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Family Resilience And Connection Promote Flourishing Among US Children, Even Amid Adversity

DOI: 10.1377/hlthaff.2018.05425
HEALTH AFFAIRS 38,
NO. 5 (2019): 729–737
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ABSTRACT The outcome of flourishing and its predictors have not been well documented among US children, especially those who face adversity. Using data for 2016 and 2017 from the National Survey of Children's Health, we determined the prevalence and predictors of flourishing among US children ages 6–17. A three-item index included indicators of flourishing: children's interest and curiosity in learning new things, persistence in completing tasks, and capacity to regulate emotions. The national prevalence of flourishing was 40.3 percent (29.9–45.0 percent across states). At each level of adverse childhood experiences, household income, and special health care needs, the prevalence of flourishing increased in a graded fashion with increasing levels of family resilience and connection. Across the sectors of health care, education, and human services, evidence-based programs and policies to increase family resilience and connection could increase flourishing in US children, even as society addresses remediable causes of childhood adversity.

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Flourishing and its predictors and links to health outcomes are well documented in adults, including among those facing adversities.^{1–6} Less is known about flourishing and its correlates among children, especially those who face circumstances such as adverse childhood experiences (ACEs), chronic illness, or poverty. Studies show that flourishing is distinct from an absence of physical or mental illness and other adversities; that flourishing can and does exist amid these circumstances; and that health outcomes vary widely among individuals exposed to similar levels of adversity.^{4,6} Understanding the factors that promote flourishing amid adversity is an important public health need for children and families.

A recent systematic review⁷ of human flourishing models identified six overlapping positive attributes used to define *flourishing*: meaning, engagement, positive relationships, competence (or accomplishment), positive emotion, and

self-esteem (or self-worth). Among these six attributes, meaning and engagement in life were common to each flourishing model. Positive emotions were least consistently included in definitions of *flourishing*.

There is a robust literature on flourishing, its specific attributes, and how it is measured and relates to other concepts such as well-being.^{1–9} In terms of the six attributes listed above, flourishing is similar to measures of subjective well-being, such as those used by the World Health Organization¹⁰ and the Organization for Economic Cooperation and Development.¹¹ However, flourishing is distinct from other comprehensive measures of well-being, such as the Gallup measure,¹² which includes reflective evaluations of life satisfaction, having financial and social needs met, and experiencing physical vitality; the United Nations Children's Fund child well-being measure,¹³ which includes objective measures related to material, educational, health, safety, housing, and environmental

resources and health behaviors and risks; and a recently developed population well-being measure to explain disparities in life expectancy.¹⁴

Attributes of flourishing identified in research on adults are reflective of goals for promoting the healthy development of children, as set forth in research¹⁵ and national frameworks and guidelines.^{16–18} This includes healthy social and emotional development and cultivating an open and engaged approach to learning. Because of children's developmental status and reliance on parent or teacher reports of children's attributes for measurement validity reasons, measuring flourishing for children typically focuses on parents' or other adults' reports of observable attributes of children.^{19–22} In contrast, adult measures of flourishing typically rely on self-reports.

Flourishing constructs for children that are amenable to parent-reported measurement have been set forth.^{19–22} Emphasized are indicators of whether children show interest and curiosity in learning new things, are able to regulate emotions and behaviors in challenging situations, and can focus and persist to achieve goals. Studies using attributes of child flourishing such as these document associations with reductions in risky health behaviors and mental health problems in children and youth,^{23–25} as well as reductions in physical, mental, and social health problems as adults.^{25,26}

Beginning with its 2011–12 administration, the National Survey of Children's Health (NSCH) included items developed to assess flourishing among children ages 6 months to 5 years and ages 6–17 years. These items were formulated by an expert panel sponsored by the Health Resources and Services Administration and facilitated by the Child and Adolescent Health Measurement Initiative in partnership with Child Trends. The issues were selected to optimize validity for parent report (tested using cognitive interviewing), align with published models of child flourishing, consider children's developmental status, and minimize survey burden. We focused on children ages 6–17 in this study, since key variables of interest are not available in the NSCH for younger children. The NSCH flourishing items for children ages 6–17 asked parents how well each of three items describes their child: “shows interest and curiosity in learning new things,” “works to finish tasks he or she starts,” and “stays calm and in control when faced with a challenge.”

Studies using data from the 2011–12 NSCH found that fewer than 50 percent of US children ages 6–17 were flourishing.^{27–30} After adjustments, modest or insignificant variations were found in flourishing by race, ethnicity, and poverty level and significant, but also modest, asso-

ciations between flourishing and obesity, neighborhood and school safety, and parenting practices such as limiting television watching or sharing family meals.^{28–30} The studies also revealed lower rates of flourishing for children exposed to ACEs.³⁰ However, children with two or more ACEs whose parent or guardian reported that their child “stays calm and in control when faced with a challenge” were substantially less likely to be identified as having an emotional, mental, or behavioral health condition.³¹ Such children were also more likely to be engaged in school.^{32,33} In addition, one study found that a higher proportion of children exhibited this resilience attribute of flourishing when their parent reported that they “can share about ideas and talk about things that really matter” with their child and thought they were handling the day-to-day demands of raising children “very well.”³¹ Studies have also shown strong evidence of a link between the attributes of child flourishing, such as resilience, with nurturing parenting and parental coping.^{34–40} To date, no studies have assessed how the parenting and family factors included in the NSCH promote child flourishing across subgroups of children according to their level of adversity, such as exposure to ACEs, poverty, or the presence of special health care needs. Knowledge about this is important for efforts to promote systems of care to improve positive outcomes for children, such as the new Integrated Care for Kids Model advanced by the Centers for Medicare and Medicaid Services.⁴¹

Beginning with the 2016 administration of the NSCH, four new items were added to assess family resilience, and large changes were made to the sampling frame and mode of administration that prevent comparisons with prior years of the NSCH.⁴² These changes require the establishment of a new baseline prevalence of flourishing among children for the US and by state. In addition, they provide an opportunity to examine population-level associations between child flourishing and attributes of family resilience and connection that research suggests foster child flourishing, for all children and those facing adversities.^{34–40}

This study used 2016 and 2017 NSCH data for US children ages 6–17 to address four objectives: establish the construct validity of a three-item child flourishing index (CFI) by examining its association with school engagement, describe the national and state prevalences of flourishing, determine whether higher scores on a created six-item family resilience and connection index (FRCI) are associated with a greater prevalence of flourishing, and determine whether the strength of the association between FRCI scores and the prevalence of flourishing varies accord-

ing to children's level of adversity (ACEs, household income, and presence of special health care needs).

Addressing these objectives will advance efforts to measure and promote child flourishing and to mitigate the ongoing adversities facing US children.

Study Data And Methods

DATA AND POPULATION The National Survey of Children's Health is funded and directed by the Health Resources and Services Administration's Maternal and Child Health Bureau and is fielded by the Census Bureau.⁴² The 2016 and 2017 NSCH used address-based sampling and was self-administered (on paper or online) by the parent or guardian of a randomly selected child in a sampled household. In this article, "parent" refers to parent or guardian.

This study focused on children ages 6–17. Combined, the 2016–17 NSCH data included 71,811 completed questionnaires, of which 51,156 were completed for children ages 6–17. Data were weighted to be representative of the nation and each state's population and adjusted for the complex sampling design. All analyses were conducted using SPSS, version 24. (See online appendix A1 for additional information on the NSCH data used in this study.)⁴³

KEY MEASURES Below is a summary of the key measures used in this study. (See appendixes A2, A3, and B for additional information on the measures, including psychometric properties of key measures.)⁴³

► **CHILD FLOURISHING INDEX:** We used three items in the NSCH, described above, to create a child flourishing index for children ages 6–17. The CFI assigns one point for each parent response of "definitely true" (versus "somewhat or not true") to each item, with the score ranging from 0 to 3. Children with a score of 3 were classified as flourishing.

► **FAMILY RESILIENCE AND CONNECTION INDEX:** A four-item family resilience index (FRI) asked parents, "When your family faces problems, how often are you likely to": "talk together about what to do," "work together to solve our problems," "know we have strengths to draw on," and "stay hopeful even in difficult times." Additionally, two items in the survey asked parents how well they "can share ideas or talk about things that really matter" with their child (parent-child connection) and how well they think they are "handling the day-to-day demands of raising children" (parent coping). We created a six-item FRCI for this study. First, one point was assigned for each time a parent respondent answered "all of the time" to one of the four FRI

items. Second, one point was assigned for each time a parent responded "very well" to the two additional items listed above.

► **SCHOOL ENGAGEMENT:** Children were classified as meeting criteria for school engagement if their parents reported "definitely true" for both of the following items: their child "cares about doing well in school" and "does all required homework."

► **SOCIODEMOGRAPHIC FACTORS, SPECIAL HEALTH CARE NEEDS, AND ADVERSE CHILDHOOD EXPERIENCES:** Child age, sex, race and ethnicity, and household income (as a percentage of the federal poverty level) were measured using standard NSCH categories.⁴⁴ Children's special health care needs status was assessed, and ACEs measures were created using validated methods documented elsewhere.^{45,46} Children with special health care needs are classified as "more complex" when they meet more than the first of the five criteria in the Children with Special Health Care Needs Screener.⁴⁶

ANALYTIC METHODS

► **CHILD FLOURISHING INDEX CONSTRUCT VALIDITY:** Multivariable logistic regression models were used to assess the construct validity of the CFI. These models used school engagement as the outcome (dependent) variable, the CFI items or scores as the predictor variables, and ACEs, special health care needs status, and sociodemographic variables as covariates. A separate regression model was developed for each CFI item, using its response levels as predictors. For the CFI score, the categories of 0 or 1, 2, and 3 were used as predictors.

► **STATE PREVALENCES OF CHILD FLOURISHING:** Nested *t*-tests were used to assess the statistical significance of the difference between each state's prevalence of child flourishing (using CFI criteria) and the national prevalence.

► **ASSOCIATIONS BETWEEN INDEXES ACROSS CHILD ADVERSITY CATEGORIES:** Chi-square tests were used to assess the significance of differences in the prevalence of child flourishing across levels of exposure to ACEs (0, 1, 2 or 3, and 4 or more), household income (four levels, expressed as a percentage of the federal poverty level), special health care needs status ("more complex needs," "less complex needs," and "no special health care needs"), and other sociodemographic characteristics. Multivariable logistic regression analysis was employed to calculate adjusted odds of flourishing by levels of the FRCI score (0 or 1, 2 or 3, and 4–6), after other variables (including ACEs) were controlled for. Finally, the strength of the association between FRCI scores and the prevalence of flourishing was separately evaluated for subgroups of children who faced different levels of adversity as

measured by ACEs, household income, and the presence of special health care needs.

LIMITATIONS Our study had several limitations. First, this study was cross-sectional and could not establish causal relationships between flourishing and family resilience and connection.

Second, the flourishing measure used in this study was not meant to be definitive and may have overestimated flourishing, since reporting bias among parents tends to be positive and only three items are used in the NSCH to operationalize the measurement of flourishing. If additional items and dimensions were assessed, a lower prevalence of flourishing likely would result, because some children would fail to meet the additional criteria. Additional research is needed—especially to determine measures of flourishing among children with disabilities, for whom the three items in the CFI might not be as meaningfully applied.

Third, the CFI and FRCI have not yet been evaluated for clinical applications, nor are child self-report versions available.

Fourth, the ACEs measure included in the NSCH did not explicitly ask about child sexual abuse or neglect. Research suggests that the experiences that are assessed are likely to co-occur with these unassessed ACEs. Thus, we do not expect children with such experiences to be

missed by the NSCH ACEs cumulative risk measure,⁴⁶ though some may be.

Study Results

VALIDITY OF THE CHILD FLOURISHING INDEX We found a significant graded relationship between greater flourishing as shown on the CFI score and the prevalence of school engagement. There was a 56.2-percentage-point difference in school engagement between children meeting zero or one versus meeting all three CFI criteria (33.2 percent versus 89.4 percent) (exhibit 1). Compared to children meeting zero or one CFI criteria, the adjusted odds of school engagement were 14.19 times greater for children meeting all three criteria and 4.97 times greater for children meeting two criteria. A significant graded relationship was also found between parent endorsement of each CFI item (from “not true” to “somewhat true” to “definitely true”) and the prevalence of school engagement, but there was a stronger graded relationship between school engagement and levels of the CFI score. (See appendix D for detailed regression findings.)⁴³

NATIONAL AND STATE PREVALENCES OF CHILD FLOURISHING The prevalence of flourishing among US children ages 6–17 was 40.3 percent (exhibit 2). This ranged from 29.9 percent to 45.0 percent across states. (See appendix exhibits C1 and C2 for findings for each state.)⁴³

VARIATIONS IN PREVALENCE OF FLOURISHING BY CHILD CHARACTERISTICS The prevalence of flourishing varied by about 5 percentage points across age and sex categories, with a higher prevalence observed in older children and females (exhibit 2). Prevalence varied by about 12 percentage points across income categories, with the highest prevalence among children living in households with incomes 400 percent of or higher than the federal poverty level (46.9 percent). Prevalence of flourishing varied about 7 percentage points across racial and ethnic groups. After other factors were adjusted for, race and ethnicity were not significantly associated with flourishing. Prevalence varied most (by 33.2 percentage points) across subgroups of children with special health care needs and second-most (by 27.3 percentage points) by children’s level of exposure to ACEs.

ASSOCIATION OF FAMILY RESILIENCE AND CONNECTION WITH FLOURISHING The FRCI and each of its components showed a graded association with child flourishing. Compared to children with a FRCI score of 0 or 1, those with scores of 2 or 3 and 4–6 had 2.11 times and 3.71 times greater odds of flourishing, respectively, after covariates were adjusted for (exhibit 3). Specifically, a 30.0-percentage-point difference in

EXHIBIT 1

Percent of US children ages 6–17 who were engaged in school and adjusted odds ratios, by child flourishing index (CFI) score and score items, 2016–17

	Percent	Adjusted odds ratio	95% CI
CFI score			
3	89.4	14.19	12.42, 16.21
2	73.6	4.97	4.39, 5.61
0 or 1	33.2	Ref	
CFI score items			
Shows interest and curiosity in learning new things			
Definitely true	75.0	5.98	5.24, 6.83
Somewhat true or not true	28.7	Ref	
Works to finish tasks he or she starts			
Definitely true	84.9	9.02	8.12, 10.03
Somewhat true or not true	34.9	Ref	
Stays calm and in control when faced with a challenge			
Definitely true	82.8	3.98	3.58, 4.43
Somewhat true or not true	51.4	Ref	

SOURCE Authors’ analysis of data for 2016 and 2017 from the National Survey of Children’s Health. **NOTES** All percentages are weighted to represent the US population of children ages 6–17. The percentage of children who engaged in school differed significantly ($p < 0.001$ using chi-square tests) across each level of the CFI score and within each level of the CFI score item. Adjusted odds ratios controlled for age, sex, race/ethnicity, household income, special health care needs status, and adverse childhood experiences (ACEs) status.

EXHIBIT 2
Percent of US children ages 6–17 who were flourishing and adjusted odds ratios, by child and family characteristics, 2016–17

	Percent with characteristic	Flourishing (“Definitely true” response to all 3 CFI items)			“Definitely true” response for each CFI item: ^a		
		Percent	Adjusted odds ratio ^b	95% CI	Interested and curious in learning new things	Works to finish tasks started	Stays calm and in control when faced with a challenge
All children	100.0%	40.3	— ^c	— ^c	83.1%	64.4%	50.3%
Child’s age (years) ^d							
6–11	50.0	38.7	Ref		88.6	64.5	46.4
12–14	24.8	40.4	1.26	1.12, 1.41	79.1	63.1	51.6
15–17	25.1	43.6	1.51	1.35, 1.68	76.0	65.6	56.8
Child’s sex ^{****}							
Male	51.1	37.4	0.81	0.74, 0.89	80.5	59.8	48.0
Female	48.9	43.4	Ref		85.8	69.3	52.8
Child’s race/ethnicity ^e							
Non-Hispanic white	50.9	40.6	Ref		85.1	65.2	49.3
Non-Hispanic black	13.8	35.6	0.93	0.80, 1.08	78.0	57.9	49.5
Non-Hispanic other	10.0	42.8	1.13	0.99, 1.28	83.6	65.1	52.6
Hispanic	25.3	41.5	1.05	0.92, 1.21	81.6	66.2	51.8
Household income (percent of FPL) ^{****}							
0–99%	21.1	35.2	0.71	0.61, 0.82	77.9	58.9	46.5
100–199%	22.1	37.2	0.73	0.64, 0.84	80.1	60.7	47.7
200–399%	26.5	39.6	0.77	0.70, 0.85	84.3	64.0	49.7
400% or more	30.3	46.9	Ref		87.7	71.5	55.4
Child has special health care needs ^{****}							
Yes (more complex needs)	15.8	12.8	Ref		65.4	35.1	19.1
Yes (less complex needs)	6.9	40.7	4.04	3.36, 4.85	84.9	63.0	51.8
No	77.3	46.0	4.64	4.03, 5.34	86.5	70.6	56.6
Number of adverse childhood experiences ^{****}							
4 or more	7.3	20.6	Ref		71.6	44.5	30.0
2 or 3	17.5	30.6	1.32	1.04, 1.68	76.5	54.4	41.8
1	25.3	37.8	1.62	1.28, 2.06	82.0	60.3	49.0
0	49.9	47.9	2.10	1.67, 2.65	87.9	73.1	56.6
FRCI score ^{f ****}							
0 or 1	25.5	21.5	Ref		68.6	45.9	31.3
2 or 3	26.5	38.1	2.11	1.86, 2.39	85.1	64.8	48.9
4–6	48.0	51.5	3.71	3.31, 4.15	89.7	74.1	61.0
Family resilience index score ^{g ****}							
0 or 1	45.1	30.4	Ref		76.7	55.6	40.4
2 or 3	21.0	40.7	1.55	1.36, 1.75	86.5	66.3	51.9
4	33.9	53.1	2.55	2.30, 2.83	89.6	75.0	62.1
Parent-child connection ^{h ****}							
Not very well or not at all	4.4	5.3	Ref		36.7	21.8	12.8
Somewhat well	27.1	23.4	3.90	2.56, 5.92	70.6	48.6	34.0
Very well	68.5	49.9	12.55	8.32, 18.93	91.1	73.6	59.1
Parent coping ^{i ****}							
Not very well or not at all	1.4	16.4	Ref		61.3	32.9	21.7
Somewhat well	32.7	24.5	1.32	0.72, 2.43	74.7	50.3	34.6
Very well	65.9	48.7	3.56	1.94, 6.53	87.9	72.3	58.7
Engaged in school ^{j****}							
No	32.9	13.1	Ref		63.2	29.5	26.4
Yes	67.1	54.2	6.64	5.88, 7.50	92.8	81.5	61.9

SOURCE Authors’ analysis of data for 2016 and 2017 from the National Survey of Children’s Health. **NOTES** All percentages are weighted to represent the US population ages 6–17. Statistical significance refers to chi-square tests comparing the percentage of children who are flourishing or have “definitely true” responses to child flourishing index (CFI) items across levels of each characteristic. CI is confidence interval. FPL is federal poverty level. FRCI is family resilience and connection index. ^aCFI items are given in full in exhibit 1. ^bAdjusted odds ratios controlled for age, sex, race/ethnicity, income, adverse childhood experiences (ACEs), and special health care needs status. ^cNot applicable. ^dDifferences in percentages by age category are all significant ($p < 0.001$) except for “works to finish tasks started” ($p > 0.10$). ^eDifferences in percentages by race/ethnicity category are all significant ($p < 0.001$) except for flourishing, which is significant ($p < 0.05$), and “stays calm and in control when faced with a challenge” which is not significant ($p > 0.10$). ^fSix-item score (0–6) with one point for each “all of the time” response to the four family resilience index items, and one point for each “very well” response to the parent-child connection and parent coping items. ^gFour-item score (0–4) with one point for each “all of the time” response. ^hBased on response to a single item: “How well can you and this child share ideas or talk about things that really matter?” ⁱBased on response to a single item: “How well do you think you are handling the daily demands of raising children?” ^j**** $p < 0.001$

EXHIBIT 3

Percent of US children ages 6–17 who were flourishing and adjusted odds of flourishing, by family resilience and connection index (FRCI) score and score components, 2016–17

	Percent	Adjusted odds ratio ^a	95% CI
FRCI score			
0 or 1	21.5	Ref	
2 or 3	38.1	2.11	1.87, 2.39
4–6	51.5	3.71	3.31, 4.15
FRCI components 1–4:			
Family resilience index score			
0 or 1	30.4	Ref	
2 or 3	40.7	1.55	1.36, 1.75
4	53.1	2.55	2.30, 2.83
FRCI component 5:			
Parent-child connection			
Not very well or not at all	5.3	Ref	
Somewhat well	23.4	3.90	2.56, 5.92
Very well	49.9	12.55	8.32, 18.93
FRCI component 6:			
Parent coping			
Not very well or not at all	16.4	Ref	
Somewhat well	24.5	1.32	0.72, 2.43
Very well	48.7	3.56	1.94, 6.53

SOURCE Authors' analysis of data from the combined 2016 and 2017 National Survey of Children's Health. **NOTES** Parent-child connection and parent coping items are explained in the notes to exhibit 2. *Flourishing* is defined as having a "definitely true" response to all 3 items in the child flourishing index (index score = 3). All percentages are weighted to represent the US population ages 6–17. Statistical significance refers to chi-square tests comparing the percentage of children who were flourishing across the levels of FRCI score or components. CI is confidence interval. ^aAdjusted odds ratios controlled for age, sex, race/ethnicity, income, adverse childhood experiences (ACEs), and special health care needs status.

flourishing was found between children in the highest FRCI category and those in the lowest (51.5 percent versus 21.5 percent). A 16.6-percentage-point difference was observed between children with an FRCI score of 2 or 3 and those with a score of 0 or 1 (38.1 percent versus 21.5 percent).

Across FRCI components, the association with child flourishing was strongest for the parent-child connection component. The adjusted odds of flourishing were 12.55 times greater for children whose parents reported "very well" (versus "not very well or not at all) to the item "how well can you and this child share ideas or talk about things that really matter." The adjusted odds were 3.90 times greater for children whose parents reported "somewhat well." (See appendix F for regression details.)⁴³

Despite the significant association between ACEs and flourishing (exhibit 2), there were only small changes in the adjusted odds of child flourishing associated with FRCI scores before or after adjusting for ACEs, which indicates that the FRCI is associated with flourishing independent of ACEs. (See appendix exhibit C3 for regression details.)⁴³

ASSOCIATION OF FAMILY RESILIENCE AND CONNECTION WITH FLOURISHING ACROSS LEVELS OF ADVERSITY For groups of children within each level of exposure to ACEs, household income, or special health care needs, there was a similar graded association between flourishing and FRCI scores, with a greater prevalence of flourishing at higher levels of family resilience and connection. Overall, the adjusted odds of flourishing were three to four times greater for children with an FRCI score of 4–6 (compared to a score of 0 or 1) within groups of children at all four levels of exposure to ACEs and at all four levels of household income (exhibit 4). Adjusted odds of flourishing for those with a score of 2 or 3 versus that of 0 or 1 were smaller but also significant.

More specifically, the adjusted odds of flourishing for children with a score of 4–6 versus a score of 0 or 1 within the categories of ACEs ranged from 3.15 to 3.88. For children's household income level, this range was 3.67–3.86.

Among children with "more complex" special health care needs, the adjusted odds of flourishing for those with an FRCI score of 4–6 were 3.69 times greater than for those with a score of 0 or 1. The same comparisons within two other groups of children—those with "less complex" needs and those without any special health care needs—produced similar results. (See appendix E for regression details.)⁴³

Discussion

Approximately 40 percent of school-age children in the US meet criteria for flourishing, as operationalized by an index derived from three items designed to assess flourishing in the National Survey of Children's Health. With only four in ten US children meeting flourishing criteria, populationwide approaches to promoting attributes of flourishing are suggested, even as targeted efforts address the needs of children exposed to adversity. The promising news is that the prevalence of flourishing was associated in a graded fashion with greater levels of family resilience and connection, and the strength of this association was similar across groups of children defined by varying levels of adversity—as measured by exposure to ACEs, household income as a percentage of the federal poverty level, and the presence of special health care needs.

The especially strong association between flourishing and the parent-child connection component of the family resilience and connection index score is consistent with the science showing the primacy of safe, stable, and nurturing relationships to optimal child development. Such relationships are advanced through the

EXHIBIT 4

Percent of US children ages 6–17 who were flourishing and adjusted odds of flourishing, by family resilience and connection index (FRCI) score, stratified by number of adverse childhood experiences (ACEs), household income, and special health care needs status, 2016–17

	Percent flourishing, by FRCI score ^a			Adjusted odds of flourishing, by FRCI score (ref: 0 or 1)			
	0 or 1	2 or 3	4–6	2 or 3		4–6	
				Adjusted odds ratio ^b	95% CI	Adjusted odds ratio ^b	95% CI
All children	21.5	38.1	51.5	2.11	1.87, 2.39	3.71	3.31, 4.15
Number of ACEs							
0	26.8	44.3	57.6	2.06	1.74, 2.44	3.74	3.20, 4.38
1	20.1	36.6	48.4	2.24	1.75, 2.87	3.88	3.08, 4.88
2 or 3	16.8	30.6	40.8	2.15	1.61, 2.88	3.73	2.88, 4.82
4–9	11.9	21.6	30.5	1.91	1.12, 3.26	3.15	1.94, 5.12
Household income (% of FPL)							
0–99%	16.0	37.1	43.7	2.96	1.98, 4.44	3.86	2.70, 5.52
100–199%	18.2	31.3	49.8	1.85	1.35, 2.55	3.84	2.84, 5.19
200–399%	21.3	35.5	51.5	1.92	1.57, 2.35	3.72	3.08, 4.51
400% or more	27.4	45.4	58.9	2.06	1.76, 3.42	3.67	3.17, 4.26
Child has special health care needs							
Yes (more complex needs)	5.7	14.7	18.9	2.84	2.08, 3.88	3.69	2.75, 4.95
Yes (less complex needs)	17.6	43.2	52.4	3.86	2.69, 5.53	5.70	4.05, 8.03
No	27.4	41.9	56.4	1.95	1.70, 2.24	3.58	3.15, 4.07

SOURCE Authors’ analysis of data from the combined 2016 and 2017 National Survey of Children’s Health. **NOTES** All percentages are weighted to represent the US population of children ages 6–17. *Flourishing* is defined as having a “definitely true” response to all 3 items in the child flourishing index (index score = 3). All percentages are weighted to represent the US population ages 6–17. CI is confidence interval. FPL is federal poverty level. ^aWithin each level of ACEs, household income, and special health care needs status, the percentage of children who were flourishing differed significantly ($p < 0.001$) both within and across the three FRCI scores. ^bAdjusted odds ratios controlled for age, sex, race/ethnicity, household income, ACEs, and special health care needs; the exception is that when one of these variables is the dependent variable (for example, ACEs, household income, special health care needs), that variable was not included in the model as an independent variable.

Centers for Disease Control and Prevention’s Essentials for Childhood framework¹⁸ and the national Bright Futures Guidelines.¹⁶

Across the US, efforts are emerging to identify the concrete approaches and resources required to improve resilience and connection within families.^{47–50} Many of these strategies, such as those advanced in the Institute of Medicine report on family-focused interventions,⁴⁷ focus on families as the key social unit for increasing child flourishing and mitigating the negative effects of adversities. These strategies also emphasize the broader social factors that influence family resilience and connection by including family supports related to housing, jobs, transportation, neighborhood safety, social support, and access to resources.

Across the sectors of health care, education, and human services, evidence-based programs and policies to increase family resilience and connection could increase flourishing in US children, even as society addresses remediable causes of childhood adversity. Efforts such as the emerging national Integrated Care for Kids Model⁴¹ seek to promote well-being and value in children’s health care and assessing and tracking

child flourishing and family resilience and connection may support these goals. Similarly, assessing child flourishing and family resilience and connection in the context of emerging initiatives to screen for and address ACEs, as in California’s Medicaid program,⁵¹ may help target and assess the outcomes of efforts to prevent and mitigate the negative effects of ACEs.

People trying to successfully engage families and children in this process must make them partners and give them a voice.^{48,52} Success will also require efforts to increase flourishing among people who provide health care, social, or educational services so that they have sustained meaning and engagement in their work with families.^{53,54}

Promoting the specific aspects of flourishing assessed here could increase the level of meaning and engagement that children have in their relationships and activities in their homes, schools, and neighborhoods. Success relies on people who wish to create safe, stable, and nurturing relationships with children and families as the basis for intergenerational flourishing in the face of aging, disease, and other unavoidable challenges across the life span. ■

Partial findings from this study using only 2016 National Survey of Children's Health data were presented at the AcademyHealth Annual Research Meeting in Seattle, Washington, June 26, 2018. A presentation on this study was presented at Pediatric Academic Societies Meeting in Baltimore, Maryland, April 29, 2019. The authors

thank the Robert Wood Johnson Foundation and the Health Resources and Services Administration of the Department of Health and Human Services for their support of this study. The viewpoints represented in this article are those of the authors and do not represent those of the funding agencies of this work. This is an open

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