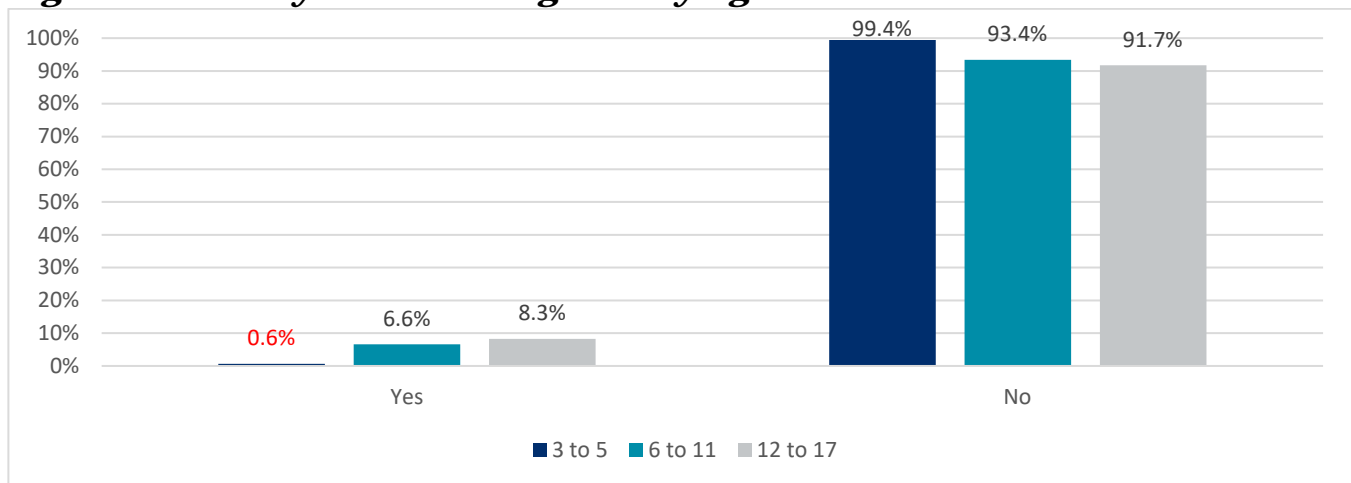
Note: Ages 3+. 3 to 5 population estimate = 17,915; 6 to 11 population estimate = 27,978; 12 to 17 population estimate = 27,137. Red indicates statistically unstable estimates.

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[19] https://www.cdc.gov/ncbddd/adhd/data.html
[20] https://www.cdc.gov/childrensmentalhealth/depression.html

Overall, approximately 5.3% of local children ages 3 and over have been diagnosed with developmental delay; this rate does not vary much based on age, as illustrated in the figure below.

Figure 54. Developmental Delay Diagnosis by Age

Note: Ages 3+. 3 to 5 population estimate = 17,915; 6 to 11 population estimate = 27,978; 12 to 17 population estimate = 27,137.

Mental Health Treatment

There were three follow-up questions targeted at children age 3 and older who had been diagnosed with a mental health disorder and/or those who had behavioral health difficulties (e.g., with emotions, concentration, behavior, and/or getting along with other people). These three questions included whether the child had received treatment for these issues in the past year in the form of 1) visiting a mental health professional, 2) visiting a doctor/pediatrician, or 3) taking medication.

Results showed that **42.1% of children age 3 and older with a mental health disorder and/or behavioral health difficulties had received at least one of these three types of treatment in the past year**. Conversely, about 57.9% of children age 3 and older with a mental health disorder and/or behavioral health difficulties did *not* receive any of these three treatments in the past year, which equates to 13,759 children.

Overall, 30.8% of children age 3 and older with a mental health disorder and/or behavioral health difficulties have visited a mental health professional for treatment. As illustrated in the figure below, it is much more common to visit a mental health professional for older children than for younger children. Only 13.6% of children ages 3 to 5 have visited a mental health professional for treatment, compared to 46.8% of children 12 to 17.
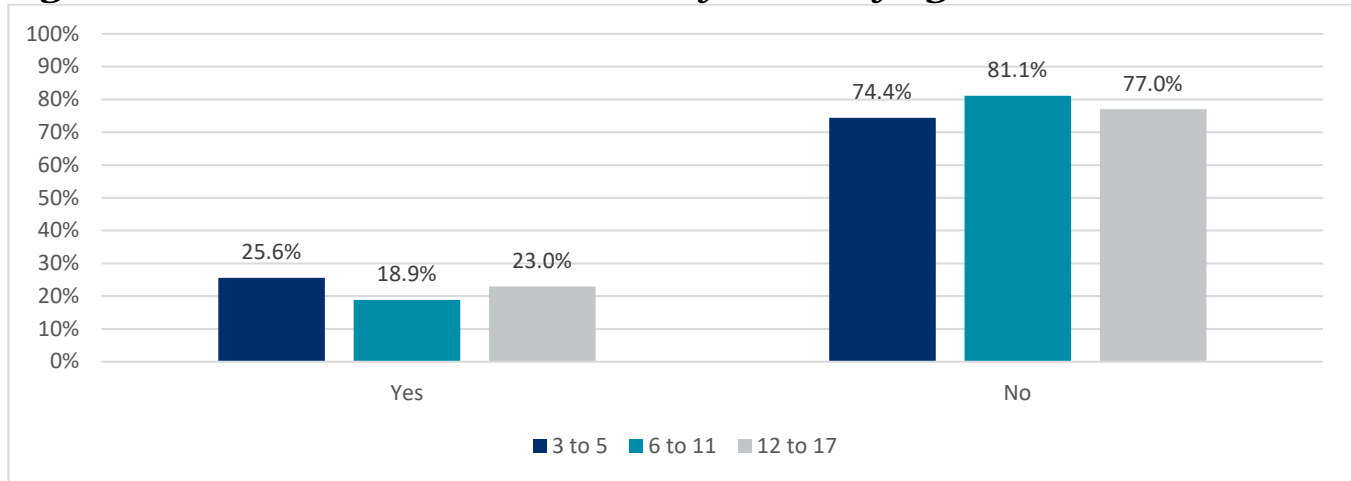
Figure 55. Visited a Mental Health Professional by Age
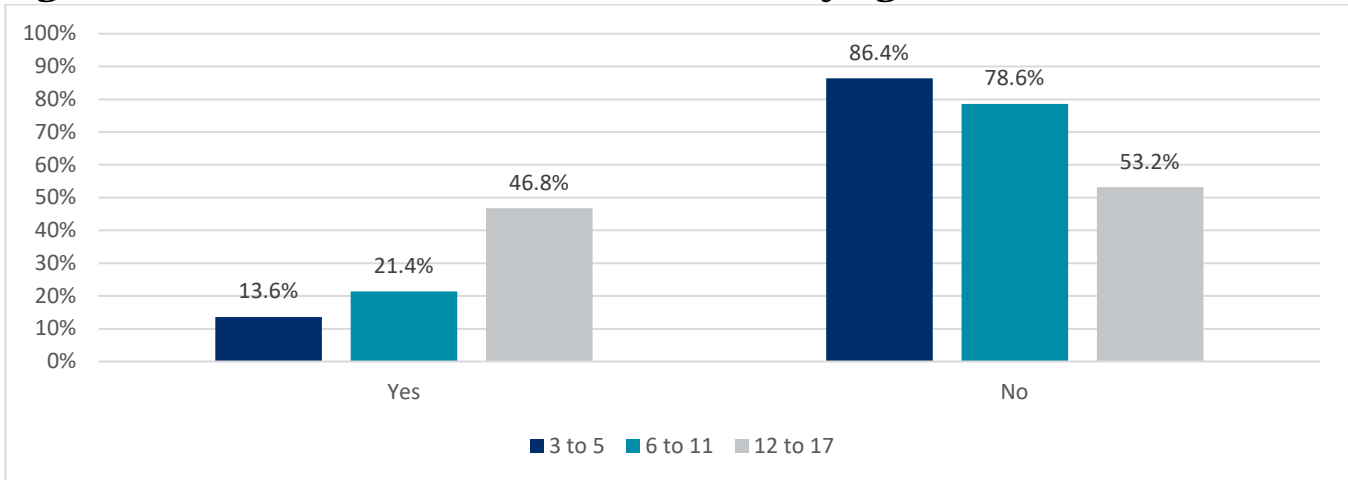
Note: Ages 3+, restricted to only those children who were diagnosed with one or more mental health disorders and/or those who experienced a difficulty with emotions, concentration, behavior and getting along with others. 3 to 5 population estimate = 4,173; 6 to 11 population estimate = 9,494; 12 to 17 population estimate = 10,078.

Approximately 21.8% of children age 3 and older with a mental health disorder and/or behavioral health difficulties have visited a pediatrician or other primary care provider for treatment. This did not seem to vary based on age, as illustrated in the figure below.
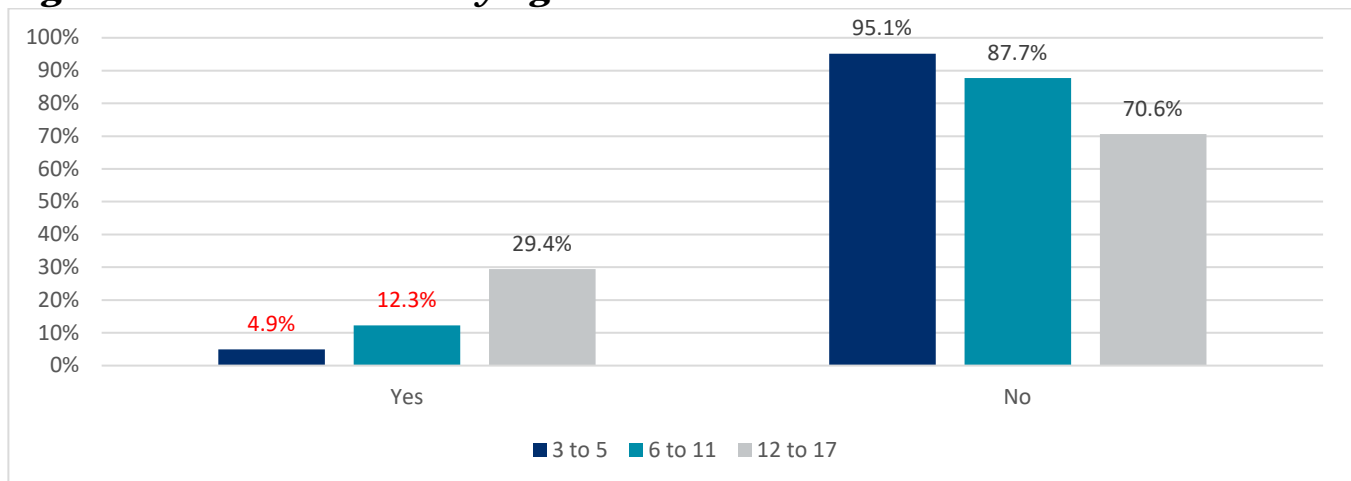
Figure 56. Visited a Pediatrician or Family Doctor by Age

Note: Ages 3+, restricted to only those children who were diagnosed with one or more mental health disorders and/or those who experienced a difficulty with emotions, concentration, behavior and getting along with others. 3 to 5 population estimate = 4,173; 6 to 11 population estimate = 9,494; 12 to 17 population estimate = 10,078.

Medication is the least common form of treatment; 18.2% of children age 3 and older with a mental health disorder and/or behavioral health difficulties have visited taken medication to address their mental health issue. Taking medication for mental health is most common among the oldest age group, 12 to 17, and less common among younger groups, as illustrated in the figure below.

Figure 57. Taken Medicine by Age

Note: Ages 3+, restricted to only those children who were diagnosed with one or more mental health disorders and/or those who experienced a difficulty with emotions, concentration, behavior and getting along with others. 3 to 5 population estimate = 4,173; 6 to 11 population estimate = 9,494; 12 to 17 population estimate = 10,078. Red indicates statistically unstable estimates.

Local Resources Available for Mental Health

Most of the primary care providers, such as the federally qualified health centers (like Borrego Health, Clinicas de Salud del Pueblo, etc.) and the local hospitals (e.g., Eisenhower Health, Desert Care Network) provide mental health resources. Beyond this, there are also several resources that are specific to mental health, as illustrated below.

360 Behavioral Health
About: 360 Behavioral Health offers applied behavior analysis therapy in a center-based setting. Their program is designed to increase language and communication, improve attention and focus, and decrease problem behaviors.
Location: Palm Desert
Website: https://www.360behavioralhealth.com/

417 Recovery Palm Desert
About: 417 Recovery offers an Intensive Outpatient Program (IOP), an after-school program for adolescents who struggle with mental health issues, behavioral issues, and/or substance abuse and their families.
Location: Palm Desert
Website: https://www.417recoverypalmdesert.com/

All-Desert Wellness Centers
About: All-Desert Wellness Centers provides mental and behavioral health services to individuals including children, adolescents, and families. Services include family counseling, groups for adolescents, trauma and crisis services, among many others.
Location: Palm Desert
Website: http://www.alldesertwellness.org/

Jewish Family Services of the Desert (JFS)
About: JFS provides a full range of counseling services to individuals including children, adolescents, and families. Their licensed clinicians and interns help teach coping skills to manage issues such as child abuse, divorce, partner/marital conflict, alcohol and drug addiction, and many more.
Location: Palm Springs
Website: http://jfsdesert.org/

Olive Crest
About: Olive Crest's mental health staff crisis intervention, therapy, substance abuse treatment, psychiatric assessments, medication management, and Therapeutic Behavioral Services (TBS). Services include child/adolescent individual therapy, family therapy, child abuse treatment, trauma focused behavioral therapy, and parenting skills.
Location: Palm Desert
Website: https://www.olivecrest.org/desert-communities/mental-health/

Riverside University Health System – Behavioral Health
About: Children's Mental Health Clinics provide services to children with severe emotional and behavioral problems. Services include psychiatric evaluations, medication services, individual and family therapy, and case management services.
Location: Indio
Website: http://www.rcdmh.org/

Riverside Latino Commission
About: Riverside Latino Commission is a nonprofit that provides services such as individual psychotherapy for children and adolescents, adolescent substance abuse treatment, and the "Strengthening Families" program that builds skills among parents and children.
Location: Coachella
Website: https://www.latinocommission.com/mental-health

Riverside-San Bernardino County Indian Health, Inc.
About: This program provides culturally sensitive mental health and comprehensive alcohol and other drug abuse counseling services to eligible Native American/Alaskan Native clients and their dependents. They provide prevention, assessment, treatment, and rehabilitative services to individuals and families.
Location: Thermal
Website: http://www.rsbcihi.org/about/services-2/

Weight, Activity, Nutrition

Body Mass Index (BMI) Percentile

Body mass index (BMI) is a calculated value based on the height and weight of a person. For children and adolescents, however, their weight status depends on their age- and sex-specific percentile for BMI.[21] A percentile ranking is used because children and adolescents' body composition varies with age and gender.[22] While BMI does not directly measure body fat, it is an indicator of body fat, and is highly correlated with direct measures of body fat.[23] BMI percentiles are then grouped into four categories: underweight, normal weight, overweight, and obese.

Parents/guardians were asked to report their child's height, weight, age, and gender. This was then used to calculate BMI percentile based on federal guidelines from the Centers for Disease Control and Prevention.

BMI percentile was only calculated for children ages 2 and older, as measurement of BMI for younger children should be measured in person.

Results showed that **46.1% of local children age two and older have a BMI percentile in the "overweight" or "obese" category**.

Children's BMI percentile varied significantly by age. The majority of older children (that is, 64.7% of children 12 to 17) were "about the right weight". In contrast, the majority of the youngest children (56.4% of children 2 to 5) were "obese".

Figure 58. Child's BMI Percentile by Age
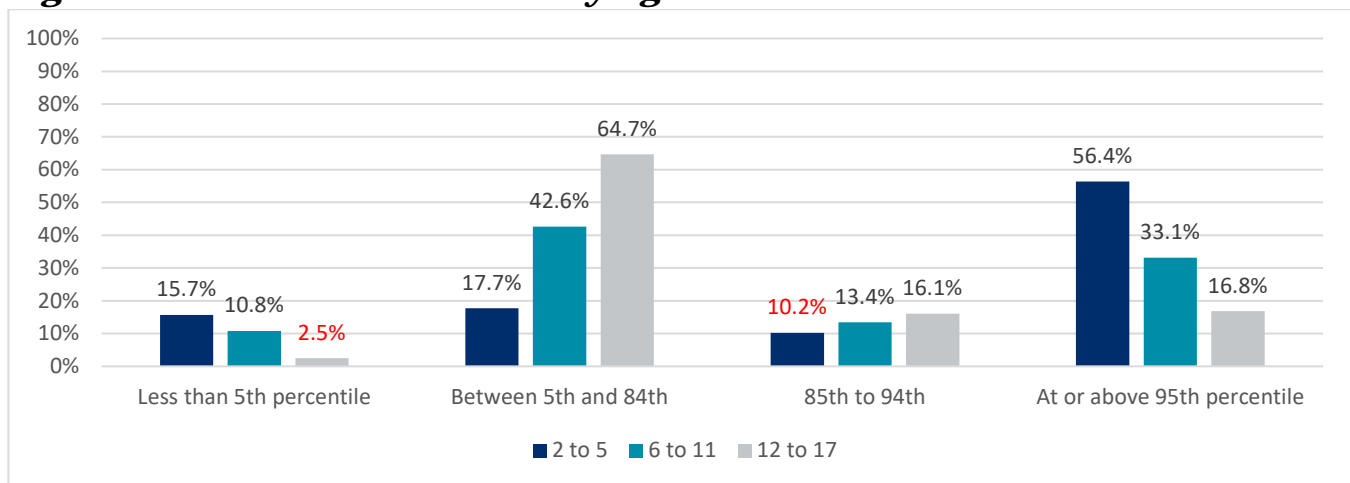
Note: Ages 2+. 2 to 5 population estimate = 14,380; 6 to 11 population estimate = 18,700; 12 to 17 population estimate = 22,860. Red indicates statistically unstable estimates.

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[21] Defining Childhood Obesity. (2018). Centers for Disease Control and Prevention. https://www.cdc.gov/obesity/childhood/defining.html
[22] Ibid.
[23] About Child & Teen BMI. (2018). Centers for Disease Control and Prevention. https://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html

There are noticeable differences when comparing the BMI percentile of children by the household income. Families with lower incomes have higher rates of children at or above the 95th percentile, also categorized as "obese". In contrast, children in families with higher incomes, are more likely to have a BMI between the 5th to 84th percentile, that is, "normal weight".

Figure 59. Child's BMI by Income
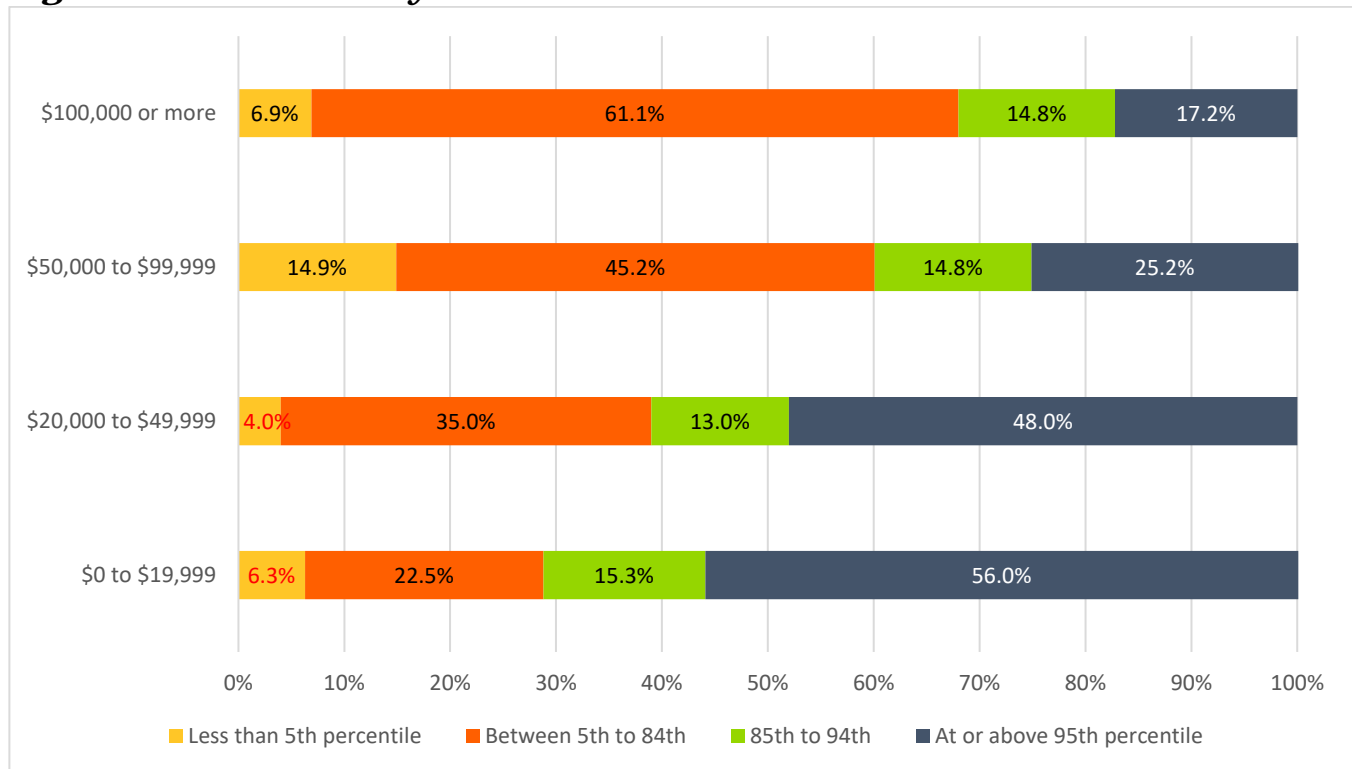
Note: Ages 2+. $0 to $19,000 population estimate = 6,426; $20,000 to $49,999 population estimate = 10,188; $50,000 to $99,999 population estimate = 1,1047; $100,000 or more population estimate = 20,009. Red indicates statistically unstable estimates.

Parent/Guardian Perception of Child's Weight

Parents/guardians were asked if they believe their child is, "overweight", "underweight", or "about the right weight".

Results show that despite the fact that 46.1% of local children ages 2 and older have a BMI percentile that puts them in the "overweight" or "obese" category, only 14.4% of parents believe their child is overweight. **The majority of parents/guardians (78.0%) believe that their child is "about the right weight"**. Parents/guardians of younger children (ages 2 to 5) are especially unlikely to recognize that their child is overweight: only 1.0% of these parents/guardians believe their child is overweight, when in reality, more than two-thirds of children 2 to 5 have a BMI percentile that puts them in the "overweight" or "obese" category. In short, while children of all ages experience parent/guardian misconceptions about their weight, these misconceptions are most severe for younger children.

Figure 60. Parent/Guardian Perception of Child's Weight by Age
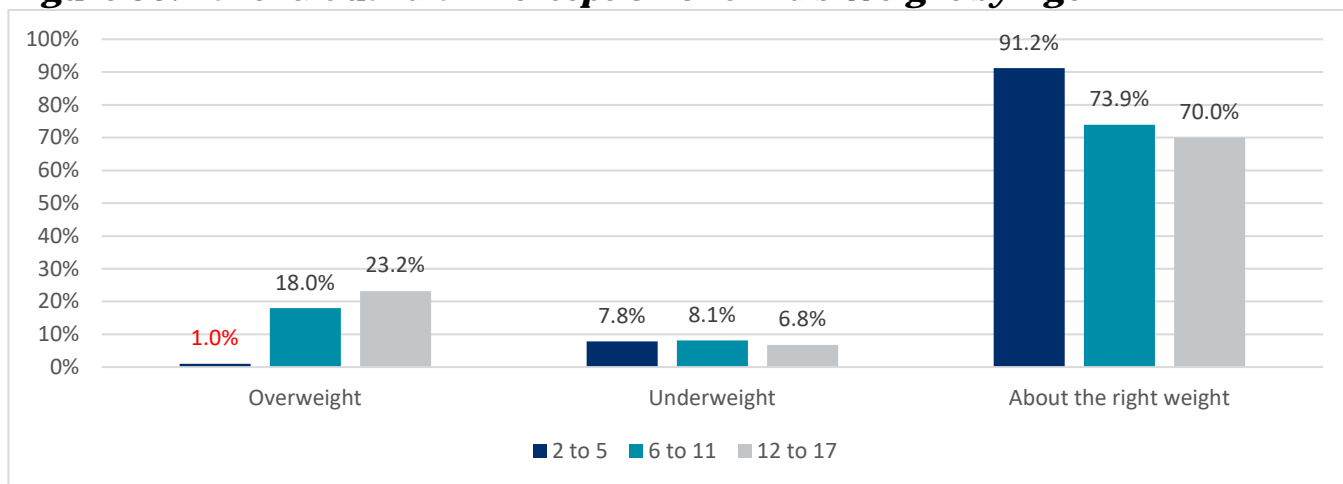
Note: Ages 2+. 2 to 5 population estimate = 25,087; 6 to 11 population estimate = 27,978; 12 to 17 population estimate = 27,137. Red indicates statistically unstable estimates.

Based on gender, fewer boys than girls were perceived to be "about the right weight." More boys were considered to be overweight by their parents/guardians, as illustrated in the figure below.

Figure 61. Parent/Guardian Perception of Child's Weight by Gender
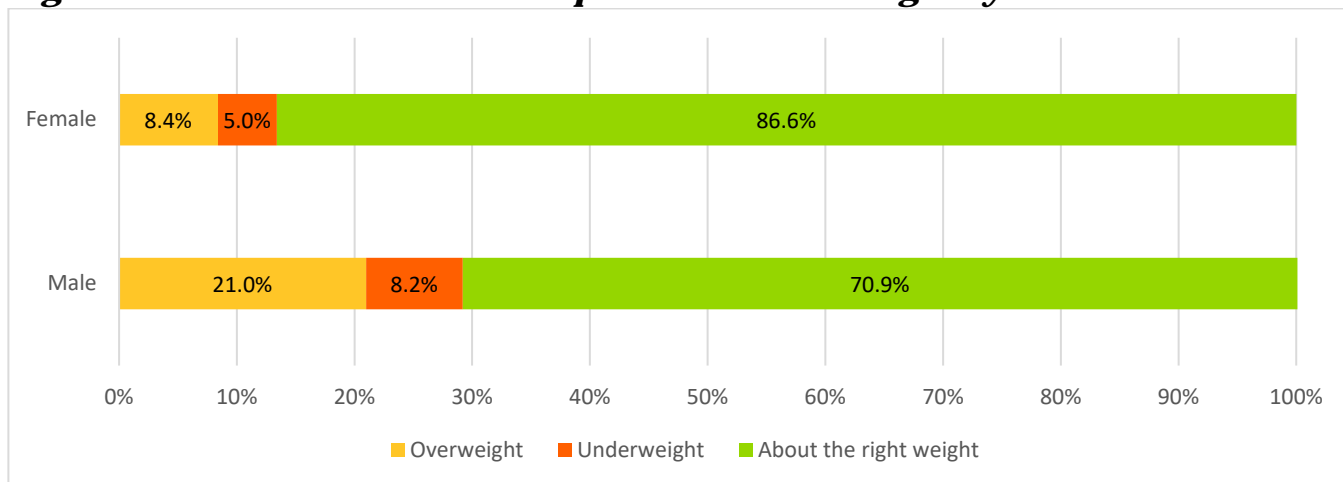
Note: Ages 2+. Male population estimate = 39,856; Female population estimate = 38,498.
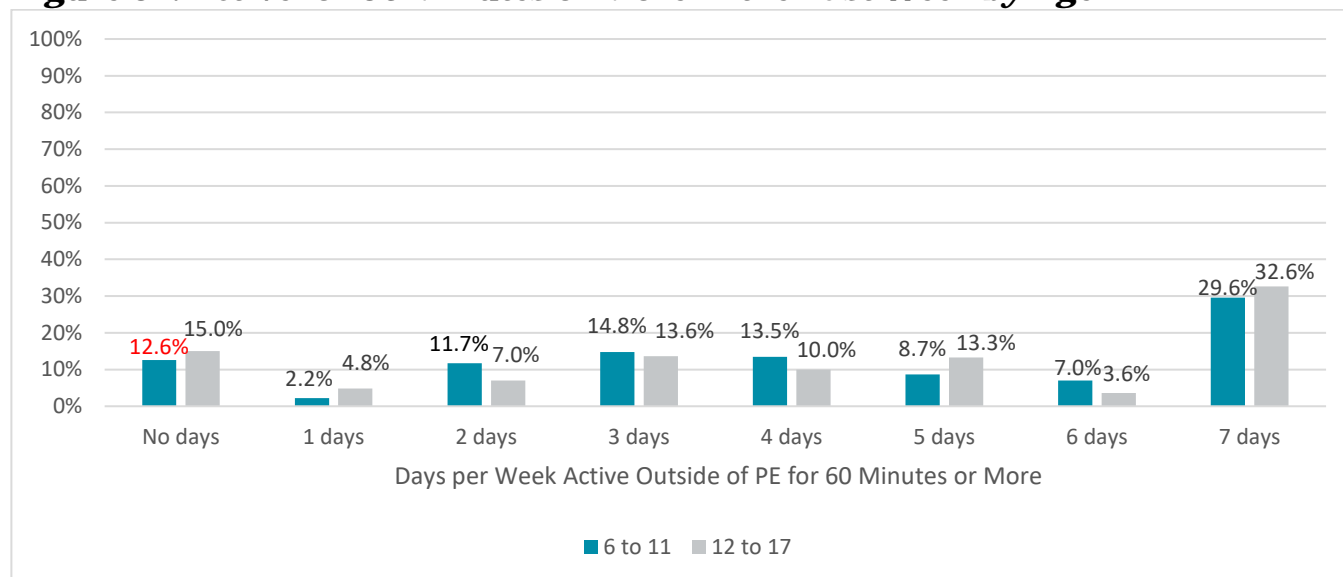
Physical Activity

The U.S. Department of Health and Human Services recommends that children ages three to five should be physically active throughout the day while those aged six to 17 should do 60 minutes or more of moderate-to-vigorous activity daily.[24]

Parents/guardians of children ages 6 and older were asked, "Not including school PE (Physical Education), on how many days of the past 7 days was (child's name) physically active for at least 60 minutes?"

Results show about a third of local children ages six and up (31.0%) are active every day for at least an hour a day outside of school. The remainder of children, however, are likely not getting sufficient physical activity.

Physical activity did not vary based on age, as illustrated in the figure below. It is worth noting that 12.6% of children ages 6 to 11 and 15.0% of children ages 12 to 17 were not active any days of the week.

### *Figure 62. Active for 60 Minutes or More in the Past Week by Age*

Note: Ages 6+. 6 to 11 population estimate = 27,367; 12 to 17 population estimate = 25,805. Red indicates statistically unstable estimates.

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[24] Physical Activity Guidelines Advisory Committee. 2018 Physical Activity Guidelines Advisory Committee Scientific Report. Washington, DC: US Dept of Health and Human Services; 2018. https://health.gov/paguidelines/second-edition/report/pdf/PAG_Advisory_Committee_Report.pdf

Physical activity levels differed based on gender; as illustrated in the figure below, male children were significantly more likely than female children to be active outside of school all seven days of the week.

Figure 63. Active for 60 Minutes or More in the Past Week by Gender
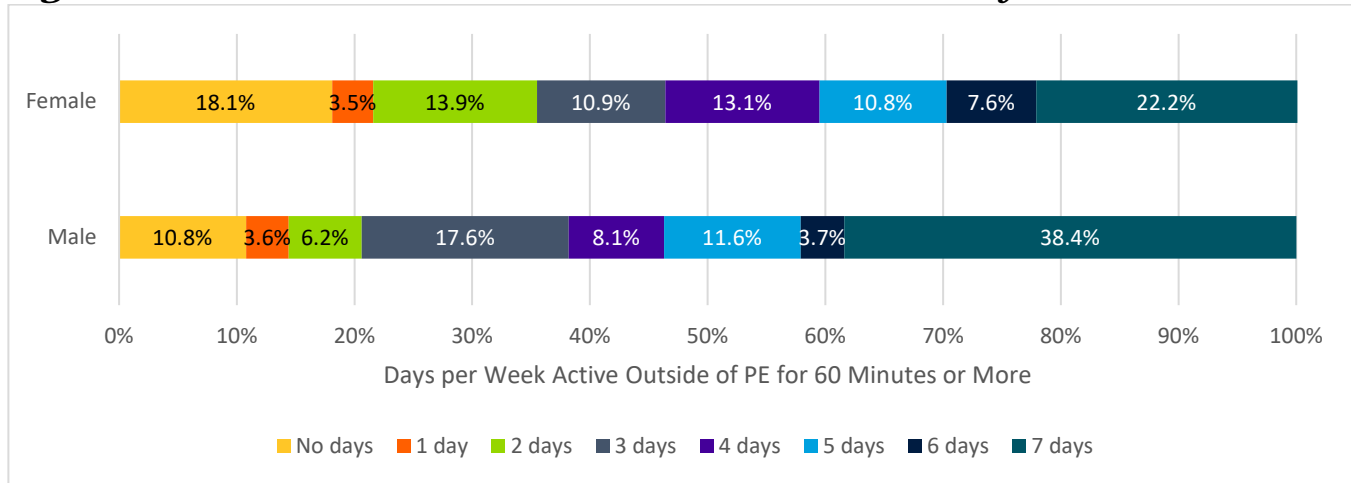
Note: Ages 6+. Male population estimate = 28,356; Female population estimate = 23,552

The number of active days for children also varied by household income. Lower income children were more likely to be completely inactive than higher income children, as illustrated in the figure below.

Figure 64. Active for 60 Minutes or More in the Past Week by Income
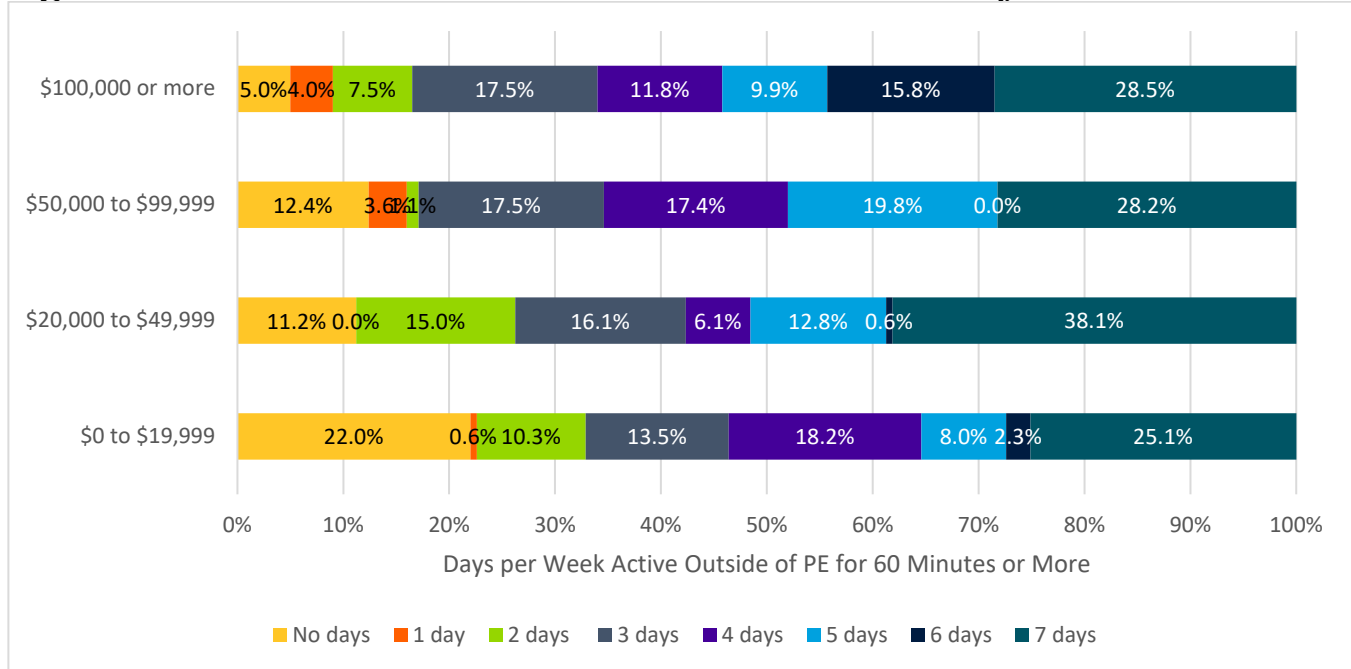
Note: Ages 6+. $0 to $19,999 population estimate = 8,809; $20,000 to $49,999 population estimate = 10,577; $50,000 to $99,999 population estimate = 8,571; $100,000 or more population estimate = 16,250.

Local Resources Available for Physical Activity
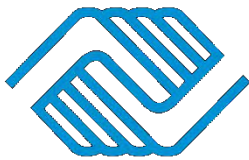
Boys & Girls Clubs
About: There are three Boys & Girls Clubs organizations in the region: Boys & Girls Club Cathedral City, Boys & Girls Clubs of Coachella Valley, and Boys & Girls Club Palm Springs. These clubs offer many opportunities for physical activity, including basketball, swimming, golf, baseball, and softball, among others.
Websites: https://www.bgcccity.org/, https://www.bgcofcv.org/, and https://www.bgcps.org/
Locations: Cathedral City, Coachella, Indio, La Quinta, Mecca, Palm Springs

Desert Recreation District
About: Desert Recreation District offers a wide variety of physical activity programs for children and adolescents such as basketball camp, martial arts, sports programs, gymnastic programs, dance programs, swim and water activities, after school clubhouse, and adaptive/therapeutic sports and recreation.
Website: https://www.myrecreationdistrict.com/
Locations: Bermuda Dunes, Coachella, Indio, Indio Hills, La Quinta, Mecca, North Shore, Palm Desert, Thermal, Thousand Palms

Family YMCA of the Desert
About: Their day camps provide a fun, educational environment for children to enjoy learning and participate in exercise and fitness.
Website: http://www.ymcaofthedesert.org/
Location: Palm Desert

American Youth Soccer Organization (AYSO)
About: Volunteer-run youth soccer program
Websites: ayso588.org, ayso443.org, ayso1200.org, ayso90.org, ayso813.org
Locations: Cathedral City, Desert Hot Springs, Indio, La Quinta, Palm Springs

The First Tee Coachella Valley
About: Nonprofit organization dedicated to introducing golf and its values to youth.
*Website*: https://www.firstteecoachellavalley.org/
Location: Palm Desert

Nutrition

Parents/guardians of children ages 2 and older were asked the number of times that the child consumed fast food in the past week.

Results show that **about half of Coachella Valley children ages 2 and older (56.2%) consume fast food once a week or less**. However, 12.9% of local children ages 2 and older consumed fast food four or more times per week, which is likely connected to obesity.

Fast food consumption varied significantly by age; young children (2 to 5) were significantly less likely to eat fast food multiple times per week than their older counterparts, as illustrated in the figure below.

Figure 65. Fast Food Consumption in the Past Week by Age
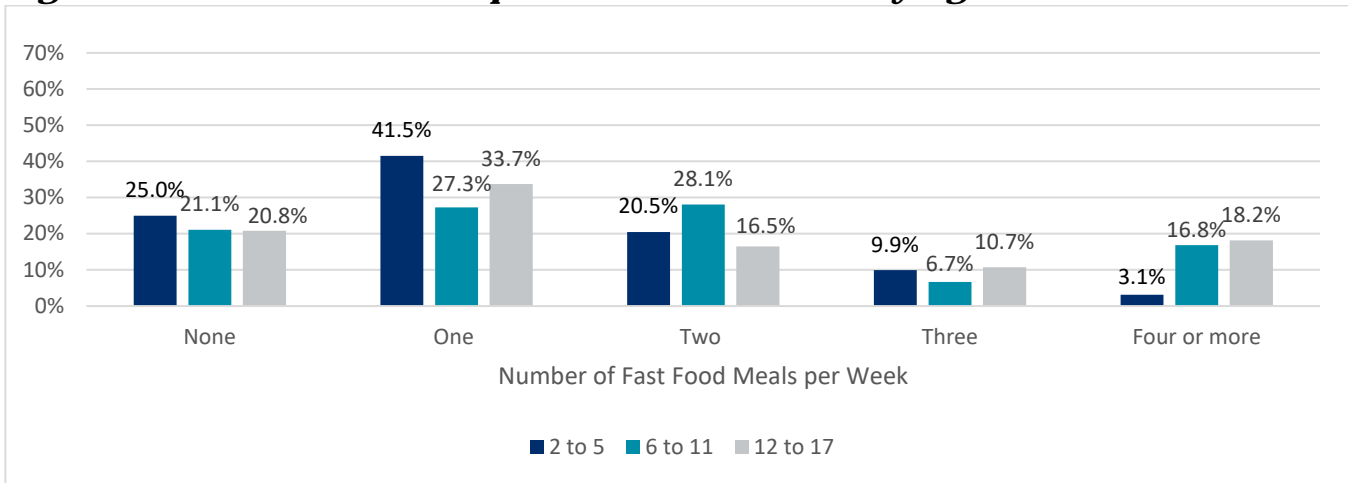
Note: Ages 2+. 2 to 5 population estimate = 24,645; 6 to 11 population estimate = 27,672; 12 to 17 population estimate = 25,723.

Fast food consumption in the past week varied by income. As illustrated in the figure below, children in the highest income bracket ($100,000 or more) were significantly more likely to completely abstain from fast food than children in the lower income brackets.

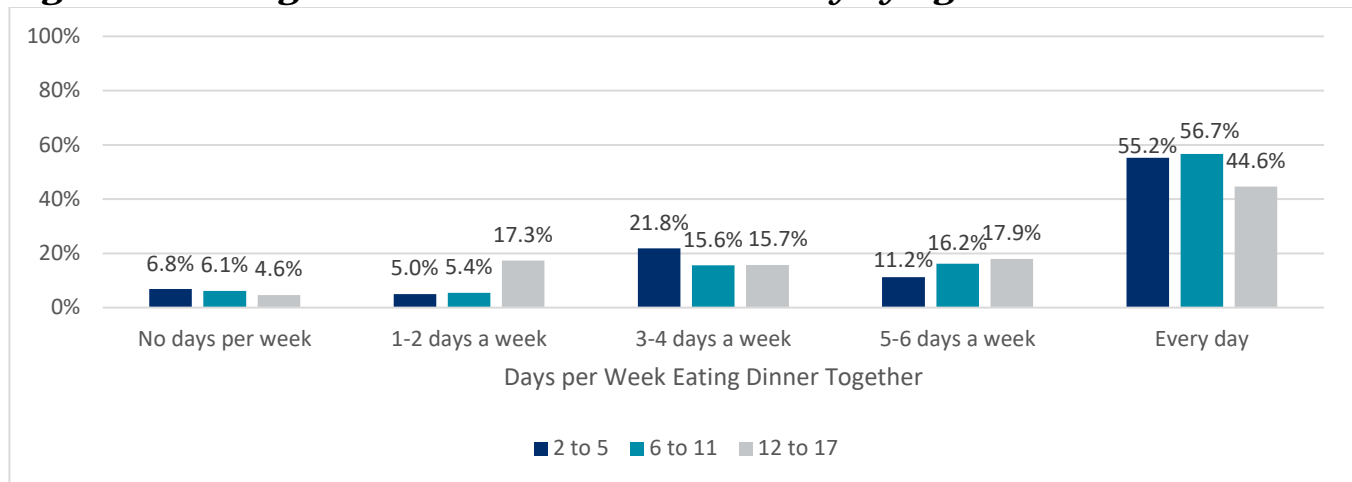### Figure 66. Fast Food Consumption in the Past Week by Income
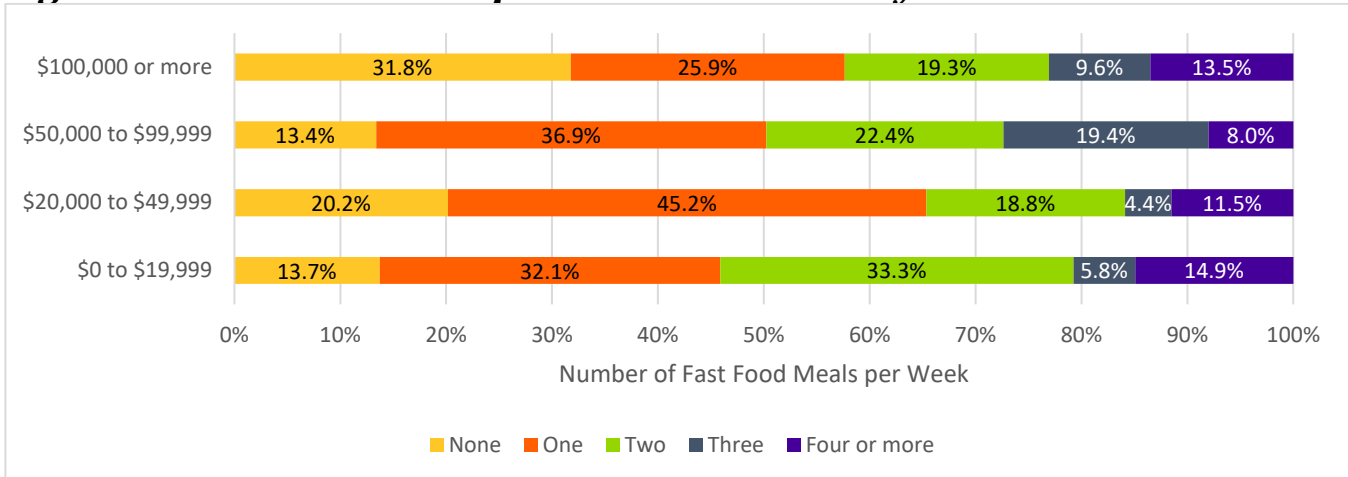
Note: Ages 2+. $0 to $19,999 population estimate = 12,325; $20,000 to $49,999 population estimate = 15,788; $50,000 to $99,999 population estimate = 14,172; $100,000 or more population estimate = 23,308. Red indicates statistically unstable estimates.

Studies have shown that children who eat family meals more frequently were more likely to be in a normal weight range compared to those who have fewer family meals together per week.[25] Thus, parents/guardians of children age 2 and older were asked, "How many times a week do you sit down together to eat dinner with your family?"

Results show that about half of children ages 2 and older (52.1%) eat dinner with their families every day. Unfortunately, **5.8% of children ages 2 and older do not eat dinner with their families any day during the week**. This does not differ based on age, as illustrated in the figure below.

Figure 67. Sitting Down to Eat Dinner with Family by Age

Note: Ages 2+. 2 to 5 population estimate = 25,087; 6 to 11 population estimate = 27,903; 12 to 17 population estimate = 27,069.

The number of times per week families sat down for dinner varied by income. Lower income children were significantly more likely to eat dinner with their family every night than higher income children, as illustrated in the figure below.

Figure 68. Sitting Down to Eat Dinner with Family by Income
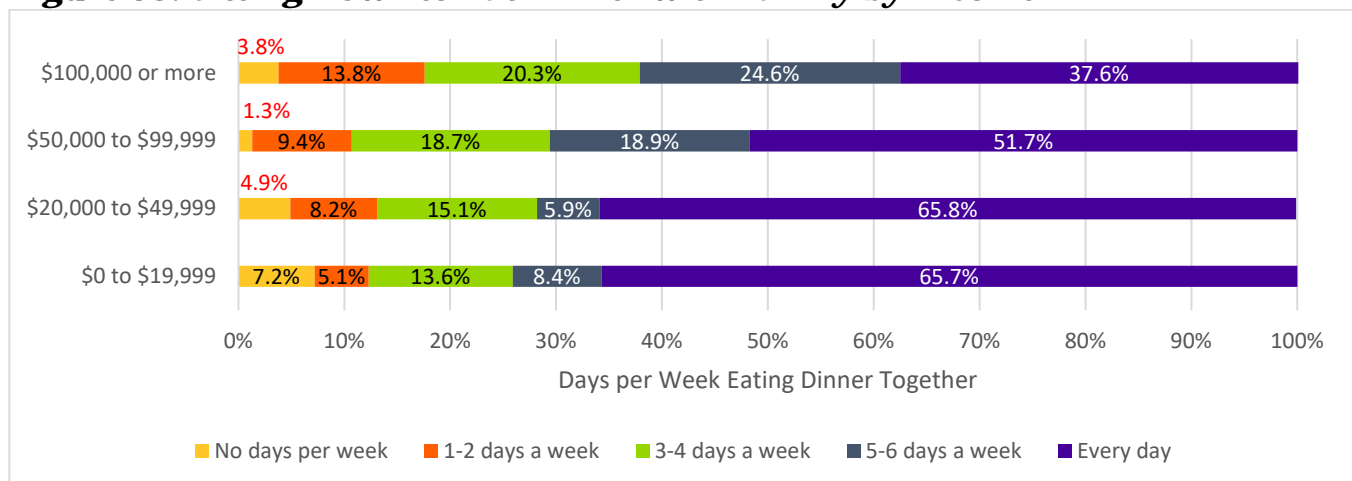
Note: $0 to $19,999 population estimate = 12,672; $20,000 to $49,999 population estimate = 15,788; $50,000 to $99,999 population estimate = 14,200; $100,000 or more population estimate = 24,176. Red indicates statistically unstable estimates.

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[25] Is Frequency of Shared Meals Related to the Nutritional Health of Children and Adolescents? (2011). Pediatrics, volume 127, issue 6. http://www.ncbi.nlm.nih.gov/pubmed/21536618

The World Health Organization (WHO) recommends exclusive breastfeeding up to six months of age, and to continue breastfeeding with complementary food up to two years of age or beyond.[26] Breastfeeding provides health benefits for both the infant and the mother; however, not all mothers are able to breastfeed and supplement their child's nutrition with formula.

Parents/guardians of children ages 5 and younger were asked whether the child was ever breastfed. Results show that **the majority of local children age 5 and younger (82.9%) were breastfed** for at least a short while. The remaining 17.1% of children age 5 and younger were never breastfed.

Breastfeeding rates varied by gender, such that male children were significantly less likely to have been breastfed than female children, as illustrated in the figure below.

Figure 69. Breastfeeding by Gender
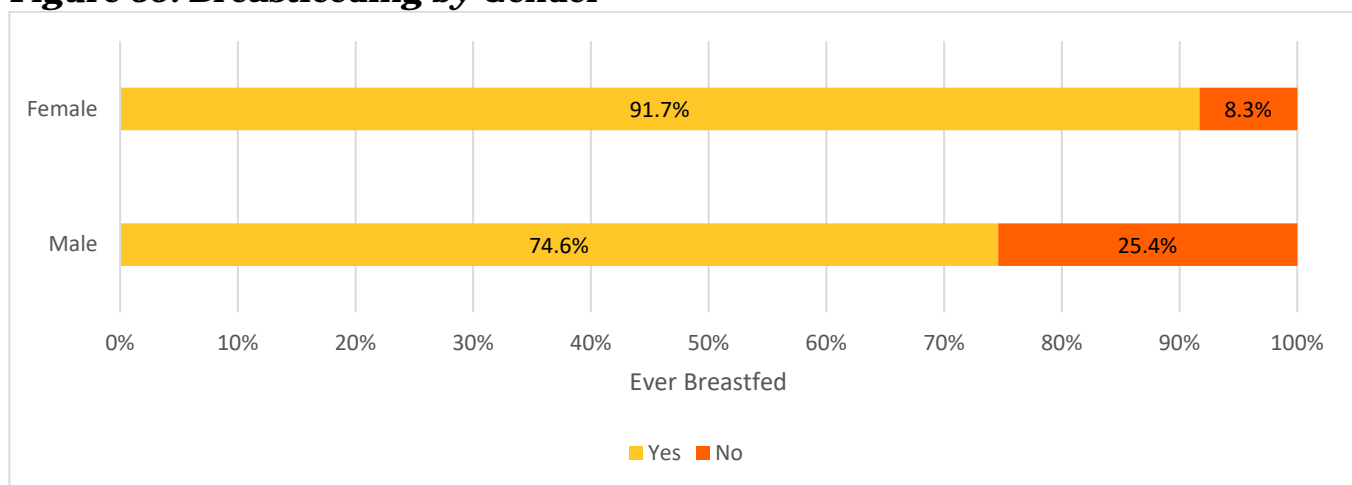
Note: Ages 5 and younger. Male population estimate = 15,198; Female population estimate = 17,440.

Of the 27,322 children ages 0 to 5 that were breastfed, about half had completely stopped breastfeeding before the child reached 12 months old, as illustrated in the table below.

Age at Which Child Completely Stopped Breastfeeding *Children Ages 0 to 5*	Weighted Percent	Population Estimate
Less than 1 month	1.9%	508
1 to 3 months	10.4%	2,752
4 to 6 months	9.9%	2,621
7 to 12 months	26.7%	7,077
More than a year	35.2%	9,336
Still breastfeeding	15.9%	4,206
Total	**100.0%**	**26,500**

[26] Breastfeeding. (n.d.). World Health Organization. https://www.who.int/topics/breastfeeding/en/

Food Insecurity

Food insecurity is defined by the U.S. Department of Agriculture Economic Research Service as "limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways."[27]

To measure stress related to food insecurity, parents/guardians were asked to rate how much they agreed with the statement, "We worried whether our food would run out before we got money to buy more."

Results show that **16.7% of children live in households where their parents/guardians were "often" or "sometimes" worried about food running out before they had money to buy more.** This did not differ based on age; children of all ages were equally likely to experience this type of food-related stress.

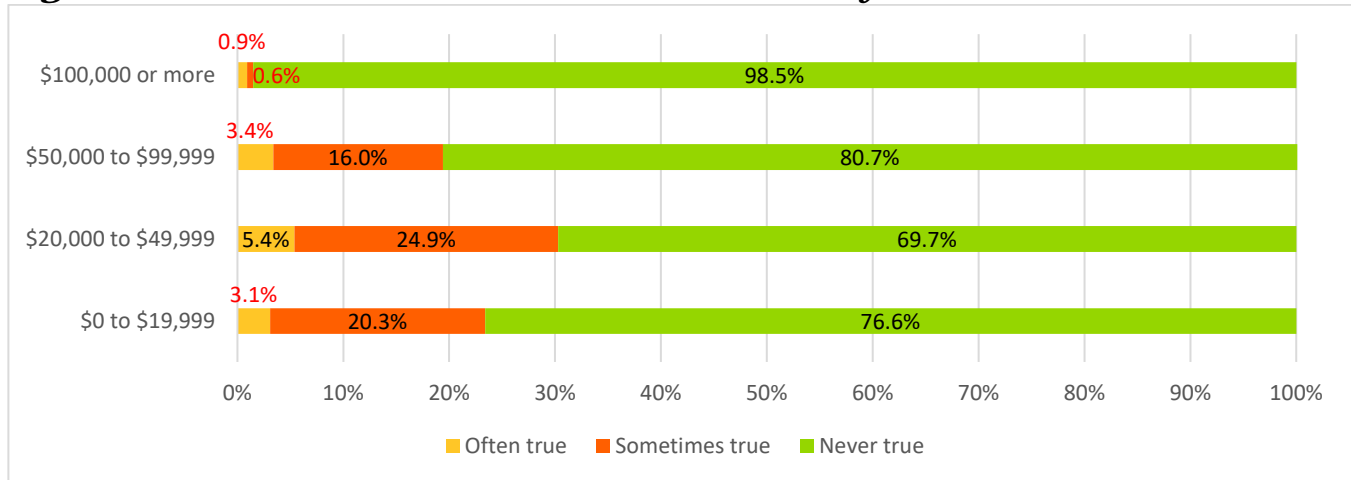*Figure 70. Worried Whether Food Would Run Out by Age*
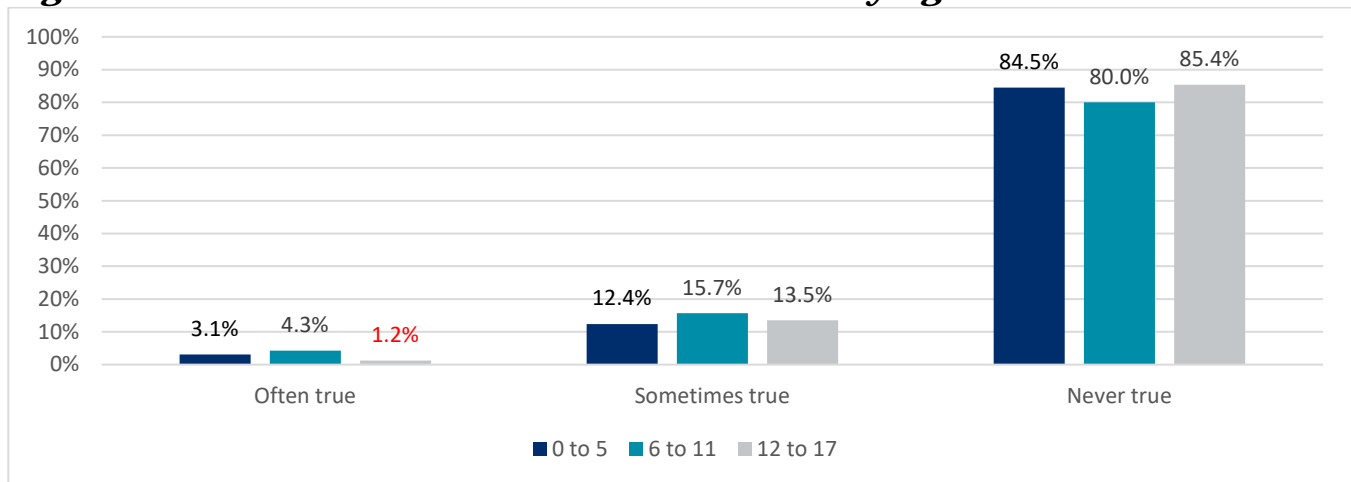
Note: 0 to 5 population estimate = 32,862; 6 to 11 population estimate = 27,978; 12 to 17 population estimate = 27,082. Red indicates statistically unstable estimates.

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[27] Measurement. (2019).United States Department of Agriculture and Economic Research Service. http://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/measurement.aspx

Not surprisingly, this level of worry varied based on income, such that higher income families worried less than lower income families about food running out. As illustrated in the figure below, virtually none of the families making $100,000 or more worried whether their food would run out without money to buy more.

Figure 71. Worried Whether Food Would Run Out by Income

Note: $0 to $19,999 population estimate = 13,648; $20,000 to $49,999 population estimate = 18,285; $50,000 to $99,999 population estimate = 15,308; $100,000 or more population estimate = 25,978. Red indicates statistically unstable estimates.

Significant differences also appeared based on ethnicity. Specifically, Hispanic/Latino children were more likely to live in households where their parents/guardians were "often" or "sometimes" worried about whether food would run out before they had money to buy more.

*Figure 72. Worried Whether Food Would Run Out by Ethnicity*
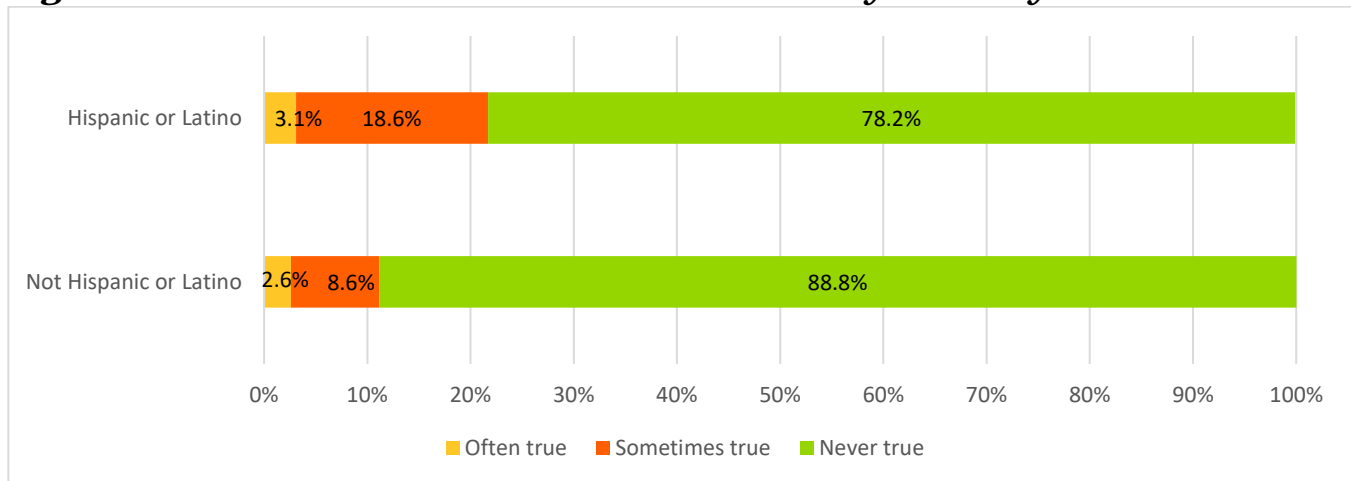
Note: Not Hispanic or Latino population estimate = 42,504; Hispanic or Latino population estimate = 45,418.

Parents were asked if the statement, "The food we bought didn't last and we didn't have money to get more" is "often true", "sometimes true", or "never true."

Results show that **11.0% of children live in households where their parents/guardians "often" or "sometimes" ran out of food and didn't have money to buy more**. There were no significant differences based on age; that is, children of all ages were equally likely to struggle with the issue of having enough money to buy more food when it ran out.

Figure 73. Food Didn't Last and Didn't Have Money to Buy More by Age
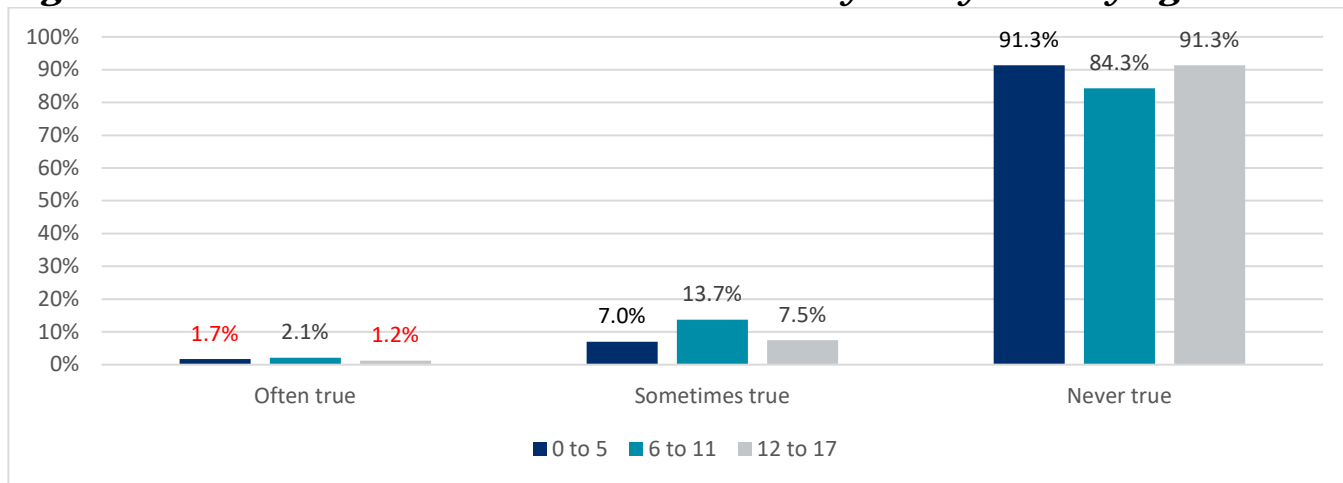
Note: 0 to 5 population estimate = 32,862; 6 to 11 population estimate = 27,978; 12 to 17 population estimate = 27,082. Red indicates statistically unstable estimates.

Not surprisingly, there were significant differences in this measure based on income. Virtually no children in homes with a household income of over $100,000 experienced this problem, as illustrated in the figure below.

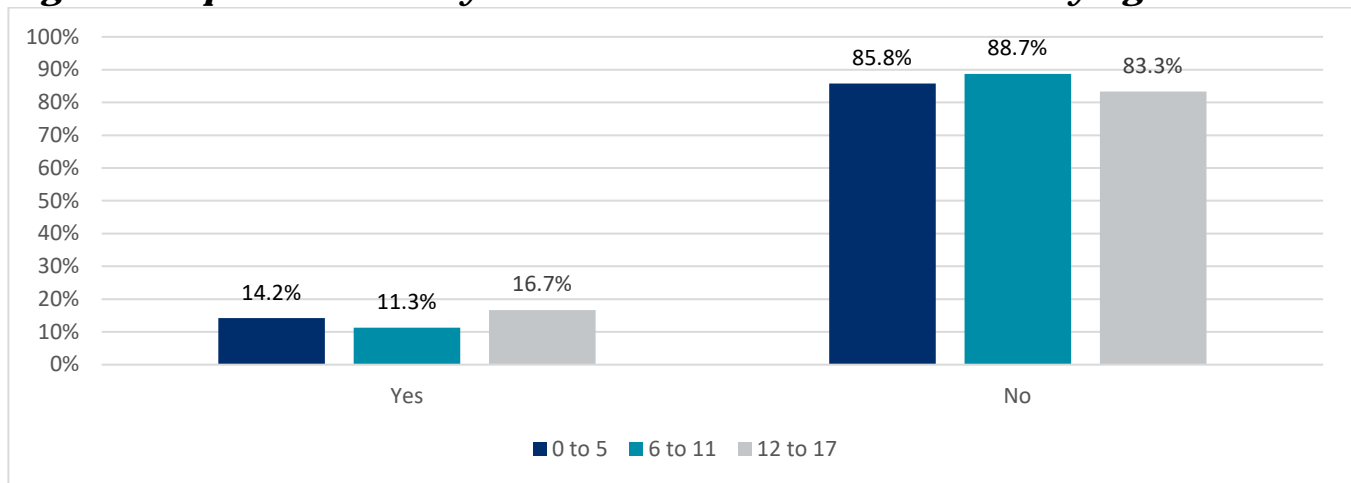*Figure 74. Food Didn't Last and Didn't Have Money to Buy More by Income*
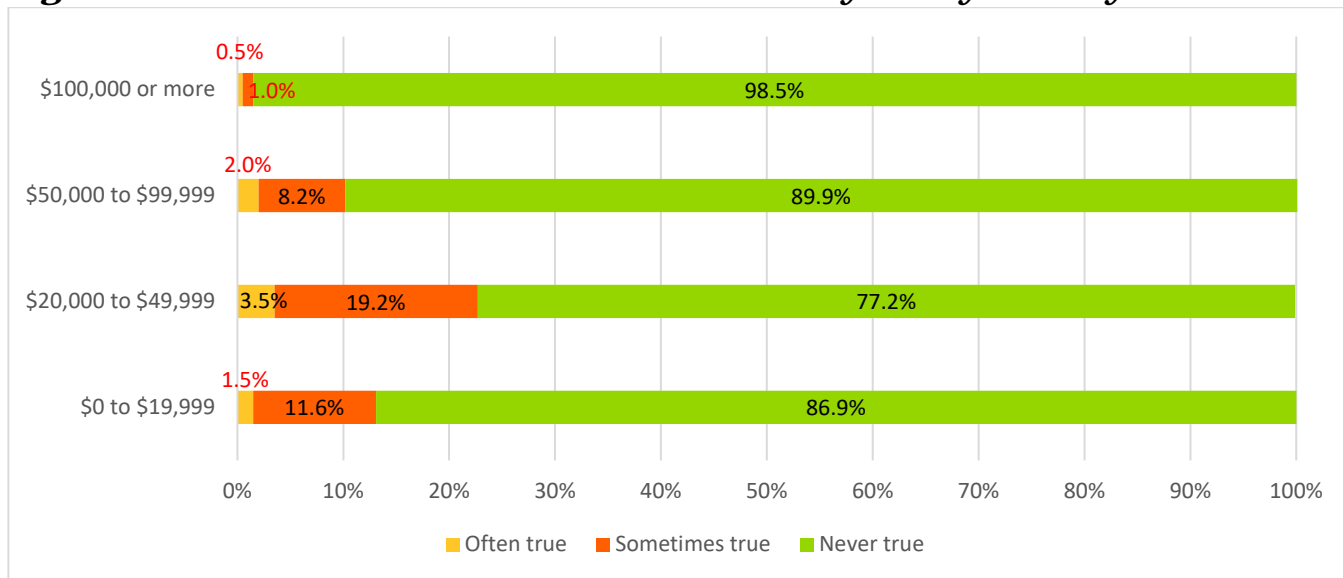
Note: $0 to $19,999 population estimate = 13,648; $20,000 to $49,999 population estimate = 18,285; $50,000 to $99,999 population estimate = 15,308; $100,000 or more population estimate = 25,978. Red indicates statistically unstable estimates.

Parents/guardians were also asked, "In the past 12 months, have you spent less money on food because you needed to prioritize other basic needs, such as healthcare, housing, transportation, or utilities?"

Results showed that **14.0% of local children live in households where they had to cut back on food spending in order to prioritize other basic needs**. Rates of having to cut back on food spending did not differ based on the child's age.
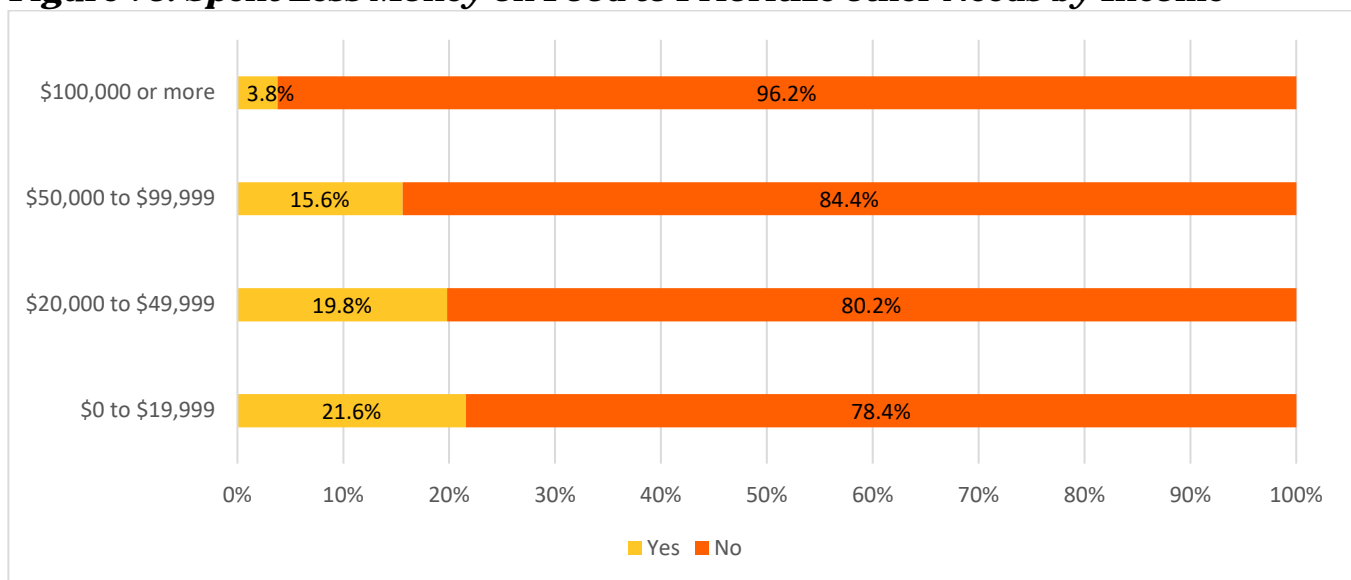
Figure 75. Spent Less Money on Food to Prioritize other Needs by Age

Note: 0 to 5 population estimate = 33,245; 6 to 11 population estimate = 27,978; 12 to 17 population estimate = 26,911.

Once again, there were significant differences in this measure of food insecurity based on income; those children living in homes with an annual household income of $100,000 or more were significantly less likely to need to cut back spending on food in order to prioritize other basic needs.

Figure 76. Spent Less Money on Food to Prioritize other Needs by Income

Note: $0 to $19,999 population estimate = 13,648; $20,000 to $49,999 population estimate = 18,340; $50,000 to $99,999 population estimate = 15,082; $100,000 or more population estimate = 25,978.

There were also significant differences based on ethnicity, as illustrated in the figure below. Hispanic/Latino children were significantly more likely to live in households that had to spend less money on food in order to afford other basic needs than their non-Hispanic/Latino counterparts.

*Figure 77. Spent Less Money on Food to Prioritize other Needs by Ethnicity*
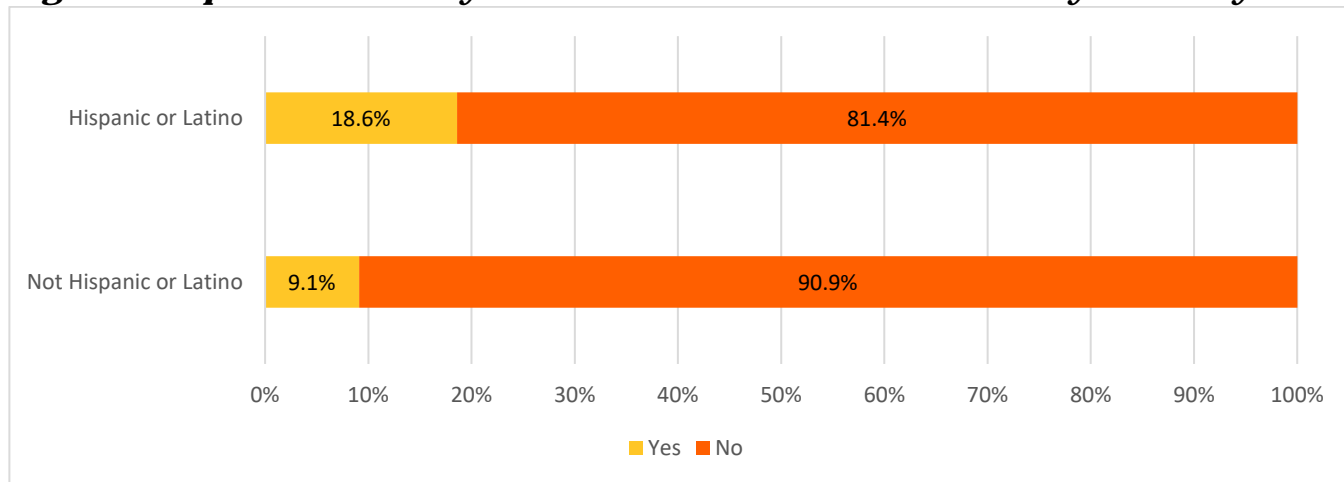
Note: Not Hispanic or Latino population estimate = 42,278; Hispanic or Latino population estimate = 45,856.

Parents/guardians were asked, "In the last 12 months, did you ever cut the size of or skip meals for (child's name) or any of the children in the household because there wasn't enough money for food?"

Fortunately, the vast majority of local children did not have to cut back on food because of lack of money. However, **4.1% of children had to cut the size of their meals or skip meals due to lack of money for food**. There were no significant differences in food insecurity based on the age of the child, as illustrated in the figure below.
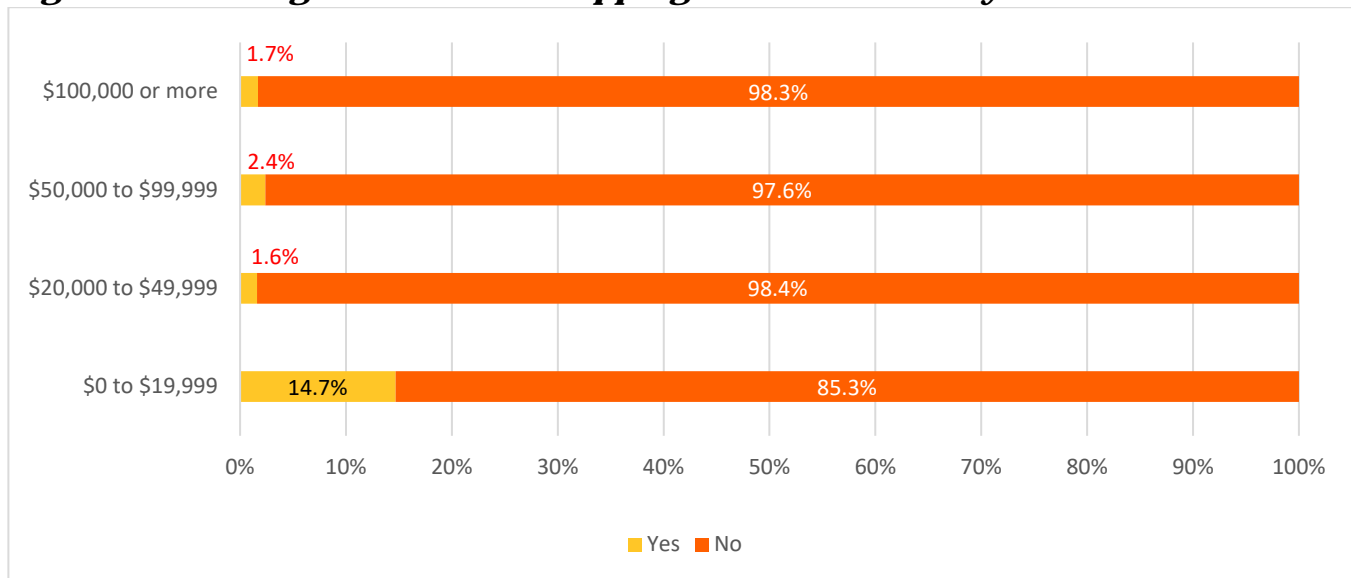
Figure 78. Cutting the Size of or Skipping Meals for Child by Age
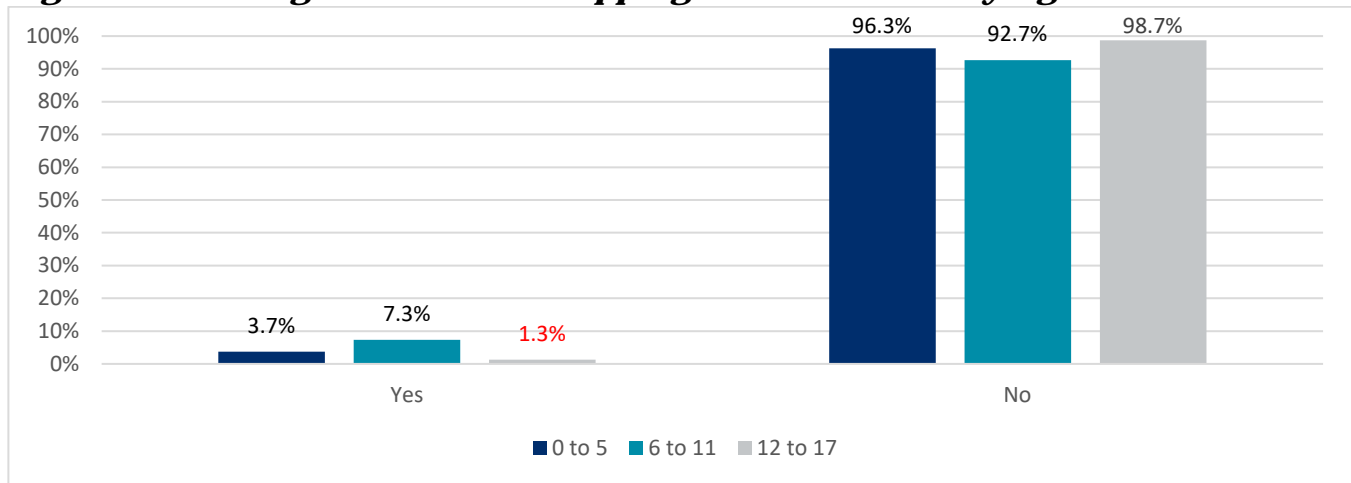
Note: 0 to 5 population estimate = 33,245; 6 to 11 population estimate = 27,978; 12 to 17 population estimate = 26,911. Red indicates statistically unstable estimates.

Children in households with lower income (0 to $19,999) were more likely to have to skip meals or cut the size of meals than children in higher income households, as illustrated below.

Figure 79. Cutting the Size of or Skipping Meals for Child by Income

Note: $0 to $19,999 population estimate = 13,648; $20,000 to $49,999 population estimate = 18,114; $50,000 to $99,999 population estimate = 15,308; $100,000 or more population estimate = 25,979. Red indicates statistically unstable estimates.

Children who had experienced one or more ACEs were also more likely to skip or cut the size of meals than children who had not experienced any of the ACEs measured in this survey, as illustrated in the figure below.

Figure 80. Cutting the Size of or Skipping Meals for Child by ACE
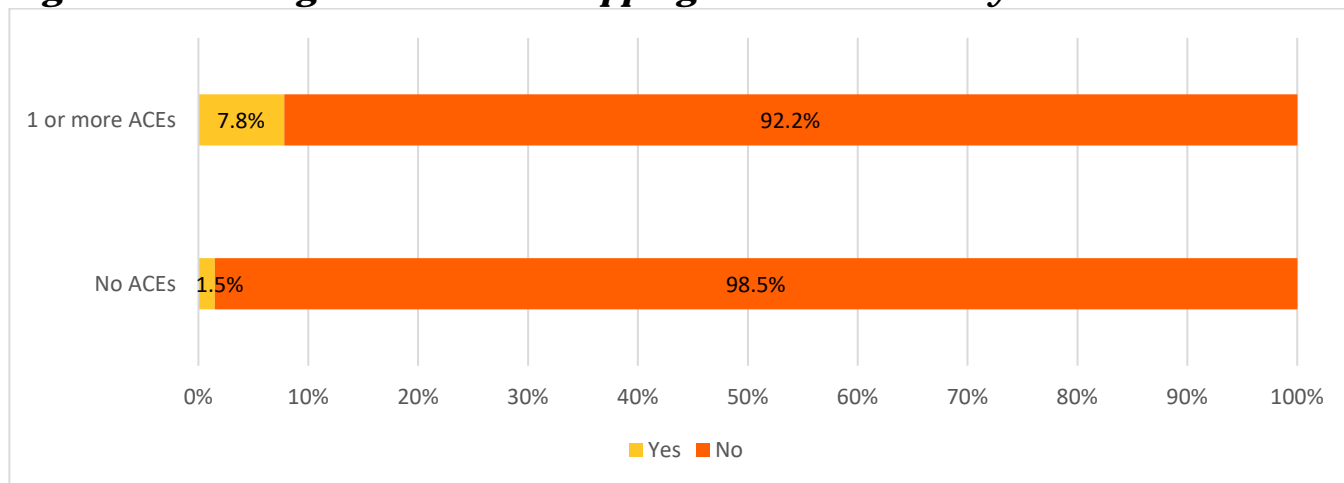
Note: 1 or more ACEs population estimate = 36,309; No ACEs population estimate = 51,773.

Supplemental Food Sources

Fortunately, there are several programs available to support low-income families and combat hunger, including both federal and local programs.

General Emergency Food Sources

Parents/guardians were asked, "In the last 12 months, did (child's name) ever get emergency food from a food assistance program, for example, from a church, a food pantry, or a food bank, or eat in a soup kitchen?" Results show that **6.9% of local children received emergency food assistance in the past year**. This did not vary significantly based on age.

Figure 81. Use of Emergency Food Sources in the Past Year by Age
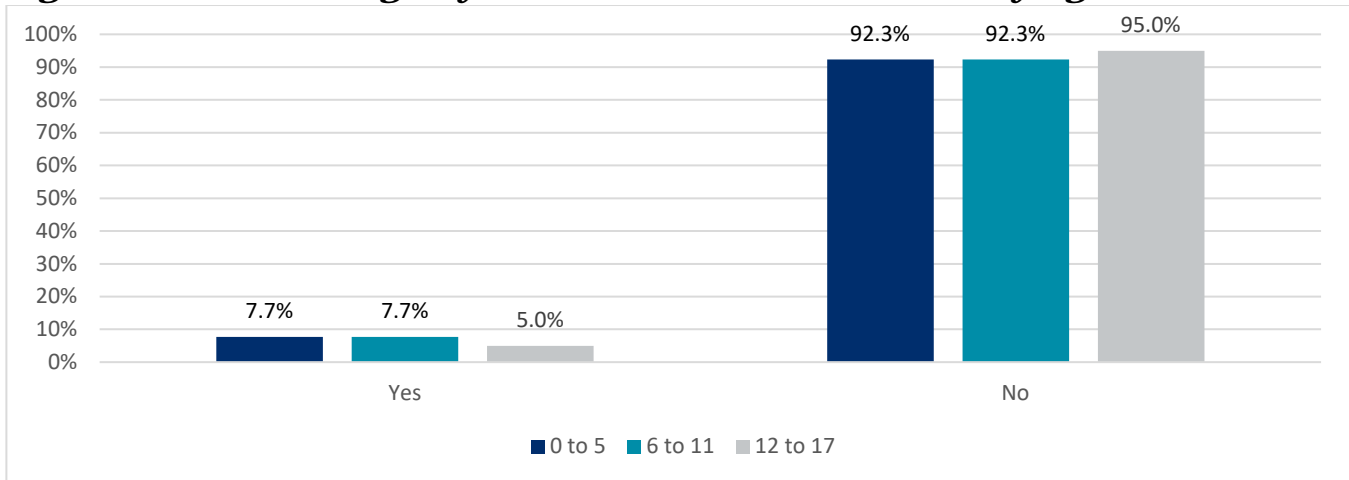
Note: 0 to 5 population estimate = 33,245; 6 to 11 population estimate = 27,978; 12 to 17 population est. = 26,546.

There was a significant difference based on income, however. As illustrated in the figure below, children living in lower-income households were significantly more likely to access emergency food assistance programs than children living in higher-income households.

Figure 82. Use of Emergency Food Sources in the Past Year by Income
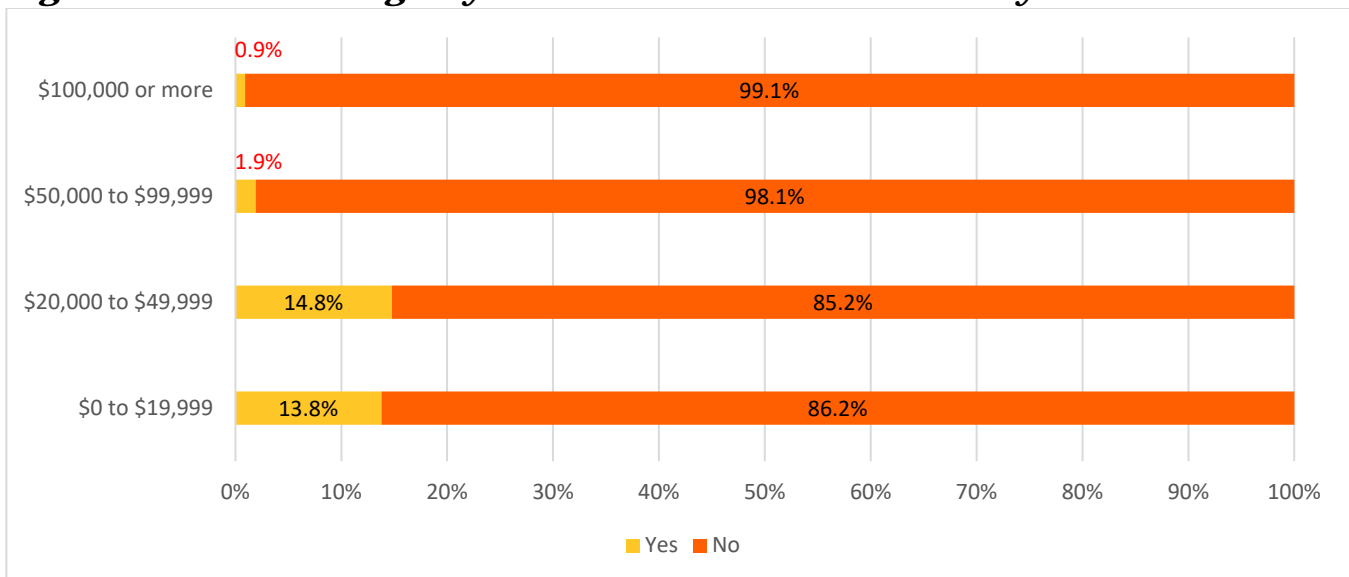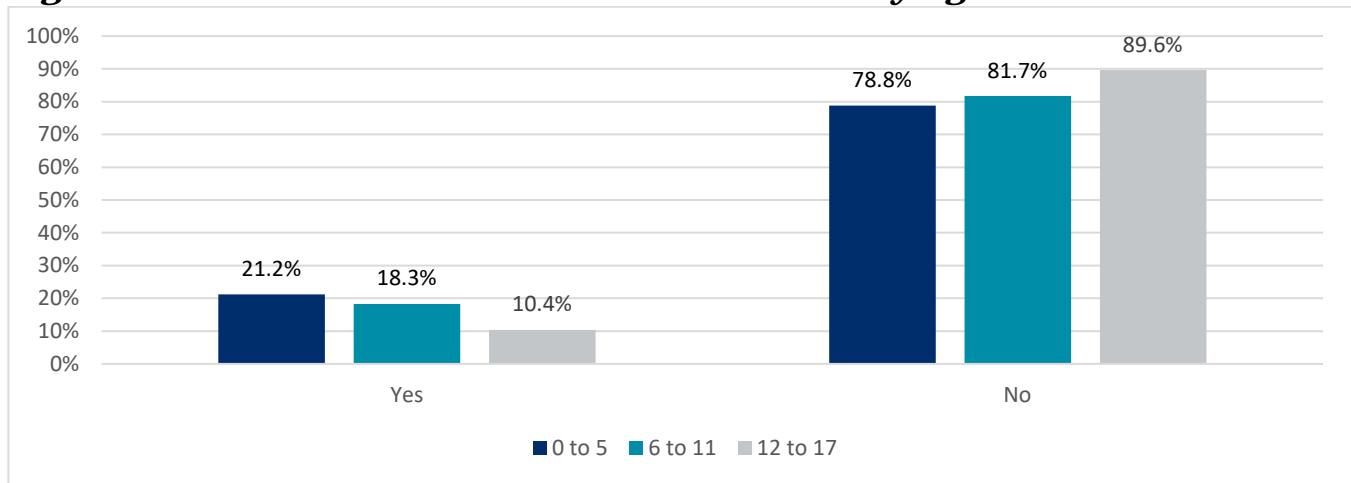

Note: $0 to $19,999 population estimate = 13,648; $20,000 to $49,999 population estimate = 18,340; $50,000 to $99,999 population estimate = 15,308; $100,000 or more population estimate = 25,596. Red indicates statistically unstable estimates.

CalFresh

Supplemental Nutrition Assistance Program (SNAP) is a federal program designed to supplement the food budget of needy families so they can purchase healthy food.[28] In California, this program is called CalFresh, also known as food stamps. Parents/guardians were asked, "In the last 12 months have you or anyone in your household used CalFresh benefits (food stamps) to purchase food?" Results show that **17.0% of local children live in homes that utilize the CalFresh program**. Compared to teens, younger children are more likely to live in homes that utilize CalFresh, as illustrated in the figure below.

Figure 83. Use of CalFresh Benefits in the Past Year by Age

Note: 0 to 5 population estimate = 33,245; 6 to 11 population estimate = 27,978; 12 to 17 population est.= 27,137.

CalFresh is intended for use by low-income families, and thus, it is not surprising that children living in low-income households are significantly more likely to utilize CalFresh than children in higher income families, as illustrate in the figure below.

Figure 84. Use of CalFresh Benefits in the Past Year by Income
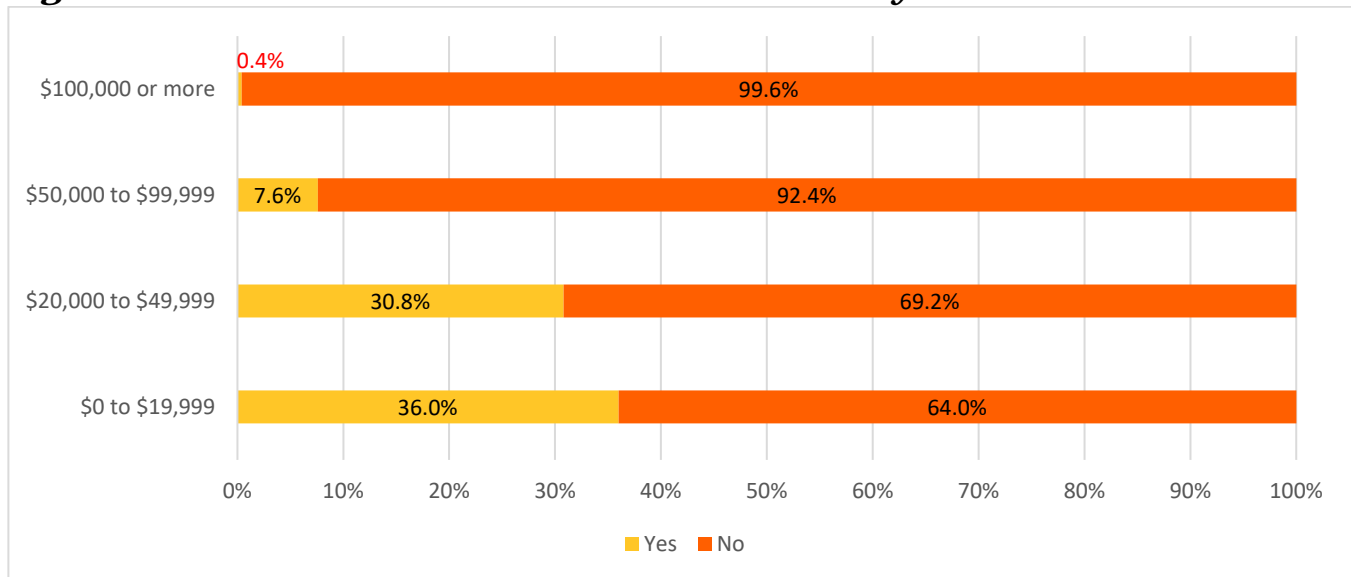
Note: $0 to $19,999 population estimate = 13,648; $20,000 to $49,999 population estimate = 18,340; $50,000 to $99,999 population estimate = 15,308; $100,000 or more population estimate = 25,978. Red indicates statistically unstable estimates.

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[28] https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program

The Special Supplemental Nutrition Program for Women, Infants, and Children, commonly known as WIC, provides supplemental foods, and nutrition education for low-income pregnant women, and to infants and children up to age five who are found to be at nutritional risk.[29]

Parents/guardians were asked, "In the last 12 months have you or anyone in your household used WIC benefits (women, infants, and children's program) to purchase food?" Results show that **14.7% of local children live in homes that utilize the WIC program**. Young children (0 to 5) are significantly more likely to live in homes that utilize WIC than older children, because this the age group targeted by the WIC program. However, older children may live in homes that receive WIC benefits because they have younger siblings also living in the home who are eligible.

Figure 85. Use of WIC Benefits in the Past Year by Age
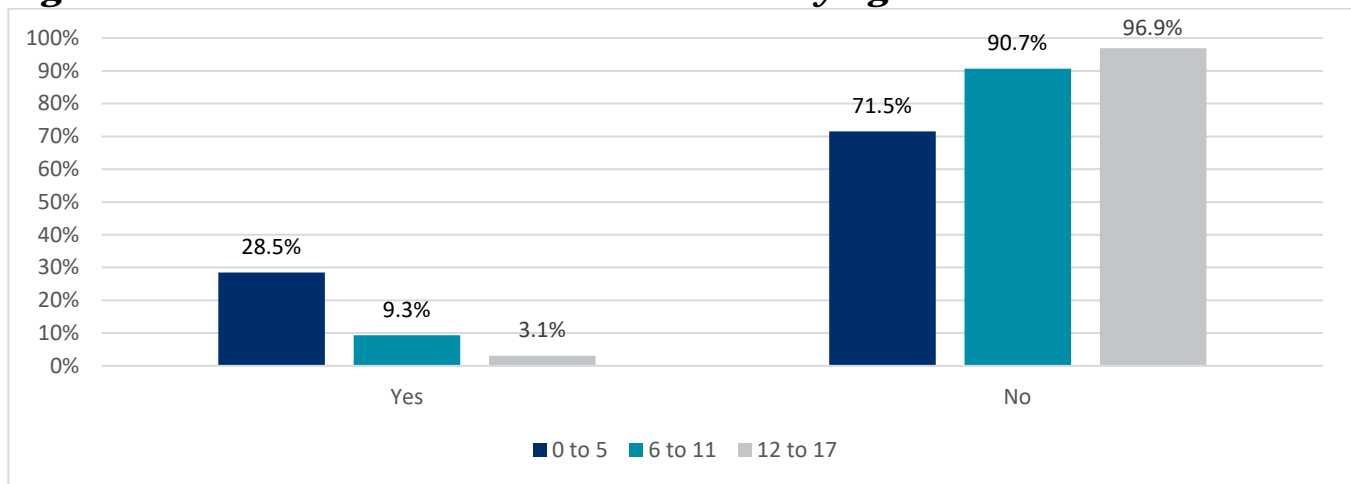
Note: 0 to 5 population estimate = 33,245; 6 to 11 population estimate = 27,705; 12 to 17 population est. = 27,082.

Because WIC is intended for low-income households, virtually no children in households with an income of $100,000 or more utilize this program, as illustrated in the figure below.

Figure 86. Use of WIC Benefits in the Past Year by Income
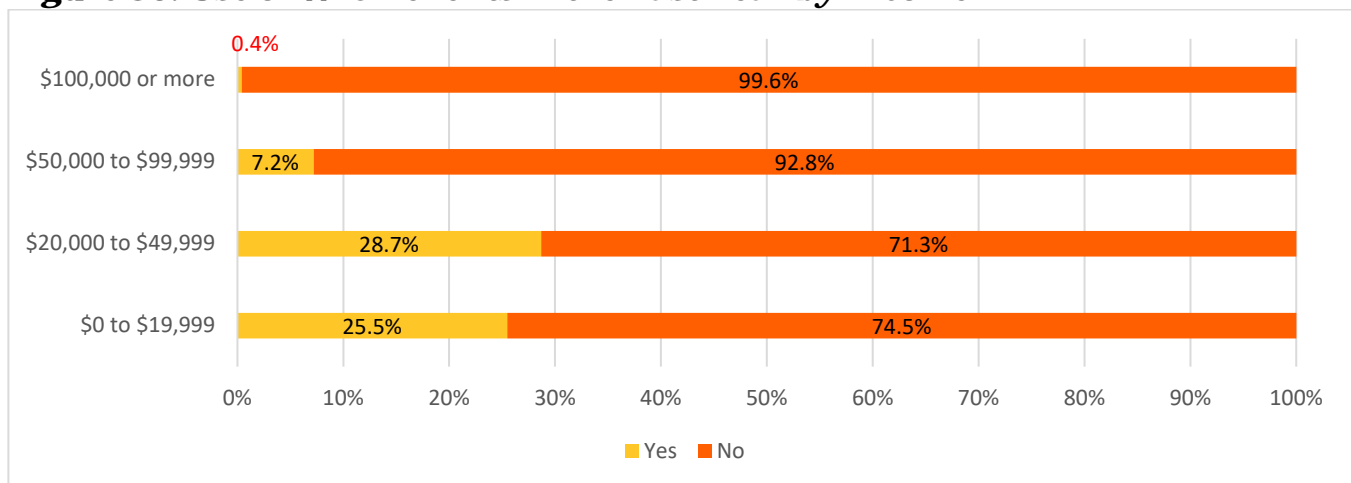
Note: $0 to $19,999 population est. = 13,592; $20,000 to $49,999 population est. = 18,067; $50,000 to $99,999 population est. = 15,308; $100,000 or more population est. = 25,978. Red indicates statistically unstable estimates.

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[29] https://www.fns.usda.gov/wic

WIC usage also varies based on ethnicity, as illustrated in the figure below. Hispanic/Latino children are three times more likely to be utilizing the WIC program than non-Hispanic/Latino children.

Figure 87. Use of WIC Benefits in the Past Year by Ethnicity
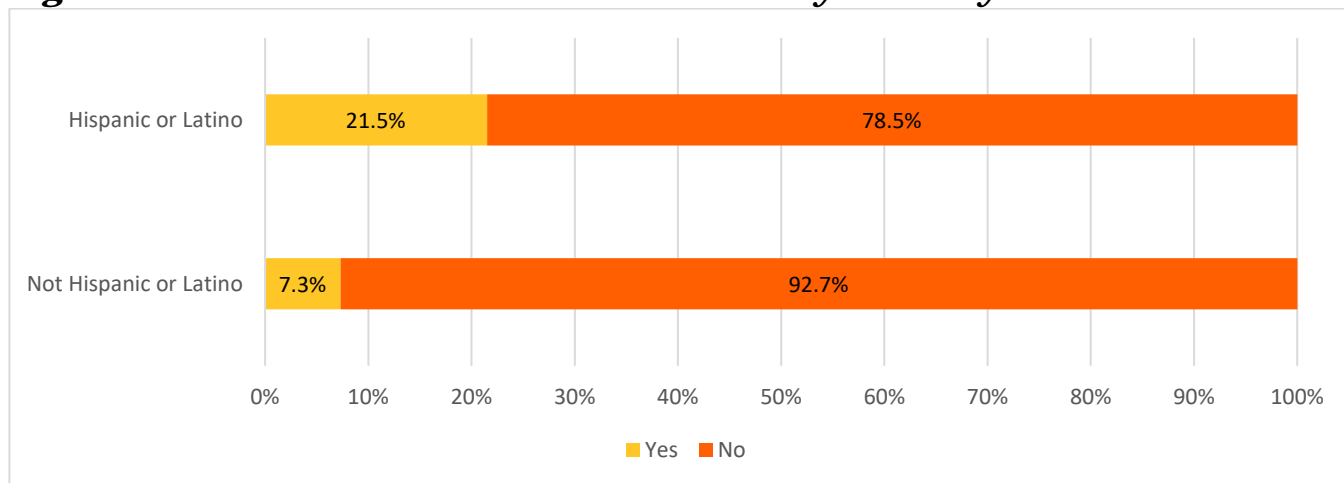
Note: Not Hispanic or Latino population estimate = 42,504; Hispanic or Latino population estimate = 45,528.

Local Resources Available for Food Insecurity

FIND Food Bank

About: As the Feeding American site for the Coachella Valley, FIND Food Bank provides food to dozens of food distribution sites across the Coachella Valley.

Website: https://www.findfoodbank.org/
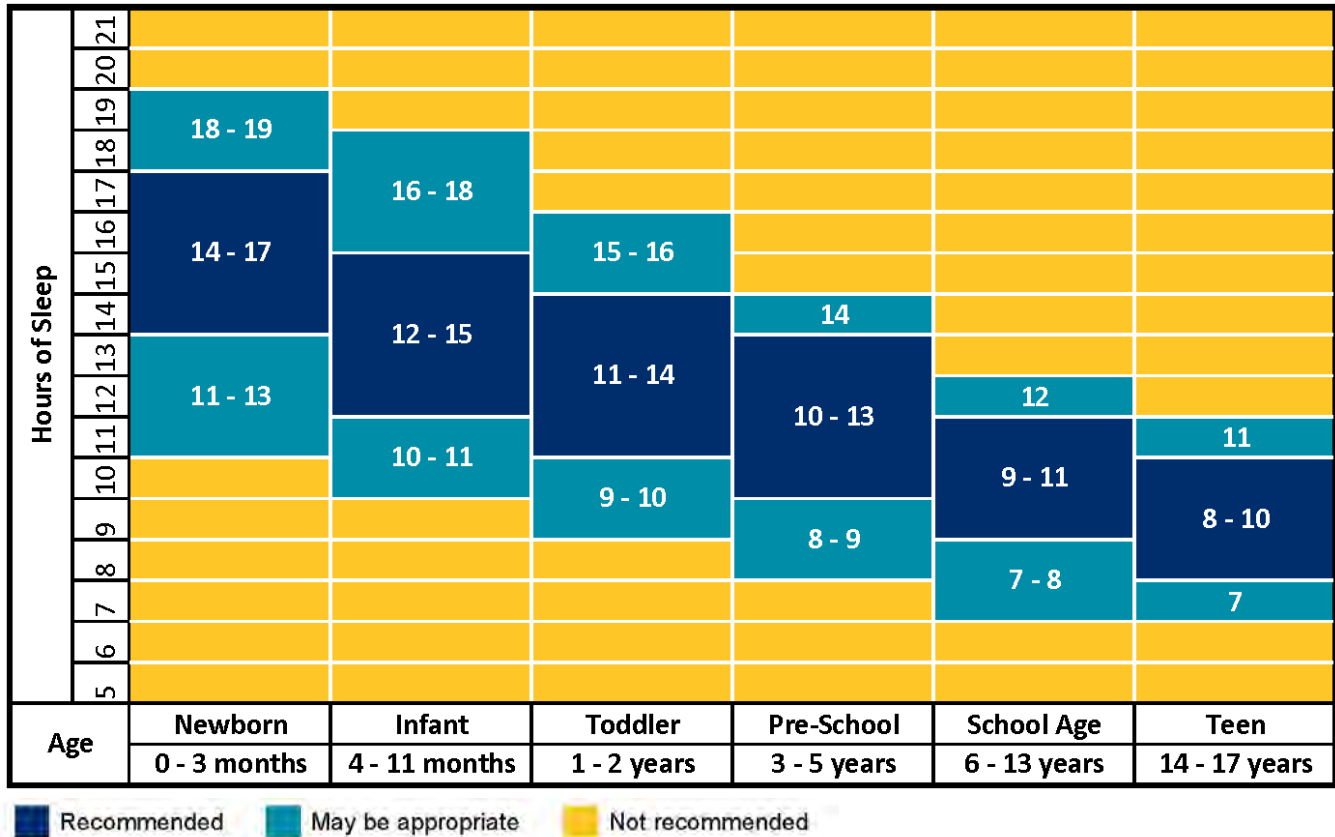
Locations: Find food distribution dates, times, and places here: https://www.findfoodbank.org/find-food/

Distribution sites are present in every one of the nine cities as well as the unincorporated areas of Bermuda Dunes, Mecca, North Shore, Oasis, Thermal, and Thousand Palms. See below for a list of some of the food distribution sites in the Coachella Valley:

- Abundant Life Church
- Agua Caliente Elementary School
- Apostolic Church
- Caesar Chavez Elementary School
- Calvary Bible Church
- Catholic Charities
- Centro Libre
- Chicanitas Market
- Church of the Nazarene
- Coachella Valley High School
- Coachella Valley Rescue Mission
- Desert AIDS Project
- Desert Chapel
- Desert Recreation District
- Destiny Church
- Family Worship Center
- First AME Church
- First Assembly of God
- FISH
- Food Now
- Galilee Center
- Iglesia Bethel
- Iglesia Un Manantial en el Desierto
- Indio Community Center
- Indio Hills Community Center
- James O. Jessie Desert Highland Gateway Unity Center
- John Kelly Elementary School
- La Quinta High School
- Love of Christ

- Martha's Village and Kitchen
- Mathis Brothers
- Ministerios Un Manantial
- Monte de Los Olivos
- Mountain View Estates
- Oasis Elementary School
- Our Lady of Guadalupe
- Pacific Southwest Cesar Chavez Villas
- Painted Hills Middle School
- Palm Desert Church of Christ
- Palm Desert Community Center
- Palm Desert High School
- Palm Desert Oasis Church
- Palm Springs Convention Center
- Pawley Pool
- Presbyterian Church
- Shadow Hills High School
- St. Elizabeth's Pantry
- St. John's Episcopal Church
- St. John's Lutheran Church
- St. Theresa's Catholic Church
- Summerfield Apartments
- The LGBT Community Center of the Desert
- The Narrow Door
- Thousand Palms Community Center
- Valley View Elementary School
- Vision Eterna
- Well in the Desert
- West Shores High School

Sleep

Children who do not get enough sleep can have social problems, anger problems, feelings of sadness or depression, lack of motivation, and can have trouble fighting common infections.[30] The National Sleep Foundation recommends that school-aged children get between seven and 12 hours of sleep per night, as illustrated in the image below.[31]

Hours of Sleep	Newborn	Infant	Toddler	Pre-School	School Age	Teen
21						
20						
19	18 - 19					
18		16 - 18				
17	14 - 17					
16			15 - 16			
15		12 - 15				
14			11 - 14	14		
13	11 - 13			10 - 13		
12					12	
11		10 - 11			9 - 11	11
10			9 - 10			8 - 10
9				8 - 9		
8					7 - 8	
7						7
6						
5						
Age	0 - 3 months	4 - 11 months	1 - 2 years	3 - 5 years	6 - 13 years	14 - 17 years

Legend: ■ Recommended ■ May be appropriate ■ Not recommended

Source: National Sleep Foundation.

Parents/guardians were asked, "On average, how many hours of sleep does (child's name) get in a 24-hour period?" Results show that 94.0% of local children are getting an appropriate amount of sleep every night, but **5.3% of local children are sleep deprived.**

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[30] Why is Sleep Important? (2012). U.S. Department of Health & Human Services. http://www.nhlbi.nih.gov/health/health-topics/topics/sdd/why
[31] National Sleep Foundation (2016). Sleep Duration Recommendations. https://sleepfoundation.org/sites/default/files/STREPchanges_1.png

Sleep deprivation does not differ significantly based on age, as illustrated in the figure below. Virtually no children get more than the recommended amount of sleep based on their age-specific recommendations from the National Sleep Foundation.
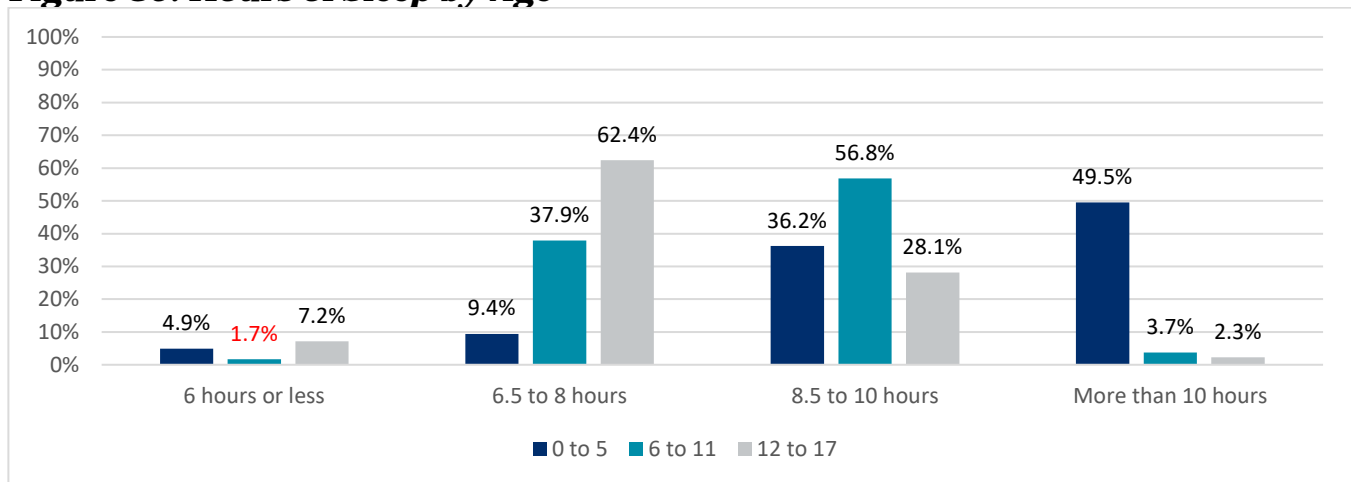
Figure 88. Sleep Amount by Age
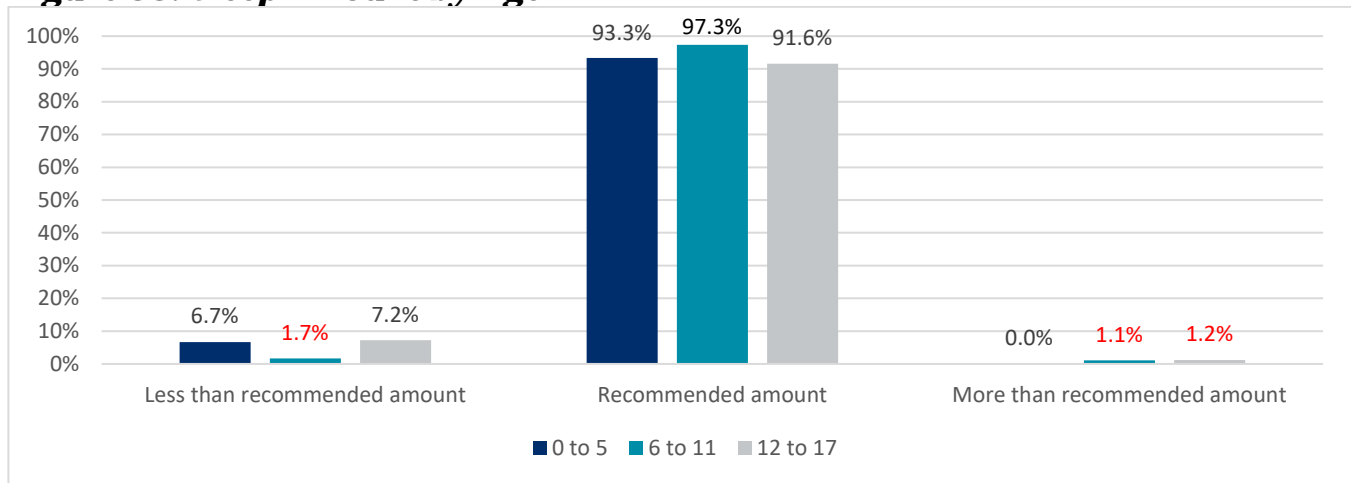
Note: 0 to 5 population estimate = 32,570; 6 to 11 population estimate = 27,831; 12 to 17 population estimate = 26, 353. Red indicates statistically unstable estimates.

Not surprisingly, young children (0 to 5) get significantly more hours of sleep per night than their older counterparts. This is consistent with the recommendations that younger children need more sleep.

Figure 89. Hours of Sleep by Age

Note: 0 to 5 population estimate = 32,570; 6 to 11 population estimate = 27,831; 12 to 17 population estimate = 26,353. Red indicates statistically unstable estimates.

Learning and Socialization

Childcare

Parents/guardians of children ages 12 and younger were asked, "In the past year, was there a time when you could not find childcare when you needed it for a week?" Results show that **11.4% of parents/guardians of children age 12 and under struggled to find childcare for a week or more**. There were no differences based on age, as illustrated in the figure below.

Figure 90. Childcare by Age
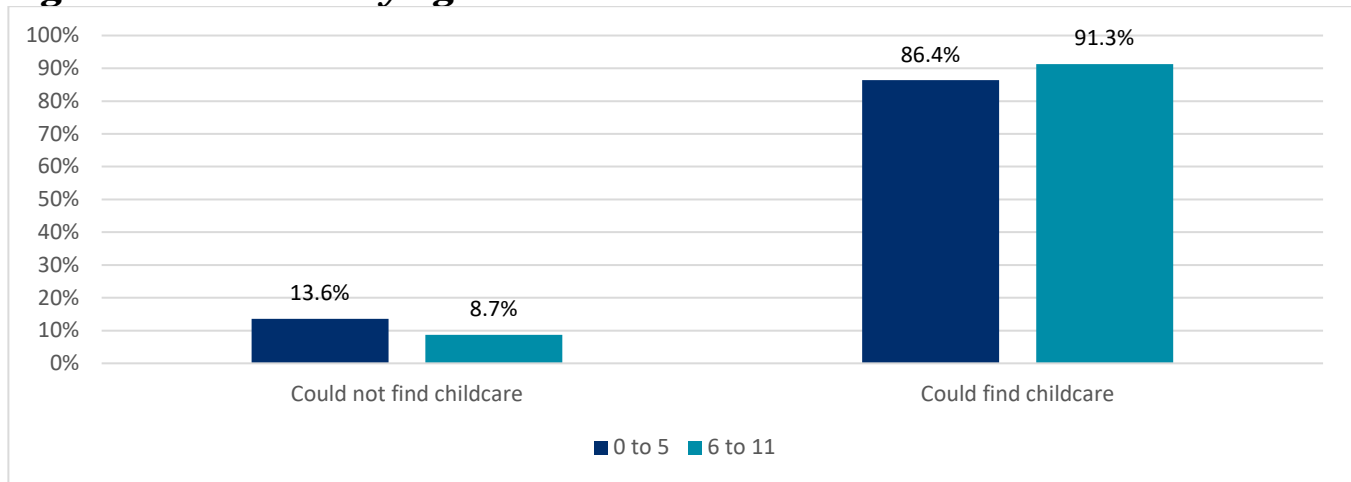
Note: Ages 12 and younger. 0 to 5 population estimate = 33,245; 6 to 11 population estimate = 27,581; 12 to 17 population estimate = 26,353.

Parents/guardians of children who had experienced one or more ACEs were twice as likely to struggle to find childcare when compared to children who had not experienced any of the four ACEs measured in this survey. This may be because one of the ACEs that was measured was whether the child's parents were divorced; it is logical that a single parent/guardian would have more difficulty finding childcare than a two-parent household.

Figure 91. Childcare by ACEs
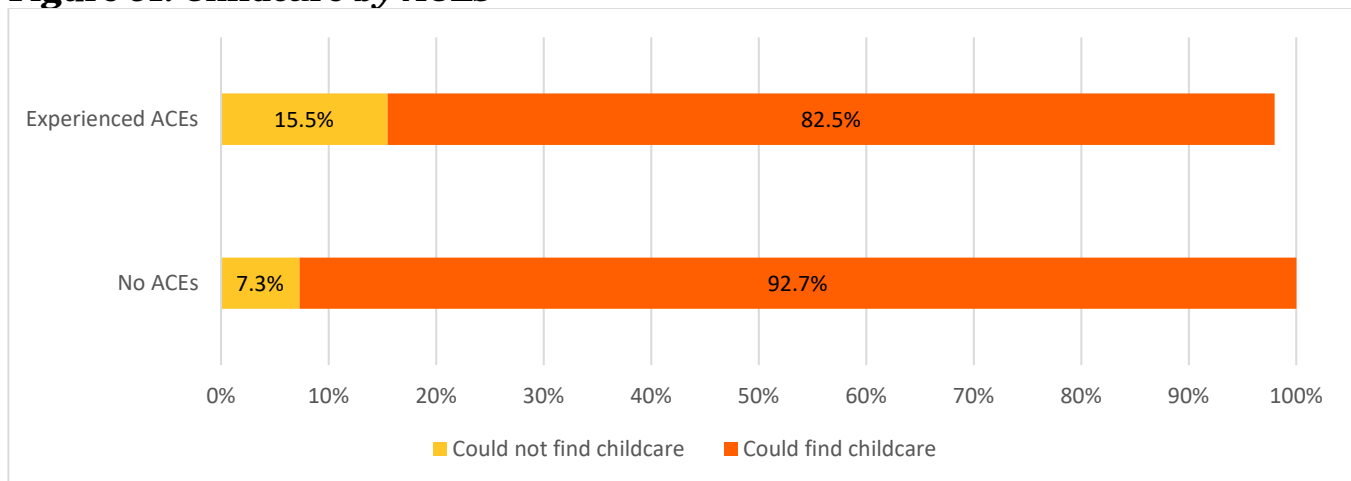
Note: No ACEs population estimate = 36,272; 1 or more ACEs population estimate = 24,553.

Local Resources Available for Finding Childcare

Bermuda Dunes Learning Center
About: They provide a hands-on, positive learning environment approach where children are constantly experiencing personal growth and success. Children must be participating in a childcare subsidy program to be eligible for the learning center.
Location: Palm Desert
Website: https://bermudaduneslearningcenter.com/

Martha's Village and Kitchen
About: This shelter offers high-quality care for children ages 0 to 5. Parents may take important steps towards self-sufficiency, while their children enjoy the facility and its playground.
Location: Indio
Website: https://marthasvillage.org/programs/childrens-services/

Head Start, Early Head Start, Migrant Head Start
Riverside County Office of Education
About: Riverside County Office of Education provides the Head Start program (3 to 4-year-olds) and Early Head Start program (infants to 2-year-olds) for low-income children and children with disabilities free of charge. Each of our three school districts has the Head Start program, while Palm Springs Unified also has an Early Head Start program. Migrant Head Start, intended for children of migrant and seasonal workers ages 0 to 5, is available in Mecca and Thermal.
Locations: Cathedral City, Coachella, Desert Hot Springs, Indio, La Quinta, Mecca, Palm Desert, Palm Springs, Thermal, Thousand Palms
Websites: https://www.rcoe.us/early-learning-services/head-start-early-head-start-programs/
https://www.rcoe.us/children-family-services/migrant-head-start/

Renu Hope Foundation
About: This program cares for children who are 6 years old and younger. They provide full day/full year general childcare in a preschool program setting.
Website: https://www.renuhope.org/programs-and-admissions-requirements
Location: Indio

YMCA of the Desert
About: The Family YMCA of the Desert is the largest provider of licensed childcare in the Coachella Valley, with facilities Valley-wide.
*Location:* Palm Desert
Website: https://www.ymcaofthedesert.org/about-desert-ymca/

School Absenteeism

Low levels of school attendance may lead to poor academic achievement, illiteracy, and school dropout.[32] Parents/guardians of children age 6 and older were asked, "In the past 12 months, how many days did (child's name) miss school?" Results show that a quarter of children age 6 and older have not missed a single day of school in the past year. Unfortunately, **7.5% of students missed 11 or more days of school**, and are likely struggling to keep up. There were no significant differences in absenteeism based on age.

Figure 92. School Days Missed per Year by Age
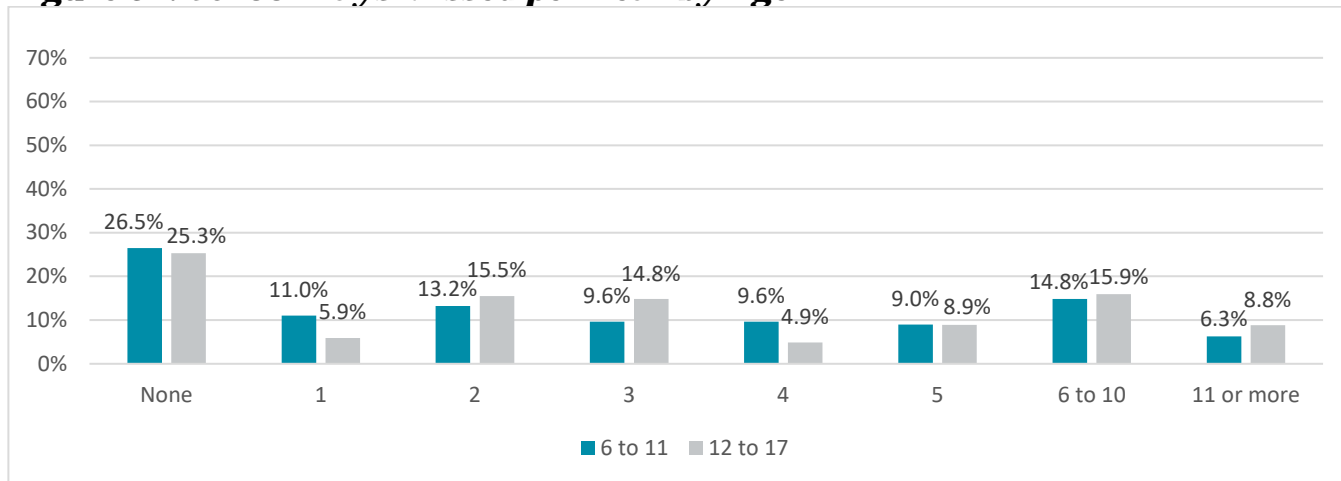
Note: Ages 6+. Population estimate = 6 to 11 population estimate = 26,716; 12 to 17 population estimate = 25,993.

Parents/guardians of children who missed at least one day were asked to describe why the child missed school. As illustrated in the table below, illness was the most common reason for absence.

| Reason for Missing School in the Past Year *Children Ages 6 to 17 Who Were Absent at Least Once*	Weighted Percent	Population Estimate
Illness	73.7%	28,762
Vacation	20.1%	7,842
Doctor appointment	14.4%	5,638
Death (of a relative)	1.8%	714
Caring for a sibling or other family member	1.1%	436

Because "death" and "caring for a sibling or other family member" were so uncommon, they are not represented in the following charts, as the sample size is too small to produce statistically significant breakdowns by age.

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[32] Chronic Absence. (n.d.). Attendance Works Website. https://www.attendanceworks.org/chronic-absence/the-problem/

Absence due to Illness

There is a significant difference in absence due to illness based on age, as illustrated in the figure below. Children age 6 to 11 are more likely than those 12 to 17 to miss school because they are sick.
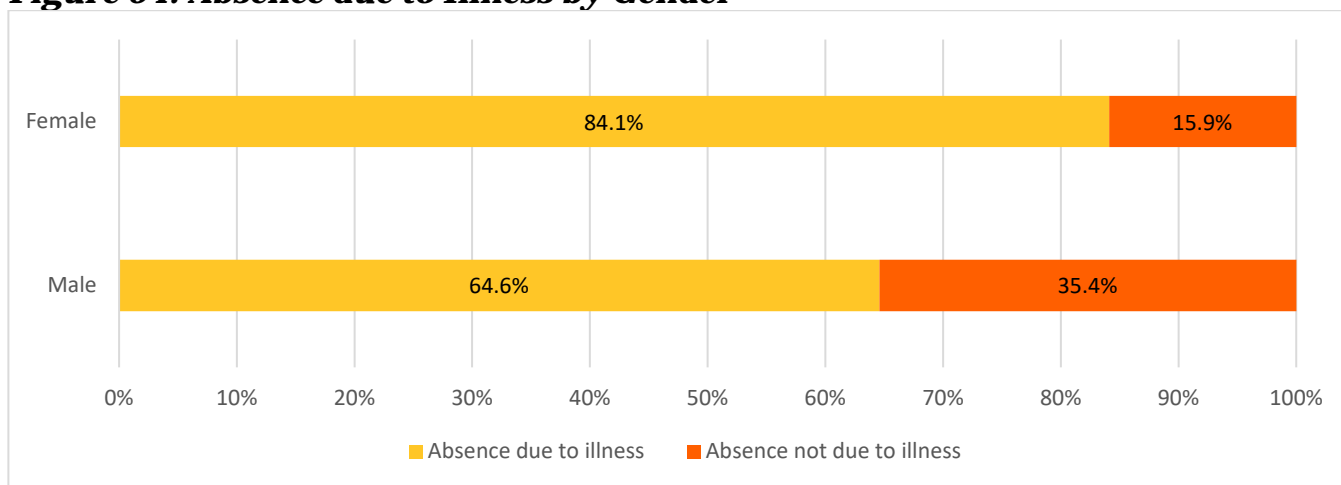
Figure 93. Absence due to Illness by Age
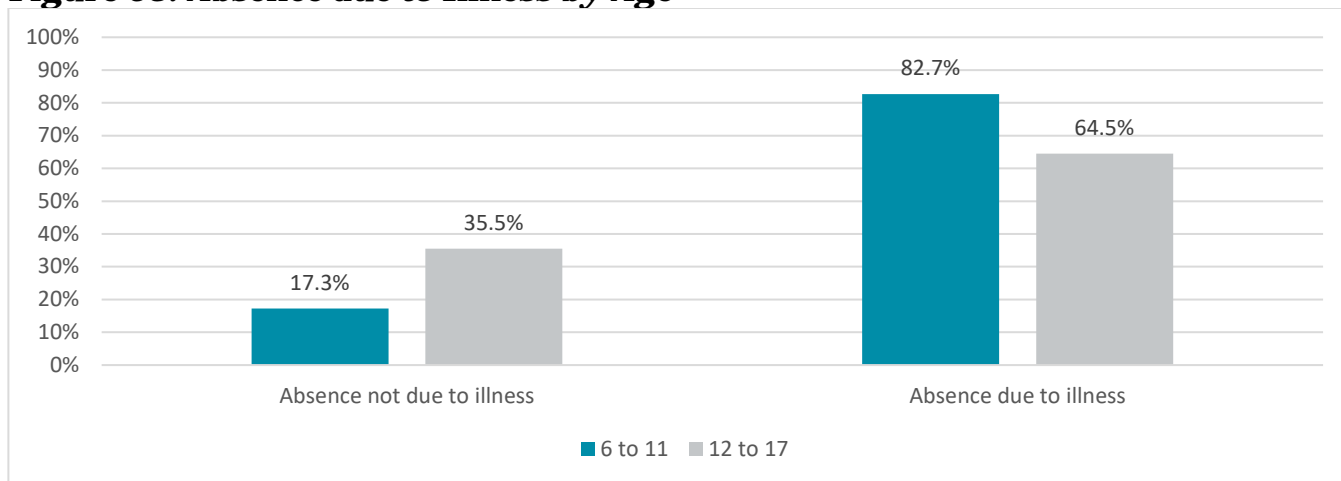
Note: Ages 6+, only includes children who missed one or more days of school in past year. 6 to 11 population estimate = 19,625; 12 to 17 population estimate = 19,424.

There is also a significance difference based on gender; female students who've been absent at least once are significantly more likely to have missed school due to illness than their male counterparts, as illustrated in the figure below.
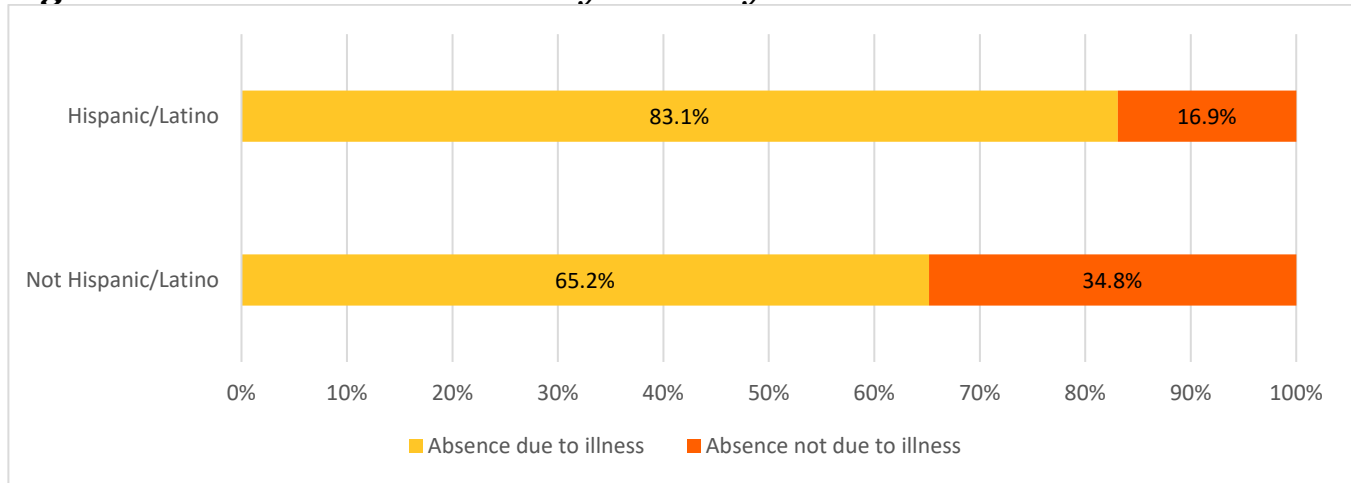
Figure 94. Absence due to Illness by Gender

Note: Ages 6+, only includes children who missed one or more days of school in past year. Male population estimate = 20,294; female population estimate = 17,473.

Being absent due to illness also varies significantly by ethnicity, as illustrate in the figure below. Hispanic/Latino children are more likely to be absent because of illness than non-Hispanic/Latino children.

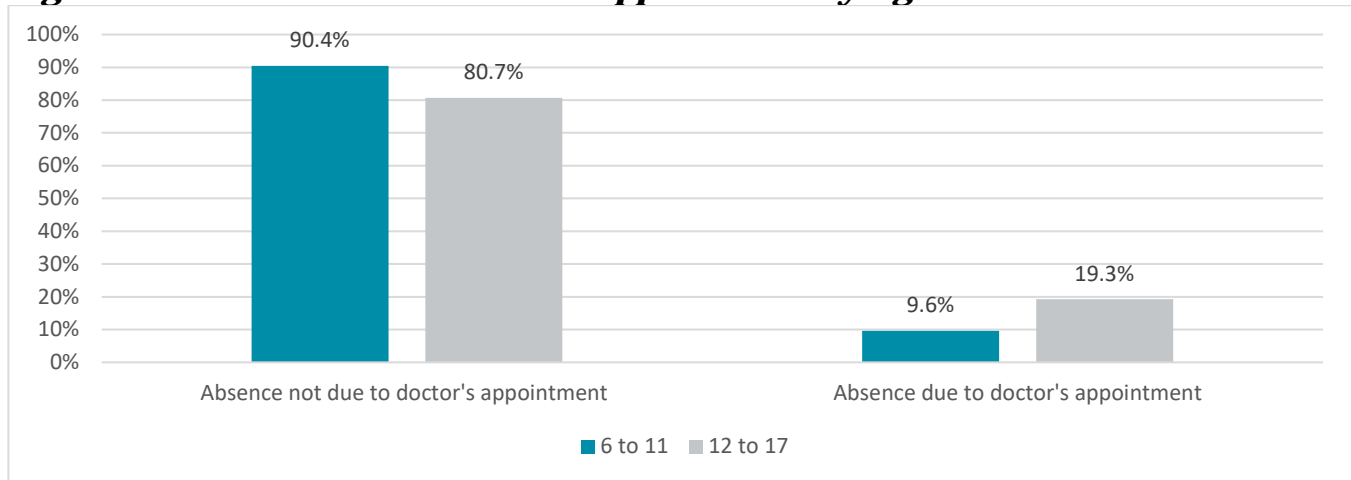**Figure 95. Absence due to Illness by Ethnicity**

Note: Ages 6+, only includes children who missed one or more days of school in past year. Not Hispanic/Latino population estimate = 20,590; Hispanic Latino population estimate = 18,459.

Absence due to Doctor Appointment

The third most common reason for absence among local children is to attend a doctor's appointment. There were no statistically significant differences on this reason for absence based on age, as illustrated in the figure below.

Figure 96. Absence due to Doctor's Appointment by Age

Note: Ages 6+, only includes children who missed one or more days of school in past year. 6 to 11 population estimate = 19,625. 12 to 17 population estimate = 19,424.

Absence due to Vacation

There are no age differences among students who are absent for vacation, as illustrated in the figure below.

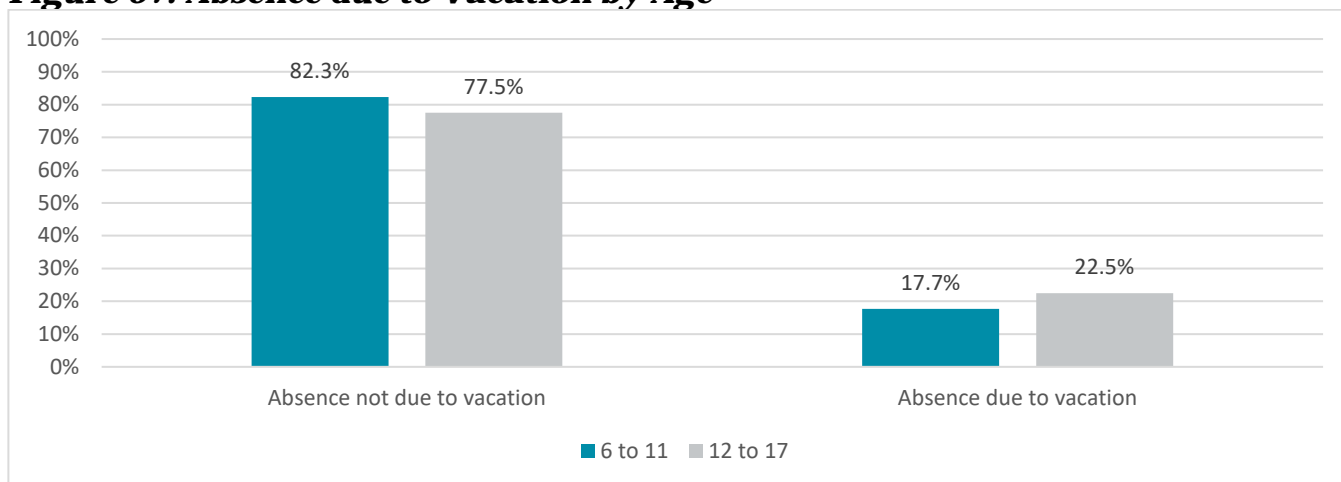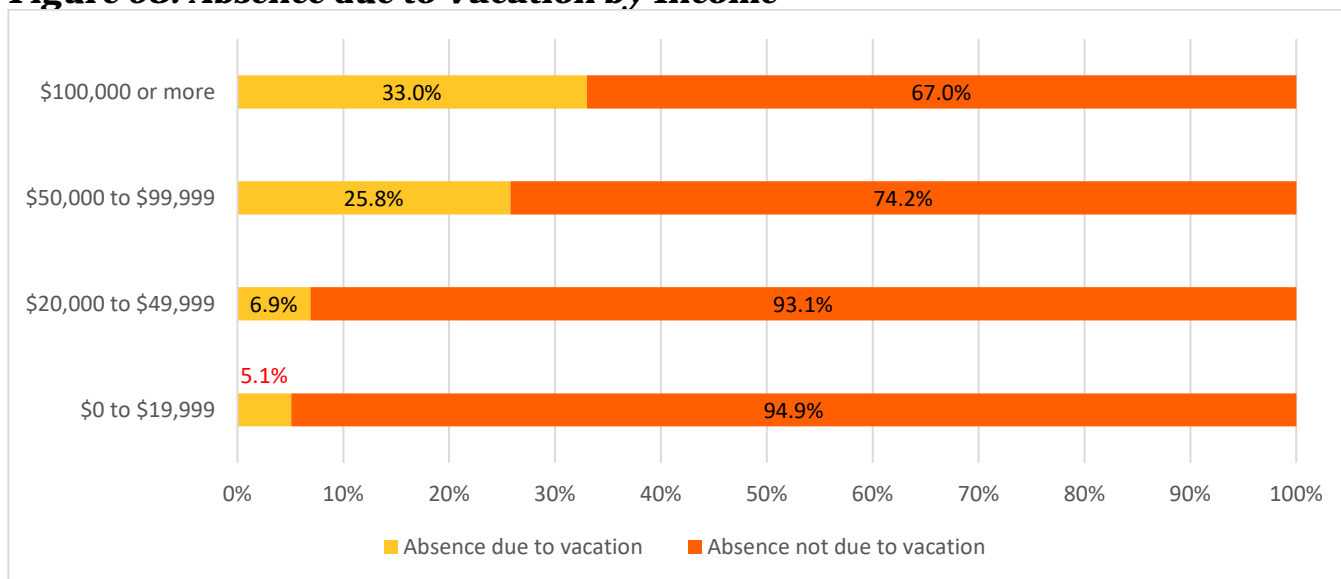**Figure 97. Absence due to Vacation by Age**

Note: Ages 6+, only includes children who missed one or more days of school in past year. 6 to 11 population estimate = 19,625; 12 to 17 population estimate = 19,424.

However, there were significant differences in vacation-driven absences based on income. Not surprisingly, lower-income children were significantly less likely to be absent for the purposes of a vacation when compared to higher-income children. Children living in wealthier households are more able to afford vacations, and thus, more likely to miss school to go on vacation.
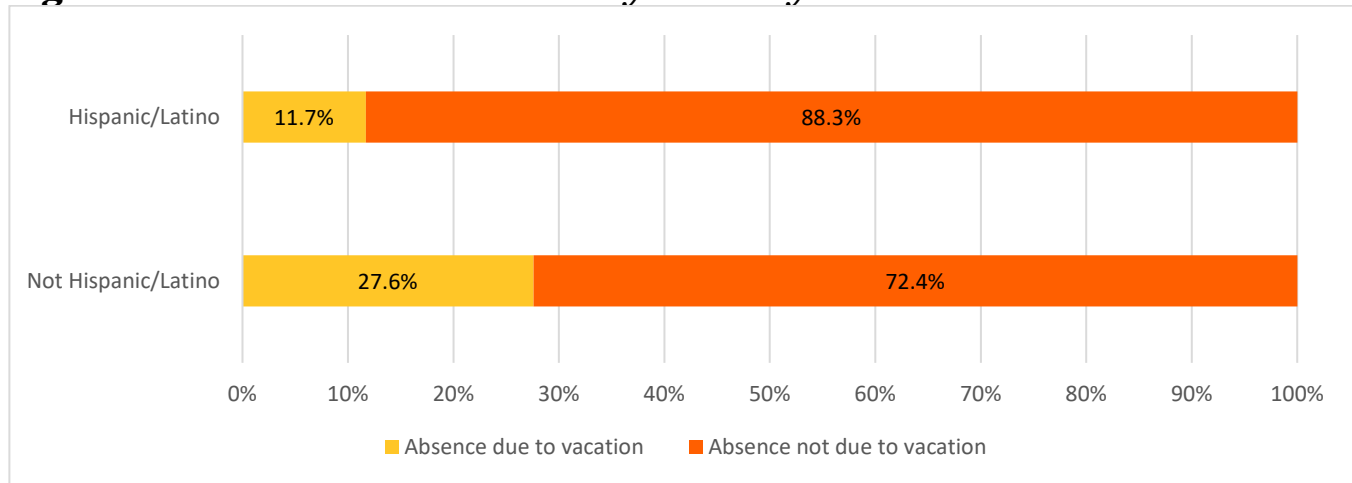
Figure 98. Absence due to Vacation by Income

Note: Ages 6+, only includes children who missed one or more days of school in past year. $0 to $19,999 population estimate 5,831; $20,000 to $49,999 population estimate = $7,510; $50,000 to $99,999 population estimate = 7,030; $100,000 or more population estimate = 12,488. Red indicates statistically unstable estimates.

Finally, absence due to vacation also varied based on ethnicity. Non-Hispanic/Latino children are significantly more likely than Hispanic/Latino children to miss school to take a vacation, as illustrated in the figure below.

Figure 99. Absence due to Vacation by Ethnicity

Note: Ages 6+, only includes children who missed one or more days of school in past year. Not Hispanic/Latino population estimate = 20,590; Hispanic/Latino population estimate = 18,459.
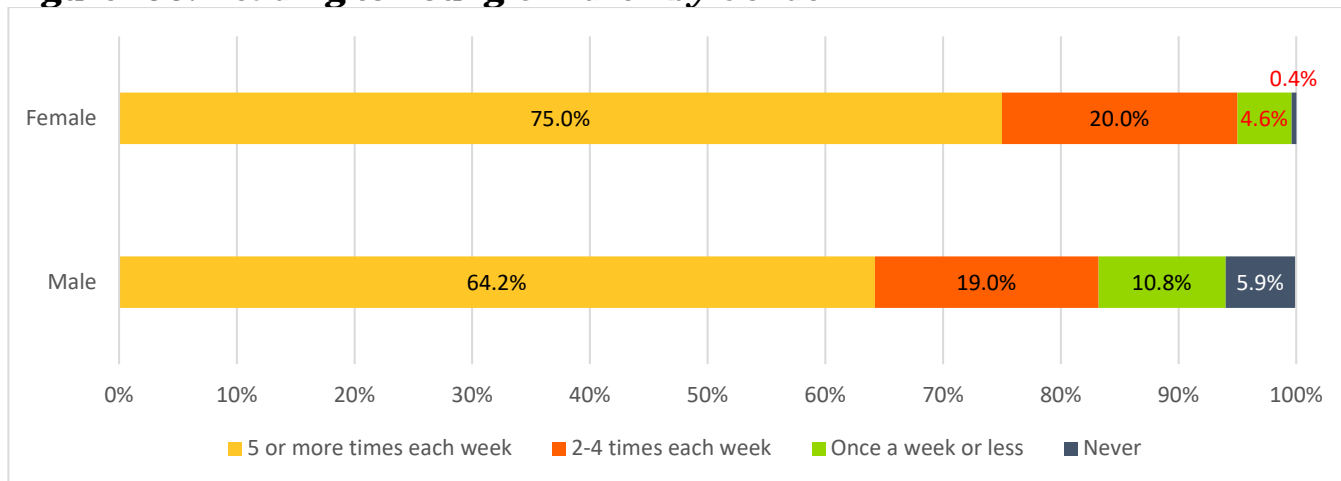
Reading to Child

Reading to children is an important step in teaching children to read and has many additional benefits. For example, parent-child reading has been found to help with oral language development and understanding of letters, words, and punctuation.[33]

Parents/guardians of local children ages five and under were asked to report how often an adult read to their child in the home within the past three months. **The majority of young children (69.3%) were read to five or more times per week in their home**; very few children were not read to at all (2.9%).

Number of Times/Week an Adult Read to the Child in the Home *Children Ages 0 to 5*	Weighted Percent	Population Estimate
Never	2.9%	966
Once a week or less	8.4%	2,784
2 to 4 times a week	19.4%	6,384
5 or more times per week	69.3%	22,838
Total	**100.0%**	**32,972**

Reading to children varied significantly based on gender; parents/guardians were significantly more likely to read to their daughters than their sons, as illustrated in the figure below.

### Figure 100. Reading to Young Children by Gender

Note: Ages 0 to 5. Male population estimate = 15,197; female population estimate = 17,439. Red indicates statistically unstable estimates.

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[33] Home Reading Environment and Brain Activation in Preschool Children Listening to Stories. (2015). Pediatrics, volume 136, issue 3. http://pediatrics.aappublications.org/content/early/2015/08/05/peds.2015-0359

Hispanic/Latino children are read to significantly less than non-Hispanic/Latino children. As illustrated in the figure below, 56.7% of Hispanic/Latino children 0 to 5 are read to five or more times per week; in contrast, 84.2% of non-Hispanic/Latino children 0 to 5 are read to that frequently. Nearly 1 in 5 Hispanic/Latino children 0 to 5 are read to once a week or less or not at all.

Figure 101. Reading to Young Children by Ethnicity
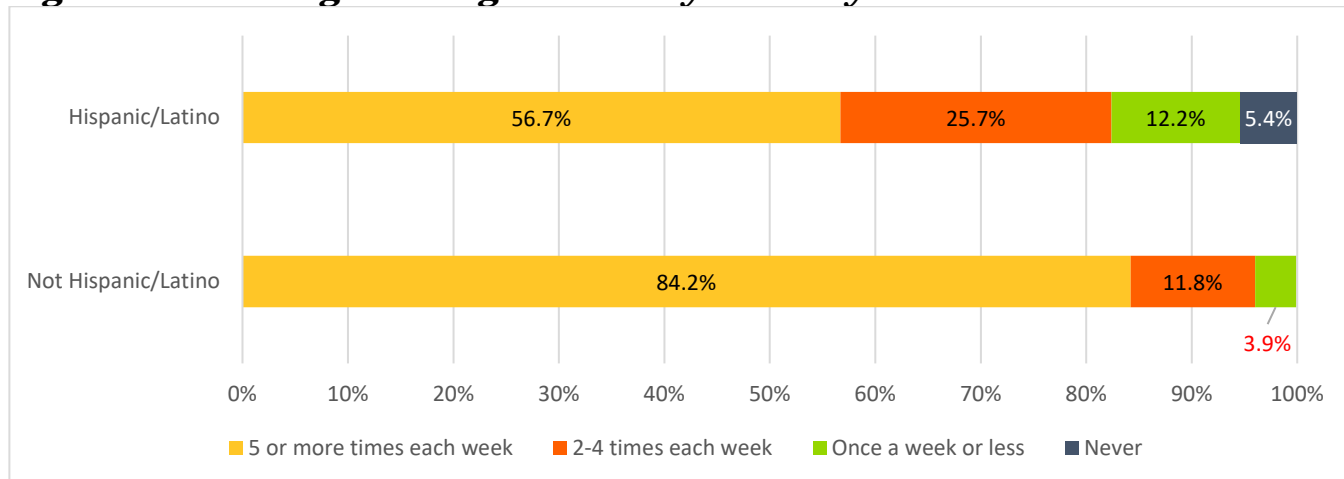
Note: Ages 0 to 5. Not Hispanic/Latino population estimate = 15,073; Hispanic/Latino population estimate = 17,898. Red indicated statistically unstable estimates.

Literacy, Language, & Cultural Centers (LiLaC)
About: This nonprofit works closely with low-income Latino families in Desert Hot Springs to increase learning and literacy development of young children in both English and Spanish.
Website: https://lilaccenters.org//
Location: Desert Hot Springs

Read With Me
About: This nonprofit connects volunteers to elementary students who are low income, limited English speaking. The tutors help students develop to their fullest potential by learning to read, comprehend and speak English.
Website: https://www.readwithmevolunteers.com/
Locations: Present in 14 elementary schools across the Coachella Valley

Riverside County Library System
About: The County Library System offers many free resources, including literacy tutoring, English as a second language classes, live online homework help, among others. Available reading materials include audio books, large print books, newspapers, magazines, and more.
Website: http://www.rivlib.info/website/homepage-684
Locations: Cathedral City, Coachella, Desert Hot Springs, Indio, La Quinta, Mecca, Palm Desert, Thousand Palms, and a mobile bookmobile.

Other Libraries
About: There are also two libraries in the Coachella Valley that are not a part of the Riverside County system: the public libraries in Palm Springs and Rancho Mirage.
Websites: https://www.palmspringsca.gov/government/departments/library
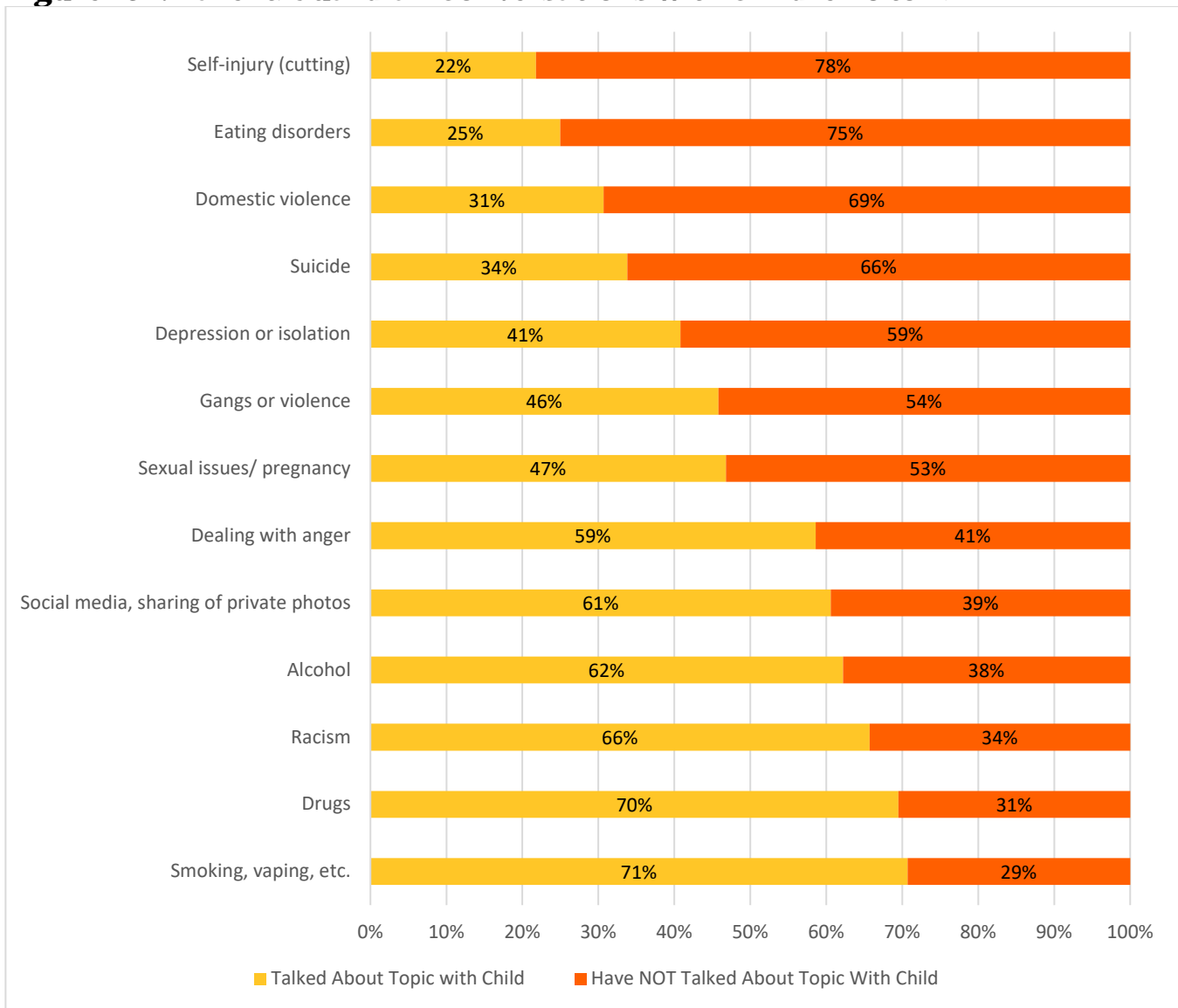https://ranchomiragelibrary.org/

Discussions with Child

As children grow into adolescence, it is important for them to receive guidance from their parents/guardians or other adults in the household about topics such as substance use, gangs and violence, and reproductive health. Difficult conversations about racism, mental health issues and social media use should also be had in order for children to be prepared for complex situations in the future.

Parents/guardians of children ages 6 to 17 were asked, "During the past 12 months, have you or another adult in the household spoken with (child's name) about any of the following topics…"

As illustrated in the figure below, most parents/guardians of children ages 6 to 17 have talked to their children about smoking, drugs, and racism; discussion around topics like self-injury, eating disorders, and domestic violence are less common.

Figure 102. Parent/Guardian Conversations with Children 6 to 17

| Topic	Talked About Topic with Child	Have NOT Talked About Topic With Child
Self-injury (cutting)	22%	78%
Eating disorders	25%	75%
Domestic violence	31%	69%
Suicide	34%	66%
Depression or isolation	41%	59%
Gangs or violence	46%	54%
Sexual issues/ pregnancy	47%	53%
Dealing with anger	59%	41%
Social media, sharing of private photos	61%	39%
Alcohol	62%	38%
Racism	66%	34%
Drugs	70%	31%
Smoking, vaping, etc.	71%	29%

Note: 6 to 11 population estimate = 27,977; 12 to 17 population estimate = 27,136.

Tobacco Use

Parents/guardians of children ages 6 and older were asked, "During the past 12 months, have you or another adult in the household spoken with (child's name) about smoking, e-cigarettes, vaping, chewing, or other tobacco use?"

Results show that **70.7% of local children ages 6 and older have had a discussion with their parents/guardians about tobacco use**. Older children (12 to 17) are significantly more likely to have had a discussion with their parents/guardians about tobacco than younger children (6 to 11).

Figure 103. Conversations about Tobacco Use by Age
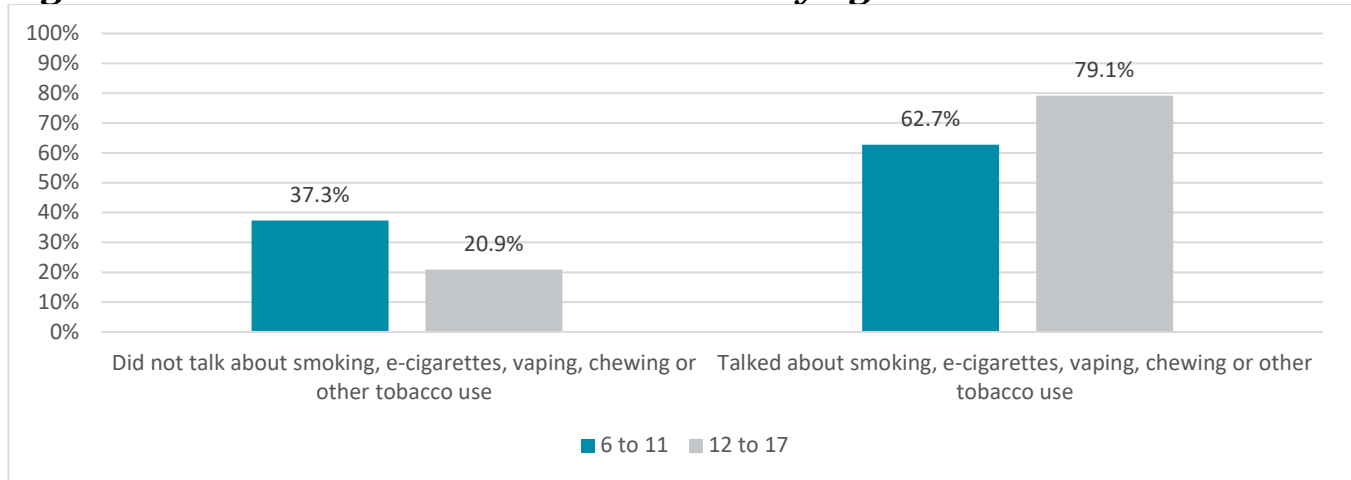
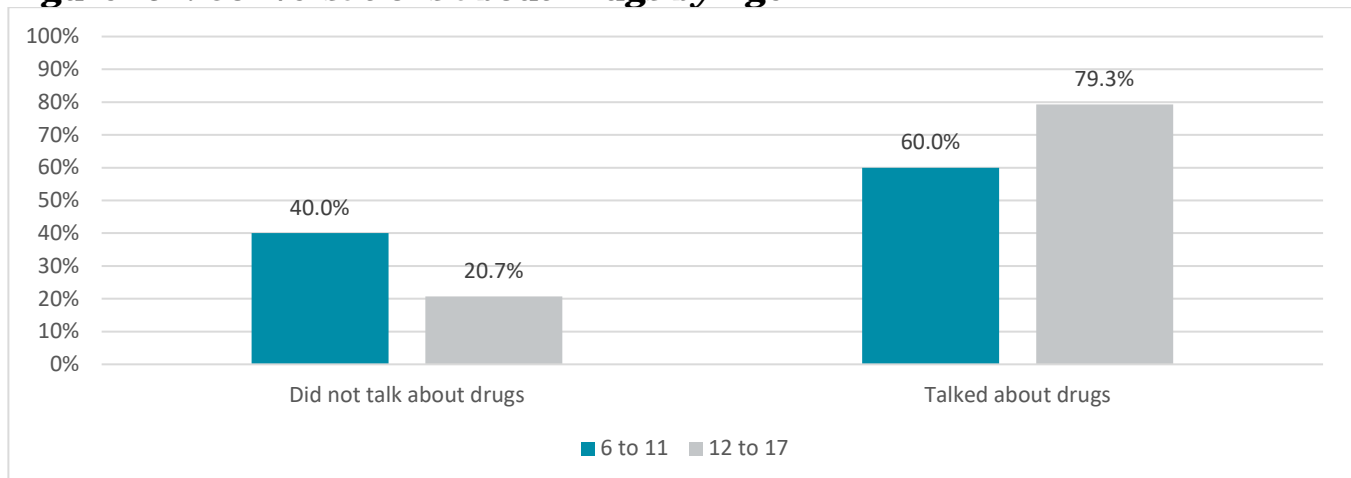
Note: Ages 6+. 6 to 11 population estimate = 27,977; 12 to 17 population estimate = 27,136.

Drugs

Parents/guardians of children ages 6 and older were asked, "During the past 12 months, have you or another adult in the household spoken with (child's name) about drugs?"

Overall, **69.5% of children ages 6 and older have had a conversation with a parent/guardian about drugs**. Older children (12 to 17) are significantly more likely to have talked to their parents/guardians about drugs than younger children (6 to 11).
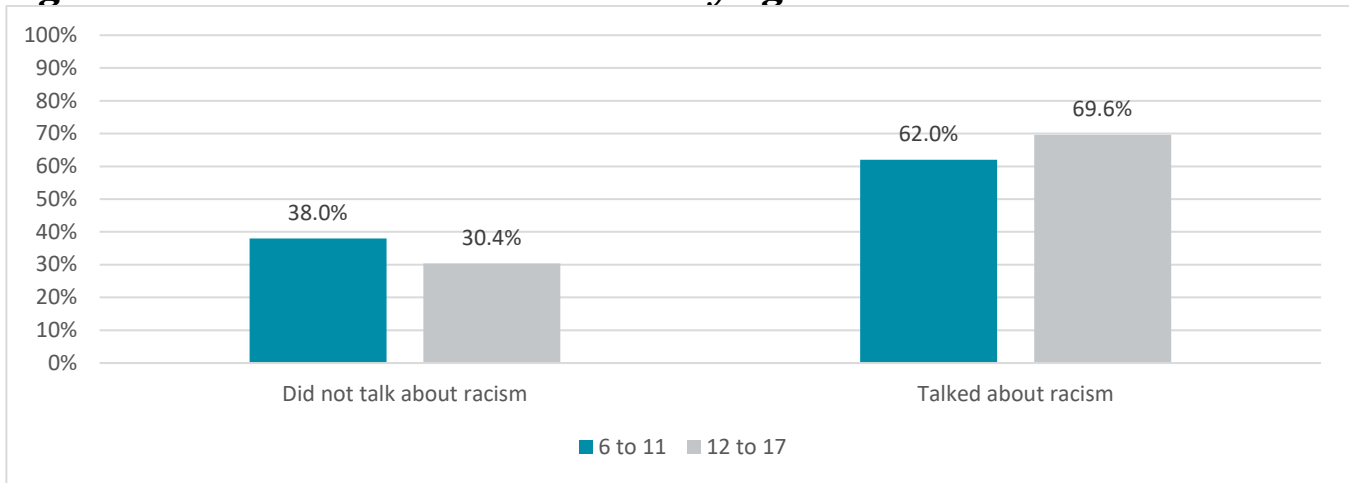
Figure 104. Conversations about Drugs by Age

Note: Ages 6+. 6 to 11 population estimate = 27,977; 12 to 17 population estimate = 27,136.

Racism

Parents/guardians of children ages 6 and older were asked, "During the past 12 months, have you or another adult in the household spoken with (child's name) about racism?"

Overall, **65.7% of children ages 6 and older have had a conversation about racism with their parents/guardians**. There were no significant differences in the rates of racism discussions with children based on age; that is, children 6 to 11 and those 12 to 17 are equally likely to have a conversation about racism with their parents/guardians.
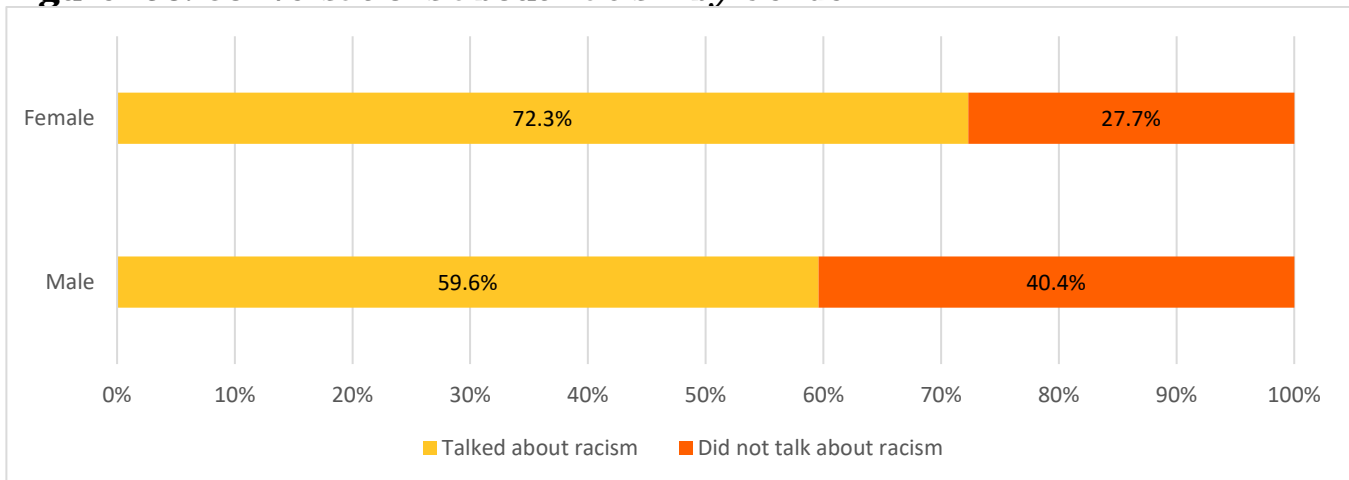
Figure 105. Conversations about Racism by Age

Note: Ages 6+. 6 to 11 population estimate = 27,977; 12 to 17 population estimate = 27,136.

However, there were significant differences in racism discussions based on gender. Specifically, parents/guardians were significantly more likely to have talked about racism with their daughters when compared to their sons, as illustrated in the figure below.

Figure 106. Conversations about Racism by Gender

Note: Ages 6+. Male population estimate = 28,632; female population estimate = 24,970.
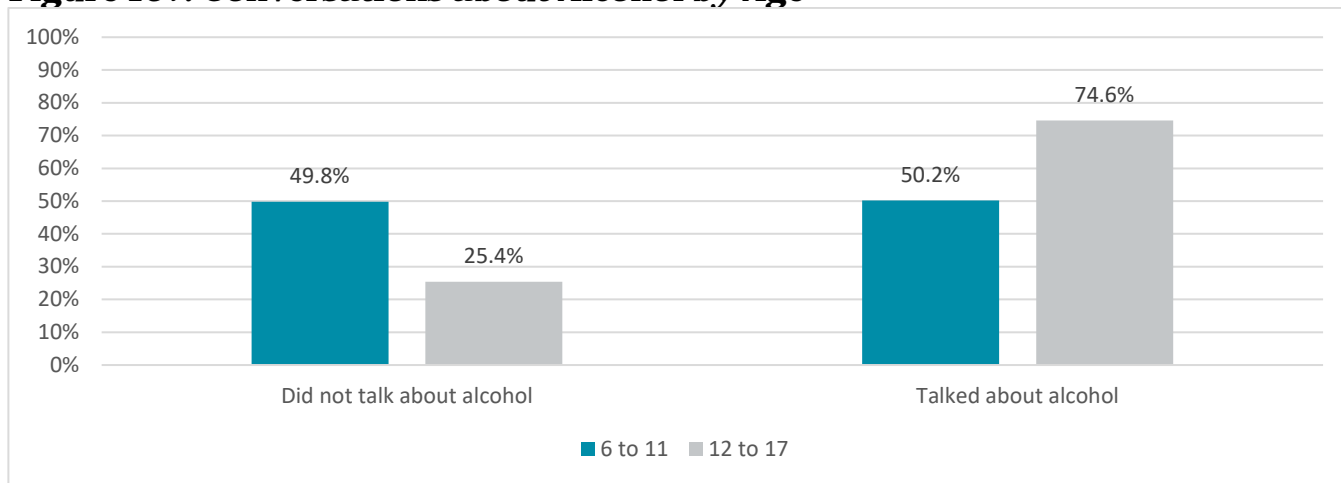
Alcohol

Parents/guardians of children ages 6 and older were asked, "During the past 12 months, have you or another adult in the household spoken with (child's name) about alcohol?"

Overall, **62.2% of children ages 6 and older have had a conversation with their parents/guardians about alcohol**. Once again, older children (12 to 17) are significantly more likely than younger children (6 to 11) to have had a discussion about alcohol with their parents/guardians.

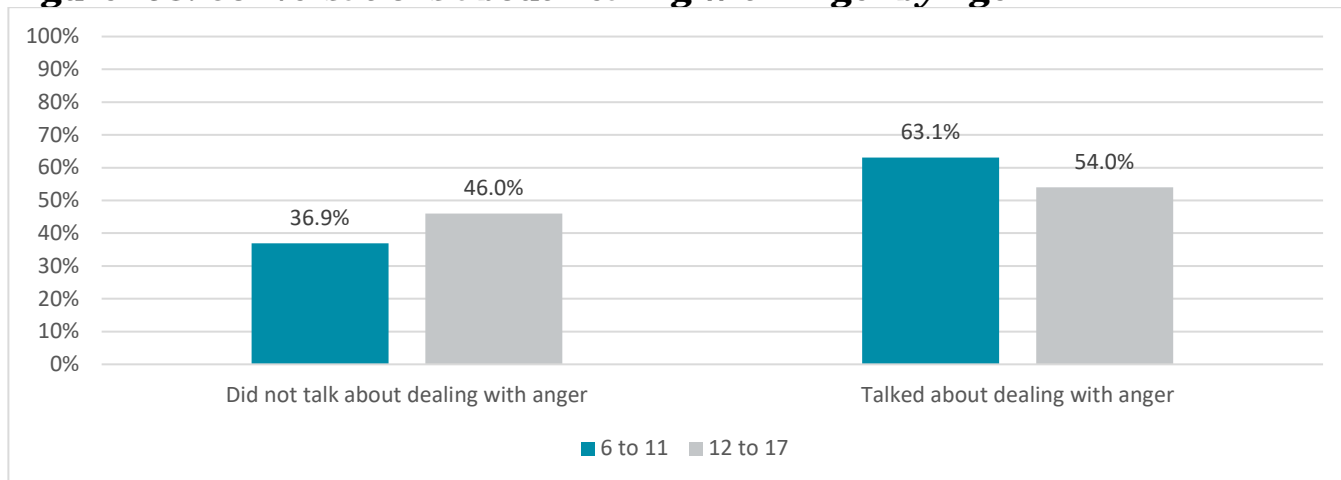***Figure 107. Conversations about Alcohol by Age***

Note: Ages 6+. 6 to 11 population estimate = 27,977; 12 to 17 population estimate = 27,136.

Dealing with Anger

Parents/guardians of children ages 6 and older were asked, "During the past 12 months, have you or another adult in the household spoken with (child's name) about dealing with anger?"

Overall, **58.6% of children ages 6 and older have had a conversation with their parents/guardians about dealing with anger**. There were no significant differences in discussions of dealing with anger by age. That is, children 6 to 11 and those 12 to 17 are equally likely to have had a discussion about dealing with anger with their parents/guardians.

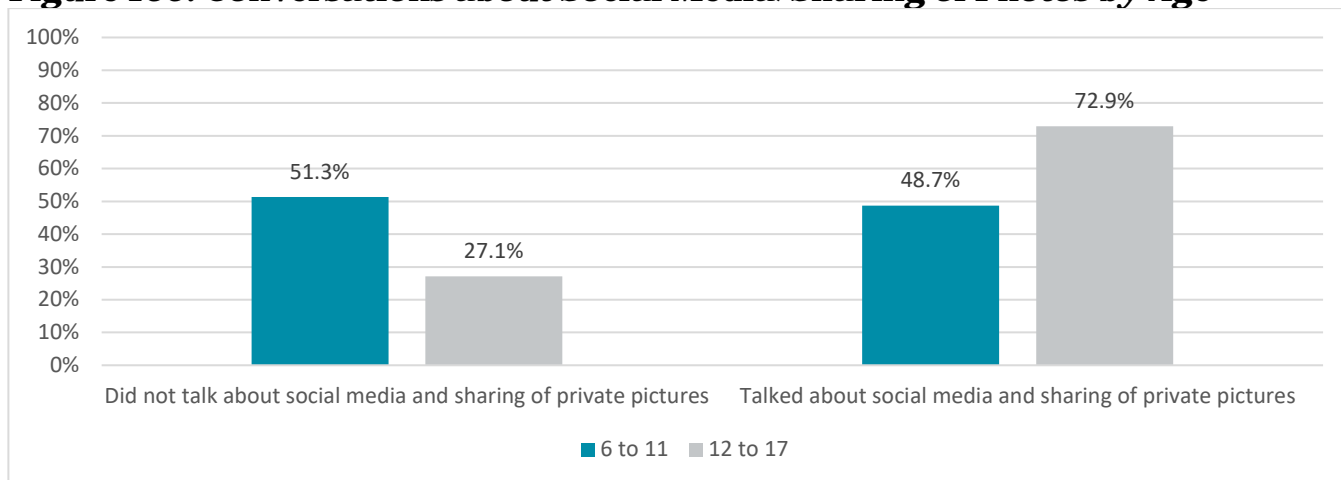***Figure 108. Conversations about Dealing with Anger by Age***

Note: Ages 6+. 6 to 11 population estimate = 27,977; 12 to 17 population estimate = 27,136.

Social Media/Sharing of Photos

Parents/guardians of children ages 6 and older were asked, "During the past 12 months, have you or another adult in the household spoken with (child's name) about social media and sharing of private pictures?"

Overall, **60.6% of children ages 6 and older have had a conversation with their parents/guardians about social media and sharing of private pictures online**. Once again, older children (12 to 17) are significantly more likely to have had a discussion about social media with their parents/guardians.

Figure 109. Conversations about Social Media/Sharing of Photos by Age

Note: Ages 6+. 6 to 11 population estimate = 27,977; 12 to 17 population estimate = 27,136.

There was a significant difference in discussions about social media/sharing of photos based on gender. Specifically, parents/guardians of female children were significantly more likely to have had a discussion about social media and sharing of private photos than parents/guardians of male children, as illustrated in the figure below.

***Figure 110. Conversations about Social Media/Sharing of Photos by Gender***
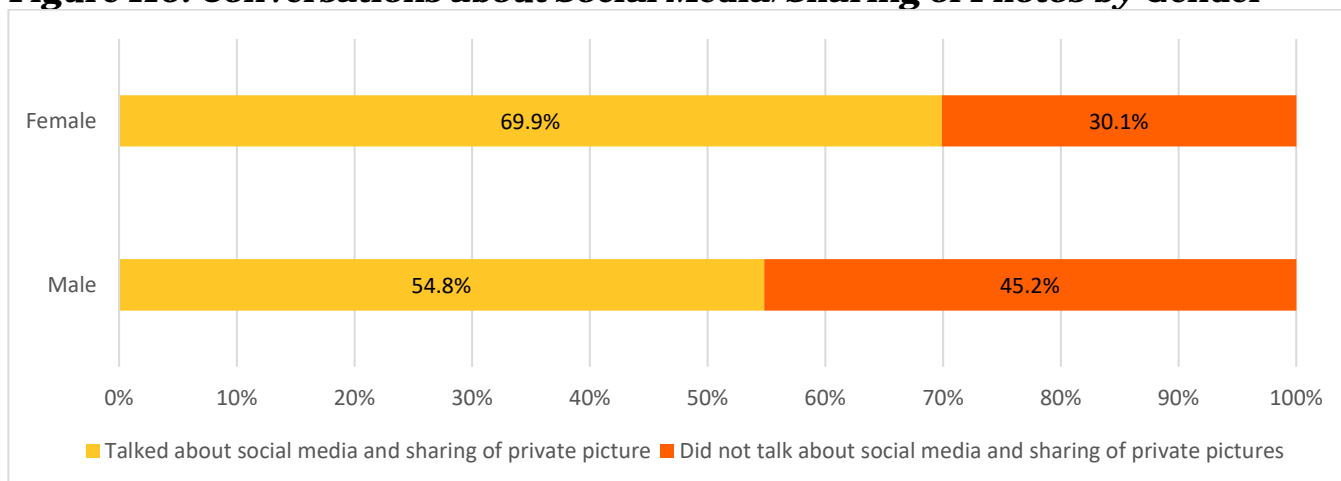
Note: Ages 6+. Male population estimate = 28,632; female population estimate = 24,970.

Sexual Issues/Pregnancy

Parents/guardians of children ages 6 and older were asked, "During the past 12 months, have you or another adult in the household spoken with (child's name) about sexual issues/pregnancy?"

Overall, **46.8% of children ages 6 and older have had a conversation about sex and pregnancy with their parents/guardians**. Again, older children (12 to 17) are significantly more likely to have had these discussions with their parents than younger children (6 to 11).

Figure 111. Conversations about Sexual Issues/Pregnancy by Age
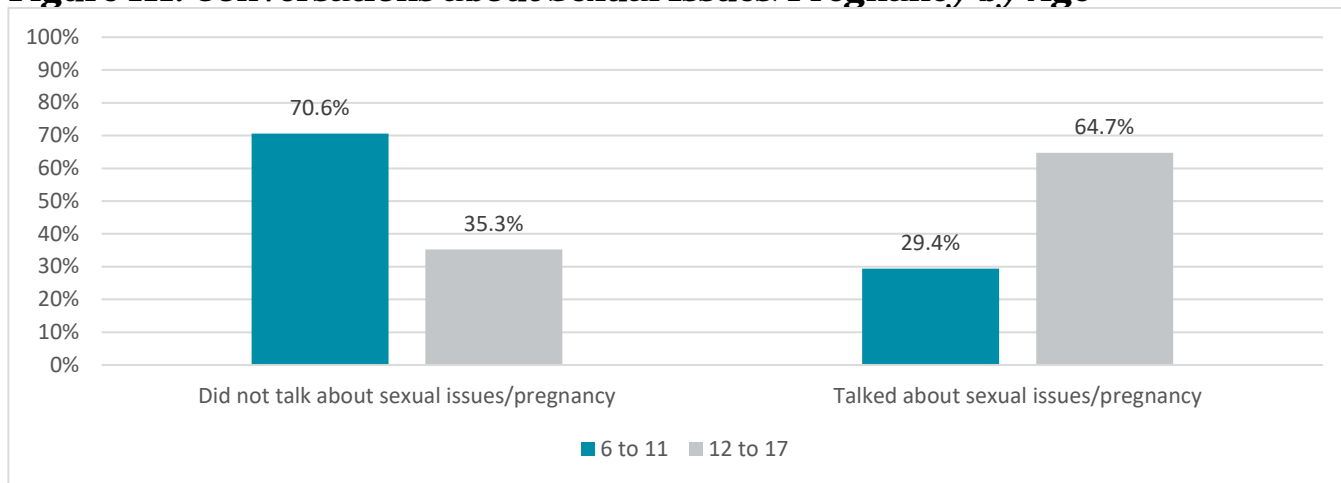
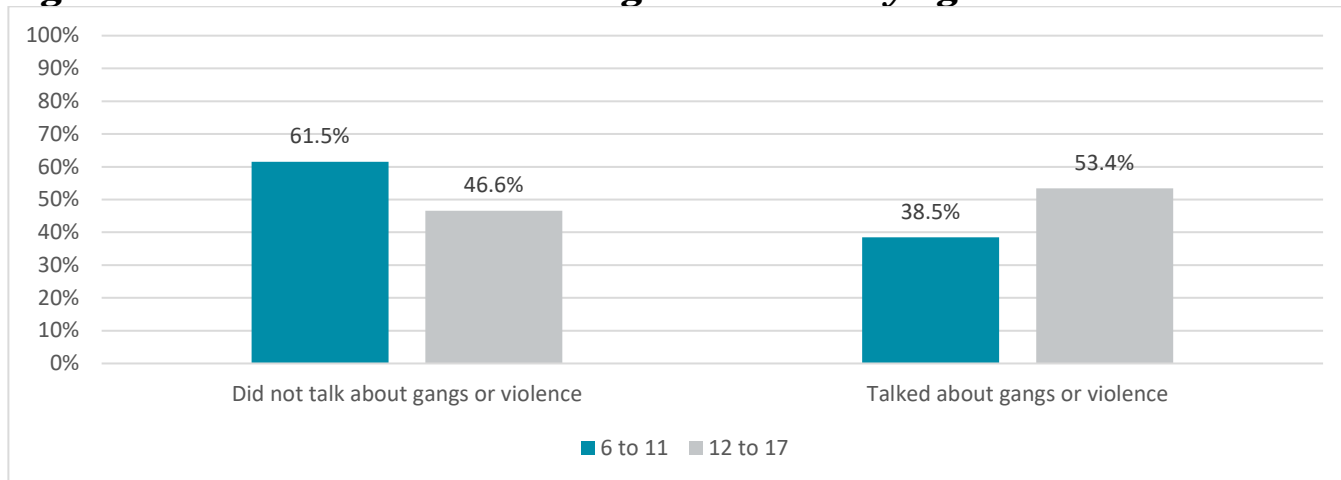
Note: Ages 6+. 6 to 11 population estimate = 27,977; 12 to 17 population estimate = 27,136.

Gangs/Violence

Parents/guardians of children ages 6 and older were asked, "During the past 12 months, have you or another adult in the household spoken with (child's name) about gangs or violence?"

Overall, **45.8% of children ages 6 and older have had a conversation with their parents/guardians about gangs or violence**. As with the many other discussions, this is a topic that is more commonly discussed with older children than younger children, as illustrated in the figure below.
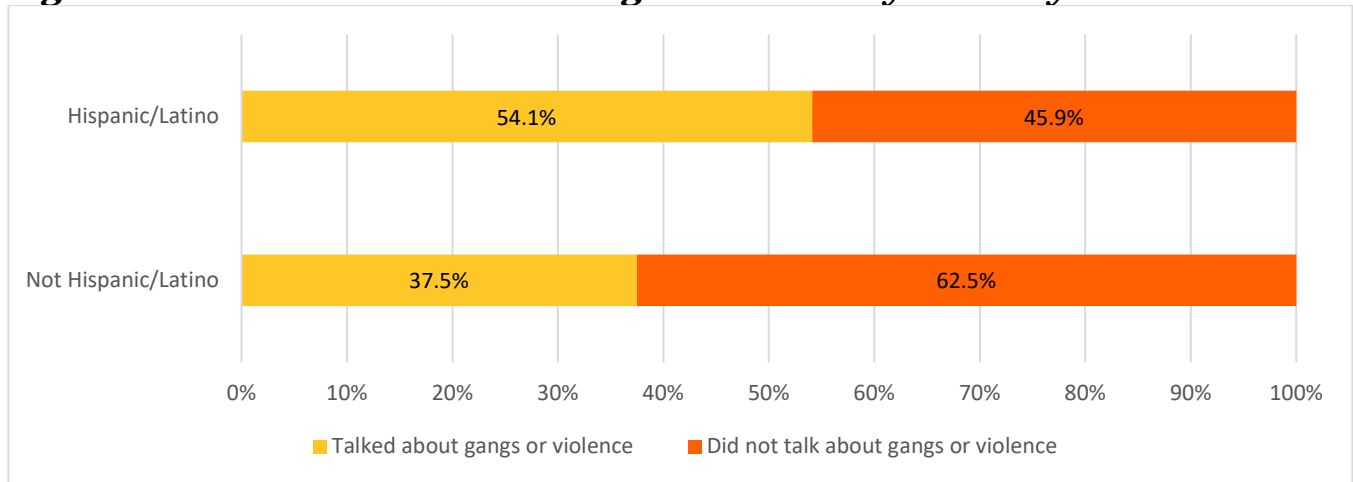
Figure 112. Conversations about Gangs or Violence by Age

Note: Ages 6+. 6 to 11 population estimate = 27,977; 12 to 17 population estimate = 27,136.

There was also a significant difference in discussions of gangs and violence based on ethnicity. As illustrated in the figure below, significantly more Hispanic/Latino children discussed gangs and violence with their parents/guardians when compared to non-Hispanic/Latino children.

***Figure 113. Conversations about Gangs or Violence by Ethnicity***

Note: Ages 6+. Not Hispanic/Latino population estimate = 27,430; Hispanic/Latino population estimate = 27,684.

Depression/Isolation

Parents/guardians of children ages 6 and older were asked, "During the past 12 months, have you or another adult in the household spoken with (child's name) about depression or isolation?"

Overall, **40.8% of children age 6 and older have had a discussion with their parents/guardians about depression and isolation**. There were no significant differences based on age.

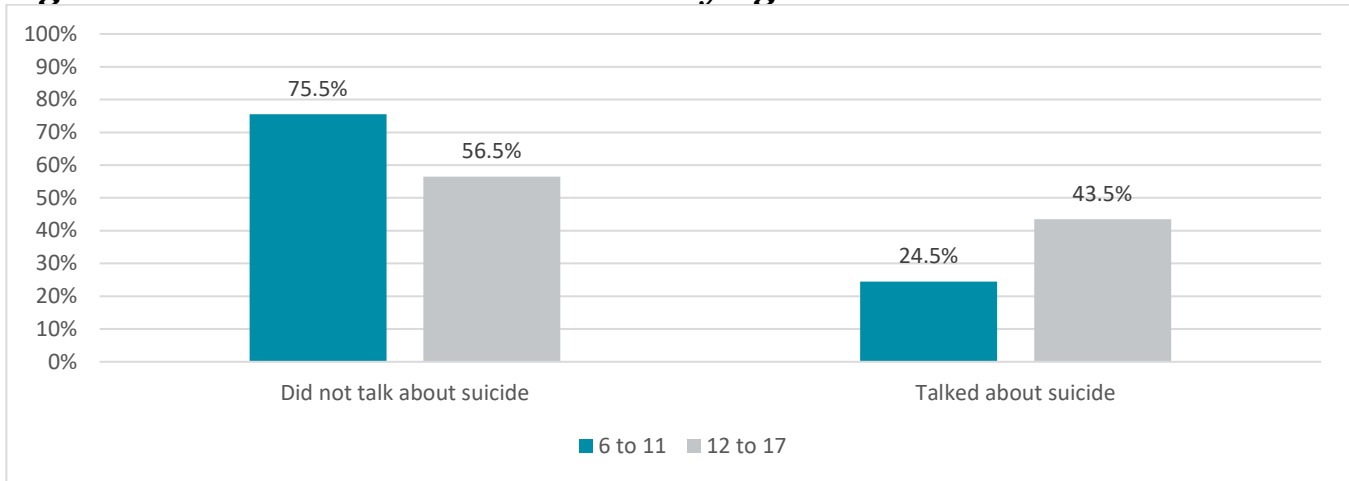***Figure 114. Conversations about Depression or Isolation by Age***
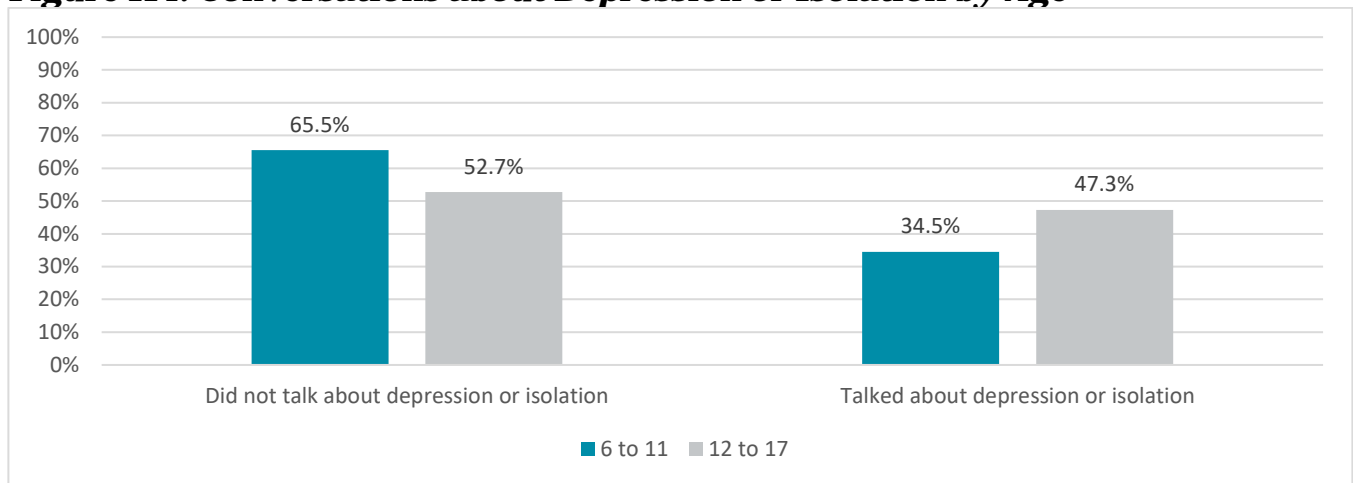
Note: Ages 6+. 6 to 11 population estimate = 27,977; 12 to 17 population estimate = 27,136.

Suicide

Parents/guardians of children ages 6 and older were asked, "During the past 12 months, have you or another adult in the household spoken with (child's name) about suicide?"

Overall, **a third of local children ages 6 and older (33.8%) have discussed suicide with their parents/guardians**. Older children were significantly more likely to have had a talk about suicide than younger children.
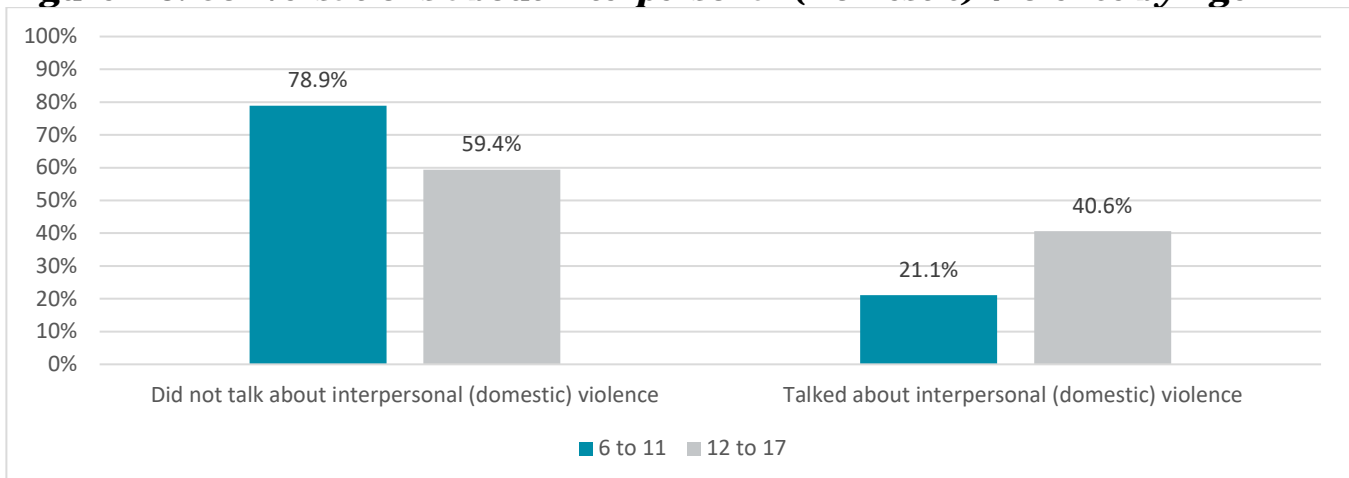
Figure 115. Conversations about Suicide by Age

Note: Ages 6+. 6 to 11 population estimate = 27,977; 12 to 17 population estimate = 27,136.

Domestic Violence

Parents/guardians of children ages 6 and older were asked, "During the past 12 months, have you or another adult in the household spoken with (child's name) about interpersonal (domestic) violence?"

Overall, **30.7% of children ages 6 and older have had a discussion with their parents/guardians about interpersonal or domestic violence**. Older children are significantly more likely to have discussed domestic violence with their parents/guardians than younger children.

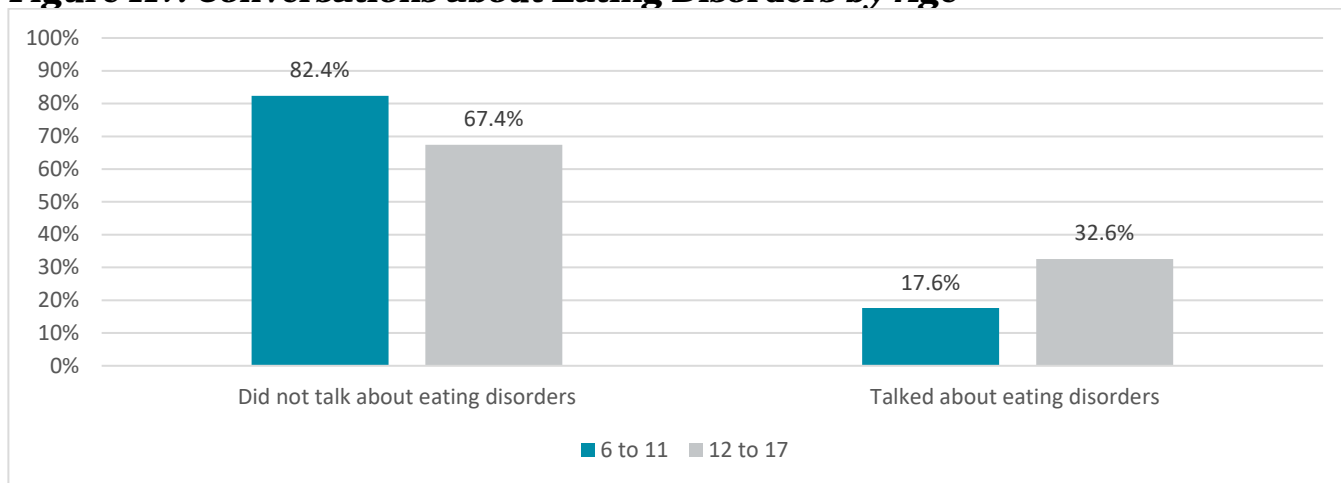### *Figure 116. Conversations about Interpersonal (Domestic) Violence by Age*

Note: Ages 6+. 6 to 11 population estimate = 27,977; 12 to 17 population estimate = 27,136.

Eating Disorders

Parents/guardians of children ages 6 and older were asked, "During the past 12 months, have you or another adult in the household spoken with (child's name) about eating disorders?"

Overall, **a quarter of children ages 6 and older (25.0%) have had a conversation with their parents/guardians about eating disorders**. This is again a conversation that is had more frequently with older children than younger children, as illustrated in the figure below.

***Figure 117. Conversations about Eating Disorders by Age***

Note: Ages 6+. 6 to 11 population estimate = 27,977; 12 to 17 population estimate = 27,136.

Self-Injury

Parents/guardians of children ages 6 and older were asked, "During the past 12 months, have you or another adult in the household spoken with (child's name) about self-injury like cutting?"

Only 21.8% of children ages 6 and older have had a conversation with their parents/guardians about self-injury. Older children are significantly more likely to have had this discussion than younger children, but it is still very uncommon.

Figure 118. Conversations about Self-Injury by Age
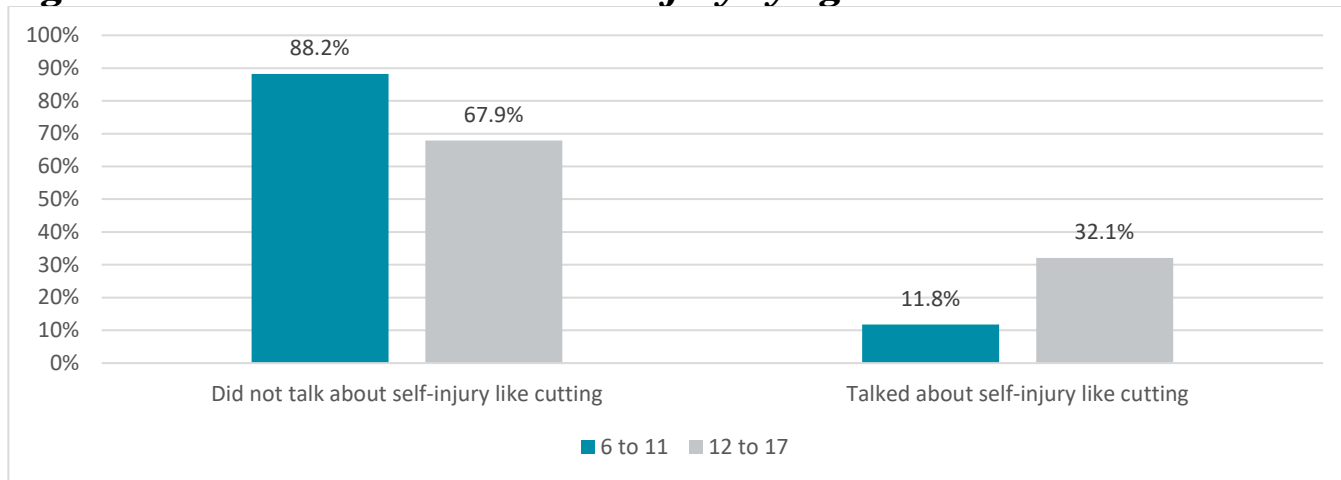
Note: Ages 6+. 6 to 11 population estimate = 27,977; 12 to 17 population estimate = 27,136.

Conclusion

The Coachella Valley is home to more than 88,000 children. This number equates to more than a fifth of the Coachella Valley population. At least a third of children are ages 0 to 5, a third are ages 6 to 11, and a third are ages 12 to 17.

High percentages of children have experienced at least one ACE. These traumatic experiences are problematic as children who experienced an ACE have a greater risk for developing health problems. Further, the number of children who experienced an ACE varies by income. Fewer children living in high income households experienced an ACE.

Despite the availability of health insurance resources for children, there are still thousands of children who do not have healthcare coverage, including 5.3% of children ages 0 to 5 (ages for when identifying developmental issues is critically important). Furthermore, thousands of children do not have dental coverage, prescription coverage, or vision coverage. Prescription coverage appears to be a bit more common than dental and vision.

Utilizing healthcare is paramount to a child's well-being and positive development. Fortunately, most children are in excellent, very good, or good health. However, there are some who are in fair or poor health. That said, about a quarter of children in each age group (0 to 5, 6 to 11, 12 to 17) have not visited a doctor for a routine checkup. Visiting a healthcare provider significantly varies based on household income, with children living in higher income homes being more likely to have a routine checkup.

Children should be active, and while they are active, they should be safe. Fortunately, most children do have a safe place to play outside. However, there are many children who are sometimes, seldom, and even never wearing a helmet. What's more is that thousands of children, regardless of age group, never wear a helmet. These thousands of children are at risk of acquiring head trauma, or even death.

Mental or behavioral health difficulties exist among many children, ages 3 and older in our community. About one-fifth, of children ages 3 to 5 and one fourth of children ages 6 to 11 and 12 to 17 have difficulties with emotions, concentration, or behavior. These difficulties are more likely to impact males and non-Hispanic/Latino children.

High percentages of children in the valley are overweight or obese. However, parents do not perceive their children to have a weight problem.

Reading to children is critical for language development and comprehension. Fortunately, more than two-thirds of children ages 0 to 5 were read to by an adult in their home five or more times each week. Nearly one-fifth of children in the same age group were read to two to four times each week by an adult in their home. Demographic differences exist in the rate at which children are read to. For example, male children and Hispanic/Latino children are not read to as often.

Having conversations with children regarding dangerous and common situations they are likely to encounter throughout life is important. That said, discussing topics such as substance use, gangs and violence, and reproductive health with a child, is more likely to occur at older ages. However, substantially high percentages of parents do not discuss these issues, even with older children, ages 12 to 17. For instance, among children ages 12 to 17, a quarter of parents do not discuss social media; a third of parents do not discuss racism, sexual issues; half of parents do not discuss violence or gangs, dealing with anger, depression or isolation, suicide; and more than half of parents do not discuss self-injurious behavior, eating disorders, and interpersonal violence with their children.

Altogether, this report provides a snapshot of the health and wellness of children across our community. Many needs exist, and many of these needs are adversely exacerbated depending on demographics and socioeconomic characteristics. Nonprofits serving children in the Coachella Valley will be able to utilize the data in this report to respond to disparities that exist.