Protection and Advocacy and Client Assistance Program Services in Arkansas

Fiscal Year 2020
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BACKGROUND

DISABILITY RIGHTS ARKANSAS (DRA) is a private non-profit agency located in Little Rock, Arkansas. Since 1977, the Governor of Arkansas has designated DRA the independent Protection and Advocacy system for persons with disabilities in Arkansas. DRA operates under authority outlined in federal law, is funded primarily by the federal government and is governed by a Board of Directors. DRA collaborates with other disability rights and civil rights organizations, service agencies, the private bar and legal services to accomplish identified goals and objectives. DRA’s services are offered statewide at no cost to individuals with disabilities.

Protection & Advocacy for Individuals with Mental Illness (PAIMI)
PAIMI serves individuals with a diagnosis of serious mental illness. PAIMI prioritizes services to individuals receiving care and treatment in a facility and has a mandate to investigate complaints of neglect and abuse. See the Protection and Advocacy for Individuals with Mental Illness Act of 1986, as amended, 42 U.S.C. § 10801 et seq.

Protection & Advocacy for Individuals with Developmental Disabilities (PADD)
PADD serves individuals with developmental disabilities, including intellectual disabilities, autism, epilepsy, cerebral palsy and neurological impairments. A developmental disability is a mental or physical impairment beginning before the age of 22, which is likely to continue indefinitely, limits certain major life activities and reflects a need for special care, treatment and/or individualized planning. See the Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. § 15001, et seq.

Client Assistance Program (CAP)
CAP assists individuals with disabilities who have questions or have encountered problems while receiving or applying for vocational rehabilitation (VR) services from state VR agencies. CAP also advocates for those who receive services from Independent Living Centers (ILCs), The Division of Services for the Blind (DSB), and for those applying for or receiving services from Tribal VR offices. See the Rehabilitation Act of 1973, as amended, Title I, Part B, Sec. 112, 29 U.S.C. § 732.

Protection & Advocacy of Individual Rights (PAIR)
PAIR serves individuals with disabilities who do not qualify for the protection and advocacy services described above. It is not limited to individuals with a specific disability or facing a certain issue. See the Protection and Advocacy of Individual Rights Program of the Rehabilitation Act of 1973, as amended, 29 U.S.C. § 794e.

Protection & Advocacy for Assistive Technology (PAAT)
PAAT serves individuals with disabilities with issues related to assistive technology devices and services. This includes investigating the denial of, and negotiating access to, assistive technology devices and services, as well as educational outreach efforts. See the Assistive Technology Act of 2004, 29 U.S.C. § 3004.
Protection & Advocacy for Beneficiaries of Social Security (PABSS)
PABSS serves individuals with disabilities who receive Social Security Disability Insurance (SSDI) or Supplementary Security Income (SSI) and who are trying to return to work, obtain employment, or receive certain employment-related training and services. PABSS educates beneficiaries about Social Security’s work incentives and provides vocational rehabilitation and employment services advice. Additionally, PABSS assists beneficiaries with understanding their rights regarding representative payees. See the Ticket to Work and Work Incentives Improvement Act of 1999, as amended, 42 U.S.C. § 1320b-21.

Protection & Advocacy for Traumatic Brain Injury (PATBI)
PATBI serves individuals diagnosed with a traumatic brain injury (TBI). PATBI works to ensure that individuals with traumatic brain injuries and their families have access to information, referrals and advice, individual and family advocacy services, legal representation, and support and assistance with self-advocacy. See the Traumatic Brain Injury Act, authorized as part of the Children’s Health Act of 2000, 42 U.S.C. § 300d-53.

Protection & Advocacy for Voting Access (PAVA)
PAVA educates and assists individuals with disabilities so they may enjoy full participation in the electoral process. These efforts include ensuring physical accessibility of polling places and informing individuals about the rights of voters with disabilities. See the Protection and Advocacy for Voting Access program of the Help America Vote Act of 2002, 42 U.S.C. § 15461-15462.

Strengthening Protections for Social Security Beneficiaries (SPSSB)
SPSSB, also known as the Representative Payee program, serves individuals with disabilities whose social security benefits are managed by a representative payee. DRA coordinates with the Social Security Administration to conduct periodic onsite reviews as well as additional discretionary reviews to determine whether a representative payee is carrying out their duties in keeping a beneficiary safe and ensuring their needs are being met. See the Strengthening Protections for Social Security Beneficiaries Act of 2018, 42 U.S.C. § 405(j).

CLIENTS

Arkansas is known for having one of the highest percentages of residents with disabilities in the country, although because its total population is relatively low, Arkansas is a minimum allotment state for the federal grants that fund DRA’s work. The United States Census Bureau’s population estimates as of July 2019 indicates the state’s total population to be 3,017,804, with a disability rate of 12.6%. The following chart provides a breakdown of the 936 service requests received by DRA in FY2020, by age range and disability.
Clients by Age and Disability

DRA assisted individuals from infant to age 99 in FY2020. A breakdown of the age demographic showed 61% of the service requests represented individuals between the ages of 19 and 64, which is often considered “working age”, while 7.2% of the service requests represented individuals 65 and older and 30.7% of the service requests represented individuals 18 and younger (1.1% were of an unknown age).

The following chart shows a breakdown of the service requests by an individual’s disability:

<table>
<thead>
<tr>
<th>Disability</th>
<th>Number of Service Requests</th>
<th>Percentage of Service Requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Illness</td>
<td>206</td>
<td>22%</td>
</tr>
<tr>
<td>Developmental Disability</td>
<td>240</td>
<td>25.7%</td>
</tr>
<tr>
<td>Physical/Orthopedic</td>
<td>194</td>
<td>20.7%</td>
</tr>
<tr>
<td>Visual/Hearing</td>
<td>64</td>
<td>6.9%</td>
</tr>
<tr>
<td>Brain Injury</td>
<td>31</td>
<td>3.3%</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>31</td>
<td>3.3%</td>
</tr>
<tr>
<td>Neurological Disorders</td>
<td>34</td>
<td>3.6%</td>
</tr>
<tr>
<td>Other Disabilities</td>
<td>136</td>
<td>14.5%</td>
</tr>
</tbody>
</table>

SERVICE REQUESTS

DRA received 936 requests for services in FY2020, a decrease of 26.5% over the 1,274 requests received in FY2019, but only an 8.8% decrease over the 1,026 requests received in FY2018. The charts below show the distribution of the requests by grant funding and by priority. The “None” category represents requests for services that did not fall into one of the established priority areas; requests that do not meet a priority are still provided assistance, but will usually be provided with information and referral services rather than case-level advocacy.

Service Requests by Program

<table>
<thead>
<tr>
<th>Program Funding Source</th>
<th>PAIMI</th>
<th>PADD</th>
<th>CAP</th>
<th>PAIR</th>
<th>PAAT</th>
<th>PABSS</th>
<th>PATBI</th>
<th>PAVA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count of Service Requests</td>
<td>127</td>
<td>231</td>
<td>42</td>
<td>455</td>
<td>12</td>
<td>39</td>
<td>27</td>
<td>3</td>
</tr>
</tbody>
</table>
Priority Areas Covered by Service Requests

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Count of Service Requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse, Neglect, and Exploitation</td>
<td>73</td>
</tr>
<tr>
<td>Employment</td>
<td>44</td>
</tr>
<tr>
<td>Education (Vocational Rehabilitation)</td>
<td>120</td>
</tr>
<tr>
<td>Institutionalization of Youth</td>
<td>19</td>
</tr>
<tr>
<td>Medicaid/Managed Care</td>
<td>29</td>
</tr>
<tr>
<td>Self-Advocacy/Guardianship</td>
<td>13</td>
</tr>
<tr>
<td>Voting</td>
<td>3</td>
</tr>
<tr>
<td>None/Other</td>
<td>635</td>
</tr>
</tbody>
</table>

Some of the requests for services that fell in to the “None/Other” category include government benefits and services (105 requests), employment (non-vocational rehabilitation- 92 requests), housing (87 requests), education (that did not meet priority- 77), accessibility (52 requests), rights violations (38 requests), and healthcare (27 requests). DRA also continues to receive numerous calls related to guardianship, transportation, and home- and community-based services. Information and referral services are provided to clients with issues that do not meet DRA priorities or for which DRA does not have sufficient resources to provide a higher level of assistance.

Whenever possible, DRA seeks to inform and educate clients so they may effectively self-advocate. In addition to empowering an individual to resolve issues for themselves, this serves to make the relationship between the client and the other party less adversarial than when a third party such as DRA intervenes, and is also a means by which DRA can serve more individuals with fewer resources.

Case Examples of DRA work in FY2020

Example 1: DRA represented a family trying to obtain an increase in private duty nursing services for their infant son. The use of a feeding tube and supplemental oxygen necessitated constant supervision 20 hours a day and made him eligible for private duty nursing services. The client’s father had recently become paralyzed and was undergoing rehabilitation, so he was not able to assist in the care of his child. The client’s mother was the sole wage-earner in the home, and worked 10 hours a day, five days a week. The Arkansas Department of Human Services (DHS) approved only eight hours a day of private duty nursing, due to its presupposition that it could “cap” service hours. Meanwhile, the mother was required to supervise the child’s feeding tube and oxygen the 14 hours a day she was not at work, since the approved hours were provided while she was at work. DRA attorneys filed an administrative appeal of the eight hours of services per day decision, and after three days of testimony the family was awarded 20 hours of private duty nursing, seven days per week. This decision allowed the mother to continue working and providing for her family, and potentially
prevented the child from being placed in a residential facility to meet his complex medical needs.

Example 2: DRA was approached by a youth at one of the juvenile treatment centers (JTC) DRA has been monitoring with a request to assist him with not being able to take a general educational development (GED) test. This youth was at the JTC to receive mental health services with a goal of preventing further contact with law enforcement once he was released. He told DRA monitors he had requested to take the GED exam for which he had been independently studying; however, despite the onsite GED instructor’s endorsement of the student’s readiness to test, the facility staff repeatedly failed to arrange transportation to the testing site for the student. The facility also had a protocol in place whereby only two residents were permitted to take the test each month, resulting in a months-long delay from the time a resident initiated the process to test until the date in which they could finally take the exam. A DRA attorney advocated for the resident to take the exam without further delay, noting that needlessly prolonging a juvenile’s commitment—which occurs when a facility hampers the ability of a resident to meet preconditions for release—risks an infringement on that juvenile’s constitutional rights. Ultimately, the facility agreed to ensure that exams would be scheduled in a timelier manner, and this resident earned his GED shortly thereafter.

Example 3: A student diagnosed with autism spectrum disorder was being restrained excessively at school following the implementation of a due process settlement agreement, and the school district subsequently decided to remove the student from school for the remainder of the 2018-2019 school year in violation of the Individuals with Disabilities Education Act (IDEA). DRA responded on the student’s behalf by filing a second due process complaint. The student’s parents and the school district executed a second settlement agreement in which the school district agreed to allow the student to return to school and provided the student with a new paraprofessional, compensatory education, and a behavior intervention plan (BIP) developed by a Board-Certified Behavior Analyst (BCBA). The school district also agreed to train school staff on the BIP. The student started the 2019-2020 school in regular classes and has remained in regular classes, without a single incident of being physically restrained.

Example 4: An individual with a spinal cord injury who receives attendant care services to assist him with activities of daily living contacted DRA after his attendant care hours were drastically reduced following a needs assessment, despite a decline in his physical state. The client had experienced several pressure ulcers that were preventing his return to work, and the reduction of attendant care hours were making his return to work less likely. To ensure the client accessed adequate home healthcare services, a DRA attorney appealed the reduction in hours. After a full-day hearing, the client was permitted to be reassessed consistent with the orders of the hearing officer. After the reassessment, the client was reinstated to his previous number of hours, allowing him the attendant care necessary to address his immediate healthcare needs and removing the barrier to returning to work.
Example 5: An assisted living facility resident who was deaf was not being provided an effective means of communication by the facility. DRA attorneys educated the facility’s attorney about the client’s rights to effective communication under the Americans with Disabilities Act (ADA) and the Fair Housing Act (FHA). Although the client moved to another facility to be closer to her son before a resolution was reached, prior to her leaving the facility did provide the client with a strobe light device to alert her of a fire or a carbon monoxide leak, provided her with an electronic tablet for communicating, and recruited and hired a certified nursing assistant (CNA) who knew some American Sign Language (ASL).

Example 6: A student who requested brailled sheet music so he could participate in an All-Region and All-State choir and band tryouts was denied this accommodation; the organization in charge of the tryouts also refused to make any other accommodations. The student called DRA before the annual tryout and requested assistance in securing brailled sheet music. A DRA attorney contacted the organization in charge of the tryouts and advocated on behalf of the client, explaining to the organization its legal obligations to accommodate individuals with disabilities. The organization subsequently agreed to provide the student with brailled sheet music and extended time to read the music prior to his performing.

Example 7: An individual with physical disabilities contacted DRA in September 2020 to request assistance with a county courthouse whose accessible entrance was being kept locked because of the pandemic, requiring all visitors to use the inaccessible front entrance. When the caller complained to the county clerk, she reportedly told him the entrance was locked by order of the county judge and would not be unlocked to accommodate voters with disabilities, despite the courthouse’s designation as an early voting site. The judge was reportedly also refusing to post a phone number visitors could call to have it opened on an as-needed basis. DRA contacted the county clerk, who stated the door was now unlocked and would remain unlocked through election day.

Example 8: The parent of a PADD-eligible student contacted DRA after the student’s school district refused to allow the student back in class, refused to provide homebound services, and advised the parent her only option was to seek residential treatment for her son. The parent alleged this occurred because of behavioral issues manifested by her son’s autism. A DRA attorney attended a placement meeting in which the school ultimately agreed to provide homebound services to the student. This proved in the short-term to be a positive experience for the student and his family, although they subsequently decided to move to a different school district for a fresh start. The child will begin attending the new school district one day per week and all parties are working to continue homebound services with the same teacher from the original school district, effectively extinguishing the ultimatum to secure residential treatment services.

Example 9: A family member of a man with an orthopedic impairment contacted DRA when the individual was transferred to a cashier position after working in maintenance for 18 years. In his previous role he worked on his knees for 50% of his shift, but as a cashier he was on his feet for the entire shift, which was causing him a lot of pain. He requested a stool so he could
Example 10: DRA assisted an advocate in Northwest Arkansas who was working with a student diagnosed with a mental illness who was presenting a significant elopement risk at school. The client’s school district was seeking to place him in a psychiatric residential treatment facility (PRTF) because they determined they could not provide him with an appropriate educational setting. The client’s treating psychiatrist stated that a PRTF is not a suitable environment for him, so DRA advised the advocate to press for mental health outpatient therapy as a viable alternative, and for a classroom aid, which should significantly mitigate the elopement risk. Ultimately, the client was able to remain in school, and with access to better mental health services and supports.

Example 11: The mother of a deaf student whose Individualized Education Plan (IEP) specified a full-time American Sign Language (ASL) interpreter contacted DRA when the school district did not follow through with providing an interpreter full-time. The district did not have enough ASL interpreters for each of the students to always have someone available, so there were certain classes each day where students did not have an interpreter available to them. This led to extreme frustration for this student and resulted in behavior issues and declining grades. A DRA attorney filed a state complaint on the student’s behalf, and the school district was told they must comply by giving this student a means to communicate throughout the entire day. The school hired more ASL interpreters to ensure that each student would have appropriate access to full-time interpreters. DRA’s client also received the speech therapy services he needed and is now performing according to his ability and without behavioral issues because he can communicate and interact with his classmates and teacher all day at school.

PROJECTS

Systemic Issues

DRA has been working to address the overreliance on institutional placements to treat youth diagnosed with serious mental illnesses, as well as youth with less severe mental health and behavioral disorders. These adolescents are often placed in psychiatric residential treatment facilities (PRTFs), juvenile treatment facilities, and/or juvenile detention facilities due to a lack of community-based resources, the proliferation of for-profit residential treatment entities, lax regulations, and a lack of understanding regarding the utility of institutional-based services. Like many other states, Arkansas lacks sufficient community-based resources, and while this issue has been acknowledged by various stakeholders in relation to the state’s juvenile justice system, tangible steps to increase community-based services have yet to be formulated. DRA
has discovered an alarming overlap between the juvenile justice system and PRTFs. Among our observations: children being continuously cycled amongst the PRTFs and acute care facilities, children committed to the Arkansas Department of Human Services, Division of Youth Services (DYS) prior to and upon release from PRTFs and acute care facilities, and PRTFs being used as a diversion option from DYS without officials understanding the true nature of the programs or experiences of youth institutionalized in these facilities. Minimal regulations and lax oversight by the state have led to a proliferation of for-profit PRTF beds and facilities in the state, mostly for out-of-state placements. The monitoring of facilities by the state is disjointed and has not adequately addressed health and safety concerns for residents, much less examined the quality of care and outcomes for youth receiving treatment. DRA monitored, and will continue to monitor, all 12 PRTFs and all five DYS juvenile treatment centers, with a goal of issuing a public report in FY2021 on the overreliance of institutionalization in the state, specifically focusing on PRTFs. The hope is this report will bring attention to the issue and persuade more stakeholders to engage in these issues. We also plan to assess and compare Arkansas’ regulations with other states’ regulations and work with DHS to propose and advocate for meaningful changes to the state’s regulations and oversight of these facilities.

In response to the COVID-19 pandemic, we had to alter the way that we monitor facilities while simultaneously trying to track and understand these facilities’ responses to infectious disease. The increased risk of infection inherent in congregate care settings was not the only risk COVID-19 posed to residents; it also meant no visitation for the residents, no trips outside the facilities, decreased oversight of the facilities, and the potential for substantially decreased staffing due both to infection and attrition based on unwarranted risk. Early in the pandemic, we recognized these realities would exacerbate the problems we had already encountered and foster environments ripe for abuse and neglect. Tracking cases by facility would not be sufficient; therefore, we developed a survey to send to all youth treatment facilities. In developing the survey, we were mindful of balancing our need for comprehensive feedback and an overly cumbersome survey that would negatively impact our response rate, which ended up being 100%. As the pandemic continued, we updated the survey and periodically sent it to facilities. These survey results allowed us to gauge the efficacy of facility precautions and be alert to potential red flags such as high infection rates or significant staff vacancies. Through these efforts we were also able to identify and report discrepancies between infection rates reported to DRA and those reported to the Arkansas Department of Health.

Meanwhile, DRA received several complaints from staff at a PRTF regarding the infection control protocols implemented in response to the COVID-19 pandemic. Staff reported that they were not provided masks and had to bring their own, many staff were not wearing masks, residents were not wearing masks, new residents were not being quarantined, and while facility-wide testing occurred, staff were not notified of their results, or the results were inconclusive. DRA monitors conducted video interviews with residents in which they reported that mask-wearing was lax and that if a resident tested positive for COVID-19, they were quarantined in their room, essentially in solitary confinement. Upon receiving this information, DRA staff spoke by telephone with the person responsible for infection control at the facility, who agreed to reinforce the facility’s mask policy with staff, ensure masks are provided to all...
staff and residents, and investigate allegations that youth testing positive were being kept in
their rooms instead of on a dedicated unit that would allow for some movement and
interaction.

Arkansas- like the rest of the United States and indeed the world- faced an unprecedented
public health crisis in FY2020 due to the COVID-19 pandemic. The risk of infection, serious
illness, and possible death from this coronavirus, especially among vulnerable populations, led
Arkansas to take the extraordinary measure of declaring a public health emergency and closing
public schools for much of the 2020 Spring semester; yet the rate of COVID-19 infection in
Arkansas continued to rise. COVID-19 infections in the state’s correctional facilities made up a
substantial portion of the infections statewide; in fact, it was one of the highest prison infection
rates in the country. Of particular concern to DRA is the vulnerability of incarcerated people
with disabilities, advanced age, and/or underlying medical conditions that could easily render a
COVID-19 infection a death sentence. Those individuals with chronic underlying health
conditions such as diabetes, heart disease, chronic lung and liver diseases, respiratory disease,
and compromised immune systems are at particular risk for grave outcomes from infection.
People incarcerated in prisons overall are more likely to have diagnoses of hypertension,
diabetes, heart disease, various respiratory diseases, and various infectious diseases, all of
which have been found to increase the mortality of a COVID-19 infection. As a result of the
sweeping rate of infection within the state prison system due to inadequate precautions, DRA
collaborated with the NAACP Legal Defense Fund and the Arkansas chapter of the ACLU in filing
a class action lawsuit seeking the implementation of Centers for Disease Control (CDC)
recommendations to minimize the risk of an unchecked spread of COVID-19 throughout the
prison system. We requested the court mandate CDC precautions including personal protective
equipment, social distancing, and access to hygiene and cleaning products. Litigation has
continued into FY2021.

As the COVID-19 pandemic began its sweep across the United States, we observed concerning
circumstances occurring in other states related to the potential to ration medical care during
this crisis. Some states adopted “crisis standards of care” (sometimes called “altered standards
of care”) to respond to the anticipated or realized shortage of medical resources, particularly
ventilators. Other states have had ventilator allocation policies in place for some time and are
now altering or considering altering such policies to meet the current crisis caused by the
pandemic. DRA’s research determined the Arkansas Department of Health (ADH) had not
adopted such a plan in anticipation of the needs of the community during the current COVID-19
health crisis. We wrote to the Governor to request he empower the ADH with the authority to
issue crisis standards of care in a way that does not discriminate against individuals with
disabilities. In response, the ADH contacted us through their equity office to discuss the
standards they had observed. This resulted in communications between DRA, the ADH, and the
University of Arkansas for Medical Sciences (UAMS) about the application of bioethics to crisis
standards of care and the proper modification of current crisis standards of care. While the
Governor subsequently refused to mandate crisis standards of care for the state, DRA was able
to collaborate with the ADH and UAMS to ensure a mutual understanding of ethical crisis
standards of care that do not discriminate against people with disabilities. DRA was also invited
to participate in a committee that was developed to ensure adequate information and education about the COVID-19 pandemic is provided to individuals in unserved and underserved communities around the state.

In FY2020, Arkansas Rehabilitation Services (ARS) informed the Arkansas Rehabilitation Council (ARC) about a proposed merger between ARS and the Division of Services for the Blind (DSB). A meeting was held between the ARC and representatives from ARS to discuss the details of the potential merger. ARS explained that combining the two state agencies would result in a savings that could then be used to increase services to its clients. During the discussion, however, no details were provided as to when services would be consolidated, what the potential savings would be, how that savings would be created, and how funding would be directed towards client services after Year Two. ARS representatives admitted they had not conducted any fiscal impact studies, but still urged the ARC to vote in support of the merger. An ARC member developed a white paper, endorsed by ARS, that provided some insight into a potential merger while still leaving many unanswered questions regarding the impact on client services. During a subsequent ARC meeting, ARS again urged the ARC to support the integrated program, even as the DSB Board was submitting a letter to the Governor in opposition to the merger. In response, the ARC formed a subcommittee and developed a series of questions for the Commissioner to respond to prior to the ARC taking any position on the merger. As FY2020 ended, the ARC was still trying to obtain additional information from ARS and the Governor’s office related to any cost savings and the impact a merger would have on client services.

DRA adapted our voting outreach activities during the pandemic to minimize risk both to the individuals we serve and to our staff. To that end we adapted our voter training materials for remote presentations conducted over Zoom. As the pandemic also created issues with travelling around the state to monitor polling sites, we scaled back this work accordingly but still conducted surveys during early voting and on election day. We also began using an online survey tool for polling site monitoring that would allow us to organize our data more efficiently, and we will continue to develop this protocol as pandemic restrictions are lifted in the state. We continued to be in contact with state and county officials regarding accessibility and helped several of them with planning and access concerns in the lead up to the election. We also continued to partner with other voter outreach organizations for training events and registration activities which were conducted remotely, as well as educating individuals on the absentee voting process.

Coalition Building

DRA is a part of the Developmental Disabilities Network, along with Partners for Inclusive Communities (Partners) and the Governor’s Council on Developmental Disabilities (GCDD), which continues to collaborate on issues impacting the developmental disabilities community in Arkansas. The Self-Advocacy Network Development (SAND) initiative described in previous years’ reports continues to be a focused collaborative effort, with a goal of developing a strong self-advocacy network in Arkansas. DRA also continues to collaborate with the Trauma
Rehabilitation Resources Program and the Traumatic Brain Injury State Partnership Program at UAMS to work on issues impacting individuals who have sustained traumatic brain injuries. DRA is continuously seeking additional opportunities to develop partnerships with various disability communities in Arkansas to address systemic issues impacting those groups.

Veterans’ Issues

DRA welcomes the opportunity to work with veterans; we occasionally receive requests for assistance from veterans, typically involving an accommodation they need on the job or at a business or some other public venue because of a traumatic brain injury or PTSD. Should your offices receive requests for assistance from veterans regarding these types of issues, we would encourage your staff to refer them to us for assistance.

We hope this report has been beneficial in providing an overview of our programs and services. Please do not hesitate to reach out to us if we can answer any questions or provide your office with further information about our work.

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