



The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

MAURA T. HEALEY
Governor

KIMBERLEY DRISCOLL
Lieutenant Governor

KATHLEEN E. WALSH
Secretary

ROBERT GOLDSTEIN, MD, PhD
Commissioner

Tel: 617-624-6000
www.mass.gov/dph

December 21, 2023

Steven T. James
House Clerk
State House Room 145
Boston, MA 02133

Michael D. Hurley
Senate Clerk
State House Room 335
Boston, MA 02133

Dear Mr. Clerk,

Pursuant to Chapter 24 of the Acts of 2021, please find enclosed a report from the Department of Public Health entitled "Tele-behavioral Health Pilot Program in Schools."

Sincerely,

A handwritten signature in black ink, appearing to be "R. Goldstein", written in a cursive style.

Robert Goldstein, MD, PhD
Commissioner
Department of Public Health

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MAURA T. HEALEY
GOVERNOR

KIMBERLEY DRISCOLL
LIEUTENANT GOVERNOR



KATHLEEN E. WALSH
SECRETARY

ROBERT GOLDSTEIN, MD, PhD
COMMISSIONER

Tele-behavioral Health Pilot Program in Schools

September 2023

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Legislative Mandate

The following report is hereby issued pursuant to Chapter 126 of the Acts of 2022 as follows:

The Department of Public Health “in consultation with the department of mental health and the department of elementary and secondary education, shall expend not less than \$3,532,000 for a pilot program to increase student access to telebehavioral health services in schools; provided further, that not later than June 30, 2023, the department of public health shall report to the joint committee on mental health, substance use, and recovery and the house and senate committees on ways and means detailing the: (i) number of students participating in the program; (ii) frequency with which students use the program; (iii) cost of the services provided, including the use of support staff; and (iv) manner in which costs have been supported by third party reimbursement”

Executive Summary

The Tele-behavioral Health Pilot Program in Schools is a state-funded initiative to increase access to quality youth mental health and substance use services by leveraging technology in the delivery of care and building the capacity of schools and providers. In fiscal year 2023, the initiative began engaging school districts identified in the pilot's needs assessment. Since July 2022, the pilot has expanded from zero to 10 school districts across the Commonwealth of Massachusetts. As a result of this effort, the pilot has serviced 260 students (as of March 31, 2023) through 2,199 tele-behavioral health sessions and has offered schools an additional referral option for students struggling with mental health or substance misuse. Early findings from the process evaluation indicate a high demand for these services as well as referrals related to social determinants of health.

The goals of the pilot are to:

- Expand access to mental health and substance use services for school-age youth;
- Evaluate the impact of services and capture any needed adaptations; and
- Demonstrate feasibility for statewide replication, including best practices for school tele-behavioral health service delivery, strategies for expanding existing models, and elements necessary for success in other schools.

Beyond service delivery, the Brookline Center for Community Mental Health (BCCMH), the pilot's implementation vendor, is working to build the capacity of schools and service providers to support the pilot's goals and ensure sustainability. In FY23, BCCMH has provided training and technical assistance to both schools and providers. This has included supporting the development of sustainable partnerships and workflows, training clinical and school staff on topics such as telehealth technologies, cultural responsiveness, trauma-informed care, and process improvement, and leveraging other state initiatives to align resources and maximize impact. Additionally, the pilot is making needed investments in the behavioral health workforce by engaging community clinics as prospective tele-behavioral health providers and developing opportunities to expand the role of community health workers in schools.

As part of the evaluation, the pilot is capturing systemic barriers to sustainable financing, comparing delivery models, assessing impact, and identifying best practices. Currently, the pilot is comparing two models of school tele-behavioral health service delivery: one that includes a telehealth clinician paired with an on-site community health worker and another that includes a telehealth clinician paired with a remote care coordinator. As the project continues to engage additional provider organizations, additional service models may be assessed.

As the pilot continues in FY24, the Massachusetts Department of Public Health (MDPH) expects continued service expansion through increased engagement of priority school districts (as defined and discussed more below). Other FY24 activities will include building the capacity of community-based clinics to become school tele-behavioral health providers, expanding the number of community health workers supporting service delivery in schools, and ongoing

evaluation activities to assess program impact, capture best practices, and begin outlining a replication guide.

Introduction

The need for child and adolescent behavioral health services was significant and growing prior to the COVID-19 pandemic, and the pandemic only further highlighted the need for accessible, high quality, behavioral health care for youth. Recognizing that school can be an important access point to engage youth in behavioral health services, the state legislature provided funding for a pilot program implementing telebehavioral health (TBH) services in schools. In FY22, MDPH issued a Request for Response (RFR) for a vendor to implement the pilot program.

The Brookline Center for Community Mental Health (BCCMH) was awarded the contract to implement the TBH pilot on October 1, 2021. This second report covers the period of July 1, 2022, through March 31, 2023.

BCCMH has been charged with:

- Designing a pilot program after conducting a thorough needs assessment and investigation of past successful projects
- Implementing the pilot program including site selection, funding, and support to sites to achieve sustainability in the provision of services
- Providing a rigorous evaluation of the program
- Producing a replication guide to assist additional schools in starting a TBH program

BCCMH is working closely with school administrators and behavioral health professionals to identify and engage school districts who could benefit from TBH services. The services are being provided by licensed mental health professionals who are trained in the use of telehealth technologies.

In compliance with the legislative mandate, MDPH, in collaboration with BCCMH, is reporting on the progress of the Fiscal Year 2023 School Based Telebehavioral Health Project. In addition to the metrics required by legislative mandate, BCCMH includes information on the project infrastructure and capacity-building activities, evaluation/impact report, and ongoing and proposed activities for Fiscal Year 2024.

Report

During this reporting period (July 1, 2022 – March 31, 2023), activities focused on initiation of service and continued infrastructure and capacity building.

Number of students participating in the program: 260

The program is currently being implemented in collaboration with 10 schools/districts across the state:

School / District	Implementation Start Date
Gardner	July 2022
Athol-Royalston	July 2022
Narragansett	January 2023
Ralph C Mahar	January 2023
Salem	January 2023
Berkshire Hills	January 2023
North Adams	March 2023
Lowell	April 2023*
Fitchburg	April 2023*
Boston Arts Academy	April 2023*

*Note: These sites were brought on after the reporting period and, therefore, are not reflected in the data shared throughout the report.

School districts were identified through a preliminary needs assessment. All districts that were identified in the needs assessment have been invited to participate in the pilot and BCCMH is conducting ongoing outreach to engage additional sites in FY24. Three active districts - Narragansett, Ralph C Mahar, and Berkshire Hills – were not included in the preliminary needs assessment but have demonstrated a significant need and interest in providing tele-behavioral health services to their students. Additional information on the needs assessment and site selection can be found on page 11.

During FY23, the project provided TBH services to 260 students in selected schools across the state (see Appendix A, Table 1). We expect this number to increase by the end of the fiscal year and even more significantly in FY24 as the pilot expands to additional school districts.

Frequency with which students use the program: 2,199 sessions completed

The frequency with which students used the program varied based on their individual needs. Some students receive weekly individual therapy sessions, while others receive sessions once or twice a month. Currently, this project does not provide group or crisis intervention services. Group and crisis intervention services are coordinated with community-based agencies.

Cost of the services provided, including the use of support staff: BCCMH is projecting to spend \$2,597,343.28 in FY23 to implement clinical services and to provide training, technical assistance and other support to schools and tele-behavioral health providers. Costs will continue to rise as the program expands in FY24.

The total cost of the services provided varies by site based on student enrollment, the needs of each district, and the partnering TBH provider. Total costs include the startup costs of the telehealth technologies, sub-contracts with licensed behavioral health service providers, the salaries of clinicians and support staff, including community health workers (CHWs) and administrative staff, and the costs of training and technical assistance to schools and provider agencies.

Manner in which costs have been supported by third-party reimbursement: A portion of the costs are being reimbursed through third-party billing.

The program is only contracting with clinical service vendors that are credentialed to secure reimbursement for a portion of the costs through third-party payers, such as MassHealth, MassHealth managed care organizations, and private insurance companies. However, given the aim to initiate and build service capacity, a significant portion of the costs have been covered by the program due to challenges and limitations of third-party billing, as described below.

This information has been obtained through engagement with existing school-based tele-behavioral health service providers and additional community-based agencies contacted to assess interest in participating in the pilot. Several agencies cited barriers to participation due to concerns around workforce and fiscal sustainability. MDPH recently began conversations with MassHealth to share this information and explore opportunities to provide additional technical assistance to provider agencies. In FY24, the goals of this cross-agency collaboration are to support providers in addressing these challenges, to build financial sustainability of school tele-behavioral health service delivery, and to encourage broader participation in the pilot.

The challenges reported by providers in FY23 include:

- **Reimbursement:** Providers reported that reimbursement rates for mental health and substance use services, across payers, make it hard to offer competitive salaries to recruit and retain staff and generally do not cover the full cost of care. Providers reported that varying reimbursement rates across payers as well as non-billable activities (e.g., development of treatment plans) create additional difficulties in managing costs. Providers also highlighted the credentialing process as an area of concern, reporting challenges in scaling clinical capacity to meet increasing demand. For example, the need to avoid waitlists requires hiring clinicians prior to them being able to get through credentialing, resulting in a lack of reimbursement for some sessions.

- **Administrative burden:** Providers reported that complex billing and documentation requirements, including credentialing providers with numerous different payers, can be time-consuming and costly. Beyond the reimbursement issue highlighted above, providers reported additional costs related to credentialing, including software costs and costs to hire staff to support the credentialing process.
- **Limited reimbursement for Community Health Workers:** Services delivered in schools by Community Health Workers (CHWs) are not eligible for third-party reimbursement. Providers using CHWs in their service delivery reported that CHWs play a key role, including student outreach, triage and intake, service engagement (e.g., helping students transition to/from the classroom and their appointment), social support, and referrals to additional services, including those that address social determinants of health. As part of ongoing project evaluation, MDPH will continue to gather data related to the CHW contributions and their impact on school TBH services.
- **Workforce:** Providers reported difficulty finding licensed clinicians, especially bilingual and multicultural staff.
- **Lack of Access to Technology:** Community-based outpatient mental health and substance use providers may not have access to the technology necessary to provide telehealth services.

As of 2023, to be eligible for tele-behavioral health reimbursement, the service must be delivered in real-time and meet the same clinical standards as in-person services. Providers must be licensed and qualified to provide the service, and the service must be medically necessary and appropriate for the patient's needs. Additionally, the patient must be in an eligible originating site, which includes schools, and the provider must be located in an eligible distant site.

Additional challenges include technology access and privacy concerns that need to be addressed to ensure all children and adolescents have access to mental health services. Addressing these challenges will require ongoing efforts to improve technology infrastructure. Such efforts are crucial to ensure access to behavioral health services for youth and their families, particularly those in underserved and vulnerable communities.

Infrastructure and Capacity Building Activities

BCCMH conducts comprehensive needs assessments for schools engaged in the pilot, working with school administrators and staff to tailor the project to meet the unique needs of each district. This assessment includes an analysis of existing resources and identified gaps. This assessment is implemented at the time of engagement with school districts and clinical providers and informs partnerships in planning, development, and implementation of TBH services at each site. BCCMH also provides technical assistance and training on telehealth technologies, cultural responsiveness, trauma-informed care, and care coordination, and facilitates a learning collaborative for school staff to provide ongoing implementation support.

Learning collaborative

BCCMH has established a virtual learning collaborative that aims to:

- Augment and enhance training and technical assistance with pilot sites and encourage sharing, creating a virtual learning community among pilot sites
- Host specific learning opportunities via webinars, online modules, and discussion boards to support ongoing capacity building and collaboration
- Allow sites to network, learn from one another, and jointly address shared problems
- Be responsive to pilot sites' unique and shared needs by highlighting relevant best practices
- Include technical troubleshooting, discussion boards, an events calendar, a resource center, a spotlight on new ideas, and quick links

The learning collaborative includes:

- Existing clinical service providers and school districts
- The University of Massachusetts BIRCh (Behavioral Health Integrated Resources for Children) Project, for the coordination of memoranda of understanding and Policies and Best Practices Work Group
- MDPH School-Based Health Centers for coordination of efforts around the role of CHWs
- Interagency Work Group with state agencies (MPH, DMH, DESE, EHS, and MassHealth)

Training

In FY23, BCCMH provided a total of 12 live training sessions and 13 asynchronous modules to clinical and school staff, covering topics such as telehealth technologies, cultural responsiveness, trauma-informed care, and process improvement. The live training sessions were attended by a total of 96 people, including school administrators, clinicians, and CHWs. There have been 24 enrollments in the asynchronous modules. Feedback from the trainings has been limited but positive, with participants reporting increased knowledge and confidence in providing culturally responsive TBH services to students. All provider agencies received cultural and linguistic competency training prior to providing services.

To further promote participation in the trainings, BCCMH is implementing ongoing process improvement strategies. For the live training sessions, this includes collaborating with school district professional development directors to offer content that is being requested by staff and to better identify dates. BCCMH will also offer continuing education credits and professional development points for FY24 to further incentivize participation. For the asynchronous trainings, BCCMH is redesigning the website, developing more specific goals for forum discussions, and incorporating requirements for staff onboarding.

Workforce Investments

In addition to the training outlined above, the pilot is making several investments in the behavioral health workforce. This includes building clinics' capacity for TBH service delivery, supporting new service partnerships between schools and community providers, and recruiting and training CHWs to enhance TBH service delivery in schools.

In FY23, BCCMH has been primarily working with Heywood Healthcare and Cartwheel Care as the primary TBH providers. However, to further bolster the community-based behavioral health workforce and meet the growing need for services, BCCMH began outreach to additional clinics across the state to explore interest in serving as TBH providers in the pilot. This outreach occurred in coordination with MDPH and MassHealth as an opportunity to align state initiatives and maximize state investments. Many of the clinics being engaged in this outreach are participating in the Roadmap for Behavioral Health Reform as Behavioral Health Urgent Care Providers and all were Children's Behavioral Health Initiative (CBHI) providers. Additionally, given the need for a more racially and linguistically diverse behavioral health workforce, the program has ensured smaller clinics owned by Black, Indigenous and other people of color are engaged and offered support to build their capacity in TBH service delivery. BCCMH plans to support these clinics in working through the insurance/financial challenges outlined in previous sections of this report to make TBH service expansion more financially feasible and by supporting partnerships between the clinics and schools. These conversations will continue into FY24.

BCCMH is also developing plans to recruit and train additional CHWs in the program pilot. CHWs are an essential part of the healthcare system and can play a significant role in improving access to behavioral health services, particularly in underserved and vulnerable communities. CHWs are trained to provide culturally appropriate and linguistically competent services, and

they can help bridge the gap between students and TBH clinical providers. In school settings, CHWs can help identify students who may be struggling with mental health or substance use issues and provide support and resources to these students and their families. CHWs can also assist with navigating social services and the healthcare system and connecting students with appropriate services. In the pilot, CHWs are essential components to supporting the implementation of TBH services in schools. They contribute to the outreach, triage, service engagement and implementation within each site. Most importantly, CHWs serve as a point of contact and resources for the student and their family. In addition to facilitating onsite logistics, the CHW is often the student's onsite support person before and after TBH sessions. To increase the number of CHWs supporting the delivery of health services in schools, BCCMH is working with the MDPH School Based Health Program, the MDPH Workforce Innovation Center, and Heywood Healthcare to develop a strategy for training and recruiting additional CHWs for the program.

Partnership Development

As part of the pilot's capacity building efforts, BCCMH is working to establish sustainable partnerships between schools, provider agencies, and community-based behavioral health providers to support care coordination and referrals. This includes outlining clear roles and responsibilities, developing memoranda of understanding, establishing planning meetings, and setting up of custom workflows that integrate the pilot into the existing system of care. These efforts ensure that schools, TBH providers, and community-based agencies are working together to meet student needs.

In collaboration with MDPH and the interagency working group, BCCMH is also actively exploring opportunities to better align the pilot with other state behavioral health initiatives, primarily the Roadmap for Behavioral Health Reform. This includes:

- Exploring coordination with regional Community Behavioral Health Centers, particularly around youth crisis response, care coordination and supporting referrals to additional community-based services;
- Engaging community clinics currently supported by the Roadmap for Behavioral Health Reform to build their school TBH service capacity; and
- Exploring training of current and future TBH providers on how to utilize the Behavioral Health Helpline for community referrals.

Evaluation

BCCMH is contracting with Brandeis University to conduct the evaluation of the pilot program. The evaluation aims are to understand the feasibility of implementing TBH services for students and families within school districts, to identify key elements needed for successful implementation, and to study the effectiveness of those services as well as any needed adaptations. All aspects of the evaluation are being driven through an equity lens and on-going conversations with clinical providers have led to consensus regarding data collection and data sharing around MDPH-defined High Priority populations. This consensus reflects 1) the information that is important to collect; 2) the methods of collecting it; 3) the timeframe for

accessing it, and; 4) the frequency of data sharing moving forward. All stakeholders agree on the necessity to collect and share data related to student race, ethnicity, gender identity, sexual orientation, and family income, as well as provider demographic characteristics in order to assess the SBTBH pilot initiative in addressing 1) equity in service access; 2) equity in service utilization; and 3) equity in outcomes. Data collection of information will be sensitive, confidential, and limit burden to clinicians and CHWs. Data collection will utilize multiple methods to enhance trustworthiness of the data and seek opportunity to amplify student voices whenever possible. For this fiscal period (July 1, 2022, through June 30, 2023), Brandeis completed a [preliminary needs assessment](#), implemented an on-going process evaluation, designed a preliminary outcome evaluation plan, and initiated plans to develop a community resource dashboard for local providers.

Needs assessment and site selection

The purpose of the preliminary needs assessment was to inform the identification of potential school districts across the Commonwealth of Massachusetts in which TBH services in schools would be most appropriate and feasible. Data from multiple sources were analyzed by Brandeis University researchers, including the Massachusetts Department of Elementary and Secondary Education, Brandeis University's Child Opportunity Index, Behavioral Risk Factor Surveillance System (BRFSS), the University of Massachusetts BIRCh Project, and the Massachusetts Department of Public Health (MDPH). Using five key indicators (community mental health status, child opportunity, school needs, race/ethnicity, and school district resources), 43 school districts (38 non-charter and 5 charter districts) located in 13 of the 14 counties in Massachusetts were identified for priority participation in the pilot project. A [final report](#) on the needs assessment was completed in August 2022.

Of all active sites, three districts - Narragansett, Ralph C Mahar, and Berkshire Hills – were not included in the preliminary needs assessment. Berkshire Hills was incorporated into the pilot to address significant behavioral health provider shortages in this region and emerging needs identified by the district, including a growing numbers of immigrant families and families experiencing socioeconomic hardships who are in need of culturally responsive and linguistically appropriate behavioral health services. Narragansett and Ralph C. Mahar were invited into the pilot to ensure continuity of pre-existing school-based tele-behavioral health services when external funding was not renewed. These districts serve a high percentage of students who face behavioral health inequities, including students with disabilities, students who are lower-income, and students who identify as LGBTQ+.

Process evaluation

The process evaluation utilizes a mixed-methods design, utilizing multiple data sources (e.g., providers' electronic record management systems, meeting notes, contract information, key informant interviews, focus groups, and surveys from providers, student participants, and their parents/guardians). One component of the evaluation is to differentiate and define the different models of school-based TBH as well as to investigate aspects of service uptake and delivery. Currently, there are 2 main models of school-based TBH services: 1) TBH clinician + CHWs available in-person and 2) TBH clinician + Care Coordinator available remotely. As the

project continues to expand additional provider organizations, there may be other models of service delivery.

Another component of the evaluation is to track the TBH services provided to students and families. As of March 31, 2023, 289 students were referred for school-based TBH services and 260 students and families are currently receiving services through this pilot. On average, students receive 14 TBH sessions during the time they are engaged in the pilot. Additionally, by engaging the Narraganset and Ralph C. Mahar school districts, this pilot prevented approximately 120 students in rural areas with limited-service access from being prematurely terminated from active TBH services due to a loss of external funding. Preliminary data are provided in the appendix to this report.

A third component of the evaluation is to identify additional needs for high priority populations. Emergent findings related to equity in access will be explored with ongoing evaluation efforts to investigate service experiences of high priority populations. Early findings from the process evaluation indicate a high demand for services (all sites have referrals pending), as well as additional needs for supports related to social determinants of health (SDoH), including housing, food, clothing, and employment support. There have been 170 referrals for SDoH-related needs with data from three active sites still pending.

Next steps of the process evaluation will include an expanded presentation of service delivery data for each site, as well as information about the clinicians and CHWs/Care Coordinators, including demographics, TBH and equity-driven trainings accessed, satisfaction with work, and their insights on program improvement. Additionally, disaggregated data based on race/ethnicity and LGBTQ+ identity will be reported for service access, with information on service use, outcomes, and satisfaction with services.

Outcome evaluation

The outcome evaluation will rely on multiple data sources, including publicly available data from Massachusetts Department of Elementary and Secondary Education and Brandeis University's Child Opportunity Index, as well as data obtained from participating provider organization's electronic health record system. The key questions explored will include:

- Improvements in provider's competency (e.g., cultural sensitivity, evidence-based practices, assessments).
- Improvements in behavioral health outcomes (e.g., anxiety, depression, substance use) for student participants).
- Reduced barriers to behavioral health services (e.g., reductions in wait times, length of engagement in services).
- Reduced racial/ethnic disparities in behavioral health services (e.g., monitor demographic characteristics of school district level vs. students receiving TBH services over time).

The evaluation plan is being discussed with MDPH, with feedback from the interagency working group, and will be developed in fall 2023 before additional schools onboard with the pilot program.

Ongoing and Proposed FY2024 activities

BCCMH, in collaboration with the MDPH's Division of Child/Adolescent and Reproductive Health and the Interagency Working Group, will continue the pilot implementation and evaluation process in FY2024 with the following goals:

- Service expansion to an additional 10-15 school districts
- Increased engagement of additional community-based behavioral health providers to better meet the growing need for youth mental health and substance use services
- Broadening the type of services provided to include both early intervention services (and more intensive school-based treatment
- Expansion of CHWs at pilot sites
- Comprehensive data collection and ongoing evaluation

Conclusion

In conclusion, the Fiscal Year 2023 Tele-behavioral Health Pilot Program in Schools was successful in achieving its goals. The project increased access to mental health services for students in selected school districts across the state, built the capacity of schools and provider agencies to support sustainability, and began capturing needed data to evaluate impact and capture best practices. BCCMH will continue to work with MDPH to expand the use of telehealth technologies in the provision of mental health and substance use treatment services to students across the state.

Thank you for your support and for the opportunity to implement this important project.

Appendix A: Table 1.

Summary of School-Based Telebehavioral Health Services Between July 1, 2022-March 31, 2023

School District	School Sites (grades served)	Number of Referrals (Students)	Completed Intakes (Students)	Number of TBH Sessions (Students)	Number of TBH 'No Shows' (Students)	Number of Referrals Closed w/o Services	Pending Referrals End of Month	Active Caseload End of Month	Number of Additional Needs Referrals*
Athol	Athol-Royalston Middle ^A (5-8)	53	27	533	57	18	14	46	12
	Athol High ^B (9-12)	13	6	239	25	0	11	30	31
Gardner	Gardner Middle ^A (5-7)	56	36	490	71	23	10	29	87
	Gardner High (8-12) & Gardner Academy ^B (9-12)	11	7	201	54	3	3	30	6
Ralph C Mahar ¹	RC Mahar Regional ^B (7-12)	10	5	243	13	2	21	32	8
Narragansett Regional ²	Narragansett Regional Middle (5-7) & High ^B (8-12)	9	7	332	32	7	15	40	11
Berkshire Hills	Muddy Brook Elem. ^B (PK-4), DuBois Middle ^B (5-8), & Monument Mountain High ^B (9-12)	22	10	38	2	3	19	9	Pending
Lowell	TBD specific schools ^C (9-12)	3	0	0	0	0	3	0	Pending
Salem	TBD specific schools ^B (3-12)	112	59	123	35	14	23	44	Pending
TOTALS		289	157	2199	289	70	119	260	170

Contract start dates: ^AJuly 1, 2022, ^BJan 1, 2023, ^CMarch 15, 2023

¹Serves students in the towns of New Salem, Orange, Wendell, and Petersham

²Serves students in the towns of Templeton and Phillipston

³Serves students in the towns of Great Barrington, Stockbridge, and West Stockbridge

*Began tracking October 1, 2022: Mental Health (51), Health Insurance (31), Other (20), Recreation (11), Clothing/Personal Items (10), Employment/Volunteer (9), Food (7), Educational Support (7), Housing (6), Support Group (6), Peer Support (4), Furniture/Household (1), Legal (1).