

PART A & B

Below is a **clinical youth screening workflow** you can use in outpatient, school-based, or integrated care settings to triage for **ADHD, anxiety, depression, ACEs, and PCEs**. It's structured as a quick **triage screen (3–5 minutes)** followed by **validated full screens** when triage is positive. This keeps burden low while anchoring decisions in established measures and cut-offs.

Important: Screening tools flag risk; they do **not** establish diagnoses. Always follow up positives with clinical interview, multi-informant data, risk/safety assessment, and, where indicated, comprehensive evaluation.

Youth Resilience & Mental Health Screen (YR-MHS)

Target age: 8–17

Informants: Youth self-report (≥ 12), caregiver, and (for ADHD) teacher when possible. Multi-informant input improves accuracy for ADHD.

Estimated time:

- **Triage (Part A):** 3–5 minutes
- **Full screens (Part B):** 15–25 minutes (if any Part A domain is positive)

Part A — Triage (3–5 minutes)

Have the youth (≥ 12) and caregiver each answer; if either endorses risk, proceed to the validated tool in Part B.

A1. ADHD (attention/impulsivity/behavior)

Over the **past 6 months**, how often (Never / Occasionally / Often / Very Often) has the youth:

1. Had **difficulty sustaining attention** in tasks or play?
2. Been **easily distracted** by noises or other stimuli?
3. **Fidgeted**, felt “on the go,” or acted as if “driven by a motor”?

Positive triage: Any item marked **Often/Very Often** → administer **SNAP-IV (26 or 18 item)** or **Vanderbilt** parent/teacher forms (Part B).

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A2. Anxiety

Over the **past 3 months**, does the youth:

1. Often feel **very nervous or worried**?
2. Avoid **school or social situations** because of fear/worry?
3. Have **somatic symptoms** (e.g., dizziness, racing heart) when frightened?
Positive triage: ≥ 2 “Yes” → administer **SCARED (Child & Parent, 41 items)** (Part B).

A3. Depression

Over the **past 2 weeks**, how often (0–3) has the youth had:

1. **Little interest or pleasure** in doing things?
2. **Feeling down, depressed, irritable or hopeless**?
Positive triage: Either item ≥ 2 (“More than half the days”) → administer **PHQ-A (9 items)** (Part B).

A4. ACEs (adversity exposure)

Has the youth **ever** experienced ≥ 1 of the following: abuse, neglect, caregiver mental illness/substance use, parental separation/divorce, incarceration, intimate partner violence in household?

Positive triage: “Yes” → administer **PEARLS** (caregiver and adolescent versions) (Part B).

A5. PCEs (protective experiences)

Thinking about childhood so far, does the youth **often**:

- Feel able to **talk with family** about feelings;
- Feel **family support** during difficult times;
- Feel **belonging** at school and enjoy community traditions;
- Have **supportive friends** and ≥ 2 **caring non-parent adults**;

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- Feel **safe and protected** by an adult at home?
Positive triage: ≤ 3 “Yes” responses suggests low PCEs → administer **PCEs-7** (Part B).

Part B — Validated Full Screens & Scoring

Use these when a Part A domain is positive (or if you prefer full screening for all).

B1. ADHD — SNAP-IV (26 or 18 item) or Vanderbilt (Parent/Teacher)

- **SNAP-IV (26):** ADHD likely if **Inattention** $\geq 6/9$ or **Hyperactivity/Impulsivity** $\geq 6/9$ (count items rated **2–3**) and consider **ODD** $\geq 4/8$. Provide both **parent and teacher** forms when possible.
- **Vanderbilt:** ADHD criteria if **≥ 6 positives** in inattentive and/or hyperactive sets (**2–3** = “often/very often”) **AND impairment** (performance items with ≥ 1 score of **5** or ≥ 2 scores of **4**). Also screens for ODD, conduct, and anxiety/depression.

B2. Anxiety — SCARED (Child & Parent, 41 items)

- **Total score** ≥ 25 suggests an anxiety disorder; ≥ 30 more specific. Subscale cutoffs: **Panic/Somatic** ≥ 7 , **GAD** ≥ 9 , **Separation** ≥ 5 , **Social** ≥ 8 , **School Avoidance** ≥ 3 . Use **both child and parent** versions when feasible.

B3. Depression — PHQ-A (9 items)

- **Severity bands:** 0–4 none/minimal; 5–9 mild; 10–14 moderate; 15–19 moderately severe; 20–27 severe.
- **Diagnostic screen for MDD:** Items **1 and/or 2** ≥ 2 , plus **≥ 5 positives** (items 1–8 counted at ≥ 2 ; item 9 counted at ≥ 1) **AND** functional impairment $\geq$ “**Somewhat difficult.**” **Always** follow up any **item 9** endorsement with a **suicide risk assessment**.

B4. ACEs — PEARLS (Caregiver; Adolescent self-report)

- **Two parts:** **Part 1** (10 ACE categories) and **Part 2** (additional adversities: discrimination, food/housing insecurity, etc.). **Higher scores** → **higher toxic stress risk**; many programs use **≥ 4 ACEs** as a **high-risk** threshold to trigger enhanced supports. Use **de-identified** format if disclosure comfort is a concern.

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- Note: Several pediatric and public health bodies caution that **ACEs screens are not diagnostic** and should be embedded in trauma-informed care; consider potential harms and ensure pathways to resources.

B5. PCEs — PCEs-7 (Bethell et al.)

- **Score 0–7** by summing “often/most of the time” endorsements. **Higher PCEs** correlate with **better adult mental and relational health**, buffering adversity (dose-response). Use alongside ACEs to **balance risk with strengths** and to plan **protective, attachment-informed** interventions.

Administration & Follow-Up Guidance

- **Screening cadence:** USPSTF recommends routine screening for **depression ≥ 12** and **anxiety ≥ 8** , even without symptoms; repeat based on clinical judgment and setting.
- **Primary care workflow:** GLAD-PC endorses structured identification, assessment, and initial management pathways (use PHQ-A; integrate safety planning and follow-up).
- **ADHD best practice:** Use **multi-informant** measures (caregiver + teacher) and document functional impairment; do not rely on rating scales alone.
- **Trauma-informed ACEs use:** If PEARLS is positive, offer **anticipatory guidance**, resource linkage (e.g., care coordination, resilience clinics), and monitor for **toxic stress**; consider **de-identified** screening formats to enhance disclosure.
- **Safety protocols:** Any **suicidal ideation** (PHQ-A item 9 ≥ 1) → immediate **risk assessment**, safety planning, and crisis resources; escalate per local policy.

Patricia Bianca Torres, LMFT, PhD - Predicting Flourishing in ADHD Youth: Positive Childhood Experiences and Mood Disturbances in Context of Adversity from the ACAMH – ACEs SIG, Day Conference, ADVERSITY, PROTECTION, AND PREVENTION: RETHINKING CHILDHOOD EXPERIENCES THROUGH NEW EVIDENCE -September 2026
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