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VIA EMAIL: dbh.policy@dc.gov

April 1, 2026
Mia Olsen
Interim Deputy Director, Data, Quality and Compliance
Department of Behavioral Health
64 New York Ave NE
Washington, DC 20002

Re: Comments on Community Support Second Notice of Proposed Rulemaking

Dear Mia Olsen:

Thank you for the opportunity to comment on the Second Notice of Proposed Rulemaking for Community Support services authorization criteria. I write to submit these comments on behalf of Children's Law Center (CLC), which fights so every DC child can grow up with a stable family, good health, and a quality education. Our clients include children who are in foster care, students with special education needs or health conditions, and caregivers who need legal support. Our team of guardians ad litem (GAL) represents over half the kids in DC's foster care system. Over a third of the children represented by our GAL team last year were diagnosed with behavioral health conditions.¹ Our clients rely heavily on Community Support services to remain safely housed, engaged in school, and connected to outpatient behavioral health care. Because Community Support services often function as the only immediately available intervention for children who do not yet meet—or cannot access—higher levels of care, authorization criteria that improperly restrict access create a significant risk of harm. Children's Law Center urges DBH to revise the proposed Community Support authorization criteria to avoid restricting access to essential services for children and youth. As drafted, the rule relies on functional assessment cutoffs and diagnostic categories that are inconsistent with clinical practice, misaligned with DSM-5-TR standards, and insufficiently responsive to the realities of service availability in the District. These provisions risk disadvantaging children—particularly those in foster care or awaiting higher levels of care—by reducing or terminating Community Support at moments of heightened need. CLC recommends targeted revisions to ensure that criteria reflect developmental differences, permit appropriate clinical judgment, and do not create service gaps that undermine stability, safety, and treatment continuity.

Subsection 3421.6 (c)

This subsection proposes a method of determining how many Community Support units a consumer can receive based on their functional assessment score. The manner in which impairment levels are delineated conflict with DBH's goals of ensuring the most appropriate level of care and promoting transitions to higher and lower levels of care based on needs and

functioning. This approach lacks any articulated clinical or empirical justification and creates internal contradictions within DBH's own service eligibility framework.

For the Child and Adolescent Functional Assessment Scale (CAFAS), the impairment level justifications detailed in the proposed rulemaking ignore dysfunction level cutoffs and descriptions provided in the CAFAS self-training manual.² The rulemaking's arbitrary choice of cutoff scores not only conflicts with official CAFAS implementation guidance, it also provides justifications that do not match with practice across DC's continuum of care for children.

In the rulemaking, CAFAS between 80-110 qualifies a child for the highest number of Community Support units. A CAFAS score of 80 also qualifies a child to receive Community-Based Intervention (CBI) services, a higher, more intensive level of care. In the impairment level/justification column of the rulemaking, there is no recommendation to refer to a higher level of care for this score range. This recommendation only appears for the higher score range of 120 or more. With the proposed breakdown, a child can receive the most Community Support units at the precise point they become eligible for intensive clinical services. This contradicts DBH's stated goal of shifting from a reliance on non-clinical services to clinical services. By authorizing the highest number of Community Support units at the same CAFAS score that triggers eligibility for Community-Based Intervention, the rule encourages continued reliance on non-clinical services at the precise moment DBH asserts a need to transition youth to clinical care.

For those children who do have higher scores, the availability of higher levels of care should be considered in rulemaking. With a dwindling number of CBI providers, limited options for Intensive Outpatient Programs and Partial Hospitalization Programs, and no local Psychiatric Residential Treatment Facility, cutting off eligibility for Community Support puts youth with CAFAS scores of 120 or more in a predicament of waiting for higher levels of care without any type of support present. Cutting off eligibility without ensuring immediate access to higher levels of care places youth in an untenable position of documented need with no authorized service and disproportionately harms children involved in the child welfare system and children of color, who already face longer wait times and fewer provider options.

This subsection also problematically creates a false equivalence between the adult Daily Living Activities assessment (DLA-20) and CAFAS tools by using cutoff scores that do not recognize the substantive differences between the tools and could lead to biased impacts on adult and child consumers.

First, the DLA-20 and CAFAS assess functioning through wildly diverging constructs. The DLA-20 assesses "how often or how well the consumer independently performed or managed each of the 20 Activities of Daily Living (ADLs) in the community during the last 30 days."³ The CAFAS, meanwhile, presents a list of behaviors indicating varying levels of impairment across 8 subscales⁴ and tasks the rater with indicating the worst behavior the consumer has exhibited in each subscale. The time period of assessment can be over the last month, three months, or some other range of time.⁵ Mapping the allowable number of Community Support units to the results of assessment tools that use different frequencies and methods of assessment leads to important discrepancies in how adult and child consumers will qualify for units of service. Because the CAFAS captures fewer domains and can be less responsive to deterioration in daily functioning relevant to Community Support interventions, children are structurally less likely than adults to qualify for increased units—even when their needs escalate.

The DLA-20 assesses more areas of functioning than the CAFAS, offering more opportunities for changes in score and thus resulting allowances for different levels of Community Support units. Nutrition, grooming, dress, and managing money are some of the activities of daily living assessed in the DLA-20 that are not assessed by the CAFAS. The effect this has is, for instance, if a child's grooming⁶ worsens due to their mental health status, this will have no impact on their CAFAS score, therefore not influencing a potential increase in how many Community Support units they can receive. However, the same deterioration in grooming could push an adult over the threshold to receive more units. The age bias created by this subsection puts children at a disadvantage in their ability to receive services that fit their needs.

Subsection 3421.14 (a)

The clinical necessity criteria detailed in this subsection require that a consumer have a primary diagnosis that falls under one of seven listed diagnostic categories. The naming of these categories leaves open questions about which specific diagnoses make a consumer eligible for Community Support, and the rulemaking does not explain why other diagnoses would not meet eligibility.

First, the diagnostic category names should align with those contained in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR), the latest version of the manual that qualified practitioners use to diagnose. This would help to avoid confusion around what diagnoses qualify. Clarity in the rulemaking is necessary to understand Community Support authorization requirements and decision-making related to accepting or rejecting authorizations. For example, the category (3) Affective Disorders is not in the DSM-5-TR. Rather, Bipolar and Related Disorders and Depressive Disorders together cover what seems to be intended by this category.⁷ Also, Delusional Disorder is categorized under Schizophrenia Spectrum and Other Psychotic Disorders in the DSM-5-TR rather than a separate category as this subsection denotes. Another issue is displayed in categories (5) Obsessive Compulsive Disorder and (6) Personality Disorder. The use of singular nouns here implies that only the specific diagnoses named qualify, but the DSM-5-TR lists multiple diagnoses under the categories of Obsessive-Compulsive and Related Disorders and Personality Disorders. For instance, Hoarding Disorder is categorized under the DSM-5-TR's Obsessive-Compulsive and Related Disorders, but the way this subsection is written it appears this diagnosis would not qualify a consumer for Community Support.

To align with DSM-5-TR nomenclature and diagnostic practice, the subsection must be revised to at minimum read as follows:

- (a) A Diagnostic Assessment of the consumer has been performed within twelve (12) months of the request for Community Support services that contains at least one (1) primary diagnosis within the following DSM- 5-TR diagnostic categories:
 - (1) Schizophrenia Spectrum and Other Psychotic Disorders
 - (2) Bipolar and Related Disorders
 - (3) Depressive Disorders
 - (4) Trauma- and Stressor-Related Disorders
 - (5) Obsessive-Compulsive and Related Disorders

- (6) Personality Disorders
- (7) Anxiety Disorders

Additionally, there are several other DSM-5-TR diagnostic categories that are not included in this subsection, and DBH has not provided any explanation for why. For example, the DSM-5-TR's Neurodevelopmental Disorders category includes Attention-Deficit/Hyperactivity Disorder, a very common childhood diagnosis⁸ that should allow a child to receive Community Support services. DBH should review each DSM-5-TR diagnostic category to ensure there is no unjustified exclusion of diagnoses and thus consumers. DBH should clarify that diagnoses within the referenced categories—including childhood-onset and neurodevelopmental conditions—are not excluded absent an express and clinically supported rationale.

Subsection 3421.15

As Children's Law Center pointed out in earlier public comments on the initial proposed rulemaking, part (a) of this subsection does not account for subjectivity that is baked into some of the CAFAS subscales. Just because an objective number results from scoring the assessment does not mean the methods are fully objective. There are CAFAS subscales with a level of subjectivity that contradicts DBH's desire to have objective clinical necessity criteria. A case study in Michigan highlighted concerns around the subjectivity and superficiality of the CAFAS as a reason that some providers hesitated to use it to determine service eligibility.⁹ For instance, in the Behavior Toward Others subscale, a score of 10, reflecting mild impairment, can be assigned if a child is "unusually quarrelsome, argumentative, or annoying to others".¹⁰ These are subjective behaviors because "unusual", "quarrelsome", "argumentative", and "annoying" all have no objective clinical definition. Due to this, different raters can assess these behaviors differently, potentially leading to an unchanging score after 180 days and incorrect interpretation that progress hasn't been made and Community Support isn't working.

The CAFAS also contains some subscales that are more resistant to change than others. For example, within the School/Work subscale, a child can score a 20, reflecting moderate impairment, by having a grade average lower than "C".¹¹ This grade average could persist after 180 days due to factors outside of what Community Support services can directly impact. This should not prevent a child from receiving a reauthorization of services. Conditioning reauthorization on numerical improvement alone risks penalizing children for factors unrelated to treatment efficacy, and a lack of score change should not be equated with lack of clinical benefit.

Lastly, a child's lack of improvement could be due to the Community Support Worker's lack of engagement or poor skills, an issue many of our clients have experienced. To prevent reauthorization of services based on lack of improved CAFAS scores punishes children who receive low-quality services.

Subsection 3421.16

This subsection also presents a problem due to the subjective nature of some CAFAS subscales. A consumer may not experience measured functional declines but could still require more time with their provider than allotted in a 180 period in order to make progress.

Concerns raised about the content validity of the CAFAS present a roadblock in measuring functional decline in the way DBH is expecting in this proposed rulemaking. Within each CAFAS subscale, there are behaviors described within each level of impairment that arguably should not be grouped together.¹² For instance, in the Home subscale, frequent use of profane, vulgar, or curse words to household members is rated as moderate impairment with a score of 20, but so is the act of deliberate damage to the home.¹³ These two behaviors could reasonably be perceived to have different severities, but the CAFAS doesn't allow for that. So, a child's behavior could change from cursing in the home to damaging the home, and the CAFAS score would stay the same, preventing authorization for more Community Support units even though it could reasonably be said the child's behavior has worsened.

We recommend that DBH explicitly authorize the clinical summary written by a qualified practitioner to explain why a consumer needs more Community Support units despite the CAFAS score not worsening. There needs to be room for clinical judgement to explain what can't be captured in a functional assessment. DBH should allow supplemental Community Support units based on a qualified practitioner's clinical summary even in the absence of measurable functional decline, because standardized tools may fail to capture meaningful deterioration during periods of crisis.

Conclusion

Thank you for the opportunity to provide comments on this Proposed Rulemaking. As the District comes up with ways to reign in overuse of Community Support, clinical criteria for authorization must align with clinical practice and not disadvantage children. If you have any questions or would like to discuss anything further, please feel free to reach out to me at cgamble@childrenslawcenter.org.

Sincerely,

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¹ Internal Children's Law Center Data Collection, "GAL Deep Dive," October 1, 2024 through September 30, 2025.

² Kay Hodges, *CAFAS Self-Training Manual*, MHS, (2012). In this manual, the levels of overall dysfunction based on youth's total score are as such:

0-10: Youth exhibits no noteworthy impairment.

20-40: Youth likely can be treated on an outpatient basis, provided that risk behaviors are not present.

50-90: Youth may need additional services beyond outpatient care.

100-130: Youth likely needs care which is more intensive than outpatient and/or which includes multiple sources of supportive care.

140 & higher: Youth likely needs intensive treatment, the form of which would be shaped by the presence of risk factors and the resources available within the family and the community.

³ W.S. Presmanes and R.L. Scott, *Daily Living Activities* (©DLA-20): Adult Mental Health, *available at*: <https://recoverytechnology.org/wp-content/uploads/DLA20-Adult-Assessment-of-Functioning09.pdf>.

⁴ The subscales are School/Work Role Performance, Home Role Performance, Community Role Performance, Behavior Toward Others, Moods/Emotions, Self-Harmful Behavior, Substance Use, and Thinking.

⁵ Kay Hodges, *CAFAS Self-Training Manual*, MHS, (2012).

⁶ Defined by the DLA-20 as caring for hair, hands, general appearance; shaving.

⁷ DSM-5 Table of Contents, *available at*:

https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-5-Contents.pdf.

The Organization of DSM-5-TR, *available at*: <https://www.psychiatry.org/getmedia/0191c8c8-4151-4bde-9cba-263db78a2734/APA-DSM5TR-TheOrganizationofDSM.pdf>.

⁸ Data and Statistics on ADHD, *available at*: <https://www.cdc.gov/adhd/data/index.html>.

⁹ Patti Banghart & Janice L. Cooper, *Unclaimed Children Revisited: Focusing on Outcomes – A Case Study of the Michigan Level of Functioning Project*, National Center for Children in Poverty (May 2010), *available at*: <https://www.nccp.org/unclaimed-children/>.

¹⁰ Kay Hodges, *CAFAS Self-Training Manual*, Multi-Health Systems Inc, (2012).

¹¹ *Id.*

¹² Michael Phillip Bates, *The Child and Adolescent Functional Assessment Scale (CAFAS): Review and Current Status*, Clinical Child and Family Psychology Review, (April 2001), *available at*: <https://www.semanticscholar.org/paper/The-Child-and-Adolescent-Functional-Assessment-and-Bates/86838aede278e44cb11160b7de32ff22c53fbb97>.

¹³ Kay Hodges, *CAFAS Self-Training Manual*, Multi-Health Systems Inc, (2012).