EXHIBIT 25

Sheppard Pratt Health System Treatment Protocols

General Adult Unit Protocol

Admission:

1. very acute patients from ER/CWIC, many with recent suicide attempts or active psychosis; age range from late teens to late 60's
2. need for careful screening of safety & management of acute symptoms + not infrequent need for suicidal precautions or even 1:1 monitoring
3. meds need to start immediately – both prn's and continuance and initiation therapies
4. families are often a part of the admission process & need rapid education
5. most frequent diagnoses are major depression, bipolar disorder, PTSD, personality disorders, mixed mood/psychotic disorders usually have large percentage of pts who have never been in treatment previously

Course of stay:

1. immediate contact with OP providers
2. high volume/rapid turnover
3. focus on stabilization of symptoms, close monitoring of safety needs, psycho-education, daily assessment for lower level of care
4. chief modality for groups is CBT, with our SW providing cycle of 3 groups per week & the Activity Therapist following a similar format
5. high percentage of pts start or are referred for ECT
6. SW's maintain nearly daily contact with families & almost always have family meeting to focus on aftercare needs
7. trend has been for more medically compromised pts/more DOM referrals/more new medical diagnoses (hypertension, thyroid illness, diabetes, high lipids, etc.)
8. frequent need for diagnostic tests (MRI, CT, EEG)
9. reliance on tx team for rounds, so patient has access to MD, SW, PCC daily & treatment approach is consistent
10. usually have large numbers of visitors each night

Discharge:

1. needs follow-up appointments within 7 days; often need bridge appointments at SP
2. increased difficulty finding providers who accept commercial insurance
3. families have to feel comfortable with discharge arrangements & often have short meeting with SW & patient on day of discharge; if not, the SW will call before d/c
4. liberal use of PHP or IOP
5. since families are often working, most discharges don't occur until afternoon or eve.
6. PCC has been spending increased time assisting pts in setting up aftercare appointments for PCP's and specialists
7. sometimes, scripts are faxed to pharmacies to address possible compliance issue
8. discharge coordinator is key to successful discharge, especially since some discharges are done on short notice

Special considerations:

High percentage of patients have commercial insurance or Medicare
Population as a whole has involved families and more community resources
Often have high percentage of professionals on the unit (e.g., MD's, nurses, lawyers, teachers, etc.)
Seeing more people with habitual cannabis use, as well as people who have become psychotic after using cannabis
Majority of pts use tobacco products
Usually have 5-6 groups per day

Geriatric Unit Protocol

1. Purpose of the unit: This unit treats patients with dementing illnesses such as Alzheimer's disease who are experiencing behavioral and psychiatric symptoms (e.g., aggressiveness; paranoia) that cannot be safely treated at a less intensive level of care.
2. Referral sources: Generally patients are referred from local emergency rooms after medical and psychiatric evaluations.
3. Admission processes:
    a. Nursing performs a psychogeriatric nursing assessment focusing on general health status, fall risk, functional status (including level of cognitive functioning), and suicide risk. Based on this assessment, the severity of the dementia is determined and the patient is assigned a "GEM" level. Nursing also completes the Geriatric Neuropsychiatric Clinical Indicators Scale (GNCIS) to document the psychiatric, behavioral, verbal, and somatic symptoms that will be targeted during the hospitalization.
    b. A thorough physical examination, including a neurological examination, is performed.
    c. The attending psychiatrist conducts a psychiatric interview and reviews the results of the nursing assessment, the physical examination, and the evaluation performed in the emergency room.
    d. Additional laboratory testing is ordered, if necessary,
    e. Based on all these data, the cause of the dementia is determined (e.g., Alzheimer's disease, Parkinson's disease, fronto-temporal dementia, etc.).
    f. The social worker contacts family or other informants to obtain a detailed social history and to begin planning for discharge. Prompt attention to discharge is particularly vital if the patient will need to go to an Assisted Living Facility or a Nursing Home.
4. Treatment planning
    a. The behavioral and psychiatric symptoms documented in the GNCIS are identified, and a patient-specific behavior plan is devised. This plan takes into account the severity of the dementia (i.e., the GEM level).
    b. Medical conditions are treated appropriately with the assistance of the consulting internist.
    c. Psychotropic medications are ordered if needed to ameliorate the behavioral and psychiatric symptoms that are the focus of treatment (e.g., antidepressants for depression; antipsychotic medications for psychosis).
    d. The unit social worker documents the initial approach to discharge planning, including, if appropriate, facilities to which the patient might be discharged.
    e. A comprehensive treatment plan containing these findings, diagnoses, and interventions is documented.

5. Treatment course
    a. Vital signs are obtained every shift, and fall risk assessments are performed daily
    b. The severity and frequency of behavioral and psychiatric symptoms of dementia are documented every shift using the GNCIS.
    c. Based on the observations documented in the GNCIS and elsewhere in the medical record, the behavior plan is modified.
    d. Based on the observations documented in the GNCIS and elsewhere, as well as medical monitoring data (e.g., vital signs), the psychopharmacological regimen is modified.
    e. The social worker is in regular contact with the family and assists them in finding a facility (e.g., ALF, NH) if needed.
6. Discharge
    a. When the behavioral and psychiatric symptoms prompting admission have improved sufficiently, the patient will be deemed ready for discharge.
    b. By this time, the social worker and family will have arrived at a discharge plan.
    c. A discharge summary is prepared describing
        i. the behavior plan that was found to be helpful and
        ii. the rationale for the medication regimen that was prescribed
    d. The discharge summary is transmitted to the facility and/or physician that will provide follow-up care.
    e. Prescriptions are given for all medications.
    f. The patient is discharged.

Adolescent Unit Protocol

Admission:

1. Admissions come from ER/CWIC, age ranges from 12-18. Patients are admitted because they are a danger to themselves and/or others.
2. Admission assessments are completed by unit nurses and physicians. Patients are evaluated for level of safety and lethality of symptoms. Substance abuse history is also assessed at this point. Nurses and physicians will also communicate with family to better understand situation.
3. Current psychotropic medication use is assessed.
4. Social Workers complete a more thorough assessment of family dynamics, past history and school situation. This is done by contact with the parents and patient.
5. Physician will place patient on a level (SO 1:1, SO, BO) depending on patients symptomology. This will dictate how the patient is monitored.
6. Frequent diagnosis include major depression, bipolar, substance induced psychosis and ADHD.
7. We have a mix of patients who have had frequent admissions to Sheppard Pratt or another local inpatient psychiatric hospital. We do have a subset population who has had multiple re-admissions to Sheppard Pratt.

Course of Stay:

1. Focus is on stabilization. Social workers will have family therapy to identify areas of need. The physician works with the patient and family to initiate or adjust psychotropic medications.
2. Nursing staff is monitoring for safety during hospitalization. This is done through completing rounds, assessing individual patients each shift and continuous monitoring of patients.
3. Physicians are meeting with patients daily.
4. Psychoeducational groups are being conducted throughout the day by nursing staff, art therapists and music therapists.
5. Treatment team is conducted daily. The treatment team discusses each patient individually to plan and implement treatment. The social worker will typically have contact with each family to discuss course of treatment.
6. The Diagnostic and Prescriptive Teacher will make contact with the patients school to assess any school needs.

Discharge:

1. The discharge coordinator is contacting outpatient providers to ensure transition of care. This contact is typically made in the early stages of the admission. As the discharge date gets closer, and outpatient appointment is made for the patient. If PHP is needed, the discharge coordinator will arrange.
2. Social workers are working with families and patients to develop a “safety plan”. This is a specific plan to manage any dangerous behavior after discharge.

3. A nurse meets with every family before discharge to review discharge plans, outpatient appointments and reviews medications.

Special Considerations:

It can be a challenge finding appropriate out of home placements.

Parents will often times have their own psychiatric issues. Often times the social workers will have to either make referrals or encourage parents to get the help they need.

There is a percentage of the parents who will not visit or make contact with their child during the hospitalization, making it difficult to address family dynamics.

TREATMENT PROTOCOL, YOUNG ADULT UNIT

The Young Adult Unit in Towson, the prototype for the proposed unit in Elkridge, is a co-ed inpatient psychiatric unit designed to serve patients between the ages of 18 to 29, who are in need of acute psychiatric stabilization. Common presenting diagnoses include Major Depressive Disorder, Bipolar Disorder, Anxiety Disorders, as well as first episodes of psychotic symptoms. Concurrent conditions such as substance use disorders, PTSD, and eating disorders, are also prevalent and are identified over the course of the admission, and consultations from our specialty services are provided when appropriate.

For many of our patients and families, this may be the first psychiatric hospitalization, or even their first psychiatric contact, and as such, providing education regarding diagnosis, treatment options, and prognosis is a major focus of the hospitalization. Having a cohort of peers in a similar age range is an important strategy, in that patients can relate better to each other's experiences and that it can often keep them from being overwhelmed, as may be the case on a larger generalized unit. For this age range in particular, as our patients are making the transition to adulthood, hospitalization occurs at a 'critical window' and our goal is to provide a safe and therapeutic environment in which they can stabilize and mobilize for their future.

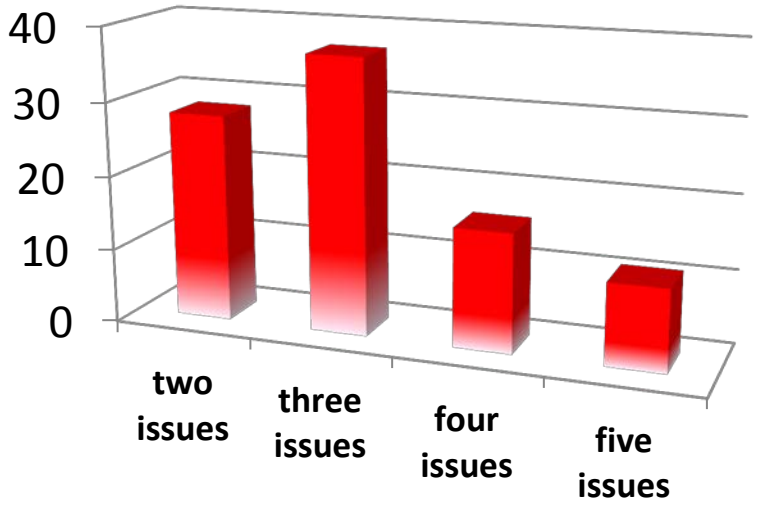
Significant attention is focused early in the admission to involve family members in order to clarify presenting symptoms for diagnosis, and then to start the treatment planning process, which includes arranging aftercare, coordinating with the patient's outpatient team, and creating a safety/crisis plan for discharge. While on the unit, patients work with a multidisciplinary team including an attending physician, nurse, and social worker, and also work with an occupational therapist and a team of mental health workers. Patients meet daily with a psychiatrist for medication management and assessment. Groups focus on illness education, medication management, and working to develop healthy coping skills. Some of the specific challenges this population may face includes navigating interpersonal relationships, the social media landscape, as well as individualized academic and occupational issues.

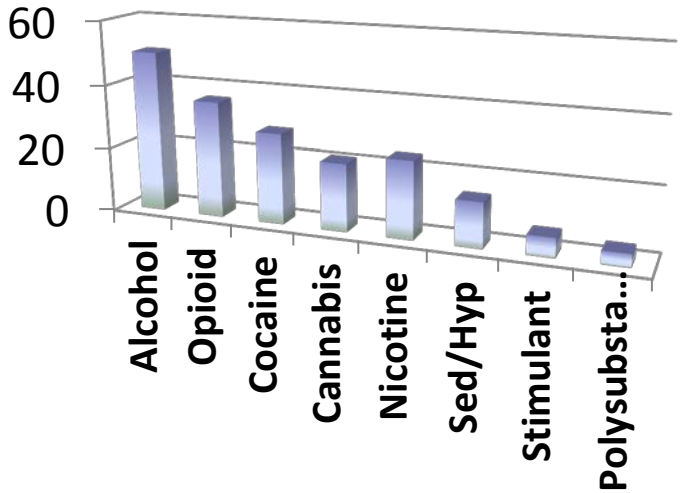
Additional treatment protocols on this unit include incorporating DBT groups, as well as developing additional multimedia or web-based approaches to psychoeducation, to which patients in this age range may respond particularly well.

TREATMENT PROTOCOL FOR TREATMENT OF PATIENTS SUFFERING FROM CO-OCCURRING DISORDERS

MODAL PATIENT- Patient suffering from an unstable psychiatric condition or have a psychiatric crisis that co-occurs with an unstable substance use disorder or addictive disorder, or something that occurs in the context of an active substance use or addiction issue

EXAMPLES – Patient suffering from a mood disorder, anxiety disorder, psychotic disorder, and trauma-based disorder along with alcohol, opioid, cocaine use disorder. It is not atypical for patients to have more than two co-occurring disorders. Hence the conditions are called Co-occurring disorders (formerly known as Dual Disorders).





FREQUENCY OF SPECIFIC ADDICTION DIAGNOSES IN A SAMPLE OF HUNDRED PATIENTS

GOALS OF TREATMENT- It is a short length of stay unit (with an average Length of stay of 7-8 days) with a comprehensive list of needs that patients and referrers bring to us for our attention and expertise. For every patient we offer the following options.

- Detailed multidisciplinary assessment of co-occurring conditions and clarification of diagnosis
- Creation of a treatment plan (includes both psychopharmacological and psychotherapeutic options. It also comments on appropriate aftercare programs that a patient might be referred to)
- Restoration of Safety and Functioning
- Stabilization of the psychiatric condition
- Detoxification from substance(s) of Dependence (such as alcohol or opioids)
- Monitoring of sleep, Activities of Daily Living, Interpersonal functioning, nutrition and we offer assistance when required
- Connecting and collaborating with or creating an aftercare plan and referral to an aftercare locus of treatment in order to ensure ongoing support for recovery
- Introduction to the 12-step philosophy
- Introduction to coping skills (such as basics of CBT, DBT)
- Psychoeducation
- Ensuring a greater degree of self-reliance and empowerment as treatment progresses
- Relapse Prevention strategies and tools
- Family Engagement and Education
- Assistance with transition to next level of care (help with transportation, prescriptions, communication with employers)
- Referrals to community resources
- Activities (such as art) that might aide recovery or coping skills
- Diagnosis and short-term management of acute or chronic medical conditions
- Some consultations (trauma, eating disorders, forensic, pharmacy) if needed

DIAGNOSIS- It is important for us to try and tease out the directionality and causality of these disorders as much as possible within a short length of stay duration.

DETOXIFICATION – We detoxify these complex psychiatrically unstable and at times very agitated patients from alcohol, opioids, benzodiazepines using appropriate psychopharmacological therapies to ensure safety, comfort and a quick onset of engagement into their journey to recovery.

TREATMENT PHILOSOPHY- We offer an integrated treatment philosophy where the same professional team is able to offer assistance with both psychiatric and addiction needs in the midst of an unstable crisis.

Typical Course of Treatment
for the Psychotic Disorder Programs at Sheppard Pratt (including Fenton Unit)

Patients admitted to the Psychotic Disorders Programs are typically severely ill, with a major mental illness such as Schizophrenia, Schizoaffective Disorder or Bipolar I Disorder. They often have other comorbidities such as Substance Use Disorders and one or more serious medical diagnoses such as insulin dependent diabetes, hypertension, osteoarthritis, etc. They typically have some cognitive deficits. Major psychosocial stresses are also frequent, including homelessness, poverty, social isolation and inability to access basic entitlements due to gross disorganization in the patient's life. Finally, many such patients have already been involved significantly in the criminal justice system, often with active charges pending and/or a parole or probation officer or forensic program.

The treatment approach for such patients is therefore comprehensive, even if still crisis oriented. Addressing the acute crisis without also understanding the patient's total situation leads to rapid decompensation post discharge, creating the "revolving door" patient who is in and out of hospitals, sometimes more than 20x a year.

Patients are assessed by an MD, RN and SW in the first 24 hours and DSM-5 diagnoses and medical diagnoses are verified, based on examination of the patient and labs and other medical tests as indicated. Social Work gets extensive history from the family, significant other, and/or outpatient residential and rehabilitations care providers or programs, including Assertive Community Treatment Teams. Psychiatrists contact the outpatient prescriber and sometimes the medical doctor, too. An initial plan of treatment is recommended to the patient at the end of the first day, and Master Treatment Plan is fully developed by day 5. During these early days, the patient may be very disturbed, often violent or homicidal, requiring close nursing observation in a locked setting for the protection of the patient and others. Patients are often admitted as "certified" because they refused to sign voluntary agreements after being brought to the ER by police on an Emergency Petition. If the patient refuses the recommended treatment, we document this and take them to an involuntary commitment hearing and if they are retained by the Administrative Law Judge, a Clinical Review Panel is requested to obtain permission to medicate the patient involuntarily. Once patients begin to get medicated, their behavior usually starts to improve, although the response time for this population is usually many days. During this period, patients may require emergency intramuscular medication and even brief episodes of seclusion and restraint to maintain their safety and the safety of others. Medical consultation is very frequent with this population to manage their diabetes, wounds, etc., and active medical treatment for specific problems is common.

As the patients improve, they are able to be mobilized for re-entry into the community, which usually involves meetings with family or care providers or agency staff. Community passes accompanied by family or staff are used to assess patients' readiness to tolerate the increased stress and freedom of outpatient settings. Often patients remain very fragile and additional treatment is required, so that patients will "step down" to a Crisis Residential Program and the Sullivan Day Hospital, where the same psychiatrist can continue to work with the patient in a highly supervised but outpatient level of care for additional days to weeks. A successful discharge is one where the patient is no longer psychotic or behaviorally out of control, and can be expected to dependably follow through with the outpatient treatment. They may well still be quite symptomatic with some residual hallucinations, delusions, or disorganization, but can at least cooperate safely with an unlocked setting and the expectation of aftercare.