



Protection and Advocacy and Client Assistance Program
Services in Arkansas

Fiscal Year 2021

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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. Following is a description of DRA's nine federal Protection and Advocacy grants, as well as a grant awarded through the Arkansas Governor's Council on Developmental 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)

The 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. 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. PABSS also 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 performing 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).

Arkansas Alliance for Disability Advocacy (AADA)

AADA consists of an alliance of advocacy programs that work in concert to provide self-advocates, parents, peer advocates, and state leaders the tools they need to be active within the disability advocacy movement. AADA is comprised of Partners in Policymaking, a training program on developing relationships with elected officials to influence public policy impacting people with disabilities; Self-Advocate Network Development, which provides advocacy training and leadership development to people with disabilities across Arkansas; and Community of Champions, a community project that provides people the tools to be disability advocates in their everyday life.

CLIENTS

Arkansas is known for having one of the higher per capita rates of residents with disabilities in the country; however, because our 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 2021 population estimate indicates the state’s total population to be 3,025,891, with a disability rate of 12.6%. The following chart provides a breakdown of the 662 service requests received by DRA in FY2021, by age range and disability.

Clients by Age and Disability

DRA assisted individuals from infant to age 99 in FY2021. A breakdown of the age demographic showed 60% of the service requests represented individuals between the ages of 19 and 64, which is often considered “working age”, while 7% of the service requests represented individuals 65 and older and 33% of the service requests represented individuals 18 and younger.

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

Disability	Number of Service Requests	Percentage of Service Requests
Mental Illness	156	24%
Developmental Disability	199	30%
Physical/Orthopedic	113	17%
Visual/Hearing	36	5.5%
Brain Injury	29	4.5%
Learning Disabilities	38	5.5%
Neurological Disorders	20	3%
Other Disabilities	71	10.5%

SERVICE REQUESTS

DRA received 662 requests for services in FY2021, a decrease from FY2020 explained by both the pandemic and DRA’s increased focus on systemic activities and decreased focus on individual casework. The charts below show the distribution of the requests by grant funding and by problem area. The “Other” category in problem area represents issues with a small number of requests for services.

Service Requests by Program

Funding Source	PAIMI	PADD	CAP	PAIR	PAAT	PABSS	PATBI	PAVA
Count of Service Requests	89	180	30	288	12	36	25	2

Problem Areas Covered by Service Requests

Problem Area	Count of Service Requests
Abuse and neglect	55
Education	162
Housing	67
Gov't benefits/financial entitlements	66
Employment	57
Access (architectural and programmatic)	55
Home- and community-based services	44
Rehabilitation services	32
Guardianship	19
Assistive technology	11
Other	94

Service Requests across the state continue to include issues related to DRA's efforts to tackle abuse, neglect, and exploitation in a variety of settings, despite the limitations on facility monitoring imposed by the pandemic. Mindful of our mandate to monitor for and investigate abuse and neglect, DRA staff developed ways to monitor residential facilities, particularly the human development centers (HDCs) and psychiatric residential treatment facilities (PRTFs), in a way that did not require our staff to potentially expose residents to COVID-19 or vice-versa: we collected data about these facilities from state regulatory entities that survey the facilities and receive incident reports from them. Because issues impacting youth through placement in treatment and/or detention facilities continue to be a major focus for our attorneys and advocates, much of DRA's systemic work revolved around issues identified through these surveys and incident reports. Meanwhile, the most requested service throughout the state involves students who are not receiving needed special education services. DRA continues to prioritize issues involving suspension, expulsion, exclusion from school, and referral to the justice system related to a student's disabilities. While we understand the need for assistance with less serious education issues is significant, we do not have the resources to serve everyone who requests our help and must limit education cases to the most serious issues and the cases where we might achieve a systemic impact. By focusing on these most serious of cases, we are attempting to staunch the school-to-prison pipeline, recognizing not only how much better off a student is when they can stay in school, but also that the cost of providing services in a school setting is significantly cheaper than placement in a residential facility. DRA also assisted clients wanting to return to work (rehabilitation services) and clients needing sufficient supports to continue to live in the community; we have focused particularly on cases where a decrease in services authorized through the state's Medicaid managed care system threatens an individual's ability to remain in the community, which could lead to more costly institutional care. Architectural accessibility and program access issues like effective communication during medical appointments or reasonable accommodations in post-secondary settings continue to be a common complaint; housing issues remain a focus for callers as well, even as limited resources prevent DRA from making housing a priority area. Some of the requests for services

that fell into the “Other” category include healthcare, transportation, and custody issues. 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 FY2021

Example 1: The family of a resident at one of the state’s HDCs contacted DRA to request we investigate the circumstances of his death. The family stated they had been informed the resident choked on his lunch, and that they would need to contact the area hospital for an update on his condition. When they contacted the hospital, they were told the resident was deceased. When they requested information from the HDC about what happened, they received conflicting accountings of what had occurred. Sometime after his death, the family requested records pertaining to the incident. One report indicated the resident had been restrained prior to his choking, which they had not previously been told; their impression had been that he died at the lunch table after choking on food. By the time the family learned the circumstances surrounding his death, it was too late to request an autopsy. DRA investigators interviewed people involved in the incident and reviewed facility records and incident reports and noted several discrepancies. DRA also discovered information about the restraint was not communicated to the emergency medical services (EMS) team that responded to the incident, the hospital, or the deputy coroner; access to this information could potentially have changed responses to the incident as well as how the death was subsequently handled. Results of DRA’s investigation and findings included a change in the HDC’s policy concerning facility staff making emergency (911) calls and the development of a behavioral consultation committee, in which the Arkansas Department of Human Services (DHS) has requested DRA’s participation. DRA’s goals in participating in this committee include eliminating the use of mechanical restraints in the five HDCs and improving behavior support plans for HDC residents.

Example 2: DRA investigated the death of another HDC resident from a pharyngeal abscess. DRA had reason to believe he was not provided adequate dental care, although his active treatment plan specified he would have an intensive dental hygiene program and see a dentist quarterly. A documentation review by a DRA advocate determined the resident’s dental hygiene program was never implemented, which resulted in him not receiving timely treatment for an abscess. The client was non-verbal, so he could not communicate that he was having a problem. DHS did not identify any issues with this death, stating “people die from wisdom tooth infections all the time.” DRA met with DHS administrators to discuss our concerns and urge them to review this case again. They did investigate approximately one year later, with findings

against a facility nurse for failing to monitor for signs or symptoms of an adverse reaction to medication, a lack of documentation of a post-operative assessment, no documentation of a nursing assessment prior to the resident being taken to a hospital for pneumonia, and no documentation to verify the nurse was following doctor's orders for the resident.

Example 3: A student diagnosed with autism spectrum disorder (ASD) was allegedly threatened with being tied to a chair because of his behaviors. His parent had encountered difficulties ensuring he had access to appropriate educational services, and the student's behavior had become explosive in response to attending school. A DRA attorney agreed to evaluate whether a due process case would have merit; however, school started the following week, requiring expedited action. The attorney agreed to meet with school district staff and the parent to develop a plan for a smooth transition back to school. The school district agreed to the parent's request to have a board-certified behavior analyst (BCBA) train school staff on behavior intervention strategies and to have a one-on-one paraprofessional aide to assist the student. The school district also agreed to a flexible attendance policy until the student was prepared to attend class regularly, with no pressure on him to be in the classroom if he felt he was not ready. After the initial meeting, the student requested a separate meeting with the school principal; he also requested to meet with the teacher prior to school starting to discuss his apprehension in returning to school. The school district's cooperation and cultivation of the student's desire to self-advocate ensured he enjoyed a smoother transition back to school.

Example 4: A client who was involuntarily admitted to a psychiatric unit at a local hospital under a 72-hour psychiatric hold was delusional but was not a danger to herself or others. After she was admitted, the treating psychiatrist filed a motion for involuntary commitment. A DRA attorney reached out to the Mental Health Court public defender regarding our concerns that the client did not meet the criteria for involuntary commitment. The Court dismissed the petition for involuntary commitment and the client was released from the hospital. DRA's attorney met with counsel for the hospital and explained why the 72-hour hold and involuntary commitment were not in compliance with Arkansas law and were a violation of the client's civil rights. The hospital's attorney agreed to address DRA's concerns with hospital administration to ensure an understanding of the statute's requirements regarding 72-hour involuntary admissions and ensure that its policies would reflect these requirements.

Example 5: The guardian of an adolescent called DRA for assistance when the PRTF where the client had been admitted unexpectedly extended his stay by 14 days after initially informing the guardian of a discharge date and stating the client was ready to go home. The guardian did not agree to this extension but was told if she picked him up without the doctor releasing him, the facility would have to contact the Department of Human Services (DHS) and she might have to reimburse Medicaid for the treatment he received. Notably, this is not the first time DRA staff have heard of these unexpected treatment extensions, with a warning the guardian could be responsible for reimbursing Medicaid for the services already received if they do not comply. We contacted the facility administrator and expressed our concerns; he responded that he was unaware the guardian had been so advised. The facility subsequently released the client on the initial discharge date.

Example 6: A parent of an individual receiving services through a Medicaid managed care organization (MCO) contacted DRA to report she was having issues with the care coordinator not being available to assist her with obtaining the services her son needed. She related that the only behavioral health services the care coordinator said were available for her son was “talk” therapy unless she wanted them to make a referral for him to be admitted to a residential facility. This parent stated she did not want her son to go to an institution; she wanted services that would allow him to remain at home. A DRA advocate educated this parent about how the MCO system works, including the providers they contract with for services, and suggested the parent contact some service providers directly to discuss the services they could provide her son under the MCO system. The parent followed through with the advice DRA provided and subsequently was able to secure the services her son needed while allowing him to remain in the home.

Example 7: The brother of an individual diagnosed with autism spectrum disorder (ASD) who lives independently and is his own guardian contacted DRA regarding his efforts to provide 24/7 staff for his brother. In talking to the client, however, it was apparent to a DRA attorney that the client did not want or need staff to be ever-present. Upon discussing the issue with his service provider, they endorsed the fact the client did not need 24/7 staff; however, he did require assistance with reminders to take his medication daily. DRA connected the service provider and the client with an organization that evaluates an individual’s needs and provides assistive technology, such as medication dispensers and reminders, security systems, and other technology aimed at helping individuals who require some support but value their privacy and independence. The client was subsequently able to access assistive technology to ensure his safety and privacy and reduce his reliance on in-home caretakers.

Example 8: DRA was contacted by the parent of a second-grade student diagnosed with ASD who was not allowed to attend school because of behavioral issues. He was placed on a homebound program but was receiving virtual learning in lieu of any in-person instruction. The goal of the parent was for the student to spend a few hours each day at school and to have a functional behavior assessment (FBA) conducted. A DRA attorney attended an IEP meeting where the FBA was discussed and a behavior intervention plan (BIP) was developed, including a plan for the student to return to school by slowly increasing the amount of time spent in school each day. He has done well with the behavior plan and is now able to attend school full-time, with his parents receiving few phone calls for behavioral issues.

Example 9: An individual contacted the Client Assistance Program (CAP) regarding a dispute with Arkansas Rehabilitation Services (ARS) over the provision of a computer needed to complete coursework for medical billing certification. This lack of technology would present a barrier to program participation and ultimately a failed attempt at vocational rehabilitation. DRA’s CAP advocate contacted the client’s counselor to determine the rationale for excluding this technology from the client’s plan and requested an assistive technology evaluation be performed by ARS to provide more information about how assistive technology could assist the

client in program participation. ARS agreed to refer the client for an assistive technology evaluation which, upon completion, revealed the client would benefit from a computer to effectively participate in coursework. The assistive technology component was added to the client's plan, and she is set to begin online training for medical billing at a state university.

Example 10: An individual receiving services from ARS and majoring in early childhood education contacted the CAP after her counselor did not approve payment of tuition in her individualized plan for employment (IPE) if the client took less than a full-time course load, despite the client's disability preventing her from successfully managing that many classes. The client also sought to change counselors and district offices owing to conflicts arising at this field office due to a family member of the client being employed there. The CAP advocate contacted a field services manager, who approved these changes, and the IPE was subsequently rewritten to include continued provision of tuition without the full-time course load requirement.

PROJECTS

Systemic Issues

Upon reporting to the Division of Developmental Disabilities (DDS) our findings in the restraint related death that occurred at an HDC and recommending several corrective actions, including installation of security cameras in the HDC, modifications to behavior plans, training for staff regarding non-violent crisis intervention, and revisions to the way the state investigates deaths at its facilities, DDS created a behavioral consultation committee and requested DRA's participation. The committee deliberated on how to implement needed changes in facility operations; the result has been a significant commitment by DDS to effect these changes. The facility where the death occurred will soon have surveillance cameras installed, which will significantly aid both DDS and DRA in abuse investigations. DDS will also be modifying their policy that restricted staff from contacting 911 in cases of life-threatening situations. One of the most significant findings of this death investigation involved the length of time between the individual losing consciousness and the arrival of emergency personnel, which was directly attributable to facility staff's understanding that policy required them to call the facility's nursing staff, who would then decide whether to call 911, thus delaying the deployment of emergency responders. DDS has agreed to begin collecting data uniformly across the five HDCs regarding behavior planning and the use of restraint and seclusion, and to share that data with DRA. This will allow both DDS and DRA to evaluate these practices and will provide not only baseline data on the use of restraint, which we otherwise have no effective way to monitor, but also evidence of the effectiveness of any changes implemented. Finally, DDS agreed to retain a consultant of DRA's choosing to assist them with reviewing policies, procedures, and practices regarding the use of restraint and seclusion in the HDCs. The consultant chosen was instrumental in reducing the institutionalized population in Pennsylvania's ICFs/IID. In addition to working with the state on their facility practices, the consultant will collaborate with DRA to determine what other facility practices are detrimental to the residents of the state's HDCs.

During a monitoring visit in June 2021 to a psychiatric residential treatment facility (PRTF) located in the 2nd District but which serves youth from around the state, several residents

indicated they had received chemical restraints prior to our arrival that day. They all stated that they were calm when they received the chemical restraints. Previously, we had received information that four residents who eloped in April 2021 received chemical restraints upon their return to the facility. This information led to an investigation of chemical restraints administered at this facility in April and June 2021. Our investigation concluded that only one of the nine incidents could be justified as an intervention in response to a resident being a danger to themselves or others. Additional instances of chemical restraints being administered inappropriately were also identified. Among DRA's findings were that chemical restraints were being used punitively and in lieu of appropriate interventions, chemical restraints were being used simultaneously with seclusion, and restraints were not properly documented, including the staff members involved, assessments, and debriefings. Notably, DRA has determined there are likely issues with physical restraints at this facility as well. DRA's investigative findings regarding this facility's use of chemical restraints as a discipline tool and not exclusively to prevent harm were outlined in a report and accompanied by over 200 pages of documentation. This report was shared with the facility and all relevant state regulatory agencies. In response to our investigation and report, the facility did institute a few quality-control measures. They were also subsequently investigated and placed under a plan of correction by the Placement and Residential Licensing Unit of the state's Office of Long-Term Care.

Between August and October of 2020 three residents of a PRTF suffered broken bones during restraints. DRA's investigation into these incidents combined with ongoing monitoring efforts revealed an alarming increase in incidents that led to a broader review of this facility. Our investigation consisted of reviewing facility records, Arkansas State Police Crimes Against Children Division (CACD) investigations, Little Rock Police Department (LRPD) reports, Arkansas Children's Hospital (ACH) records, prior medical and placement records for select residents, and other relevant documentation. Interviews were conducted with current and former facility residents and video of incidents was reviewed when available. Our investigation uncovered incidents of staff abuse, staff-on-resident and resident-on-resident sexual abuse, nineteen elopements with three residents remaining missing at the time of our report, inadequate suicide precautions, the use of police to intimidate and charge residents, delayed and inadequate medical attention, a lack of medication administration policies, failure to adequately document or report incidents, and the use of dangerous restraint techniques that are improperly initiated and applied. In fact, our investigation revealed concerning practices at every stage of a restraint incident, from the reason restraints are initiated to the medical and emotional response to residents following a restraint incident. The facility subsequently discontinued the use of the Handle With Care behavior management system and is now using Crisis Prevention Institute (CPI) protocols to manage disruptive and assaultive behaviors by residents. The facility also dramatically reduced their census and have only recently resumed admissions. While there continues to be a lack of accountability with this facility, our efforts have led to increased public scrutiny through an investigative series published in Arkansas' statewide newspaper and increased regulatory scrutiny that resulted in a plan of correction and a letter of reprimand from the Child Welfare Agency Review Board.

As in FY2020, in accepting education cases this year we focused on representing juveniles who were at risk of institutionalization through our state's juvenile courts and Family in Need of Services (FINS) petitions, which are a means for school districts to access court intervention for juveniles with serious behavioral health needs. Whether through the truancy process or through anecdotes of "uncontrollable behavior," we observed many juveniles court ordered to PRTFs prior to schools evaluating them for special education and related services, which we interpreted as a circumvention of the due process rules mandated by the Individuals with Disabilities Education Act (IDEA). In some cases, we simply contacted courts with active cases for a juvenile to let them know we were providing advocacy or representation within the educational realm and asked them to stay any effort to institutionalize the child. In other cases, we successfully represented juveniles in court to prevent institutionalization in favor of appropriate education services. As a result, we have developed a particular interest in educating juvenile probation officers, judicial staff, prosecutors, and public defenders regarding the advocacy that can occur within the public-school setting with the goal of preventing institutionalization of these youth, and we will continue to seek opportunities to do so.

In addition to major investigations into abuses at two PRTFs, a death investigation at a state prison, and the off-label use of a medication/lack of informed consent at a county jail, we furthered our efforts to improve transparency of all the state's PRTFs. When individuals are seeking placement at a facility, they will often have information available to them in the form of state inspections, facility surveys, and/or quality scores, such as the Centers for Medicare and Medicaid Services provides on nursing homes. None of those metrics existed for PRTFs operating in Arkansas, so individuals from in and out-of-state were placed at facilities in Arkansas with little to no information about the quality of care or the safety of youth at these facilities. DRA made numerous requests under Arkansas' Freedom of Information Act for police reports, long-term-care inspections, childcare licensing reviews, and other relevant documents and published that information on our website for public viewing. These documents were already publicly available but reports and surveys from various regulatory agencies were located in different places; there was no single website that provided comprehensive information about PRTFs. As a result of our initiative, individuals now have easy access to substantial amounts of information relative to each PRTF in the state to better inform their decision regarding potential placement. Moreover, in the process of collecting and publishing this information, we were able to identify incidents that were reported to some agencies but not others, which exemplified the problem of a lack of communication between our state's monitoring and enforcement agencies. DRA has recommended that these regulatory and enforcement agencies speak with each other on a regular basis regarding information they each may receive from these facilities, to ensure all of them are receiving consistent, relevant information about the care and treatment of the residents.

DRA's focus on the Medicaid managed care system in Arkansas, in addition to representing clients in appeals, continued in FY2021 with the gathering of data regarding the complaint and grievance processes consumers are expected to utilize when they wish to address issues with their services, which usually involves a reduction in services. While we have not publicized the data, we have gained insight into which managed care organizations (MCOs) are struggling with

which Medicaid obligations, allowing us to better advise clients regarding the services they should be able to access, as well as strategies to access those services, based on how those services are usually requested and approved or denied. We are concerned that MCOs continue to not understand their obligations regarding the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) component of Medicaid, which was but a theory when we established our FY2020 priorities. Our data collection continues to confirm our theory about EPSDT and has informed our individual representation about this relatively unknown obligation under Medicaid. It has also led us to advise beneficiaries and their caregivers to specifically reference EPSDT when requesting services, which we hope will advance the issue and result in a broader availability of services to children and adolescents under this Medicaid mandate.

Adults with disabilities, particularly individuals with intellectual disabilities, are often affected by a loss of autonomy owing to the imposition of guardianships. While DRA continued to work individual guardianship cases in FY2021, we also collaborated with other interested parties to educate legislators on the concept of supported decision-making as an alternative to guardianship during the 2021 legislative session. A supported decision-making bill was introduced and, while there appeared to be no opposition to this bill prior to it appearing on the House floor for a vote, we learned that the Families and Friends of Care Facility Residents of Arkansas (FFCFRA) group adamantly opposed it. FFCFRA's membership primarily consists of individuals whose loved ones reside in one of the state's five human development centers, and their opposition was primarily due to their mistakenly interpreting the bill as a means to eliminate existing guardianships. The bill did not pass; however, DRA will continue to educate the public about and advocate for alternatives to guardianship in FY2022.

Coalition Building

DRA is not only committed to numerous substantive, long-term collaborations, we openly seek opportunities for new collaborations. DRA continues to partner with sister agencies the Governor's Council on Developmental Disabilities (GCDD) and Partners for Inclusive Communities (Arkansas' UCEDD), to work on issues impacting the developmental disabilities community in Arkansas. Most of these initiatives are multi-year efforts and focus on achieving impactful, systemic changes. Collaborations active in FY2021 include the Breakfast Club, Housing Arkansas, and the Arkansas Alliance for Disability Advocacy (AADA). One component of this new AADA initiative, which is a collaboration between DRA and GCDD, is a continuation of the Self-Advocacy Network Development (SAND) project, which concluded in September 2021. DRA continued collaborations 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 and also partnered with Arkansas Advocates for Children and Families (AACF) on working to address problems with fees and fines in the state's juvenile justice system. DRA is a founding member of the Arkansas Coalition for Southern Values, whose goal is to be "united for the safety, dignity, and belonging of all Arkansans. We organize and take collective action to build and sustain a strong, long-term, progressive movement in Arkansas." The coalition is interested in advancing ideals of inclusion and equality; DRA will ensure people with disabilities are represented in this group's endeavors.

DRA's executive director became involved with Fetal Alcohol Spectrum Disorder (FASD) Arkansas in FY2021; DRA's goal is to collaborate on educational and informational initiatives about FASD. DRA participated in the development of an online seminar in May 2021 and was involved during FY2021 in the planning of an FASD educational conference that took place in FY2022.

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.

Contact information:

Tom Masseau, Executive Director
Disability Rights Arkansas, Inc.
400 West Capitol Avenue, Suite 1200
Little Rock, Arkansas 72201-3455
tmasseau@disabilityrightsar.org
501.296.1775
800.482.1174 Toll Free
501.296.1779 Fax
www.DisabilityRightsAR.org