

## **Exhibit 11**

NCTSN

The National Child  
Traumatic Stress Network



# Trauma-Informed Interventions:

Clinical and Research Evidence and Culture-Specific Information Project



## Acknowledgments

This project was a collaborative effort between the National Crime Victims Research and Treatment Center in the Department of Psychiatry at the Medical University of South Carolina and the National Center for Child Traumatic Stress. This work was based on previous work on treatment guidelines for the treatment of child physical and sexual abuse conducted by Benjamin E. Saunders, PhD, Lucy Berliner, MSW, and Rochelle F. Hanson, PhD:

Saunders, B. E., Berliner, L. & Hanson, R. F. (Eds.). (2004). *Child physical and sexual abuse: Guidelines for treatment (Revised Report: April 26, 2004)*. Charleston, SC: National Crime Victims Research and Treatment Center.

The authors would like to thank all of the treatment developers for taking the time to provide detailed descriptions of their interventions for inclusion in this project and Jo Sornborger, PsyD for extensive project management support. In addition, the authors would like to thank the members of the expert panel who generously gave of their time and talent to contribute to this project. The authors would also like to extend a special thank you to the NCTSN Culture Consortium for participating in the evolution of this project and for providing feedback and guidance along the way.

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This report may be accessed electronically at <http://www.nctsn.org/cultureandtraumaresources>, or downloaded directly at <http://www.nctsn.org/nccts/asset.do?id=1392>.

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# Trauma-Informed Interventions: Clinical and Research Evidence and Culture-Specific Information Project

## Introduction

The *Trauma-Informed Interventions: Clinical and Research Evidence and Culture-Specific Information Project* is a collaboration between the National Crime Victims Research and Treatment Center at the Medical University of South Carolina (MUSC) and the National Child Traumatic Stress Network (NCTSN). This project emerged in response to the heavy emphasis on evidence-based practices in the mental health community, a trend that may ultimately affect access to services, as well as policy and funding decisions.

The purpose of this project was to identify trauma-focused interventions that have been developed and utilized with trauma-affected youth populations of various cultural backgrounds and to describe their level of cultural competence. This project also aims to describe the level of clinical and research evidence surrounding the use of specific trauma-informed treatment interventions with diverse cultural groups. Included in the term “diverse cultural groups” are factors of race, ethnicity, sexual orientation, socioeconomic status, spirituality, geographic location, and any other distinguishing factors about a particular group or population.

## Goals of the Project

The Project does not intend to provide a subjective value judgment about which interventions are the best. Instead, the primary goals of this project are as follows:

- To collect information on interventions that are currently being used for a broad array of diverse cultural groups of youth affected by trauma;
- To provide descriptions of existing clinical and/or research evidence for each of these interventions;
- To encourage practitioners and intervention developers to summarize practice-based and anecdotal evidence in written form so that treatments can be more widely disseminated and more thoroughly evaluated;
- To create a formal comprehensive report which documents our systematic process and describes the interventions that were identified and submitted by treatment developers. The report can then be used by practitioners when selecting treatments for the diverse communities they serve;
- To develop a web-based, searchable database describing the existing clinical and research evidence for the use of trauma-informed interventions with various cultural groups of youth exposed to trauma. The database will help to facilitate the identification and use of treatments for diverse communities affected by trauma.

### Methodology

In 2005, the NCTSN began compiling a list of *Empirically Supported Treatments and Promising Practices*, including interventions being implemented by sites within the NCTSN for traumatized children and their families. Treatment developers were asked to complete an intervention template, which solicited specific information about their interventions (e.g., treatment description, target population, research evidence). Fact Sheets detailing each approach were developed from each completed intervention template, and then posted on the NCTSN website for public use. The interventions and treatments selected span a continuum of evidence-based interventions for use with trauma-affected youth, ranging from rigorously evaluated interventions to promising and newly emerging practices.

In June 2006, revised intervention templates were sent to all developers of the NCTSN's *Empirically Supported Treatments and Promising Practices*. Tailored for the *Trauma Informed Interventions: Clinical and Research Evidence and Culture-Specific Information Project*, the questions on these revised intervention templates were designed to elicit information about the cultural competence of an intervention as well as the level of research supporting the treatment. We placed special emphasis on providing this level of detail about the interventions to assist practitioners' selection of which treatment or practice to implement—based not only on their levels of evidence but also on their appropriateness for a given community and target population.

Therefore, the revised intervention templates sent to developers in 2006 included questions designed to evaluate the extent of both clinical and research evidence supporting the use of trauma-informed treatment interventions with trauma-affected youth from diverse cultural groups (as defined by race, ethnicity, sexual orientation, socioeconomic status, spirituality, disability, geographic location and other factors). These questions were intended to elicit information about each of the following categories (see Appendix A, General Information Intervention Template):

- Treatment Description
- Target Population
- Essential Components
- Clinical & Anecdotal Evidence
- Research Evidence
- Outcomes
- Implementation Requirements & Readiness
- Training Materials & Requirements
- Pros & Cons/Qualitative Impressions
- Contact Information
- References

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Information gathered from the revised intervention templates replaced the previous Fact Sheets developed by the NCTSN in 2005.

In January 2007, these Fact Sheets on treatment interventions, based on revised intervention templates completed and returned by treatment developers, were sent to members of a nationally represented expert panel. The panel members were asked to meet to discuss the evidence base for the treatment interventions for use with various cultural groups and to determine future directions for this project.

### **Expert Panel**

In February 2007, an expert panel was convened at the NCTSN's annual conference. The panel was asked to review evaluation criteria for treatment interventions, and to evaluate and categorize interventions according to the evidence for their efficacy and effectiveness with various cultural groups. The expert panel members were selected because of their acknowledged expertise and commitment to promoting and developing effective, culturally competent mental health treatments. This nationally represented group consisted of the following members:

<b>Veronica Abney, PhD</b> Private Practice & UCLA School of Medicine	<b>Larke Huang, PhD</b> Substance Abuse and Mental Health Services Administration (SAMHSA)
<b>Dolores Subia Bigfoot, PhD</b> Indian Country Child Trauma Center (ICCTC)	<b>Mareasa Isaacs, PhD</b> National Alliance of Multi-Ethnic Behavioral Health Associations (NAMBHA)
<b>Ernestine Briggs-King, PhD</b> National Center for Child Traumatic Stress (NCCTS)	<b>Russell Jones, PhD</b> Virginia Tech University (VT)
<b>Elissa Brown, PhD</b> Community PARTNERS at St. John's University	<b>Sheryl Kataoka, MD, MSHS</b> Department of Psychiatry and Biobehavioral Sciences at UCLA; Los Angeles Unified School District (LAUSD)
<b>Carla Kmetz Danielson, PhD</b> Medical University of South Carolina (MUSC)	<b>Susan Ko, PhD</b> National Center for Child Traumatic Stress (NCCTS)
<b>Michael de Arellano, PhD</b> Medical University of South Carolina (MUSC)	<b>Sarah Maiter, PhD</b> American Professional Society on the Abuse of Children (APSAC)
<b>Chandra Ghosh Ippen, PhD</b> Child Trauma Research Project University of California, San Francisco (UCSF)	<b>Karen Wyche, MSW, PhD</b> University of Oklahoma Health Sciences Center (OUHSC)

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### **Expert Panel Meeting**

The rating system originally developed for this project was based very closely on the criteria used for *Child Physical and Sexual Abuse: Guidelines for Treatment* (2004). Those guidelines were developed by the Office for Victims of Crime, in collaboration with the National Crime Victims Research and Treatment Center at MUSC and the Center for Sexual Assault and Traumatic Stress at Harborview Medical Center. However, at the February, 2007 meeting, the expert panel concluded that the intervention Fact Sheets did not include enough information to provide a ranking for each treatment's level of cultural competence. Additionally, panel members raised concerns about the classification system, and expressed discomfort with categorizing interventions by assigning numerical ratings and citing inadequate information on specific ways in which the treatments address diverse cultural groups. The panel agreed that, rather than rating interventions based on the level of clinical and research evidence, it would be more helpful to solicit additional information about the degree to which cultural issues are addressed in the treatment intervention. The panel agreed that this would help more accurately capture the "cultural competence" of a given treatment.

As a result of these concerns, the panel decided to create a Culture-Specific Information Intervention Template. The panel spent the remainder of the meeting identifying additional culture-specific questions necessary to help determine the extent to which a particular treatment addresses the needs of diverse cultural groups. The panel decided that, once these Culture-Specific Information Intervention Templates were completed, the project would aim to present Culture-Specific Fact Sheets, alongside General Fact Sheets, in a comprehensive document.

Based on the culture-specific questions generated at the expert panel meeting, the Culture-Specific Information Intervention Template was developed and was sent to treatment developers to complete. This template included questions intended to address the following categories (see Appendix B, Culture-Specific Information Intervention Template):

- Engagement
- Language Issues
- Symptom Expression
- Assessment
- Cultural Adaptations
- Intervention Delivery Method/Transportability & Outreach
- Training Issues
- References

The information collected on the revised General Information Intervention Template as well as the Culture-Specific Intervention Template was used to create General and Culture-Specific Fact Sheets for each intervention. These Fact Sheets were then posted on the NCTSN website.

## **General and Culture-Specific Fact Sheets for Culturally-Competent, Evidence-Based, Trauma-Focused Interventions**

Each General and Culture-Specific Fact Sheet includes all of the information provided by developers of the intervention and has not been substantively altered.<sup>1</sup> Only trauma-informed treatment interventions and practices that have both a General and Culture-Specific Fact Sheet are included in this report. Fact Sheets for each of the following interventions begin on page 23.

- **AF-CBT:** Alternatives for Families--A Cognitive Behavioral Therapy
- **DBT-SP:** Adapted Dialectical Behavior Therapy for Special Populations
- **TAP:** Assessment-Based Treatment for Traumatized Children: Trauma Assessment Pathway
- **ARC:** Attachment, Self-Regulation, and Competency: A Comprehensive Framework for Intervention with Complexly Traumatized Youth
- **CARE:** Child-Adult Relationship Enhancement
- **CPP:** Child-Parent Psychotherapy
- **CBITS:** Cognitive Behavioral Intervention for Trauma in Schools
- **CPC-CBT:** Combined Parent Child Cognitive-Behavioral Approach for Children and Families At-Risk for Child Physical Abuse
- **CM-TFT:** Culturally Modified Trauma-Focused Treatment
- **IFACES:** International Family Adult and Child Enhancement Services, Heartland Health Outreach
- **ITCT:** Integrative Treatment of Complex Trauma
- **MMTT:** Multimodality Trauma Treatment (aka Trauma-Focused Coping in Schools)
- **PCIT:** Parent-Child Interaction Therapy
- **RLH:** Real Life Heroes
- **Sanctuary Model**
- **SPARCS:** Structured Psychotherapy for Adolescents Responding to Chronic Stress
- **TGCT:** Trauma and Grief Component Therapy
- **TARGET-A:** Trauma Affect Regulation: Guidelines for Education and Therapy for Adolescents and Pre-Adolescents
- **TF-CBT:** Trauma-Focused Cognitive Behavioral Therapy
- **TG-CBT:** Trauma-Focused Cognitive Behavioral Therapy for Child Traumatic Grief
- **Trauma-Informed Organizational Self-Assessment**
- **TST:** Trauma Systems Therapy

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<sup>1</sup> Please note: if a developer left any blanks in a template field, the question from the initial template was not included in the Fact Sheet for that particular intervention.

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### Conclusion

There is no one treatment intervention appropriate for all children who have experienced trauma. However, there are evidence-supported treatments and promising practices that share core principles of “culturally competent trauma-informed therapy,” and that are appropriate for many children and families from diverse cultural groups.

Culturally competent trauma-informed therapies should include some, or all, of the following principles:

- **Engagement with the child, the family, and the community.** For many cultural groups, there may be cultural barriers to accessing treatment. Therefore, the start of treatment should begin with addressing strategies designed to engage children and families. These engagement strategies should be culture-specific. For example, addressing issues of trust may be important when working with refugees. Engagement strategies may also consider the role of other members of the family’s immediate community, such as cultural or spiritual leaders, in reaching the child and family.
- **Sensitivity to the family’s cultural background when building a strong therapeutic relationship.** Like most forms of therapy, trauma treatment requires the skillful development of a clinical relationship with the child and caregivers. During the process of building the therapeutic relationship, the practitioner must understand the importance of asking questions in order to learn about the child and/or family’s cultural background.
- **Consideration of the impact of culture on symptom expression.** Most trauma-informed therapy includes a component that helps the child and caregivers identify and understand normal human reactions to trauma. When assessing reactions to trauma, it is important to consider the impact of culture, since cultural views may have an impact on symptom expression. If it is known that culture impacts symptom expression for a particular cultural group, assessment measures should reflect these differences.
- **Careful use of interpreters, when necessary.** Caregivers are typically powerful mediators of the child’s treatment for and recovery from trauma. Involving the parent, resource parent, or other caregiver is a vital element of trauma treatment. Some trauma-informed interventions include a parenting component to give the parent greater mastery of child management skills. Language issues may sometimes arise if the clinician does not speak the parents’ language. In such cases, it is very important to consider how the chosen treatment suggests use of interpreters in the absence of bilingual clinicians.
- **Understanding that differences in emotional expression exist among cultures.** To help with emotional regulation, it is typically necessary to teach the child (and sometimes the caregiver) practical skills and tools for gaining mastery of the overwhelming emotions often associated with trauma and its reminders. Again, it is important to assess cultural norms

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regarding appropriate levels of emotional expression and with whom it is considered culturally appropriate to share emotions.

- **Assessment of the impact of cultural views on cognitive processing or reframing.** Child trauma can result in serious misunderstandings about personal responsibility. In the aftermath of a trauma, children may assume a great deal of self-blame for the events; or, they may blame someone else for not protecting them—even though protection may have been beyond that person's capacity. Traumatized children may associate the trauma with unrelated events and draw irrational causal relationships. Therapy often helps correct these misattributions. When treating trauma-affected youth from diverse backgrounds, clinicians must be aware that some misattributions may be related to cultural worldviews. A culturally-informed assessment can help to examine how culture affects the child's and family's comprehension of traumatic events. In such cases, cognitive processing and reframing will have to include an understanding of the impact of cultural views on attitudes and behavior.
- **Construction of a coherent trauma narrative using culturally congruent methods.** Successful trauma treatment often includes building the child's capacity to talk about what happened in ways that make sense of the experience without producing overwhelming emotions. Many non-trauma-informed therapists are uncomfortable with this aspect of treatment, which sometimes involves gradual exposure to traumatic reminders while using newly acquired anxiety management skills. Clinicians should consider how trauma narratives can be constructed so that they are congruent with the ways in which specific cultural groups feel comfortable sharing personal or private information (e.g., storytelling).
- **Highlighting ways in which culture may be a source of resiliency and strength.** Trauma treatment often includes strategies that build upon children's strengths. These strategies are designed to give them a sense of control over events and risks. Treatments then often end on a positive, empowering note, giving the child a sense of satisfaction and closure as well as increased competency and hope for the future. It is important to highlight the strengths inherent in children's and families' cultures as part of this process.

The *Trauma Informed Interventions: Clinical and Research Evidence and Culture-Specific Information Project* aims to promote cultural competence using each of these core principles of culturally competent trauma-informed therapy and to recognize practices that are effectively utilizing these principles. This report provides guidelines for evaluation of the treatments and promising practices that are appropriate for the cultural groups being served. Ultimately, it is the responsibility of clinicians, agencies and consumers to recognize how the needs of the specific cultural group being treated will be addressed by a chosen evidence-based treatment or promising practice.

## Trauma-Informed Interventions: Clinical and Research Evidence and Culture-Specific Information Project

### Future Directions

The purpose of the *Trauma-Informed Interventions: Clinical and Research Evidence and Culture-Specific Information Project* was to identify trauma-focused interventions that have been developed and applied to trauma-affected youth populations of various cultural backgrounds and to describe their level of cultural competence and the level of clinical and research evidence supporting the treatment. Work on this project has revealed that significant groundwork has been established in this area by clinicians and researchers working directly with trauma-affected culturally diverse populations. However, more work will be required to improve the state of the science for the identification and application of evidence-based interventions with such populations. Advancing the science could be accomplished in a number of ways, as listed below.

First, developers of the interventions described in the Fact Sheets included in this report should seek to bring their respective interventions to the next level of evaluation. This may involve more rigorous collection of pre- and post-treatment outcome data with standardized, culturally appropriate measures. In some cases, assessment approaches may require modification in order to capture this data for a particular population. (See de Arellano & Danielson, 2008, for suggestions on culturally-informed trauma assessment.) For other interventions, developers may consider conducting a more rigorous open pilot trial or a randomized controlled trial. For the limited number of trauma-informed interventions that have been conducted with culturally diverse populations, treatment developers are encouraged to pursue ways in which to measure “real world” effectiveness—perhaps by designing and conducting community-based trials. Appendix C lists criteria for evaluating levels of evidence for interventions’ use with specific cultural groups based on those used in previous treatment guidelines projects (Saunders, Berliner & Hanson, 2004) and can help provide suggested next steps for increasing the evidence base for interventions.

Another important future direction for this project may involve collaborations between community-based clinicians and researchers in order to develop a feasible “gold standard” for evaluation of trauma-informed interventions with culturally diverse populations. This pairing of science and practice could help address findings from previous reports that ethnic minority individuals and other culturally diverse youth are less likely to receive empirically-supported, gold-standard mental health interventions (U.S. Department of Health and Human Services, 2001).

Finally, it is hoped that this project will represent a first step in the continually evolving goal of developing a stronger clinical and research base for interventions used with culturally diverse populations. The Fact Sheets provided in this report are a resource that can be used to assist practitioners in the identification of interventions that have demonstrated efficacy in their application with culturally diverse populations. As clinicians continue to use interventions with diverse populations and document their clinical and research outcomes, the information on the effectiveness and efficacy of interventions for specific populations will grow and strengthen. A more formal evaluation of the state of the science, perhaps using the criteria listed in Appendix C, could then be pursued.

## Trauma-Informed Interventions: Clinical and Research Evidence and Culture-Specific Information Project

### References<sup>2</sup>

de Arellano, M. A. & Danielson, C. K. (2008). Assessment of trauma history and trauma-related problems in ethnic minority child populations: An INFORMED approach. *Cognitive & Behavioral Practice, 15*, 53-67.

Saunders, B. E., Berliner, L. & Hanson, R. F. (Eds.). (2004). *Child physical and sexual abuse: Guidelines for treatment (Revised Report: April 26, 2004)*. Charleston, SC: National Crime Victims Research and Treatment Center.

U.S. Department of Health and Human Services (2001). *Mental health: Culture, race, and ethnicity—A supplement to mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General.

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<sup>2</sup> The reference list does not include references included in each of the Fact Sheets which follow.

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## Appendix A: General Information Intervention Template

 <b>ACRONYM:</b> Name of Intervention	
GENERAL INFORMATION	
Treatment Description	Acronym ( <i>abbreviation</i> ) for intervention: Average length/number of sessions: Aspects of culture or group experiences that are addressed (e.g., faith/spiritual component, transportation barriers): Trauma type ( <i>primary</i> ): Trauma type ( <i>secondary</i> ): Additional descriptors ( <i>not included above</i> ):
Target Population	Age range: ( <i>lower limit</i> ) _____ to ( <i>upper limit</i> ) _____ Gender: <input type="checkbox"/> Males <input type="checkbox"/> Females <input type="checkbox"/> Both Ethnic/Racial Group ( <i>include acculturation level/immigration/refugee history—e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans</i> ): Other cultural characteristics (e.g., SES, religion): Language(s): Region (e.g., rural, urban): Other characteristics ( <i>not included above</i> ):
Essential Components	Theoretical basis: Key components:
Clinical & Anecdotal Evidence	Are you aware of any suggestion/evidence that this treatment may be harmful? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain Extent to which cultural issues have been described in writings about this intervention (scale of 1-5 where 1=not at all to 5=all the time). _____ This intervention is being used on the basis of anecdotes and personal communications only ( <i>no writings</i> ) that suggest its value with this group. <input type="checkbox"/> Yes <input type="checkbox"/> No Are there any anecdotes describing satisfaction with treatment, drop-out rates (e.g., quarterly/annual reports)? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please include citation: Has this intervention been presented at scientific meetings? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please include citation(s) from last five presentations: Are there any general writings which describe the components of the intervention or how to administer it? <input type="checkbox"/> Yes <input type="checkbox"/> No

**Appendix A: General Information Intervention Template**

 <b>ACRONYM:</b> Name of Intervention															
GENERAL INFORMATION															
<b>Clinical &amp; Anecdotal Evidence continued</b>	<p>If YES, please include citation:</p> <p>Has the intervention been replicated anywhere? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Other countries? <i>(please list)</i></p> <p>Other clinical and/or anecdotal evidence <i>(not included above):</i></p>														
<b>Research Evidence</b>	<table border="1" style="width: 100%;"> <thead> <tr> <th style="width: 50%;">Sample Size (N) and Breakdown <i>(by gender, ethnicity, other cultural factors)</i></th> <th style="width: 50%;">Citation</th> </tr> </thead> <tbody> <tr> <td>Published Case Studies</td> <td></td> </tr> <tr> <td>Pilot Trials/Feasibility Trials <i>(w/o control groups)</i></td> <td></td> </tr> <tr> <td>Clinical Trials <i>(w/control groups)</i></td> <td></td> </tr> <tr> <td>Randomized Controlled Trials</td> <td></td> </tr> <tr> <td>Studies Describing Modifications</td> <td></td> </tr> <tr> <td>Other Research Evidence</td> <td></td> </tr> </tbody> </table>	Sample Size (N) and Breakdown <i>(by gender, ethnicity, other cultural factors)</i>	Citation	Published Case Studies		Pilot Trials/Feasibility Trials <i>(w/o control groups)</i>		Clinical Trials <i>(w/control groups)</i>		Randomized Controlled Trials		Studies Describing Modifications		Other Research Evidence	
Sample Size (N) and Breakdown <i>(by gender, ethnicity, other cultural factors)</i>	Citation														
Published Case Studies															
Pilot Trials/Feasibility Trials <i>(w/o control groups)</i>															
Clinical Trials <i>(w/control groups)</i>															
Randomized Controlled Trials															
Studies Describing Modifications															
Other Research Evidence															
<b>Outcomes</b>	<p>What assessments or measures are used as part of the intervention or for research purposes, if any?</p> <p>If research studies have been conducted, what were the outcomes?</p>														
<b>Implementation Requirements &amp; Readiness</b>	<p>Space, materials or equipment requirements?</p> <p>Supervision requirements <i>(e.g., review of taped sessions)?</i></p> <p>To ensure successful implementation, support should be obtained from:</p>														

**Appendix A: General Information Intervention Template**

 <b>ACRONYM:</b> Name of Intervention	
GENERAL INFORMATION	
<b>Training Materials &amp; Requirements</b>	List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.  How/where is training obtained?  What is the cost of training?  Are intervention materials ( <i>handouts</i> ) available in other languages? <input type="checkbox"/> Yes <input type="checkbox"/> No  If YES, what languages?  Other training materials &/or requirements ( <i>not included above</i> ):
<b>Pros &amp; Cons/Qualitative Impressions</b>	What are the pros of this intervention over others for this specific group ( <i>e.g., addresses stigma re. treatment, addresses transportation barriers</i> )?  What are the cons of this intervention over others for this specific group ( <i>e.g., length of treatment, difficult to get reimbursement</i> )?  Other qualitative impressions:
<b>Contact Information</b>	Name:  Address:  Phone number:  Email:  Website:
<b>References</b>	

**Appendix B: Culture-Specific Information Intervention Template**

 <b>ACRONYM:</b> Name of Intervention	
CULTURE-SPECIFIC INFORMATION	
<b>Engagement</b>	<p>For which specific cultural group(s) (i.e., SES, religion, race, ethnicity, gender, immigrants/refugees, disabled, homeless, LGBTQ, rural/urban areas) is this treatment tailored? If none, please respond "not specifically tailored."</p> <p>Do clinicians, implementing the intervention, tailor engagement for specific cultural groups? If so, how? Please be as detailed as possible.</p> <p>Are there culture-specific engagement strategies (e.g., addressing trust) that are included in the intervention?</p>
<b>Language Issues</b>	<p>How does the treatment address children and families of different language groups?</p> <p>If interpreters are used, what is their training in child trauma?</p> <p>Any other special considerations regarding language and interpreters?</p>
<b>Symptom Expression</b>	<p>Is there research or clinical evidence to suggest that the populations served manifest trauma symptoms in differential ways? If so, are there differences in the ways that symptoms are assessed for the various populations?</p> <p>If there are differences in symptom expression, in what ways does the theoretical/conceptual framework of this treatment address culturally specific symptoms?</p>
<b>Assessment</b>	<p>In addition to any differences noted above, are there any differences in assessment measures used across cultural groups? If so, please indicate which measures are used for which cultural groups. Are there normative data available for the populations for which they are being used?</p> <p>If no normative data exists for assessment measures, how is the measure used clinically to make baseline or outcome judgments?</p> <p>What, if any, culturally specific issues arise when utilizing these assessment measures?</p>
<b>Cultural Adaptations</b>	<p>Are cultural issues specifically addressed in the writing about the treatment? Please specify.</p> <p>Do culture-specific adaptations exist? Please specify (e.g., components adapted, full intervention adapted).</p> <p>Has differential drop out been examined for this treatment? Is there any evidence to suggest differential drop out across cultural groups? If so, what are the findings?</p>

**Appendix B: Culture-Specific Information Intervention Template**

 <b>ACRONYM:</b> Name of Intervention	
CULTURE-SPECIFIC INFORMATION	
<b>Intervention Delivery Method/ Transportability &amp; Outreach</b>	<p>If applicable, how does this treatment address specific cultural risk factors (i.e., increased susceptibility to other traumas)?</p> <p>Is this a clinic-based treatment or is the treatment transportable (e.g., into home, community)? If the treatment is transportable, how is it adapted into the new setting? Is it still efficacious?</p> <p>Are there cultural barriers to accessing this treatment (i.e., treatment length, family involvement, stigma, etc.)?</p> <p>Are there logistical barriers to accessing this treatment for specific cultural groups (i.e., transportation issues, cost of treatment, etc.)?</p> <p>Are these barriers addressed in the intervention and how?</p> <p>What is the role of the community in treatment (e.g., local groups such as faith-based organizations, community groups, youth and/or parent organizations, first responders, schools)?</p>
<b>Training Issues</b>	<p>What potential cultural issues are identified and addressed in supervision/training for the intervention?</p> <p>If applicable, how are potential cultural issues between the supervisor and clinician identified and addressed in supervision/training?</p> <p>If applicable, how are potential cultural issues between the clinician and the client identified and addressed in supervision/training?</p> <p>Has this guidance been provided in the writings on this treatment?</p> <p>Any other special considerations regarding training?</p>
<b>References</b>	

## **Appendix C: Treatment Protocol Classification System**

A primary goal of this project was to establish a clear, criteria-based system for classifying interventions and treatments according to their theoretical, clinical, and empirical support. This system can be applied not only to the interventions presented in this report, but also can be used to judge the utility of other current treatments, as well as treatments to be developed in the future. Therefore, the classification system is a tool that can be used by practitioners and others to make decisions about the appropriateness of certain treatments that are not included in this report. It is helpful to keep in mind that this report reflects the state of knowledge at the time of writing. Hopefully, more research will be conducted testing the efficacy of existing interventions and protocols. As more research is completed, the classifications of treatments will likely change over time. Therefore, this treatment classification system should be viewed as a tool that can be applied to a dynamic area where the body of scientific information is constantly increasing.

The classification system uses criteria regarding a treatment's theoretical soundness, clinical support, professional acceptance, potential for harm, documentation, and empirical support to assign a summary classification score. A lower score indicates a greater level of support for the treatment protocol. The summary categories are:

- 1 = Well-supported, efficacious treatment for specific cultural groups
- 2 = Supported and probably efficacious treatment for specific cultural groups
- 3 = Supported and acceptable treatment for specific cultural groups
- 4 = Promising and acceptable treatment for specific cultural groups
- 5 = Innovative or novel treatment for specific cultural groups
- 6 = Concerning or worrisome treatment for specific cultural groups

Specific criteria for each classification system category are presented below:

### **1. Well-supported, Efficacious Treatment for Specific Cultural Groups**

- a. The treatment has a sound theoretical basis in generally accepted psychological principles applicable to specific cultural groups.
- b. A substantial clinical-anecdotal literature exists indicating the treatment's value with child trauma victims and/or their families from specific cultural groups.
- c. The treatment is generally accepted in clinical practice as appropriate for use with child trauma victims and/or their families from specific cultural groups.

## Appendix C: Treatment Protocol Classification System

- d. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- e. The treatment has a book, manual, or other available writings that specify the components of the treatment protocol and describe how to administer it.
- f. At least two randomized, controlled treatment outcome studies (RCTs) have found the treatment protocol to be superior to an appropriate comparison treatment, or no different nor better than an already established treatment when used with child trauma victims and/or their families from specific cultural groups. The RCTs must have focused on the specific cultural group or must have enrolled a sufficiently large number of the target cultural group within their sample to evaluate differential efficacy for that cultural group.
- g. If multiple treatment outcome studies have been conducted, the overall weight of evidence supports the efficacy of the treatment.

### 2. Supported and Probably Efficacious Treatment for Specific Cultural Groups

- a. The treatment has a sound theoretical basis in generally accepted psychological principles applicable to specific cultural groups.
- b. A substantial clinical-anecdotal literature exists indicating the treatment's value with child trauma victims and/or their families from specific cultural groups.
- c. The treatment is generally accepted in clinical practice as appropriate for use with child trauma victims and/or their families from specific cultural groups.
- d. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- e. The treatment has a book, manual, or other available writings that specify the components of the treatment protocol and describe how to administer it.
- f. At least two studies utilizing some form of control without randomization (e.g., matched wait list, untreated group, placebo group) have established the treatment's efficacy over the passage of time; efficacy over placebo; or, found it to be comparable to or better than an already established treatment when used with child trauma victims and/or their families from specific cultural groups. The studies must have focused on the specific cultural group or must have enrolled a sufficiently large number of the target cultural group within their sample to evaluate differential efficacy for that cultural group.
- g. If multiple treatment outcome studies have been conducted, the overall weight of evidence supports the efficacy of the treatment.

## **Appendix C: Treatment Protocol Classification System**

### **3. Supported and Acceptable Treatment for Specific Cultural Groups**

- a. The treatment has a sound theoretical basis in generally accepted psychological principles applicable to specific cultural groups.
- b. A substantial clinical-anecdotal literature exists indicating the treatment's value with child trauma victims and/or their families from specific cultural groups.
- c. The treatment is generally accepted in clinical practice as appropriate for use with child trauma victims and/or their families from specific cultural groups.
- d. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- e. The treatment has a book, manual, or other available writings that specify the components of the treatment protocol and describe how to administer it.
- f1. At least one group study (controlled or uncontrolled), or a series of single subject studies suggest the efficacy of the treatment with child trauma victims and/or their families from specific cultural groups, OR
- f2. A treatment has demonstrated efficacy with non-trauma-related disorders, has a sound theoretical basis for its use with child trauma victims and/or their families from specific cultural groups, but has not been tested or used extensively with child trauma victims and/or their families from specific cultural groups.
- g. If multiple outcome studies have been conducted, the overall weight of evidence supports the efficacy of the treatment.

### **4. Promising and Acceptable Treatment for Specific Cultural Groups**

- a. The treatment has a sound theoretical basis in generally accepted psychological principles applicable to specific cultural groups.
- b. A substantial clinical-anecdotal literature exists indicating the treatment's value with child trauma victims and/or their families from specific cultural groups.
- c. The treatment is generally accepted in clinical practice as appropriate for use with child trauma victims and/or their families from specific cultural groups.
- d. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.

## **Exhibit 12**

# Dialectical Behavior Therapy Frequently Asked Questions

## What is Dialectical Behavior Therapy?

Dialectical Behavior Therapy (DBT) is a treatment designed specifically for individuals with self-harm behaviors, such as self-cutting, suicide thoughts, urges to suicide, and suicide attempts. Many clients with these behaviors meet criteria for a disorder called borderline personality (BPD). It is not unusual for individuals diagnosed with BPD to also struggle with other problems – depression, bipolar disorder, post-traumatic stress disorder (PTSD), anxiety, eating disorders, or alcohol and drug problems. DBT is a modification of cognitive behavioral therapy (CBT). In developing DBT, Marsha Linehan, Ph.D. (1993a) first tried applying standard CBT to people who engaged in self-injury, made suicide attempts, and struggled with out-of-control emotions. When CBT did not work as well as she thought it would, Dr. Linehan and her research team added other types of techniques until they developed a treatment that worked better. We'll go into more detail about these techniques below, but it's important to note that DBT is an "empirically-supported treatment." That means it has been researched in clinical trials, just as new medications should be researched to determine whether or not they work better than a placebo (sugar pill). While the research on DBT was conducted initially with women who were diagnosed with BPD, DBT is now being used for women who binge-eat, teenagers who are depressed and suicidal, and older clients who become depressed again and again.

## Why do people engage in self-destructive behavior?

A key assumption in DBT is that self-destructive behaviors are learned coping techniques for unbearably intense and negative emotions. Negative emotions like shame, guilt, sadness, fear, and anger are a normal part of life. However, it seems that some people are particularly inclined to have very intense and frequent negative emotions. Sometimes, the human brain is simply "hard-wired" to experience stronger emotions, just like an expensive stereo is "hard-wired" to produce very complex sounds. Or, it could be that severe emotional or physical trauma causes changes in the brain to make it more vulnerable to intense feeling states. Additionally, sometimes clients have mood disorders – Major Depression or Generalized Anxiety -- that are not controlled by standard medications and thus lead to emotional suffering. Any one of these factors, or any combination of them, can lead to a problem called **emotional vulnerability**. A person who is emotionally vulnerable tends to have quick, intense, and difficult-to-control emotional reactions that make his or her life seem like a rollercoaster.

Extreme emotional vulnerability is rarely the sole cause of psychological problems. An **invalidating environment** is also a major contributing factor. What is an invalidating environment? The "environment," in this case, is usually other people. "Invalidating" refers to a failure to treat a person in a manner that conveys attention, respect, and understanding. Examples of an invalidating environment can range from mismatched personalities of children and parents (e.g., a shy child growing up in a family of extraverts who tease her about her shyness); to extremes of physical or emotional abuse. In DBT, we think that borderline personality disorder arises from the **transaction** between emotional vulnerability and the invalidating environment.

Back to the example of a shy child: If a shy child is teased by his siblings or forced to go into social situations he wants to avoid, he may learn to have tantrums to let others realize that he's scared. If his shyness is only taken seriously when he has an outburst, he learns (without being conscious of it) that tantrums work. He has not been "validated." In this case, forms of validation could have included telling the person that being shy is normal for some people, teaching him that shy people have to work harder to overcome social anxiety, or helping him learn skills for managing shyness so it does not interfere with his life.

This is a relatively benign example. Some individuals, however, grow up in situations where they are abused or neglected. They may learn more extreme ways of getting other people to take them seriously. Further, because they are in painful circumstances, they may learn to cope with emotional pain by thinking about suicide, cutting themselves, restricting their food intake, or using drugs and alcohol. A vicious cycle can get started: The person is really sad and scared, she has no one who listens to her, she is afraid to ask for help or knows no help is available, and so she tries to kill herself. Then, when her pain is treated seriously at the hospital, she learns (without being conscious of it) that when she's suicidal, other people understand how badly she feels. Repeated self-injury can result if it is seen as the only means for getting better or achieving understanding from other people.

### **What kind of therapy do clients receive in DBT?**

Clients in standard DBT\* receive three main modes of treatment – individual therapy, skills group, and phone coaching. In individual therapy, clients receive once weekly individual sessions that are typically an hour to an hour-and-a-half in length. Clients also must attend a two-hour weekly skills group for at least one year. Unlike with regular group psychotherapy, these skills groups emerge as classes during which clients learn four sets of important skills – Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and Distress Tolerance. Clients are also asked to call their individual therapists for skills coaching prior to hurting themselves. The therapist then walks them through alternatives to self-harm or suicidal behaviors.

It should be noted that in standard DBT, it is the individual therapist who is “in charge” of the treatment. This means it is the individual therapist’s job to coordinate the treatment with the other people – skills group leaders, psychiatrists, and vocational counselors. In collaboration with the client, the therapist keeps track of how the treatment is going, how things are going with everyone involved in the treatment, and whether or not the treatment is helping the client reach his or her goals.

In some situations, DBT clients may also be on medications for problems like major depression bipolar disorder, are transient (short-term) psychotic episodes.

### **What are the top targets and goals of treatment in DBT?**

The most important of the overall goals in DBT is helping clients create “lives worth living.” What makes a life worth living varies from client to client. For some clients, a life worth living is getting married and having kids. For others, it’s finishing school and finding a life partner. Others might find it’s joining a religious or spiritual group and buying a house near a place of worship. While all these goals will differ, all clients have in common the task of bringing problem behaviors, especially behaviors that could result in death, under control. For this reason, DBT organizes treatment into four stages with targets. Targets refer to the problems being addressed at any given time in therapy. Here are the four stages with targeted behaviors in DBT:

#### ***Stage 1: Moving from Being Out of Control of One's Behavior to Being in Control***

Target 1: Reduce and then eliminate life-threatening behaviors (e.g., suicide attempts, suicidal thinking, intentional self-harm).

Target 2: Reduce and then eliminate behaviors that interfere with treatment (e.g., behavior that “burns out” people who try to help, sporadic completion of homework assignments, non-attendance of sessions, non-collaboration with therapists, etc.). This target includes reducing and then eliminating the use of hospitalization as a way to handle crises.

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\* “Standard” refers to outpatient DBT as it is researched and developed at Dr. Linehan’s research lab.

Target 3: Decreasing behaviors that destroy the quality of life (e.g., depression, phobias, eating disorders, non-attendance at work or school, neglect of medical problems, lack of money, substandard housing, lack of friends, etc.) and increasing behaviors that make a life worth living (e.g., going to school or having a satisfying job, having friends, having enough money to live on, living in a decent apartment, not feeling depressed and anxious all the time, etc.).

Target 4: Learn skills that help people do the following:

- a) Control their attention, so they stop worrying about the future or obsessing about the past. Also, increase awareness of the "present moment" so they learn more and more about what makes them feel good or feel bad.
- b) Start new relationships, improve current relationships, or end bad relationships.
- c) Understand what emotions are, how they function, and how to experience them in a way that is not overwhelming.
- d) Tolerate emotional pain without resorting to self-harm or self-destructive behaviors.

### ***Stage II. Moving from Being Emotionally Shut Down to Experiencing Emotions Fully***

The main target of this stage is to help clients experience feelings without having to shut down by dissociating, avoiding life, or having symptoms of post-traumatic stress disorder (PTSD). In DBT, we say that clients entering this stage are now in control of their behavior but are in "quiet desperation." Teaching someone to suffer in silence is not the goal of treatment. In this stage, the therapist works with the client to treat PTSD and/or teaches the client to experience all of his or her emotions without shutting the emotions down and letting the emotions take the driver's seat.

### ***Stage III. Building an Ordinary Life, Solving Ordinary Life Problems***

In Stage III, clients work on ordinary problems like marital or partner conflict, job dissatisfaction, career goals, etc. Some clients choose to continue with the same therapist to accomplish these goals. Some take a long break from therapy and work on these goals without a therapist. Some decide to take a break and then work with a different therapist in a different type of therapy.

### ***Stage IV. Moving from Incompleteness to Completeness/Connection***

Most people may struggle with "existential" problems despite having completed therapy at the end of stage III. Even if they have the lives they wanted, they may feel somewhat empty or incomplete. Some people refer to this as "spiritual dryness" or "an empty feeling inside." Although research on this stage is lacking, Marsha Linehan added it after realizing that many clients go on to seek meaning through spiritual paths, churches, synagogues, or temples. Clients would also change their career paths or relationships.

Although these stages of treatment and target priorities are presented in order of importance, we believe they are all interconnected. If someone kills herself, she won't get the help that she needs to change the quality of her life. Therefore, DBT focuses on life threatening behavior first. However, if the client is staying alive but is neither coming to therapy nor doing the things required in therapy, she won't get the help needed to solve non-life threatening problems like depression or substance abuse. For that reason, treatment-interfering behaviors are the second priority in stage I. But coming to treatment is certainly not enough. A client stays alive and comes to therapy in order to solve the other problems which are making her miserable. To truly have a life worth living, the client must learn new skills, learn to experience emotions, and accomplish ordinary life goals. Therapy is not finished until all of this is accomplished.

### **How is DBT different from regular Cognitive Behavioral Therapy?**

DBT is a modification of standard cognitive behavioral treatment. As briefly stated above, Marsha Linehan and her team of therapists used standard CBT techniques, such as skills training, homework assignments, symptom rating scales, and behavioral analysis in addressing clients' problems. While these worked for some people, others were put off by the constant focus on change. Clients felt the degree of their suffering was being underestimated, and that their therapists were overestimating how helpful they were being to their clients. As a result, clients dropped out of treatment, became very frustrated, shut down or all three. Linehan's research team, which videotaped all their sessions with clients, began to notice new strategies that helped clients tolerate their pain and worked to make a "life worth living." As acceptance strategies were added to the change strategies, clients felt their therapists understood them much better. They stayed in treatment instead of dropping out, felt better about their relationships with their therapists, and improved faster.

The balance between acceptance and change strategies in therapy formed the fundamental "dialectic" that resulted in the treatment's name. "Dialectic" means 'weighing and integrating contradictory facts or ideas with a view to resolving apparent contradictions.' In DBT, therapists and clients work hard to balance *change* with *acceptance*, two seemingly contradictory forces or strategies. Likewise, in life outside therapy, people struggle to have balanced actions, feelings, and thoughts. We work to integrate both passionate feelings and logical thoughts. We put effort into meeting our own needs and wants *while* meeting the needs and wants of others who are important to us. We struggle to have the right mix of work and play.

In DBT, there are treatment strategies that are specifically dialectical; these strategies help both the therapist and the client get "unstuck" from extreme positions or from emphasizing too much change or too much acceptance. These strategies keep the therapy in balance, moving back and forth between acceptance and change in a way that helps the client reach his or her ultimate goals as quickly as possible.

## **THE THREE FUNDAMENTALS OF DBT: CBT, ACCEPTANCE, AND DIALECTICS**

### **1) Cognitive Behavioral Therapy**

CBT and DBT therapists do not think that clients can be helped through insightful discussions, although insight can be helpful at times. *Learning new behaviors* is critical in DBT and is a focus in every individual session, skills group or phone call (for coaching). "Behavior" refers to anything a person thinks, feels, or does. Cognitive behavioral therapy uses a wide variety of techniques to help people change behaviors that inhibit a "life worth living." In DBT, as in CBT, clients are asked to change. Clients track and record their problem behaviors with a weekly diary card. They also attend skills groups, complete homework assignments and role-play new ways of interacting with people when in session with their therapist. In addition, clients work with their therapist to identify how they are rewarded for maladaptive behavior or punished for adaptive behavior. They expose themselves to feelings, thoughts or situations that they feared and avoided, and they change self-destructive ways of thinking. What we have just described in layman's terms are the four main change strategies: Skills Training, Exposure Therapy, Cognitive Therapy, and Contingency Management.

A great book on one main technique in behavior therapy – contingency management – is Karen Pryor's *Don't Shoot the Dog* (Bantam Books). Karen Pryor is a dolphin trainer who opened Hawaii's first ocean park. The principles an animal behaviorist like Pryor uses to teach animals are the same principles we can use with ourselves to change ourselves and make our relationships better. Karen Pryor's book is fun, humane, and easy to understand. Contrary to popular belief, behavior therapy is not cold and technical. Rather, at its best, it is about learning to change while treating ourselves and each other with respect and kindness. If you read this book (and it can be read in an evening), you'll know a lot more about how one of the main strategies cognitive behavioral therapy works. You can also take a lot of the techniques and apply them to your life at home, work, or school.

### **, Validation (Acceptance)**

As we noted in the above paragraphs, cognitive behavioral therapy techniques were not enough to help clients who were suicidal and chronically self-harming in the context of Borderline Personality Disorder (BPD). It's not that the techniques were ineffective; it's just that as stand-alone interventions, they caused clients a great deal of distress. Clients found the pushing for change *invalidating*. In a simple example, it's as if therapists were saying to someone with severe burns on the soles of their feet, "just keep walking and your feet will get stronger... try not to think about the pain," though each step was excruciatingly painful, and the patient was depressed and had no experience with keeping her mind off severe pain.

Linehan and her research team discovered that when the therapist weaved an emphasis on validation with an equal emphasis on change, clients were more likely to be collaborative and less likely to become agitated and withdrawn. So what is validation? It means a number of things. One of the things it does not mean, necessarily, is agreement. For instance, a therapist could understand that a client abuses alcohol to overcome intensive social anxiety, and yet realize that when the client is drunk, he makes impulsive decisions that may lead to self-harm. The therapist could validate that: a) her behavior makes sense as the only way she's ever gotten her anxiety to go down; b) her parents always got drunk at parties; and c) sometimes when she's drunk and does something impulsive, the impulsive behavior can be "fun." In this case, the therapist can validate that the substance abuse makes sense, given the client's history and point of view. But the therapist does not have to agree that abusing alcohol is the best approach to solving the client's anxiety.

In DBT, there are several levels and types of validation. The most basic level is staying alert to the other person. This means being respectful to what she is saying, feeling, and doing. Other levels of validation involve helping the client regain confidence both by assuming that her behavior makes perfect sense (e.g. of course you're angry at the store manager because he tried to overcharge you and then lied about it) and by treating the other person as an equal (i.e., as opposed to treating her like a fragile mental patient).

In DBT, just as clients are taught to use cognitive behavioral strategies, they are also taught and encouraged to use validation. In treatment and in life, it is important to know what about ourselves we can change and what about ourselves we must accept (whether short term or the long term). For that reason, acceptance and validation skills are taught in the skills modules as well.

There are four skills modules all together - two emphasize change and two emphasize acceptance. For example, it is extremely important that clients who self-harm learn to accept the experience of pain instead of turning to self-destructive behavior to solve their problems. Likewise, clients who cut themselves, binge and purge, abuse alcohol and drugs, dissociate, etc., must learn to simply "be with" reality, as painful as it may be at any given moment, in order to learn that they "can stand it." DBT teaches a host of skills so that clients can learn to stand still instead of running away. DBT also teaches clients how to work to understand why their lives are so hard.

### **3) Dialectics**

"Dialectics" is a complex concept that has its roots in philosophy and science. We won't go into its background here but we will attempt to explain what we mean by dialectics and give examples of thinking dialectically.

"Dialectics" involves several assumptions about the nature of reality: 1) every thing is connected to everything else; 2) change is constant and inevitable; and 3) opposites can be integrated to form a closer approximation to the truth (which is always evolving). Here's a brief example about how these assumptions would come into play in a DBT program. Suppose you are silent in groups. The other group members are affected by your silence and they try to get you to talk. You affect them and they affect you. Perhaps the group pushes you so hard that you feel like quitting and you talk even less. Then the other members get tired of your silence and withdraw. Paradoxically, this makes you feel better and causes you to talk a bit more. As you become a true member of the group, the leaders shift the way they run the group in order to manage the tension between you and the other members. In other words, you are all interconnected, influencing each other in each moment.

As time passes in the group, there are inevitable changes. Perhaps the group becomes more skilled at getting you to talk. Perhaps you take some risks and talk more. Maybe a new member enters the group while an older

member of the community transitions out and the group struggles to adjust to the new arrangement. You also may become aware that your thoughts and feelings change throughout the group, as does every other group member's. You notice that the group is constantly evolving, constantly readjusting itself. Thinking dialectically means recognizing that all points of view—yours, the other members – have validity and yet all may also be wrong-headed at the same time. If the group is working together dialectically, the group leaders and the members are in constant flux, looking at how opposing points of view can be in play and yet be synthesized. In short, the group is always balancing change and acceptance. Throughout, the group leader and the members would try to hold on to the idea that everyone is doing the best he or she can AND that everyone has got to do better.

DBT also involves specific dialectical strategies to help clients get “unstuck” from rigid ways of thinking or viewing the world. Some of these are traditional Western therapy interventions and others draw on Eastern ways of viewing life. If you read Linehan's (1993a) text, you can read about these strategies in chapter seven and review the examples she gives. But here are two examples. Suppose a client makes a strong initial commitment to do a year's worth of DBT. Rather than simply saying “Hey, that's terrific!” the therapist would gently turn the tables on the client by asking, “Are you sure you want to? It's going to be very hard work.” This strategy, called “Devil's advocate,” causes the client to argue in favor of why and how she will complete the therapy and not drop out. In this case, the therapist guides the client to strengthen her (the client's) arguments for being accepted into treatment, rather than the therapist trying to convince her to stay. “Making Lemonade out of Lemons,” another strategy, also helps the clinician handle similarly tough situations. For instance, a client may complain that she absolutely hates her group therapist and wants to switch skills groups. The therapist might respond with an opposing suggestion: This can be seen as a learning opportunity in handling intense negative emotions towards authority. The therapist could then show the similarity between the client's group therapist and other persons of authority (teachers, bosses, supervisors), and demonstrate this as a chance to tolerate a person one can't stand but has to work with. As these examples illustrate, the point of all dialectical strategies is to provide movement, speed, and flow so that therapist and client do not become stuck in “I will not do that” vs. “Oh, yes you will!”

### **Suggested Reading**

Linehan, M.M. (1993a). Cognitive behavioral therapy for Borderline Personality Disorder. New York: Guilford Press. *This is the published treatment manual for the entire treatment. Many lay-people say this is a difficult read, though very helpful. For that reason, many start by reading the skills manual listed next.*

Linehan, M. M. (1993b). Skills Training Manual for Treating Borderline Personality Disorder. New York: Guilford Press. *This manual gives an excellent overview of DBT and the skills-training in the program.*

Pryor, K. (1993). Don't Shoot the Dog! New York: Bantam Doubleday Dell Pub. *This is a great introduction to principles of learning and behaviorism by a dolphin trainer. Her techniques apply to all of us.*

**Exhibit 13**

**New Employee Orientation**

<b>Times</b>	<b>Monday</b>	<b>Tuesday</b>	<b>Wednesday</b>	<b>Thursday</b>	<b>Friday</b>
8:00 - 9:00	<b>Welcome (H/CEO)</b> Organization Intro President's Message	<b>Clinical Philosophy (C)</b>	<b>Building Bridges Initiative (C)</b>	<b>Handle with Care (M)</b>	<b>Competency Review (H)</b> HR Paperwork Preparing for Day 1 Record of Signature Survey
9:00 - 10:00	<b>Employee Engagement (H)</b> Health Insurance Compensation	<b>Therapeutic Services (C)</b> Behavioral Management Video	<b>Clinical Program (C)</b> Admissions Client Rights/IC/AD Crisis Intervention Plan (Seven Challenges)		
	Break	Break	Break		Break
10:15 - 11:15	<b>Benefits (H)</b> Team Bonus	<b>Therapeutic Services</b> Suicide Prevention-Video Age & Cultural Diversity Common Disorders	<b>Clinical Program (M)</b> GEARS Resident Handbook		<b>Unit Specific Training</b>
11:15 - 12:00	<b>Customer Service (H)</b> Dress Code-Badge Community Partners Workforce Support				<b>Time Keeping</b>
12:00-1:00	Lunch	Lunch	Lunch	Lunch	Lunch
1:00-2:15	<b>Compliance (R)</b> Client Rights QAPI/EMTALA/HIPAA Employee Handbook Code of Conduct Sexual Harassment	<b>Therapeutic Milieu (M)</b> Tools to Develop a Milieu	<b>Clinical Program (C)</b> Therapeutic Boundaries	<b>Handle with Care</b> Verbal	<b>CPR/First Aid</b>
2:15-3:15	<b>Emergency Preparedness (E)</b> Safety/Security/OSHA SDS/PPE/Waste Emergency Codes/Fire Safety	<b>Safety (N/M/C)</b> Abuse & Neglect	<b>Health (N)</b> Health & Medication Extrapyramidal SE & TD Nutrition Allergies		
	Break	Break	Break		
3:30-4:30	<b>Environment of Care (E)</b> Tour facility	<b>Safety (N)</b> S/R Prevention Debriefing	<b>Employee Health (N)</b> Blood Borne Pathogens Infection Control		
4:30-5:00	Daily Competency	Daily Competency	Daily Competency	Daily Competency	Wrap-Up

Facilitator Codes: A-Admissions; C-Clinical; E-Environment of Care; H-Human Resources; M-Milieu; N-Nursing; R-Risk Management

**New Employee Orientation**

Times	Monday	Tuesday	Wednesday	Thursday	Friday
8:00 – 8:30	LABOR DAY	Morning Review	Morning Review	Morning Review	Morning Review
8:30 – 10:00	All Staff Behavioral Management Video Review Language	All Staff Scenarios “Do you smell smoke?”	All Staff Scenarios “I thought you did it?”	All Staff Scenarios “I thought you did it?”	Department Training
10:15 – 12:00	Break	Break	Break	Break	Break
12:00-1:00	All Staff Training Schedule Review	All Staff Training Town Hall	All Staff Training Town Hall	Department Training	Department Training
1:00-4:30	Hygiene & Meds Breakfast Town Hall	Wake-Up Hygiene & Meds Breakfast Town Hall	Dinner Psych-Ed Transportation	Lunch	Lunch
4:30-5:00	Lunch	Lunch	Lunch	Lunch	Lunch
	Education Community Group Lunch Process Group Snack Fitness Journaling	Education Community Group Lunch Process Group Snack Fitness Journaling	Visitation Phone Call Family Involvement Wrap-Up Hygiene Lights Out Night Shift	Wrap-Up	Wrap-Up
	Wrap-Up	Wrap-Up	Wrap-Up	Wrap-Up	Wrap-Up

Facilitator Codes: A-Admissions; C-Clinical; E-Environment of Care; H-Human Resources; M-Milieu; N-Nursing; R-Risk Management

New Employ Orientation

Times	Thursday	Friday
8:00 – 8:30	Morning Review	Morning Review
8:30 - 10:00	All Staff Scenarios "I thought you did it?"	Nursing Department Training Chart Review Logs Notes
	Break	Break
10:15 – 12:00	Nursing Department Training Admissions Process	Incident Reports Assessment
12:00-1:00	Lunch	Lunch
1:00-4:30	Medication	Discharge Process
4:30-5:00	Wrap-Up	Wrap-Up

New Employ Orientation

Times	Thursday	Friday
8:00 – 8:30	Morning Review	Morning Review
8:30 - 10:00	<p>All Staff Scenarios "I thought you did it?"</p>	Milieu Department Training Review
	Break	Break
10:15 – 12:00	<p>Milieu Department Training Activity Groups</p> <p>Monitoring: Gym, Outside, Classroom, Halls, Appointments, Visits, Calls Transportation Visitation</p>	<p>Environment set-up for residents Staff work schedule Walkie-Talkie Use &amp; Maintenance Bin Room Contraband Band Laundry</p>
12:00-1:00	Lunch	Lunch
1:00-4:30	<p>Transitions Room Search: Daily &amp; Random Shift Report 15 Minute Checks Levels of Observation</p>	<p>Waste Basket Quiet Areas Safe Rooms Personal Belongings at discharge Room preparation</p>
4:30-5:00	Wrap-Up	Wrap-Up

New Employ Orientation

Times	Thursday	Friday
8:00 – 8:30	Morning Review	Morning Review
8:30 - 10:00	All Staff Scenarios "I thought you did it?"	Therapy Department Training Groups: Process, Psycho-Ed, Individual
10:15 – 12:00	Therapy Department Training Therapist Manual	Break Family sessions
12:00-1:00	Lunch	Lunch
1:00- 4:30	Therapist Manual	Discharge Planning
4:30-5:00	Wrap-Up	Wrap-Up

## **SBH Training Curriculum**

Training of direct care staff is focused on understanding who we serve and how our program is developed to meet our clients' needs. Our therapeutic program consists of Evidence Based Treatments that are trauma-informed, strength based, and family-driven, youth guided practices to support positive outcomes. The new hire orientation is a two week indoctrination with the first week focused on safety and principles of care with the second week consisting of ongoing education and job shadowing with an experienced staff members. As a result, all SBH staff are required to complete clinical competencies prior to providing patient care.

### **Clinical Philosophy**

- Explanation of Evidence Based Treatments
- Stages of Change
- Trauma Informed Care approach
- Clinical Outcomes

### **Therapeutic Milieu**

- Therapeutic Milieu focus on safety, structure, and education
- WhyTry? Resilience Education
- GEARS: Verbal De-Escalation initiative
- Stages of Change education

### **Evidence-based Programs Training**

- Six Core Strategies to Prevent Conflict and Violence: Reducing the Use of Seclusion and Restraint (Trauma Informed Care)
- Seeking Safety (Trauma Informed Care)
- Trauma Focused Cognitive Behavioral Therapy (TF-CBT: Trauma Informed Care)
- Illness Management & Recovery Model
- Seven Challenges
- Cognitive Behavioral Therapy for Late Life Depression

### **Suicide Prevention**

- Reviewing high risk populations
- Importance of continuity of care
- Contraband prevention

### **Abuse & Neglect**

- Education on client rights
- Prevention of abuse and neglect

### **Therapeutic Boundaries**

- Education on client and staff boundaries
- Countertransference training

### Handle with Care

- Nationally recognized crisis intervention provided by Certified Trainers.

The Evidence Based Treatment called **WhyTry** is a multimedia curriculum for children to learn resiliency to overcome personal obstacles. Your family or caregiver is also expected to participate in treatment which will include family therapy, visitation, family education group and special program functions.

**Exhibit 14**

**STRATEGIC BEHAVIORAL HEALTH, LLC  
AND SUBSIDIARIES**  
Memphis, Tennessee

**Consolidated Financial Statements –  
Modified Cash Basis**  
Years Ended December 31, 2013 and 2012

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## **INDEPENDENT AUDITOR'S REPORT**

Members  
Strategic Behavioral Health, LLC  
Memphis, Tennessee

### **Report on the Financial Statements**

We have audited the accompanying consolidated financial statements of Strategic Behavioral Health, LLC and Subsidiaries (the "Company"), which comprise the consolidated statements of assets, liabilities and members' equity on a modified cash basis as of December 31, 2013 and 2012, and the consolidated statements of revenue and expenses, changes in members' equity and cash flows on a modified cash basis for the years then ended, and the related notes to the consolidated financial statements.

### **Management's Responsibility for the Consolidated Financial Statements**

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with the modified cash basis of accounting described in Note 1; this includes determining that the modified cash basis of accounting is an acceptable basis for the preparation of the consolidated financial statements in the circumstances. Management is also responsible for the design, implementation and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

### **Auditor's Responsibility**

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk

assessments, the auditor considers internal control relevant to the Company's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

### **Opinion**

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the assets, liabilities and members' equity of the Company as of December 31, 2013 and 2012, and its revenues and expenses, changes in members' equity and cash flows for the years then ended in accordance with the modified cash basis of accounting described in Note 1.

### **Basis of Accounting**

We draw attention to Note 1 of the consolidated financial statements, which describes the basis of accounting. The consolidated financial statements are prepared on the modified cash basis of accounting, which is a basis of accounting other than accounting principles generally accepted in the United States of America. Our opinions are not modified with respect to this matter.



Memphis, Tennessee  
May 22, 2014

**STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES**  
Consolidated Statements of Assets, Liabilities and Members' Equity -  
Modified Cash Basis  
December 31, 2013 and 2012

	2013	2012
<b>ASSETS</b>		
Current assets		
Cash and cash equivalents	\$ 2,271,076	\$ 2,820,508
Patient accounts receivable, net of allowance for doubtful accounts of \$2,544,167 at 2013 and \$915,540 at 2012	13,593,272	8,195,262
Due from third-party payors	215,868	-
Inventories	86,741	67,931
Prepaid expenses	1,221,325	741,435
Total current assets	<u>17,388,282</u>	<u>11,825,136</u>
Property and equipment	73,426,065	48,843,897
Less accumulated depreciation	(4,331,553)	(2,181,981)
Property and equipment, net	<u>69,094,512</u>	<u>46,661,916</u>
Goodwill	45,326,774	28,616,112
Other assets, net	1,470,620	1,080,521
Total other assets	<u>46,797,394</u>	<u>29,696,633</u>
Total assets	<u>\$ 133,280,188</u>	<u>\$ 88,183,685</u>
<b>LIABILITIES AND MEMBERS' EQUITY</b>		
Current liabilities		
Current maturities of long-term debt	\$ 3,072,422	\$ 1,703,039
Accounts payable	3,294,809	923,373
Accrued expenses	4,694,081	2,963,365
Due to third-party payors	-	308,918
Accrued distributions to members	155,942	439,396
Total current liabilities	<u>11,217,254</u>	<u>6,338,091</u>
Long-term debt, less current maturities	<u>65,527,959</u>	<u>40,739,559</u>
Total liabilities	<u>76,745,213</u>	<u>47,077,650</u>
Members' equity		
Members' contributions	45,915,034	36,915,034
Note receivable for members' contributions	(161,878)	(71,616)
Retained earnings	10,781,819	4,262,617
Total members' equity	<u>56,534,975</u>	<u>41,106,035</u>
Total liabilities and members' equity	<u>\$ 133,280,188</u>	<u>\$ 88,183,685</u>

See accompanying notes.

**STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES**  
Consolidated Statements of Revenues and Expenses -  
Modified Cash Basis  
Years Ended December 31, 2013 and 2012

	2013	2012
<b>Revenues</b>		
Patient service revenue (net of contractual allowances and discounts)	\$ 84,341,797	\$ 50,630,683
Provision for bad debts	(3,849,410)	(748,305)
Net patient service revenue, less provisions for bad debts	80,492,387	49,882,378
<b>Expenses</b>		
Salaries and benefits	47,238,842	28,084,047
Professional fees	6,129,697	3,204,772
Supplies	4,669,356	2,632,128
Management and incentive fees	754,517	1,030,560
Depreciation and amortization	2,169,598	1,211,918
Rent	967,683	880,575
Utilities	1,264,783	900,441
Insurance	618,143	409,614
Interest	2,693,906	1,604,292
Property tax	547,463	269,646
Travel	949,598	618,461
Acquisition costs	619,877	51,263
Other expenses	2,903,656	1,752,063
Total expenses	71,527,119	42,649,780
Excess of revenues over expenses - modified cash basis	\$ 8,965,268	\$ 7,232,598

See accompanying notes.

**STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES**  
**Consolidated Statements of Changes in Members' Equity -**  
**Modified Cash Basis**  
**Years Ended December 31, 2013 and 2012**

	Members' Contributions	Note Receivable for Members' Contributions	Retained Earnings (Deficits)	Total
Balance, January 1, 2012	\$ 31,915,034	\$ (76,616)	\$ (684,519)	\$ 31,153,899
Excess of revenues over expenses - modified cash basis	-	-	7,232,598	7,232,598
Contributions	5,000,000	-	-	5,000,000
Payment on note receivable from member	-	5,000	-	5,000
Distributions to members	-	-	(2,285,462)	(2,285,462)
Balance, December 31, 2012	36,915,034	(71,616)	4,262,617	41,106,035
Excess of revenues over expenses - modified cash basis	-	-	8,965,268	8,965,268
Contributions	9,000,000	-	-	9,000,000
Issuance of note receivable from members	-	(103,185)	-	(103,185)
Payment on note receivable from members	-	12,923	-	12,923
Distributions to members	-	-	(2,446,066)	(2,446,066)
Balance, December 31, 2013	<u>\$ 45,915,034</u>	<u>\$ (161,878)</u>	<u>\$ 10,781,819</u>	<u>\$ 56,534,975</u>

See accompanying notes.

**STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES**

Consolidated Statements of Cash Flows -

Modified Cash Basis

Years Ended December 31, 2013 and 2012

	2013	2012
Cash flows from operating activities		
Excess of revenues over expenses - modified cash basis	\$ 8,965,268	\$ 7,232,598
Adjustments to reconcile excess of revenues over expenses (modified cash basis) to net cash provided by operating activities		
Depreciation and amortization	2,169,598	1,211,918
Amortization of debt issue costs	203,496	97,775
Provision for bad debts	3,849,410	748,305
Change in assets and liabilities		
Patient accounts receivable	(6,857,732)	(4,073,999)
Due from third-party payors	(524,786)	(308,918)
Inventories	1,859	3,263
Prepaid expenses	(455,713)	(138,945)
Other assets	(109,971)	-
Accounts payable	2,286,127	(216,607)
Accrued expenses	1,442,932	1,785,559
Net cash provided by operating activities	<u>10,970,488</u>	<u>6,340,949</u>
Cash flows from investing activities		
Acquisitions of property and equipment	(18,613,606)	(16,611,128)
Acquisition of SBH-El Paso, LLC	(24,764,177)	-
Reduction of acquisition price	-	195,501
Net cash used by investing activities	<u>(43,377,783)</u>	<u>(16,415,627)</u>
Cash flows from financing activities		
Debt proceeds received	77,030,626	7,915,203
Repayment of long-term debt	(50,872,843)	(1,334,616)
Cash contributions from members	8,896,815	5,000,000
Payments of debt issuance costs	(482,874)	(416,810)
Proceeds received on members' note receivable for contributions	12,923	5,000
Cash distributions to members	(2,726,784)	(2,377,177)
Net cash provided by financing activities	<u>31,857,863</u>	<u>8,791,600</u>
Net decrease in cash and cash equivalents	(549,432)	(1,283,078)
Cash and cash equivalents, beginning of year	<u>2,820,508</u>	<u>4,103,586</u>
Cash and cash equivalents, end of year	<u>\$ 2,271,076</u>	<u>\$ 2,820,508</u>
Supplemental disclosure of cash flow information		
Cash paid during the year for interest	<u>\$ 2,706,591</u>	<u>\$ 1,782,976</u>
Supplemental disclosure of non-cash investing and financing activities		
Accrued distributions to members	<u>\$ 155,942</u>	<u>\$ 439,396</u>
Purchase of members' contribution by issuance of note receivable	<u>\$ 103,185</u>	<u>\$ -</u>

See accompanying notes.

## STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES

Years Ended December 31, 2013 and 2012

### NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

#### **Note 1. Nature of Business and Significant Accounting Policies**

##### Nature of Business

Strategic Behavioral Health and its subsidiaries (collectively "SBH" or the "Company") provide a variety of services for individuals with psychiatric disorders, including emotional and behavioral disorders. Services provided include but are not limited to therapy, education, nursing and medical services, treatment planning, social skills training and substance abuse counseling.

Strategic Behavioral Health's wholly-owned subsidiaries are as follows:

SBH Wilmington, LLC ("Wilmington") is a 72 bed psychiatric residential treatment facility ("PRTF") and 20 bed acute psychiatric hospital located in Leland, North Carolina. The Hospital is uniquely designed to serve the needs of adolescents ages 12-17 with emotional and behavioral disorders such as ADHD, PTSD, depression, mood, anxiety and oppositional behavioral disorders.

SBH Colorado, LLC ("Peak View") d/b/a Peak View Behavioral Health is a 92 bed acute geriatric psychiatric hospital located in Colorado Springs, Colorado that treats adolescents, adults and seniors with psychiatric disorders.

SBH Raleigh, LLC ("Raleigh") is a 72 bed psychiatric residential and 20 bed acute psychiatric hospital located in Garner, North Carolina. The Hospital is uniquely designed to serve the needs of children and adolescents with emotional and behavioral disorders such as ADHD, PTSD, depression, mood, anxiety and oppositional behavioral disorders.

SBH-Red Rock, LLC ("Red Rock") was formed in 2011 for the purpose of acquiring substantially all the net assets of Red Rock Behavioral Health Hospital in Las Vegas, Nevada. Red Rock Behavioral Health Hospital is a 21 bed acute short-term hospital designed to diagnose and treat the complex mental health and substance abuse problems of people ages 50 and over. The acquisition was completed on January 1, 2012.

SBH-Montevista, LLC ("Montevista") was formed in 2011 for the purpose of acquiring substantially all the net assets of Montevista Hospital in Las Vegas, Nevada. Montevista Hospital is an 90 bed acute psychiatric and chemical dependency hospital providing a full continuum of care for all ages. The land and buildings of Montevista Hospital were acquired on December 30, 2011. The acquisition was completed on January 1, 2012.

SBH Charlotte, LLC ("Charlotte") is a 60 bed psychiatric residential facility in Charlotte, North Carolina, which was opened in the third quarter of 2013. The facility is specifically designed to serve the needs of children/adolescents ages 12-17 with emotional and psychiatric disorders.

SBH El Paso, LLC ("El Paso"), d/b/a Peak Behavioral Health Services, was formed in 2013 for the purpose of acquiring substantially all the net assets of Peak Behavioral Health Services

**STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES**  
Years Ended December 31, 2013 and 2012

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS**

**Note 1. Continued**

in Santa Teresa, New Mexico. El Paso is a 119 bed psychiatric hospital and residential treatment center specializing in the treatment of children, adolescents, and adults with psychiatric and chemical dependency needs. The acquisition was completed in May 2013.

SBH-College Station, LLC ("College Station") was formed in 2012 and is in the process of building a hospital in College Station, Texas to operate a 72 bed acute psychiatric facility. The Hospital will be specifically designed to serve the needs of children and adults with emotional and psychiatric disorders. The facility was opened in April 2014.

SBH-North Denver, LLC ("Denver"), d/b/a Clear View Behavioral Health was formed in 2013 for the purpose of acquiring land and constructing a new hospital in Denver, Colorado.

SBH-Kingsport, LLC ("Kingsport"), was formed in 2013 for the purpose of acquiring or constructing a hospital in Kingsport, Tennessee. Kingsport has filed for a certificate of need and is awaiting the final determination.

SBH-Mobile, LLC ("Mobile") was formed in 2013 for the purpose of obtaining a certificate of need to operate a psychiatric facility in Mobile, Alabama. The certificate of need was denied and accordingly all related costs were expensed.

The Company's significant accounting policies are summarized below:

**Accounting Policy**

The Company's policy is to prepare its consolidated financial statements on a modified cash basis of accounting. Except as described below, the Company records amounts due from patients and third-party payors at the time services are rendered and costs and expenses associated with providing services as they are incurred. If an expenditure results in the acquisition of an asset having an estimated useful life which extends substantially beyond the year of acquisition, the expenditure is capitalized and depreciated or amortized over the estimated useful life of the asset. Due to the uncertainty regarding the realization of certain enhanced revenue payments received from governmental payors, these payments are recorded as revenues when the cash is received without considering the potential uncertainties pertaining to any subsequent review by the governmental payors. Additionally, the Company has entered into interest rate swap agreements (see Note 3) with a third party, which are recorded on an accrual basis whereby cash flows are included in interest expense during the period. However, the interest swap agreement is not recorded at fair value at the end of each period as required by accounting principles generally accepted in the United States of America.

**Principles of Consolidation**

The accompanying consolidated financial statements include SBH and its wholly-owned subsidiaries. All significant intercompany accounts and transactions have been eliminated in the consolidation.

**STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES**  
Years Ended December 31, 2013 and 2012

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS**

**Note 1. Continued**

Use of Estimates

The preparation of consolidated financial statements in accordance with the modified cash basis of accounting requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenue and expenses during the reporting period.

Actual results could differ from those estimates. The amounts recorded as revenues from certain governmental payors are subject to future reviews that could result in refunds of the amounts previously received. Should any refunds of these amounts occur, they will be presented as a reduction of net revenues in the period that the amounts are refunded.

Cash and Cash Equivalents

For purposes of reporting cash flows, SBH considers all cash accounts and all highly liquid debt instruments with an original maturity of three months or less to be cash equivalents.

Accounts Receivable, Net

SBH reports patient accounts receivable at net realizable value after deduction of allowances for doubtful accounts. Management determines the allowance for doubtful accounts based on historical losses, aging of accounts and current economic and regulatory conditions. On a continuing basis, management analyzes delinquent receivables and, once these receivables are determined to be uncollectible, they are written off through a charge against an existing allowance account or against earnings. For receivables associated with services provided to patients who have third-party coverage, SBH analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts predominately based on the aging of accounts, if necessary. For receivables associated with self-pay patients (which includes both patients without insurances and patients with deductible and copayment balances due for which third-party coverage exists for the part of the bill), SBH records a provision for bad debts based on the age of the accounts. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

The Company's allowance for doubtful accounts was 16 percent and 10 percent of patient accounts receivable at December 31, 2013 and 2012, respectively. The Company has not changed its charity care policies related to discounts for certain uninsured patients during fiscal years 2013 or 2012.

## STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES

Years Ended December 31, 2013 and 2012

### NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

#### Note 1. Continued

##### Inventories

Inventories consist primarily of pharmaceutical supplies and are stated at the lower of cost using the first-in, first-out method, or market.

##### Prepaid Expenses

Prepaid expenses are amortized over the period of benefit using the straight-line method.

##### Property and Equipment

Property and equipment is stated at cost. Depreciation is computed using the straight-line method over the useful lives of the assets. Assets under capital leases are recorded at the present value of the future minimum rentals at the lease inception and are amortized over the shorter of the lease term or the useful life of the related asset. Amortization of assets under capital lease obligations is included in depreciation and amortization expense.

##### Debt Issue Costs

Debt issue costs, which include underwriting, legal and other direct costs related to the issuance of debt, are capitalized and amortized to interest expense over the contractual term of the debt using the effective interest method.

##### Long-Lived Assets

Long-lived assets, such as property and equipment, are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable from the estimated future cash flows expected. The Company will recognize an impairment loss when the carrying amount of a long-lived asset is not expected to be recoverable from its undiscounted cash flows. Such a charge is measured by the amount by which the carrying amount exceeds the estimated fair value of the asset. No such impairment losses have been recognized during 2013 or 2012.

##### Goodwill

The Company's goodwill was recorded as a result of the Company's business combinations. The Company has recorded these business combinations using the acquisition method of accounting. In 2013, the Company recorded the purchase of SBH-El Paso, which resulted in an addition of \$16,710,662 to previously existing goodwill. During 2012, the Company recorded the acquisitions of SBH-Red Rock and SBH-Montevista which resulted in \$ 28,616,112 of goodwill. The Company tests its recorded goodwill for impairment on an annual basis, or more often if indicators of potential impairment exist. The Company first assesses qualitative factors to determine whether the existence of events or circumstances leads to a determination that it is more likely than not that the fair value of a reporting unit is less than its carrying amount. If,

# STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES

Years Ended December 31, 2013 and 2012

## NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS

### Note 1. Continued

after assessing the totality of events or circumstances, the Company determines it is not more-likely-than-not that the fair value of a reporting unit is less than its carrying amount, then performing the two-step impairment test is unnecessary. Because it was determined that it was not more-likely-than-not that impairment existed, the two-step impairment test was not performed and no impairment loss was recognized during the years ended December 31, 2013 and 2012. Changes to goodwill for 2013 and 2012 are outlined below.

	Balance at 1/1	Additions to Goodwill	Balance at 12/31
2013	\$ 28,616,112	\$ 16,710,662	\$ 45,326,774
2012	\$ -	\$ 28,616,112	\$ 28,616,112

### Compensated Absences

SBH employees are granted both vacation and sick leave. Accumulated vacation pay is accrued at the balance sheet date because the employees' right to receive the compensation for the future absences is vested. Sick leave accrues but does not vest; therefore, it is not considered a liability.

### Net Revenues

Other than certain enhanced revenue payments received from governmental payors, net revenues are reported at the estimated net realizable amounts from patients, third-party payors and others for services rendered. A summary of the basis of reimbursement with major third-party payors follows:

#### Medicare

Medicare reimbursement generally is based on the Inpatient Psychiatric Facility Prospective Payment System ("IPF PPS"). Under this methodology, the facility is paid on the basis of a Federal per diem base rate, limited by a specific target amount per discharge, and adjusted annually for such factors as wage index, DRG assignment, rural location and other facility-level adjustments. These annual adjustments are subject to frequent changes and could impact future reimbursement. In addition to the per diem rate, the IPF PPS provides additional payment policies for outlier cases, stop-loss protection, Electroconvulsive Therapy ("ECT") treatments and interrupted stays.

#### Medicaid

Services rendered to Medicaid beneficiaries are generally reimbursed on a per-diem rate set by each state's division of Medicaid.

**STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES**  
Years Ended December 31, 2013 and 2012

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS**

**Note 1. Continued**

Other

SBH has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to SBH under these agreements includes prospectively determined rates per discharge, discounts from established charges and prospectively determined daily rates.

The laws and regulations under which the Medicare and Medicaid programs operate are complex and subject to interpretation and frequent changes. As a part of operating under these programs, there is a possibility that government authorities may review SBH's compliance under these laws and regulations. Such reviews may result in adjustments to program reimbursement previously received and subject SBH to fines and penalties. Although no assurance can be given, management believes that it has complied with the requirements of these programs. Due to the uncertainty regarding the realization of certain enhanced payments received from governmental payors, these payments are recorded as revenues when the cash is received. As of December 31, 2013, cost reports for fiscal years 2010 and forward have not been settled.

Charity Care

SBH provides medical care without charge or at a reduced charge to patients that meet certain criteria. Because SBH does not pursue collection of amounts determined to qualify as charity, these charges are not reported as revenue.

Advertising Costs

Advertising costs are charged to operations as incurred. For the years ended December 31, 2013 and 2012, advertising costs totaled approximately \$305,000 and \$206,000, respectively.

Income Taxes

SBH files a consolidated federal income tax return with its subsidiaries. SBH is structured as a limited liability company and therefore does not incur federal income taxes. The federal taxable earnings are reported by and taxed to the members of SBH individually. SBH also files composite tax returns in several states and makes payments for state income taxes to each of those states on behalf of its members. The state payments are reflected as distributions to members on the accompanying consolidated financial statements. The Company is subject to excise taxes on earnings allocated to the State of Tennessee. The amount of Tennessee excise tax is not considered material and accordingly no deferred or current income taxes are reflected in the accompanying consolidated financial statements.

In accordance with ASC Topic 740, the Company determines if there are any uncertain income tax positions that should be recognized in the Company's financial statements based on tax positions it has taken or is expected to take on a tax return including the entity's status as a pass-through entity. SBH had no significant uncertain tax positions at December 31, 2013 and 2012.

**STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES**  
Years Ended December 31, 2013 and 2012

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS**

**Note 1. Continued**

If interest and penalties are incurred related to uncertain tax positions, such amounts are recognized in income tax expense. Tax periods for all fiscal years 2010 and after remain open to examination by the federal and state taxing jurisdictions to which the Company is subject.

**Reclassifications**

Certain reclassifications have been made in the 2012 consolidated financial statements to conform with the 2013 presentation. There was no impact in members' equity or changes in members' equity, as previously reported.

**Note 2. Long-Term Debt**

Long-term debt consists of the following at December 31:

	2013	2012
<b>Credit Facility</b> (See below)		
Term Loan	\$ 55,670,000	\$ -
Construction Loan	6,126,709	-
Revolver Loan	6,800,000	-
Total Credit Facility	68,596,709	-
<b>Other Debt</b>		
Term loan requiring monthly escalating payments ranging from \$21,600 to 29,100 with final balloon payment due on June 30, 2017 (refinanced with Credit Facility)	-	5,386,722
Term loan agreements requiring interest only payments until June 2013 (refinanced with Credit Facility)	-	12,197,190
Term loan requiring monthly escalating payments ranging from \$88,000 to \$108,000 with final balloon payment due on June 30, 2017 (refinanced with Credit Facility)	-	21,444,000
Construction loan of up to \$7.5 million requiring interest only payments until November 2013 (refinanced with Credit Facility)	-	1,400,000

**STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES**  
Years Ended December 31, 2013 and 2012

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS**

**Note 2. Continued**

	<b>2013</b>	<b>2012</b>
<b>Other Debt - continued</b>		
Revolving loan credit loan of up to \$7 million requiring interest only payments with all outstanding principal due on November 30, 2015 (refinanced with Credit Facility)	\$ -	\$ 2,000,000
Capital lease obligation	3,672	14,686
Total long-term debt	68,600,381	42,442,598
Less current maturities	3,072,422	1,703,039
Long-term debt, less current maturities	<u>\$ 65,527,959</u>	<u>40,739,559</u>

In May 2013, the Company entered into an \$80 million Credit Facility (the "Credit Facility") with a syndicated group of lenders with a maturity date of May 2018. The Credit Facility consists of an initial Term Loan of \$57 million, a Construction Loan (the "Construction Loan") of up to \$7.5 million and a Revolving Line of Credit (the "Revolver Loan") of up to \$15.5 million. The purpose of the Credit Facility was to fund the El Paso acquisition, as well as to refinance substantially all existing debt. The terms of the Credit Facility are as follows:

<b>Monthly Principal Payments</b>	<b>Term Loan</b>	<b>Construction Loan</b>	<b>Total</b>
From January 31, 2014 through December 31, 2016	\$ 237,500	\$ -	\$ 237,500
From June 30, 2014 through December 31, 2016	\$ -	\$ 31,250	\$ 31,250
From January 31, 2017 through April 30, 2018	\$ 285,000	\$ 37,500	\$ 322,500
Final payment May 20, 2018	\$ 42,560,000	\$ 4,557,959	\$ 47,117,959

The Revolver Loan requires monthly interest only payments through maturity with all principal due at the maturity date of May 20, 2018.

The interest rates on all the loans under the Credit Facility are based on the Funded Debt to EBITDA Ratio as follows:

<b>Funded Debt to EBITDA Ratio</b>	<b>Spread</b>
Less than 2.50	30-Day LIBOR + 275 basis points
Greater than 2.50 but less 3.50	30-Day LIBOR + 300 basis points
Greater than or equal to 3.50	30-Day LIBOR + 350 basis points

**STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES**  
Years Ended December 31, 2013 and 2012

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS**

**Note 2. Continued**

The interest rate at December 31, 2013 was at 3.75 percent.

The previous debt outstanding at December 31, 2012 required interest on the loans at a variable rate equal to the 30-Day LIBOR plus a certain amount of basis points beginning at 350 (3.114 percent at December 31, 2012).

The Credit Facility is secured by substantially all of the assets of the Company.

The terms of the Credit Facility described above requires certain affirmative and negative debt covenants including the maintenance of a minimum fixed charge coverage ratio and a maximum funded debt to EBITDA ratio. At December 31, 2013 and 2012, SBH was in compliance with all required covenants.

The maturities of long-term debt are as follows:

<b>Year Ending December 31,</b>	<b>Amount</b>
2014	\$ 3,072,422
2015	3,225,000
2016	3,225,000
2017	3,870,000
2018	55,207,959
Total	<u>\$ 68,600,381</u>

**Note 3. Interest Rate Swaps**

The Company has entered into various interest rate swap agreements to manage interest costs and risks associated with changes in interest rates. These agreements effectively convert underlying variable-rate debt based on the 30-Day LIBOR to fixed-rate debt through the exchange of fixed and floating interest payment obligations without the exchange of underlying principal amounts.

At December 1, 2013 and 2012, the following interest rate swap agreements were in effect:

	<b>Description</b>		<b>Notional Value</b>	<b>Maturity</b>	<b>Pay Index</b>	<b>Receive Index</b>	<b>Fair Value</b>
<b><u>Swap 1</u></b>							
December 31, 2013	Fixed payer	\$	5,069,966	June 2017	4.29%	30-Day LIBOR	\$ (530,785)
December 31, 2012	Fixed payer		5,354,366	June 2017	4.29%	30-Day LIBOR	(782,553)
<b><u>Swap 2</u></b>							
December 31, 2013	Fixed payer		20,340,000	June 2017	1.06%	30-Day LIBOR	(67,942)
December 31, 2012	Fixed payer		21,444,000	June 2017	1.06%	30-Day LIBOR	(382,300)

**STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES**  
Years Ended December 31, 2013 and 2012

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS**

**Note 3. Continued**

	Description	Notional Value	Maturity	Pay Index	Receive Index	Fair Value
<b><u>Swap 3</u></b>						
December 31, 2013	Fixed payer	\$ 6,362,000	June 2017	.87%	30-Day LIBOR	\$ 19,585
<b><u>Swap 4</u></b>						
December 31, 2013	Fixed payer	5,581,500	June 2017	.87%	30-Day LIBOR	17,162
<b><u>Swap 5</u></b>						
December 31, 2013	Fixed payer	19,931,973	June 2017	.90%	30-Day LIBOR	7,790
<b><u>Swap 6</u></b>						
December 31, 2013	Fixed payer	45,410,000	May 2018	2.96%	30-Day LIBOR	59,507
					Fair value 2013	\$ (494,683)
					Fair value 2012	\$ (1,164,853)

Swap 6 is a forward interest rate swap that becomes effective on July 1, 2017.

As a result of the interest rate swap agreements, interest expense increased by \$343,003 and \$388,381 in relation to the required debt service for the years ended December 31, 2013 and 2012, respectively.

**Note 4. Property and Equipment**

A summary of property and equipment follows:

	<b>December 31,</b>	
	<b>2013</b>	<b>2012</b>
Land and improvements	\$ 8,739,753	\$ 7,046,476
Building and improvements	45,839,068	36,139,060
Fixed and major moveable equipment	7,124,183	4,489,785
	61,703,004	47,675,321
Less accumulated depreciation and amortization	(4,331,553)	(2,181,981)
	57,371,451	45,493,340
Construction in progress	11,723,061	1,168,576
Property and equipment, net	<u>\$ 69,094,512</u>	<u>\$ 46,661,916</u>

Depreciation expense related to these assets for the years ended December 31, 2013 and 2012 amounted to \$2,169,598 and \$1,211,918, respectively. The amount of interest capitalized by the Company was \$223,277 and \$276,459 for the years ended December 31, 2013 and 2012, respectively.

At December 31, 2013, the Company had outstanding construction commitments related to construction in progress of \$8,152,606.

**STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES**  
Years Ended December 31, 2013 and 2012

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS**

**Note 5. Other Assets**

Other assets at December 31, 2013 and 2012 consisted of the following:

	<b>2013</b>	<b>2012</b>
Debt issue costs, net of accumulated amortization of \$313,677 and \$110,181 at December 31, 2013 and 2012, respectively	\$ 1,229,820	\$ 950,442
Other	32,557	-
Deposits	208,243	130,079
	\$ 1,470,620	\$ 1,080,521

**Note 6. Leases**

SBH leases certain property and equipment from third parties and related parties under long-term operating leases. Total rental expense for all operating leases for the years ended December 31, 2013 and 2012 was \$967,683 and \$880,575, respectively. Minimum future rental payments under non-cancelable operating leases having remaining terms in excess of one year as of December 31, 2013 are as follows:

<b>Year Ending December 31,</b>	<b>Amount</b>
2014	\$ 601,885
2015	618,165
2016	481,709
2017	186,367
2018	188,434
Thereafter	111,625
Total	\$ 2,188,185

**Note 7. Patient Accounts Receivable and Net Patient Service Revenue**

**Patient Accounts Receivable, Net**

SBH grants credit without collateral to its patients. The percentage mix of receivables from patients and third-party payors is as follows:

	<b>December 31,</b>	
	<b>2013</b>	<b>2012</b>
Medicare	20%	32%
Medicaid	39	20
Commercial	35	41
Self Pay	6	7
Total	100%	100%

**STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES**  
Years Ended December 31, 2013 and 2012

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS**

**Note 7. Continued**

A summary of the activity in the allowance for doubtful accounts for 2013 and 2012 is as follows:

	<b>Balance at Beginning of Year</b>	<b>Additions to Allowance</b>	<b>Accounts Written Off, Net of Recoveries</b>	<b>Balance End of Year</b>
Allowance for doubtful accounts year ended December 31, 2013	\$ 915,540	\$ 3,849,410	\$ (2,220,783)	\$ 2,544,167

	<b>Balance at Beginning of Year</b>	<b>Additions to Allowance</b>	<b>Accounts Written Off, Net of Recoveries</b>	<b>Balance End of Year</b>
Allowance for doubtful accounts year ended December 31, 2012	\$ 264,197	\$ 748,305	\$ (96,962)	\$ 915,540

A summary of net revenue, net of the provision for bad debts, for patient services rendered for the years ended December 31, 2013 and 2012 is as follows:

	<b>2013</b>		<b>2012</b>	
	<b>Amount</b>	<b>Percentage</b>	<b>Amount</b>	<b>Percentage</b>
Medicare	\$ 15,839,812	20%	\$ 13,402,841	27%
Medicaid	29,150,783	36%	15,748,639	32%
Commercial	33,034,894	41%	17,126,526	34%
Self Pay	788,139	1%	383,151	1%
Other	1,678,759	2%	3,221,221	6%
	<b>\$ 80,492,387</b>	<b>100%</b>	<b>\$ 49,882,378</b>	<b>100%</b>

Patient service revenue, net of contractual allowances and discounts (but before the provision for bad debts), recognized in the period from these major payor sources, is as follows:

	<b>Year Ended December 31, 2013</b>		
	<b>Third-Party Payors</b>	<b>Self-pay</b>	<b>Total All Payors</b>
Patient service revenue (net of contractual allowances and discounts)	\$ 83,515,967	\$ 825,830	\$ 84,341,797

**STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES**  
Years Ended December 31, 2013 and 2012

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS**

**Note 7. Continued**

	Year Ended December 31, 2012		
	Third-Party Payors	Self-pay	Total All Payors
Patient service revenue (net of contractual allowances and discounts)	\$ 50,241,784	\$ 388,899	\$ 50,630,683

**Note 8. Charity Care**

The Company maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone for services and supplies furnished under its charity care policy. The direct and indirect cost, which includes all operating expenses excluding the provision for bad debts, associated with these services cannot be identified to specific charity care patients. Therefore, management estimated the costs of these services by calculating a ratio of cost to gross charges and multiplying that ratio by the gross charges associated with providing care to charity patients. The estimated direct and indirect cost incurred is approximately \$485,000 and \$739,000 for the years ended December 31, 2013 and 2012, respectively.

**Note 9. Insurance Programs**

SBH purchases professional and general liability insurance to cover medical malpractice claims. Management believes that any claims would be substantially covered under its insurance program and would not have a significant effect on the consolidated financial statements. Nevertheless, the future assertion of claims for occurrences prior to year-end is possible and may occur, although not anticipated.

**Note 10. Related Party Transactions**

Dobbs Management Service, LLC ("Dobbs") is a related party entity due to common ownership by certain members of SBH. SBH's business formation agreement requires a base management fee to Dobbs in an amount not to exceed \$5,000 per month. Management fees incurred to Dobbs were \$60,000 for each of the years ended December 31, 2013 and 2012.

The business formation agreement also requires that guaranteed payments be made to two of SBH's members. For the years ended December 31, 2013 and 2012, the amounts of guaranteed payments totaled \$418,636 and \$383,375, respectively, and are included in salaries and benefits on the accompanying consolidated financial statements.

**STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES**  
Years Ended December 31, 2013 and 2012

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS**

**Note 10. Continued**

Additionally, the business formation agreement requires that an incentive fee equal to 2 and 5 percent of net income be paid to both a member of SBH and Dobbs, respectively. The incentive fees for the years ended December 31, 2013 and 2012 were \$754,517 and \$709,176, respectively. Accrued incentive fees at December 31, 2013 and 2012 were \$58,868 and \$58,505, respectively.

SBH has declared certain distributions payable to its members as of December 31, 2013 and 2012 related to income tax distributions. Total accrued distributions to members as of December 31, 2013 and 2012 were \$155,942 and \$439,396, respectively.

The Company allows members from time to time to transact equity transactions in the form of secured promissory notes. At December 31, 2013 and 2012 outstanding amounts receivable from members were \$161,878 and \$76,616, respectively. Interest is charged at a variable rate with the principal to be paid at dates in the future. The Company received \$12,923 and \$5,000 of principal payments related to the notes receivable during 2013 and 2012, respectively. Note receivable balances due from members are presented as a component of members' equity on the accompanying consolidated financial statements.

The Company purchases property, casualty, and malpractice insurance coverage from a company which is owned by Dobbs. During 2013 and 2012, the Company paid insurance premiums of approximately \$1,500,000 and \$985,000, respectively to this party.

**Note 11. Employee Benefits**

SBH participates in a multi-employer defined contribution 401(k) plan sponsored by Dobbs for its eligible employees. Contributions by the Company to the plan for the years ended December 31, 2013 and 2012 were \$249,221 and \$139,399, respectively.

SBH also provides health insurance benefits to its eligible employees. Health insurance benefits provided were \$2,972,148 and \$1,834,556 for the years ended December 31, 2013 and 2012, respectively.

**Note 12. Risks and Uncertainties**

SBH is involved in litigation in the normal course of business. Management is of the opinion that likelihood of any financial impact to SBH would be minimal and would be covered by insurance.

The amounts of certain enhanced revenues received from certain governmental payors are subject to future reviews that could result in refunds of the amounts previously received. Should any refunds of these amounts occur, they will be presented as a reduction of net revenues in the period that the amounts are refunded.

SBH maintains cash deposits that are in excess of FDIC insurance limits. The Company has not experienced any losses as a result of this concentration.

**STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES**  
Years Ended December 31, 2013 and 2012

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS**

**Note 13. Acquisition**

On May 19, 2013, the Company entered into an asset purchase agreement with Universal Health Services, Inc. ("UHS") for the purchase of substantially all of the net assets and assumption of certain liabilities of Peak Behavioral Hospital. The Company's acquisition was based on management's belief that the Santa Teresa, New Mexico location is complementary to the Company's existing business and provides a base for further growth. The total original purchase price was \$24,000,000.

The Company's acquisition was recorded by allocating the cost of the acquisition to the assets acquired, including intangible assets, and liabilities assumed based on their estimated fair values at the acquisition date. The excess of the cost of the acquisitions over the net amounts assigned to the fair value of the assets acquired, net of liabilities assumed, was recorded as goodwill. The following table summarizes the valuation:

<b>Assets</b>	
Accounts receivable	\$ 2,389,688
Inventory	20,669
Prepaid expenses and other assets	24,927
Property and equipment	5,988,588
Goodwill	16,710,662
	25,134,534
<b>Liabilities</b>	
Accounts payable	85,309
Accrued expenses	285,048
	370,357
Net assets acquired	\$ 24,764,177

The difference between the original consideration paid of \$24,000,000 and assets acquired of \$24,764,177 is \$764,177 and represents a subsequent working capital adjustment paid to UHS.

On December 30, 2011, the Company entered into an asset purchase agreement with Universal Health Services, Inc. ("UHS") for the purchase of substantially all of the net assets of Montevista Hospital and Red Rock Behavioral Health Hospital. This transaction was not completed until January 1, 2012. The Company's acquisition was based on management's belief that the Las Vegas locations are very complementary to the Company's existing business and provides a base for further growth. The total original purchase price was \$43,944,726. As of December 31, 2011, the consideration was remitted by the Company in the form of cash to UHS in the amount \$21,444,726 with the additional consideration of \$22,500,000 provided to UHS from the proceeds of new debt with a financial institution.

**STRATEGIC BEHAVIORAL HEALTH, LLC AND SUBSIDIARIES**

Years Ended December 31, 2013 and 2012

**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS – MODIFIED CASH BASIS****Note 13. Continued**

The Company's acquisition was recorded by allocating the cost of the acquisition to the assets acquired, including intangible assets and liabilities assumed based on their estimated fair values at the acquisition date. The excess of the cost of the acquisitions over the net amounts assigned to the fair value of the assets acquired, net of liabilities assumed, was recorded as goodwill. The following table summarizes the valuation:

<b>Assets</b>	
Accounts receivable	\$ 3,200,647
Inventory	45,056
Prepaid expenses	277,864
Property and equipment	12,406,541
Goodwill	28,616,112
Deposits	37,692
Total assets	<u>44,583,912</u>
<b>Liabilities</b>	
Accounts payable	209,874
Accrued expenses	579,183
Capital lease obligation	45,630
Total liabilities	<u>834,687</u>
Net assets acquired	<u>\$ 43,749,225</u>

The difference between the original consideration paid of \$43,944,726 and net assets acquired of \$43,749,225 is \$195,501 and represents a subsequent working capital adjustment received from UHS to the final purchase price.

During 2013 and 2012, the Company recorded expenses of approximately \$620,000 and \$51,000, respectively, related to costs incurred in this and other potential acquisitions. The acquisition costs were primarily related to legal and professional fees and other costs incurred in performing due diligence.

**Note 14. Subsequent Events**

SBH has evaluated, for consideration of recognition or disclosure, subsequent events that have occurred through May 22, 2014, the date the consolidated financial statements were available to be issued and has determined that no significant events have occurred subsequent to December 31, 2013 but prior to May 22, 2014 that would have a material impact on its consolidated financial statements.

## Exhibit 15

Tycaesis Johnson  
1101 30th St., N.W. 4th Floor  
Washington, DC 20007

Dear Ty:

This letter of intent ("Letter of Intent") documents the present intentions of Strategic Behavioral Health, LLC ("Parent") and you ("Seller") with respect to some of the major terms of the proposed purchase by one or more affiliates of Parent (collectively "Buyer") of all of the membership interests of Seasons Residential Treatment Program, LLC, a Maryland limited liability company (the "Company").

#### **PART I - NON-BINDING PROVISIONS**

1. Type of Transaction. Pursuant to a definitive agreement or agreements to be prepared by Buyer (the "Definitive Agreement"), the transaction will be structured as a sale by Seller (and its affiliates) to Buyer of good and marketable title to all of the issued and outstanding membership interests of the Company (the "Membership Interests"). The Definitive Agreement will set forth the purchase price, and the representations, warranties, and other terms customary in this type of transaction (including, without limitation, contingencies for all necessary regulatory approvals), all of which must be acceptable to both parties in their sole discretion.

#### **PART II - BINDING PROVISIONS**

1. Access to Information; Due Diligence; Governmental Consents. Pending the execution of the Definitive Agreement or the earlier termination of this Letter of Intent, Seller will permit Buyer and its representatives full and complete access to inspect and appraise the Membership Interests, the Company and its business prospects, and will disclose and make available to representatives of Buyer all books, agreements, papers and records relating to the ownership of the Membership Interests and operation of the Company.

2. No Violation. Parent has prepared and delivered this Letter of Intent in reliance on Seller's representation that it is not currently bound under any binding or enforceable contract or agreement with any third party concerning a transaction with respect to the Membership Interests. Seller represents and warrants that this Letter of Intent, and the transactions contemplated hereby, will not violate any contract, agreement or commitment currently binding on Seller.

3. Confidentiality; Disclosure. The Second Development Agreement between Parent and Seller dated as of November 1, 2014, including the non-disclosure covenants contained therein, shall remain in effect and are not modified by this Letter of Intent.

4. Expenses. Each party shall bear its own expenses in connection with the implementation of this Letter of Intent, regardless of whether the Definitive Agreement is executed.

5. Transactions Other than in the Ordinary Course. Unless and until the Definitive Agreement has been duly executed and delivered by Buyer and Seller or this Letter of Intent has been terminated, Seller shall notify Buyer, in advance, of any conduct relating to the Company or the Membership Interests outside of the ordinary course of business and of any extraordinary transactions involving the Company or the Membership Interests.

6. Termination of Letter of Intent. Either party in its sole discretion may terminate this Letter of Intent at any time upon written notice to the other party. Upon termination of this Letter of Intent, the parties shall have no further obligations hereunder, except that the provisions of this Part II shall survive such termination.

7. Governing Law; Counterparts. This Letter of Intent shall be governed by Tennessee law, without regard for provisions relating to conflicts of law. This Letter of Intent may be executed in any number of counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one and the same instrument.

8. Non-Binding Letter of Intent. The parties agree that, except as set forth in Part II hereof, this Letter of Intent will not be binding upon Parent, Buyer or Seller, but will serve only to evidence the parties' present intentions with respect to a possible transaction, and as the authorization to Buyer to complete due diligence and to have Buyer's attorneys prepare the Definitive Agreement and other related transaction documents in keeping with the proposed terms set forth herein. Due to the complexity of the proposed transaction, it is the expressed intention of the parties, that except for the provisions of this Part II, no binding contractual agreement shall exist between them unless and until Parent (or Buyer) and Seller shall have executed the Definitive Agreement. Except as provided in this Part II, there shall be no liability between the parties as a result of the execution of this Letter of Intent or any action taken in reliance on this Letter of Intent or the termination thereof.

9. Entire Agreement; Amendment. Part II of this Letter of Intent contains the entire agreement and understanding between Parent, Buyer and Seller and no prior representations, promises, agreements or understandings, written or oral, not contained in this Part II shall be of any force or effect. Part II of this Letter of Intent may not be amended except by a writing executed by Parent and Seller.

***END OF PART II, BINDING PROVISIONS***

\* \* \*

If Part I accurately reflects your present intentions with respect to a possible transaction, and you agree with the terms set forth in Part II above, please sign this Letter of Intent in the space provided below and return one executed copy to Parent, whereupon we will proceed promptly with our evaluation and review of the Membership Interests and the Company's business prospects and with the preparation and negotiation of the Definitive Agreement. Please be advised that this proposal shall expire unless a fully executed copy of this letter has been delivered to Parent no later than 5:00 p.m., Central time, on December \_\_, 2014.

We look forward to a successful and mutually rewarding relationship in respect of the transactions set forth herein.

Sincerely,

Strategic Behavioral Healthcare, LLC

By:  \_\_\_\_\_

Title: President

THE FOREGOING IS APPROVED:

THIS 14 DAY OF DECEMBER 2014

 \_\_\_\_\_  
BY: AEISIS JOHNSON