Human Resources Administration
Department of Homeless Services
Department of Social Services

Pursuant to Local Law 115 of 2017 to amend the administrative code of the city of New York, in relation to requiring information on mental health services in shelters, the Department of Social Services respectfully submits the report for CY 2022 below.

Those most at risk of homelessness are affected by high rates of poverty, family conflict and domestic violence, as well as poor health, including high rates of chronic disease and behavioral health conditions, coupled with low access to care. At Department of Homeless Services (DHS) intake points, clients may arrive with a host of complex and interrelated challenges, but have one thing in common: a lack of safe and affordable permanent housing. The contents of this report describe mental health services for individuals experiencing homelessness and should be viewed against the backdrop of the many services Human Resources Administration (HRA) and DHS provide to address social and structural determinants of health and homelessness. By working to prevent homelessness, bring people in from the streets, rehouse those who become homeless, and transform the approach to providing shelter that has been used over nearly 40 years, we are impacting the health of low-income New Yorkers beyond the provision of direct mental health services.

DHS has implemented a series of reforms, including improvements in how DHS delivers and ensures health care for those seeking or residing in shelter. The improvements, for example, include adding appropriately licensed and experienced clinical and professional staff to the DHS Medical Director's office. These individuals assist the Medical Director in designing evidence-based standards of care, planning and implementing newly expanded program monitoring and oversight, and conducting evaluations of existing programs and services.

Improvements implemented include:

- Targeting services and programs for clients with mental health needs who may be also have criminal justice involvement
- Addressing unsheltered homelessness through the continued implementation of HOME-STAT, the largest outreach program of its kind in the nation which partners existing homeless response and prevention programs with a series of new innovations designed to better identify, engage, and transition unsheltered New Yorkers from the streets to low-threshold engagement and support services, as well as permanent housing.
- Enhancing and expanding specialized tools and services that support New Yorkers in need: the City has increased safe haven and stabilization beds, increased the number of drop-in centers, and is working to develop 15,000 units of supportive housing to provide essential tools to address street homelessness.
- Implemented a centralized complex care coordination program for DHS clients with serious medical conditions, behavioral health conditions, and/or disabilities to support engagement in care and supportive services to help stabilize them and move them along the path to permanent stable housing.
- In collaboration with our partners, developed and implemented a nurse in shelter program to provide care coordination, basic nursing and assessment, and health promotion and medication

management services with a focus on mediation assisted treatment for opioid use to clients in 5 shelters.
- Published a "NYC Harm Reduction in Shelters Strategic Plan" to guide DHS overdose prevention and system enhancements.
- Obtained funding to develop and implement a child mental health program.

High-quality transitional housing is far more than just a room to sleep in or a roof over one's head. At these sites, we work in partnership with experienced not-for-profit social service providers whose dedicated staff connect clients every day with robust wraparound resources including case management, housing placement assistance, health and mental health services, and employment counseling on site. Cost covers far more than just rent—services, staffing, security, administrative costs and overhead are all included in the contract value.

When a New Yorker in need presents at an Assessment Site through a DHS Intake Site, staff works to identify what the individual's needs are and which program shelter would best facilitate the client's transition to housing permanency, including:

- General
- Employment
- Mental Health
- Substance Use
- Young Adults
- LGBTQ
- Older Populations
- Veterans

While shelter services are mandated to a great extent by state regulation, with some services specific to the type of shelter, "mental health" shelters are a City-level designation (rather than regulated at State-level), reflecting our recognition that there is no one-size-fits-all solution to the nationwide and citywide challenge of homelessness.

Mental health needs are assessed as individuals in need of shelter are evaluated during intake by DHS program experts, including social workers, nurse practitioners, and psychiatric nurses, to determine which program focus would best address the applicant's needs. These program experts assess individuals' housing and employment histories as well as their psychiatric needs to make the most informed and effective decision about which programs would best help each individual stabilize their lives. Clients in need of shelter, services, and support and also experiencing substantial psychiatric or mental health needs and/or substance misuse challenges are prioritized for facilities with mental health and/or substance misuse treatment programs to connect the applicant to services quickly.

As has been widely reported, due to a range of factors, including a shift away from the mass incarceration approaches of the past at every level of government, which is a positive progressive policy development, and deinstitutionalization over prior decades, we are continuing to see consistently increasing need for shelter among adult individuals—and an increasingly complicated range of sometimes compounding service needs amongst the single adult individuals experiencing homelessness to whom we

are providing shelter, including, but not limited to, substance use challenges and/or mental health challenges that are also experienced by many New Yorkers who are not experiencing homelessness.

There are a variety of factors we consider to determine a client's appropriateness for a mental health placement, including:

- History of severe mental illness;
- Past or recent psychiatric hospitalizations;
- Client's current functioning and behavior based on self-report and staff observation; and/or
- Clinical recommendation as a result of recent mental health examination or psychiatric evaluation.

Additionally, because clients may not report the challenges they are experiencing at intake, staff sometimes come to understand those challenges only during the course of working directly with clients onsite in shelter. As a result, referrals are also made from other shelters in the Single Adult system to Mental Health shelters on case-by-case basis, based on the assessment conducted by and relationships developed between case managers, housing specialists, social workers, nurse practitioners, and psychological evaluators—a collaborative needs-based determination made by social service staff and Program experts working closely with clients to help them back on their feet.

Overall, NYC DHS mental health shelters provide:

- On-site behavioral health and medical services, as well as linkages to off-site care in the community.
- Behavioral health services include: psychiatric assessment, ongoing medication management, individual therapy, and group therapy related to mental illness, substance use, psychoeducation related to trauma, as well as other services.
- Medical Services include: primary care services, episodic care, and assisting the client in accessing urgent care as needed. For clients with co-occurring mental health and substance use disorders, supportive services include harm reduction and health promotion to reduce the frequency and duration of both drug/alcohol and/or psychiatric hospitalizations. For clients with opioid use disorder, medication-for-addiction-treatment is provided onsite or via linkage to care in the community.
- Medical providers are certified by the State to provide overdose prevention training and ensure that staff able to provide overdose prevention responses are present at all times, with any staff that interact with clients, including security staff, equipped to administer live-saving naloxone should they witness an overdose. Facility staff and residents at HRA HASA facilities are also trained in opioid antagonist administration to prevent overdose in these facilities.
- Medical providers also communicate with external service providers and hospitals as needed, including managing visits to emergency departments, admissions, and discharges.

Please note, however, that while shelters with qualified medical providers on site may provide supervised medication administration, generally speaking Mental Health shelters are not assisted living facilities, psychiatric centers, or medical institutions; as such, these locations do not provide skilled nursing services or assistance with activities of daily living.

The City continues to make important progress by investing in not-for-profit service provider partners, services and facilities to ensure appropriate service delivery models and sufficient funding is in place to deliver the services our homeless neighbors depend on as they get back on their feet – this

includes a people- and community-based system that is responsive to families' and individuals' unique needs. To achieve this, the City has dedicated unprecedented dollars (more than a quarter-billion new dollars annually) to modernizing rates for our vital provider partners expanding street outreach, increasing low barrier beds, and maintaining and enhancing mental health and related services.
Overall, our funding for shelters with mental health services has more than tripled between 2014 and 2022. Specifically, the FY14 mental health shelters budget was $95.5M, whereas the FY23 budget for shelters with mental health services was $345M, and $290M the year before in FY22. The budget amounts include mental health shelters and other adult shelters with enhanced mental health services.
Prior to the COVID pandemic in 2018/2019, DHS and DOHMH provided Mental Health First Aid training for DHS and provider frontline staff system wide. DHS is currently exploring ways to conduct this training for new staff members.

Outlined below is the information for Calendar Year 2022 solicited in Local Law 115 of 2017

1. The number of shelters, domestic violence shelters, and HASA facilities with on-site mental health services, as well as the total number of shelters, domestic violence shelters and HASA facilities

DHS Office of the Medical Director (OMD) performed a count of all shelter programs to collect information for on-site mental health services. A total of 76 DHS shelter programs and 13 HRA Domestic Violence shelters provided on-site mental health services (Table 1). DHS's approach is to place clients at the most appropriate location for their particular needs, as such not all shelters specialize in serving clients with mental health needs, given that only a proportion of clients have a mental health condition.

Table 1: Number of shelters programs and shelter programs with on-site mental health services, CY 2022

	Overall number of shelter programs	Number of shelter programs with on-site mental health services[1]
DHS Shelters[2]	**486**	**76**
Single adults	191	46
Streets[3]	48	19
Veterans short term housing / Criminal Justice Shelter	2	2
Adult Families	20	3
Families with Children	225	6
Domestic Violence Shelters	**55**	**13**
Domestic Violence Emergency Shelters	43	12
Domestic Violence Tier II Shelters	12	1
HASA Facilities	**97**	**14**
Emergency SRO / Family Provider Sites	83	0
Emergency Transitional Provider Sites	14	14

Note: These are shelter programs that were active as of December 31 of the reporting year

[1] This clinic data is derived from a Point in Time (PIT) count conducted in Summer 2022 by the DHS Office of the Medical Director (OMD).
[2] This data includes DHS Emergency Sites. Additionally, this data is housed on the Building Compliance System (BCS) and has historically been updated by shelter staff..
[3] Streets includes Safe Havens, Drop in Centers, and Stabilization Beds.

2. A description of the mental health services in each intake center

Families with Children: Families with children enter DHS shelter through the central intake center called the Prevention Assistance and Temporary Housing (PATH) center. All new families that report a health issue at intake (e.g., feeling sick) and those with specific needs, such as pregnant women, families with infants or who have a member with an acute medical condition or recent hospitalization are seen by the clinical provider at PATH, The Floating Hospital. The on-site clinician conducts a health screening and offers necessary emergency services, referrals as needed, and health education, as well as if needed coordination with the client's existing health care providers. As needed, families are referred to the onsite psychiatric provider for a comprehensive assessment. Once in shelter, clients are encouraged to and assisted in seeking care from their primary care physicians or a local clinic of their choice.

In addition, families self-reporting or observed to be facing mental health or substance use challenges are referred to DHS Resource Room Social Workers for further assessment. Resource Room Social Workers complete mental health and substance use assessments in the DHS CARES system. Assessment findings determine whether or not a call will be placed to 911 for EMS assistance and possible hospitalization.

Additionally, licensed master's level social workers serve as Client Care Coordinators directly in shelters as employees of DHS contracted providers. Client Care Coordinators work with clients to improve access to mental health services in the Families with Children shelter system and to assist families who are homeless as they navigate multiple systems and cope with the stressors and anxiety induced by homelessness.

Adults: After intake, all adults admitted to the shelter system are sent to an assessment shelter where providers conduct a comprehensive assessment including history and physical, brief psychiatric assessment, and substance use assessment. This assessment is used to direct new entrants into the DHS system toward either a general, mental health or substance use shelter, or an employment shelter. Mental health shelters provide specialized mental health services on-site as well as linkage to an array of outpatient mental health services. On-site services include psychiatric assessment, ongoing medication management, individual therapy, group therapy related to mental illness, substance use, psychoeducation related to trauma, etc., and crisis management and de-escalation. The following outpatient services are available to DHS clients with mental health conditions:

- Care Coordination: a specially trained individual or team that helps clients better understand and manage their conditions, works with clients to create a plan of care that meets their physical, mental health and social service needs and assists the client in finding the services and programs that are right for their needs.
- Assertive Community Treatment (ACT): an evidence-based practice model where a team composed of multiple specialized behavioral health providers, including a registered nurse and vocational supports, work together to provide treatment, rehabilitation, care coordination and support to individuals diagnosed with a severe mental illness and whose needs have not been well met by more traditional mental health services. Since mid-2017, 10 new ACT teams have been assigned to cover all the DHS mental health shelters. Note: these are not DHS-contracted or DHS-operated teams/programs.
- Intensive Mobile Treatment (IMT): a specialized team that provides intensive and non-billable treatment in settings that are convenient to clients who may be unstable. Note: these are not DHS-contracted or DHS-operated teams/programs.

- Mobile Crisis Team (MCT): a team that is contracted by the New York City Department of Health and Mental Hygiene (DOHMH) to respond to mental health crises in the community within 48 hours of receiving a referral. MCTs are staffed by mental health professionals who can assess the referred person and their situation, provide crisis counseling and make referrals to community-based mental health and substance misuse services for ongoing care, and emergency services as needed. The DHS Office of the Medical Director developed mechanisms to improve access to shelters for MCTs. Note: these are not DHS-contracted or DHS-operated teams/programs.

Adult Families: For adult families, staff assessments using a client questionnaire are conducted at intake centers where individuals respond to questions posed from staff. Clinical assessments are not conducted by a clinician at these sites.

Naloxone in Shelters and HASA Facilities: At intake, all individuals seeking shelter from NYC DHS are assessed for substance use challenges in addition to mental health challenges. Comprehensive Health Assessment Teams (CHAT), for example, help conduct an early assessment of mental health and substance use history to determine if a person may be effectively served and/or eligible for supportive housing. Individuals who are identified as experiencing substance use challenges may be referred to a Credentialed Alcoholism and Substance Abuse Counselor (CASAC) for further referral to in- or out-patient substance use treatment. If a client appears to be in crisis upon arrival at intake, intake staff contact HRA's Customized Assistance Services and request an emergency psychiatric evaluation and possible hospitalization if appropriate.

All shelters, including intake and assessment sites, are equipped with staff who are trained to act as overdose first-responders and to administer naloxone; we continue to train staff on an ongoing basis; and we continue to conduct trainings for clients as well, implementing a train-the-trainer model. To that end, DHS Peace Officers are also trained in naloxone administration and are certified Opioid Overdose Responders. In late 2016, the DHS Medical Office started systematically training DHS staff in naloxone administration to ensure that all shelters have trained staff able to administer naloxone to clients suspected of having an overdose at all times. Since November 2016, DHS has been an independent state certified Opioid Overdose Prevention Program (OOPP), led by the Office of the Medical Director. In FY 2023 (July 1, 2022 through June 30, 2023), DHS provided an initial training for 1,381 staff and a refresher training for 1,132 staff, in addition to training 1,953 shelter residents, for a total of 4,466 individuals trained in administering naloxone.

Since December 2017, HRA HASA has trained facility staff routinely as trainers and responders in the administration of the opioid antagonist, naloxone. Staff who successfully compete the training are State Certified Opioid Overdose Responders. In 2018, HRA HASA implemented an opioid overdose training plan and overdose response policy which includes training facility residents in addition to training facility staff in administering an opioid antagonist, such as naloxone, to clients suspected of having an overdose. In FY 2023 (July 1, 2022 through June 30, 2023), HRA HASA has provided an initial training for 497 facility staff and a refresher training for 208 facility staff, in addition to training 299 facility residents in administering naloxone for a total of 1,004 facility staff and residents trained in administering naloxone.

DHS Substance Use Disorder (SUD)-Related Response

FY 22 Opioid Overdose Prevention Program Enhancements
In 2021, DHS began conducting systematic follow-up after non-fatal overdoses to guide shelter staff in providing prevention counseling and linkage to harm reduction and substance use services including medications for addiction treatment. In FY23 DHS secured a three-year grant totaling approximately $1.2 million dollars in funding from SAMHSA and Healing NYC to increase overdose prevention services, including direct outreach to clients at risk, shelter-based risk reduction counseling, naloxone and fentanyl test strip training and distribution to clients, and linkage to care.

Mental Health Services for HRA's HASA and Domestic Violence Services (DVS)

Mental health services at HASA Emergency Transitional Provider Sites and Permanent Congregate Provider Sites include programs for crisis intervention and referrals for short-term hospitalization for clients diagnosed with mental illness. Treatments include individual therapy, group therapy, recreational therapy and psychological testing. Social service professionals and case managers assist clients with continuing care options that enhance their mental stability and independent functioning.

HRA's Domestic Violence Services (DVS) provides oversight for the 24-hour NYC domestic violence hotline which serves as one of the contact points for the domestic violence shelter system, but also provides safety planning and referrals. Safe Horizon, a private not-for-profit social service agency and DV service provider, is the City contracted provider operating the hotline.

Upon arrival at a domestic violence shelter, as required by State mandate a client will be assessed within 48 hours of arrival. As a part of the client assessment process, the following medical and mental health questions are asked:

- Have you or your child (ren) ever been hospitalized? If yes, please explain.
- Have you or your child (ren) ever received psychiatric treatment or counseling? If yes, please explain.
- Is anyone in the family currently in treatment (Yes) or (No)?
- If yes, Name of Psychiatrist, phone#, Treatment schedule, List of medications,
- Is anyone pregnant (Yes) or (No).
    - If yes, who and expected date of delivery?
    - If yes, receiving prenatal care (Yes) or (No)? Where?
    - Any complications with the pregnancy (Yes) or (No), Explain

Depending on the responses, referrals are made. In every case there is on-going case management at the shelter.

DVS is working in conjunction with NYC Health and Hospitals to expand the Domestic Violence Shelter (DVS) Mental Health Initiative to provide culturally competent, domestic violence-informed psychiatric and psychological mental health screening, care and treatment to children, youth and adults at domestic violence shelters. Mental health services through the Mental Health Initiative have established services in 9 DV emergency shelters and will expand to include services in an additional 16 shelters in Fall 2023.

3. A description of the mental health services provided at drop-in centers and safe havens

Drop-in centers provide a low-threshold alternative to traditional shelter for individuals experiencing street homelessness and offer temporary respite where individuals can shower, eat a meal, see a doctor, and rest. There is on-site case management and housing placement services.

Services at drop-in centers and safe havens include a psychiatric assessment and referral to care as indicated from the assessment.

All placements to low-barrier street beds, including safe havens and new stabilization beds, are processed through the Joint Command Center (JCC). This ensures that clients are receiving the level of care which they require.

Safe Havens provide an immediate transitional housing alternative for individuals who've experienced unsheltered homelessness, with a focus on those who've experienced chronic unsheltered homelessness. As a result, street outreach teams can place clients into a Safe Haven directly from the street based on individualized engagements/assessments. Safe Havens are generally smaller settings (smaller capacity), with clinically rich staffing and flexible program requirements, such as no curfew. The program embraces housing-first and harm-reduction models. The primary goal is to encourage clients to accept services and come in off the streets into flexible settings with strong clinical supports, which will help clients further transition to permanent housing. Equipped with MSW level clinicians, CASAC certified staff, and psychiatrists, the clinically rich staffing model and lower client/staff ratio allows for more intensive work with each client.

4. A description of the mental health services provided to the unsheltered homeless population directly and by referral, including the number of removals initiated pursuant to section 9.58 of the mental hygiene law

Outreach teams work from a harm reduction approach, building relationships with individuals who over time have historically rejected services. Outreach teams are also focused on the most vulnerable of those living outside to ensure they are safe and/or not at risk for injury or death. Outreach teams also perform crisis intervention assessments and work on placements to indoor settings through on-going case management and supportive services. This includes linking clients to medical benefits as they continue to work with these individuals throughout their journey. The outreach teams meet people "where they are" both literally and figuratively— whether that means conducting a psychiatric evaluation on a street corner or sending an outreach worker who can speak to a client in his or her native language.

In 2022, there were 56 removals initiated by DHS contracted outreach teams pursuant to section 9.58 of the mental hygiene law.

Overall, DHS Outreach teams provide emergency and crisis intervention, counseling, case management, assistance with entitlements, benefits, housing and other resources, and provides referrals and linkages to health care services, as necessary, to individuals choosing to live on the streets.

5. A list of the 10 most common mental health issues for adults living in shelters, as self-reported at intake/assessment, and the 10 most common medical health issues for children living in shelters, as self-reported at intake/assessment

The tables below outline the top 10 behavioral/mental health conditions among adults in Adult Families, Single Adults, and Families with Children shelters. This is self-reported data at the time of application from every adult client that spent the night in an adult family, families with children or single adult shelter in 2022. In this data collection method, each client has the ability to report several health conditions and these data are not de-duplicated. These counts include clients that turned 18 while in shelter during 2022.

Table 2. Top Ten Behavioral Health Conditions from Intake/Assessment for Adults in Adult Families Shelter in 2022

Rank	Behavioral Health Condition	n
1	Depression	608
2	Anxiety	596
3	Bipolar disorder/Manic depression	383
4	Post-traumatic stress disorder (PTSD)	252
5	Schizophrenia	153
6	Attention-deficit hyperactivity disorder (ADHD)	136
7	Substance abuse / dependence (drugs)	121
8	Panic disorder / panic attacks	89
9	Schizoaffective disorder	44
10	Alcohol abuse / dependence	34

Table 3. Top Ten Behavioral Health Conditions from Intake/Assessment for Adults in Single Adults in Shelter in 2022		
Rank	**Behavioral Health Condition**	**n**
1	Depression	5,587
2	Bipolar disorder / manic depression	4,698
3	Anxiety	4,188
4	Schizophrenia	3,021
5	Post-traumatic stress disorder (PTSD)	2,331
6	Substance abuse / dependence (drugs)	1,566
7	Attention-deficit hyperactivity disorder (ADHD)	1,035
8	Alcohol abuse / dependence	1,011
9	Schizoaffective disorder	908
10	Panic disorder / panic attacks	341

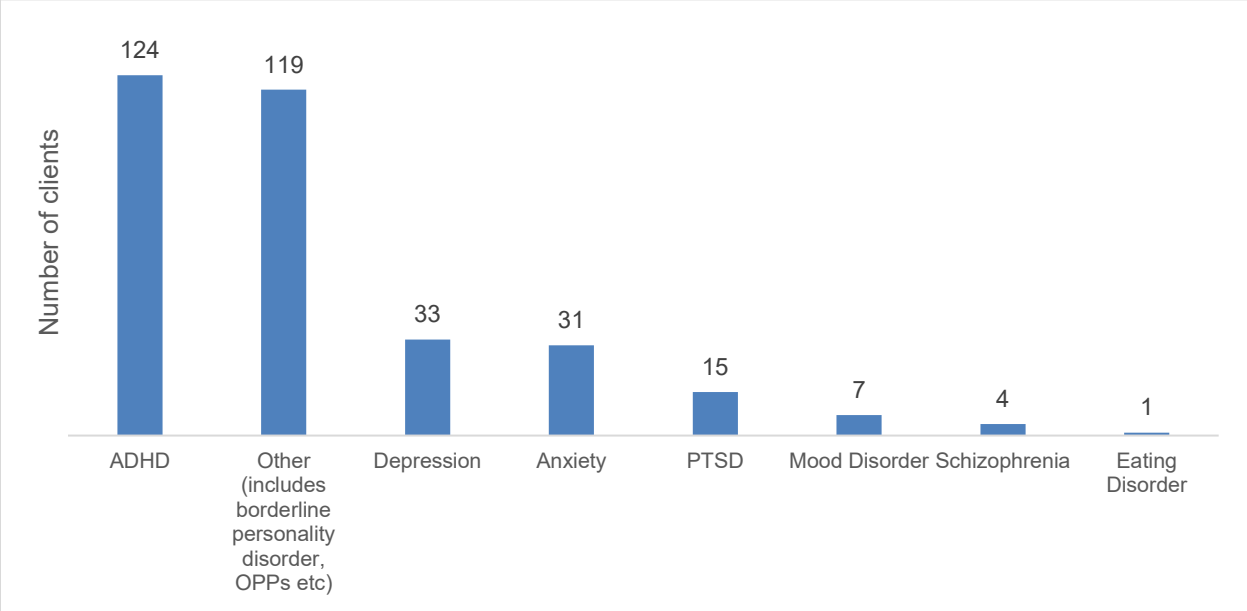
Table 4. Top Ten Behavioral Health Conditions from Intake/Assessment for Adults in Families with Children Shelter in 2022		
Rank	**Behavioral Health Condition**	**n**
1	Depression	1,253
2	Anxiety	1,236
3	Bipolar disorder / manic depression	612
4	Post-traumatic stress disorder (PTSD)	522
5	Attention-deficit hyperactivity disorder (ADHD)	268
6	Schizophrenia	156
7	Panic Disorder / panic attacks	115
8	Substance use / dependence (drugs)	44
9	Schizoaffective disorder	40
10	Obsessive Compulsive Disorder (OCD)	36

Note: These counts include clients who turned 18 while experiencing homelessness and residing in NYC DHS shelter during 2022.

The DHS Office of the Medical Director collects self-reported behavioral health conditions for new families applying for shelter at the Families with Children (FWC) intake center (PATH) that report a behavioral health issue at intake (e.g., anxiety, depression, ADHD) and also collects medical information from families that have not previously completed the expanded health screening, if they presented to the clinic for another issue (e.g., pregnancy, recent hospitalization).

- In 2022, data was collected for 6,603 children, of those, 334 children (5%) had at least one behavioral health condition, as reported by the head of the household for each family member. The leading behavioral health condition among children was Attention Deficit Hyperactivity Disorder (ADHD) (Figure 1).
- The health screening captures self-reported behavioral health information on the seven most common behavioral health conditions among children plus an option to mark 'other' with the ability to specify what the other conditions entail.
- Figure 1 shows the behavioral health conditions among children as reported by head of the household for each family member. Some children have more than one behavioral health conditions.

Figure 1: Behavioral health conditions among children as reported by head of the household for each family member at Families with Children intake center, 2022 (N=334)[4]



[4] Some children had more than one behavioral health conditions.

6. A list of the 10 most common behavioral health issues for adults living in shelters and the 10 most common behavioral health issues for children living in shelters, as reported by providers under contract or similar agreement with the department to provide mental health services in shelter

The tables below outline the most common behavioral health conditions among children (Table 5) and adults (Table 6 and 7) living in shelter as reported by the providers at Intake and Assessment. Attention deficit hyperactivity disorder and depression were the leading behavioral health conditions reported among children and adults, respectively.

Table 5: Most common behavioral health conditions among children as reported by the medical provider at PATH, CY 2022

Rank	Behavioral Health Condition
1	Attention deficit hyperactivity disorder
2	Autism
3	Depression
4	Anxiety Disorder
5	Post-Traumatic Stress Disorder (PTSD)
6	Oppositional Defiant Disorder
7	Mood Disorder
8	Schizophrenia
9	Eating Disorder
10	Down Syndrome

Table 6: Most common behavioral health conditions among adults in FWC as reported by the medical provider at PATH, CY 2022

Rank	Behavioral Health Condition
1	Depression, includes post-partum depression
2	Anxiety
3	Post-Traumatic Stress Disorder (PTSD)
4	Attention deficit hyperactivity disorder
5	Schizophrenia
6	Mood Disorder
7	Schizoaffective Disorder

8	Borderline Personality Disorder
9	Panic Disorder
10	Obsessive-compulsive Disorder

Table 7: Ten most common behavioral health conditions among adults as reported by the medical providers at assessment shelters, CY 2022

Rank	**Behavioral Health Conditions**
1	Depression
2	Anxiety Disorder
3	Cannabis Use Disorder
4	Bipolar Disorder
5	Alcohol Use Disorder
6	Post-Traumatic Stress Disorder (PTSD)
7	Schizophrenia
8	Opioid Use Disorder
9	Cocaine use disorder
10	Schizoaffective disorder

7. Any metrics relevant to the provision of mental health services reported to the department by any entity providing such services.

Please refer to the new overdose report and the annual mortality report submitted pursuant to LL225 of 2017 and LL63 of 2005, replaced by LL 7 of 2012, respectively.