PINETREE INSTITUTE

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Good morning Chair Ingwersen, Chair Meyer, and Distinguished Members of the Joint Standing Committee on Health and Human Services,

Thank you for the opportunity to provide testimony neither for nor against LD 1703, "Resolve, to Establish the Adverse Childhood Experiences Screening and Resiliency Assessment Pilot Project."

My name is Dr. Larry McCullough, Executive Director of Pinetree Institute, a nonprofit based in Eliot, Maine. We offer trauma-informed approaches to address community mental and behavioral health challenges. We strongly support the goal of expanding ACEs education to those who work with children and youth. However, we urge caution regarding the use of assessment instruments that are not validated for individual screening.

Six years ago, we partnered with Dr. Robert Anda, co-author of the original ACEs study, to develop ACEs education programs. Since then, we have trained several thousand people—educators, school staff including administrators as well as cafeteria and transportation workers, counselors, mental health professionals, and many others—on ACEs, the buffering effects of positive experiences, and effective response strategies.

The outcomes have been inspiring. Participants report greater understanding of children's needs, increased engagement of children and youth, deeper connection to support services, and reduced staff burnout.

While we fully support broad ACEs education, we caution against using the original ACEs questionnaire or similar questionnaires as an assessment tool. Dr. Anda has explained in published articles that the ACEs questionnaire was designed for population-level research, not individual screening or diagnosis. It is not a validated instrument and does not meet national standards set by the U.S. Preventive Services Task Force for safe and effective public health screening. As such, using it or similar questionnaires in an assessment context raises serious medical, ethical, and legal concerns.

At Pinetree Institute, we have adopted an alternative approach that has been very effective and which avoids the issues of potential stigma, labeling, over- or under-diagnosis and legal concerns. We begin by offering education to a broad range of professionals who work with children and youth. We then offer optional self-assessment activities that are age-appropriate and context-sensitive along with information about trusted, accessible resources—both in-

person and online. This approach avoids the challenges of using unvalidated assessments and has been remarkably effective in identifying and supporting those most in need.

In summary we are enthusiastically in favor of expanding ACEs education in Maine Schools but would not be in favor of using assessments that have not been validated for this purpose and which will raise substantial medical, ethical and legal issues.

Thank you for your time.

I would be happy to answer any questions.

Larry McCullough, Ed.D.
Executive Director, Pinetree Institute

NOTES

1. For a detailed explanation of the limitations of using the ACE Questionnaire as an individual assessment see:
   Inside the Adverse Childhood Experience Score: Strengths, Limitations, and Misapplications Anda, Robert F. et al. American Journal of Preventive Medicine, Volume 59, Issue 2, 293 – 295

2. For a brief summary of appropriate use of the ACEs Questionnaire and for a copy of the ACEs and PCEs Questionnaires, see Pinetree Institute Document:
   Understanding ACEs Scores and Positive Experience Scores
   Notes on appropriate uses of ACEs and Positive Experiences Scores and important notes on how NOT to use them (Pinetree PDF)