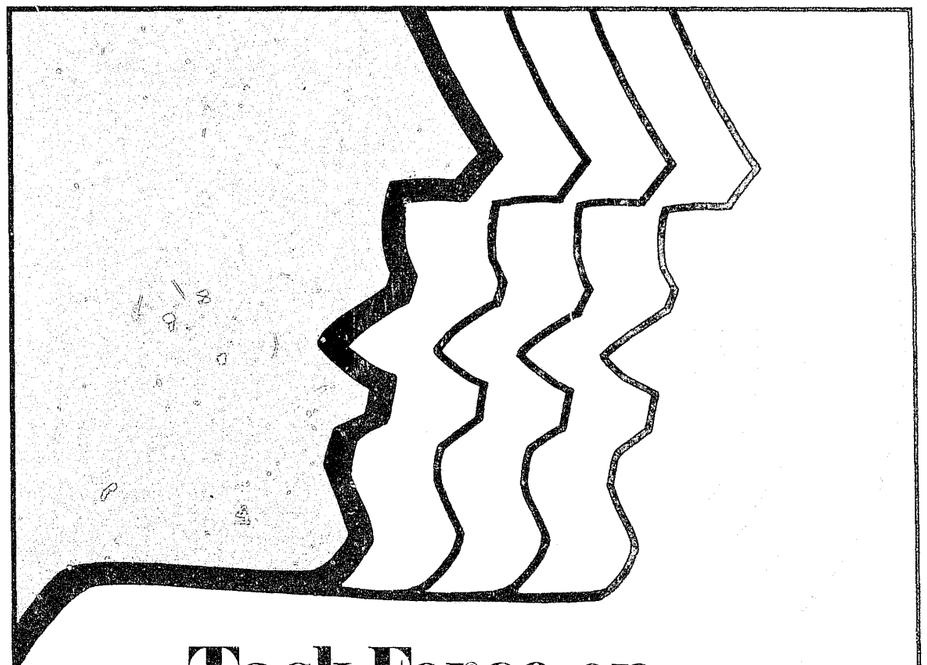

Task Force on Speech Pathology and Audiology Service Needs in Prisons

AMERICAN SPEECH AND HEARING ASSOCIATION
9030 Old Georgetown Road • Washington, D. C. 20014

TASK FORCE REPORT

ON

SPEECH PATHOLOGY/AUDIOLOGY SERVICE NEEDS

IN

PRISONS

ACKNOWLEDGEMENTS

We are deeply grateful to each member of the Task Force for providing information that previously had not been assembled on a special population with communicative disorders and for their dedication to an important project that offers new directions of pursuit for the profession.

Special appreciation is extended to Eugene Walle who assisted in initial planning for the Task Force, coordinated Task Force meetings and correspondence, and prepared major portions of the Task Force final report. In addition to general contributions, Curt Hamre prepared the section on a model for providing services in prisons; James Reading prepared the section on incidence of speech and hearing disorders in prison populations; Eugene Wiggins provided materials for the section on rationale; Henry Pressey provided materials on reading disability; and John Bess, information on noise-induced hearing impairment in prison industry.

The administration and staff of Patuxent Institution, Jessup, Maryland, courteously provided facilities and local arrangements for the June 5, 1973, meeting of the Task Force and consultants.

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Kenneth O. Johnson, Ph.D.
Executive Secretary

TABLE OF CONTENTS

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INTRODUCTION

The American Speech and Hearing Association is the national, non-profit, scientific and professional association for speech and language pathologists, audiologists, and speech and hearing scientists concerned with communication behavior and disorders. It is the accrediting agent for college and university programs offering master's degrees in speech pathology and audiology and for programs offering clinical services in speech pathology and audiology to the public. Only members who meet specific requirements in academic preparation and supervised clinical experience and who pass a comprehensive national examination may obtain the Certificate of Clinical Competence, which permits the holder to provide independent clinical services and supervise student trainees and clinicians who do not hold certification. The Association's 16,000 members are employed in speech and hearing centers, public and private clinics, school systems, colleges and universities, hospitals, private practice, government, and industry.

Speech pathologists evaluate the speech and language of children and adults, determine whether communication problems exist, and decide what type of remediation is appropriate. Typical adult clinic cases may include stuttering, voice disorders, articulation problems associated with cleft palate and other facial anomalies, and language disorders possibly associated with some strokes and other types of brain injury. The audiologist is concerned with the study and measurement of normal and defective hearing, identification of hearing impairment, and rehabilitation of those who have hearing problems. Both speech pathologists and audiologists are concerned with preventing speech, hearing, and language disorders through public education, early identification of problems, and research on the causes and treatment of these problems.

Speech pathologists and audiologists are concerned also about providing services to neglected groups, recruiting students for training to serve neglected populations, and expanding job opportunities for speech pathologists and audiologists. In 1973 a task force was appointed by the American Speech and Hearing Association to study speech pathology/audiology service needs among adult prison inmates, a group known to receive limited services.

The Task Force on Speech Pathology/Audiology Service Needs in Penal Institutions was charged with:

1. Determining the needs for speech pathology and audiology services in penal institutions;

2. Describing existing speech pathology and audiology service programs in these settings;

3. Describing briefly the prison systems in the United States and their funding sources;

4. Preparing a statement providing a rationale for extending speech pathology and audiology services to this population;

5. Listing priorities in providing services;

6. Identifying key people or offices in Congress and Federal agencies, foundations, and professional organizations to whom these concerns should be addressed;

7. Preparing a summary report of the task force proceedings that might be used for dissemination to association members and to professional groups of prison officials, penal institution rehabilitation personnel, and criminologists to encourage interest in providing speech pathology and audiology services in penal institutions.

The Task Force met January 15-16, 1973 to draft a preliminary report and to plan a workshop with key personnel from groups concerned with corrections. That workshop was held June 4, 1973 and followed by a Task Force meeting to prepare its final report.

Th lowing report contains in the Appendix an abstract ich can be duplic or distribution to appropriate agencies. As indicated in the acknow ents, certain sections of this report were prepared in whole by indi members while others represent joint efforts of the Task Force.

GENERAL INFORMATION ON PRISONS

There are approximately 309,000 prisoners (296,000 males and 13,000 females) in state and federal prisons, correctional institutions, and community treatment centers. Of this total, approximately 270,000 are in state penal institutions, 21,000 in Federal Bureau of Prisons institutions, 2,700 in prisons operated by the Army, Navy, and Air Force, and approximately 5,000 in U.S. territorial prisons.

A typical state program may be administered under a state board of corrections or a division of corrections under the department of public safety and correctional services. Each state usually has a reception center for inmates who are, in turn, confined in one of several facilities such as a house of corrections, training center, camp center, etc. Each state program of corrections is autonomous with funding through the state tax structure. Programs are initiated under the jurisdiction of the warden or superintende each institution.

The Federa reau of Prisons is an autonomous organization, funded and administered under the U.S. Department of Justice. It administers over 30 institutions. Rehabilitative and remedial services are provided through medical referral.

Two organizations are suggested as sources for additional information. The American Correctional Association, 4321 Hartwick Road, Suite L-208, College Park, Maryland 20740, represents many affiliated corrections associations and can provide information about their publications. The Law Enforcement Assistance Administration, U.S. Department of Justice, 633 Indiana Avenue, N.W., Washington, D. C. 20530, funds a variety of national, state, and local programs concerned with law enforcement and prevention of criminal behavior, including the National Criminal Justice Reference Service, established to meet the information needs of the criminal justice community.

The Criminal Population in the United States and Territories - 16 years and above in age*

State or Territory	Male	Female
Alabama	3,635	120
Alaska	376	169
Arizona	2,734	154
Arkansas	1,425	48
California	39,356	1,495
Colorado	3,130	92
Connecticut	2,873	147
Delaware	627	
District of Columbia	3,408	85
Florida	14,144	370
Georgia	6,457	250
Hawaii	644	
Idaho	617	
Illinois	7,743	147
Indiana	5,153	129
Iowa	1,972	166
Kansas	2,218	66
Kentucky	2,373	61
Louisiana	5,804	264
Maine	740	82
Maryland	6,795	173
Massachusetts	5,262	126
Michigan	12,973	488
Minnesota	2,551	122
Mississippi	5,446	157
Montana	508	72
Nebraska	905	110
Nevada	2,243	143
New Hampshire	438	40
New Jersey	9,861	605
New Mexico	1,196	19
New York	29,412	1,167
North Carolina	3,703	755
North Dakota	258	30
Ohio	12,422	1,044
Oklahoma	3,621	97
Oregon	2,484	223

*E. Walle, Task Force. Abstracted from the Directory of Correctional Institutions, American Correctional Association, 1972.

State or Territory	Male	Female
Pennsylvania	13,027	110
Rhode Island	671	
South Carolina	4,305	237
South Dakota	486	41
Tennessee	5,166	19
Texas	15,270	1,202
Utah	671	87
Vermont	331	57
Virginia	7,536	332
Washington	3,855	407
West Virginia	1,576	66
Wisconsin	4,775	362
Wyoming	321	50
Canal Zone	88	
Guam	200	
Commonwealth of Puerto Rico	4,715	
Virgin Islands	200	
Federal Bureau of Prisons		
6 penitentiaries	9,371	
3 reformatories	1,396	525
3 institutions for juvenile offenders	869	
9 correctional institutions	5,623	
3 prison camps	653	
2 detention centers	334	
1 medical center	873	
10 community treatment centers	278	
Department of Army	1,970	
Department of Navy	657	
Air Force	166	

SPEECH PATHOLOGY/AUDIOLOGY SERVICES CURRENTLY AVAILABLE IN PRISONS

Patuxent Institution, Jessup, Maryland, is the only institutional prison setting in the world that employs the full-time services of a speech pathologist and houses a completely equipped speech and hearing clinic. This clinic serves a population of 500 adult males and acts as a diagnostic facility for three other penal institutions under Maryland's Division of Correction. This program, funded entirely by the State of Maryland, has been operating on a full-time basis since September, 1970; it functioned as a part-time voluntary service from 1965 to 1970.

Lebanon Correctional Institution, Lebanon, Ohio, has employed a half-time speech pathologist-audiologist since 1964 to the present date to serve over 1,300 adult male prisoners.

Part-time (less than 20 working hours per week) speech pathology and audiology services are provided by speech and hearing consultants in state prisons in Michigan, Pennsylvania, Florida, Alabama, Massachusetts, and New York.

Two university training programs, Catholic University, Washington, D.C., and Northern Michigan University, Marquette, Michigan, have students assigned to state prisons as a part of their practicum program.

In two known instances, audiologists are serving as consultants to federal prisons.

INCIDENCE OF SPEECH AND HEARING DISORDERS IN PRISON POPULATIONS

Task Force member Eugene Walle has maintained correspondence over a number of years with speech pathologists and audiologists working in or conducting research in prison settings. He and James Reading recently reviewed available published and unpublished studies on the incidence of communicative disorders in prison populations. Sample studies are reported in some detail since much of the source material is not readily available. The bibliography at the end of this report lists all known published and unpublished studies and reports on the subject.

It is generally estimated that three to five percent of the total population has a speech impairment with the lowest incidence expected in young adults and middle-aged adults (American Speech and Hearing Association Committee on the Midcentury White House Conference, 1952). Approximately three percent of the population is estimated to have hearing impairments with a greater prevalence occurring in the over-60 age group (Public Health Surveys, 1960-62, 1962-63). Further analysis of prevalence and incidence studies may be found in Human Communication and Its Disorders (1970).

Several early studies infer a direct relationship between hearing impairment and delinquent behavior. Molitch and Adams (1936), after administering audiometric tests to 360 juvenile delinquents, stated, "We believe that defective hearing is a factor in the behavior and adjustment of children. The special groups studied by us show a higher incidence of (hearing) defects than found in the average school age populations." Slawson (1926) examined 1,648 juvenile delinquents for hearing impairment; after comparing his findings with studies on the hearing of normal school age children, he observed that the delinquent group had 4 to 10 times greater prevalence of hearing impairment. Springer (1938) said that a group of profoundly hearing impaired boys were more prone to "outbursts of temper and habits of stealing" than a group of normally hearing public school children.

Rainer, et al, (1969), in a recent publication, stated that among several outstanding personality traits of the hearing impaired were," . . . a lack of understanding of, and regard for, the feelings of others (empathy), coupled with inadequate insight into the impact of their own behavior and its consequences in relation to others." The authors cite several instances of unprovoked physical violence and criminal acts committed by deaf individuals with a history of inadequate services.

Fulling, (1973), in a master's study now in progress, analyzed terms used to describe the behavior of juvenile delinquent males who had speech and hearing disorders. Commonly recurring terms were: "problem child," "behavior problem," "inattentive," "withdrawn," "hostile," "aggressive," "rebellious," "demanding," "stubborn," "defiant," "retarded," "delinquent." Of course, more study is needed to determine whether or not these behaviors are concomitant or cause and effect phenomena.

Cozad and Rousey (1966) reported the results of their survey of hearing and speech disorders in two Kansas institutions for delinquent youth, the Boys' Industrial School in Topeka and the Girls' Industrial School in Beloit. Their investigation included 252 students, 165 boys and 87 girls. he median age of the boys was 15 with a range from 11 to 17; the median age of the girls was 16 with a range from 12 to 18. Resulting data show that 24 percent of the entire group failed the hearing screening test and subsequently demonstrated a hearing impairment. Their data further indicate that 58.3 percent of all individuals screened exhibited some type of speech disorder. In another unpublished paper, Campbell (1973) reports the results of a survey of speech and hearing problems conducted among delinquent children residing at two Texas facilities. This sample consisted of 65 boys and 109 girls. The age range was 13-18 with a median age of 15.5 years. Of the entire sample, 51 percent were white; 29 percent were Black; and 20 percent were Chicanos. Campbell states that results indicate 21 percent had an articulation disorder, one percent had a rhythm disorder, and two percent had a voice disorder. Results of a hearing survey indicated that 36 percent failed hearing screening, and more extensive testing revealed that 20 percent of the total group had hearing impairment.

Kalmenson (1968), in an unpublished master's thesis, described the hearing and articulation characteristics of a random sample of 100 delinquent boys. The sample included 25 boys from each of four age groupings (10-12, 12-14, 14-15, and 15-17) at the Baltimore, Maryland Children's Center. Of the total sample, 56 percent had below average IQ scores, 30 percent had average scores, and 14 percent had above average IQ scores. Results indicate that of the 100 boys screened, 21 percent were found to have some hearing impairment as determined by pure tone air conduction threshold testing. The incidence of "inadequate articulation" for the total population was found to be 12 percent, with the youngest group at 20 percent, the oldest at 8 percent.

Spiro (1973), in an unpublished study of a female delinquent population, indicated an incidence of hearing impairment significantly higher than that found in the general school population. Incidence of speech and language disorders was projected at three times that of comparable subjects in public schools; hearing problems were cited at four times the incidence in a comparable, non-delinquent group. Her study was based on a sample of 65 girls (45 were white, 15 Black, and one Indian). The mean age was 15.3 years and the mean I.Q. was 93.8.

Walle (1972) reported his results on evaluating 128 men at Patuxent Institution in Jessup, Maryland. The subjects in this study were self referred or referred by staff. The results indicated that 50 percent of this referred group gave evidence of a clinically significant communication disorder. Articulation disorders occurred in 17 percent of the sample population; rhythm disorders, nine percent; clinically significant voice problem, five percent; significant language disorder, two percent; hearing impairment, 17 percent. These results should be compared with the figures reported in an unpublished paper by Reading (1973), who later screened and evaluated all inmates at Patuxent Institution, a total of 522 men. The age range of the sample population was 17 to 67 years, the mean age being 25.7 years. Racial description of all subjects indicated that 51

percent were Black and 49 percent were white. Those exhibiting some degree of communication disorder were 52 percent white and 48 percent Black. The incidence of clinically significant communication disorder was seven percent; an additional ten percent had a speech deviation which was not considered to be a communication handicap. The incidence of articulation disorders was four percent, and the incidence of voice disorders was six percent. The average IQ of those with a communication disorder was 80; that of the total group was 91.

Blom (1967) in an unpublished master's thesis, also reported the results of speech and hearing screening within a group of adult offenders. His subjects included 1,630 men housed at the Indiana State Prison and the Indiana Reformatory who ranged in age from 18 to 80 years. The results of the screening indicated that 12.2 percent of the men at one facility and 11.6 percent at the other facility had speech disorders. Hearing screening found 35 percent failures at one institution and 18.9 percent at the second facility. In another unreported study, described in correspondence to the Task Force, James Mack (1973) found that, of 1,300 men housed at Lebanon, Ohio Correctional Institution in 1971, three percent had a pathological speech condition which required clinical attention and five percent had a clinically significant hearing problem as confirmed by a complete audiological diagnostic evaluation. Curt Hamre (1973) also in correspondence with this Task Force reported screening 188 adult males at the Marquette Branch of the Michigan Correctional Division; he found that 23 percent failed hearing screening and 39 percent failed speech screening. Although further evaluation might lower the percentages, he points out that the number of problems in speech and hearing would still remain significantly larger than that expected in the general population.

Melnick (1970) reported the results of hearing screening at the Columbus, Ohio State Penitentiary. His subjects were 4,858 men ranging in age from 16 to 71 years, with a mean age of 35.7 years. His results show that 40 percent of the men failed to pass the screening; of these, the largest number had high-frequency losses which did not involve the speech frequencies.

In related studies of antisocial (criminal) groups housed in a psychiatric hospital, Lamb and Graham (1962) reported 69 percent of the antisocial group had hearing impairment; there was a trend for greater incidence of hearing loss to be associated with increased severity of psychiatric involvement. Green (1962), studying the same antisocial group, also reported a high incidence of speech disorders.

While few of the studies cited have made specific references to language examinations, the high percentages of reading, writing, speech, and hearing problems found among prison inmates make it likely that specific language disabilities do exist to a high degree in this population. Joselson's (1970) unpublished study of language skills in adult prisoners, cited an incidence of deficient language skills four times greater than that found in comparable non-institutionalized adult groups. Duling, et al, (1970) summarizes the results of various investigations of reading disabilities and juvenile delinquency which report percentages of reading deficiencies significantly greater in juvenile delinquent groups than among comparable non-delinquent groups. Duling's own study of 59 male juvenile delinquents at the Robert F.

Kennedy Youth Center in Morgantown, West Virginia, revealed that 53 percent were reading below grade level. Task Force members suggest that a review of subtest scores or intelligence studies of delinquents and adult prisoners would possibly confirm observations that prison inmates have a higher percentage of language disabilities than comparable non-institutionalized groups. A review of research on brain injured inmates would similarly be expected to provide confirmatory evidence.

Task Force members, concluded, despite differences in methodology among studies reported, that the incidence of speech, hearing, and language disorders is significantly greater for juvenile delinquents and adult prison inmates than in the general population. Further, the fact that limited information is available in professional journals on the communicatively handicapped population in prisons is a clear indication prison inmates do indeed constitute a neglected group.

RATIONALE FOR PROVIDING SPEECH PATHOLOGY/AUDIOLOGY SERVICES IN PRISONS

There is considerable agreement among research studies summarized in this report that the prevalence of speech, hearing, and language disorders is higher among prison inmates than within the general population. This Task Force conservatively estimates that 10-15% of prison inmates have speech, hearing, or language disorders severe enough to warrant speech pathology/audiology services; this contrasts with equally conservative estimates of 3-5% for the general population. There is research and observational evidence that disorders in this group tend to be severe in nature and require intensive remediation. Walle and Morris (1967) cautiously suggest that among a group of 25 inmates studied at Patuxent Institution, Maryland, there appeared to be a definite causal relationship between criminal behavior and speech, language, or hearing impairment. Mack (1973), in an unpublished report on survey replies received from 179 correctional and rehabilitation personnel in federal and state programs, indicated that 76% agreed that psychological effects of serious disorders in speech or hearing could lead to criminal behavior.

However, few inmates have access to speech pathology/audiology services. Less than 10 state prisons have or have had any degree or type of speech and hearing services. In two instances where these services are available, recidivism rates are reported lower than the national level. Patuxent Institution, Maryland, with its full complement of educational and rehabilitative services, including a full-time staff speech pathologist, reports recidivism rates of 30% as compared to the national range of 60-80%. Mack (1973) in an unpublished report, said, that of 443 prisoners enrolled for communication therapy from 1964-1972, only 77, or 17 percent, were later reincarcerated.

The case can thus be made that the inability of many inmates to communicate effectively and the lack of speech pathology/audiology services have added to the experiences of failure commonly found in prison populations.

Further, the prison inmate with a communication handicap not only encounters the frustrations and failures common to all prisoners, but those experienced by the communicatively handicapped in seeking social acceptance and employment. In Human Communication and Its Disorders: An Overview (1970), it is estimated that the annual deficits in earning power among the communicatively impaired is approximately $1,750,000,000. The report further states that no price tag can be assigned to the personal tragedies and social misunderstandings which communicative disorders impose on their possessors.

Further, a growing national concern about noise pollution highlights the need for comprehensive speech pathology/audiology services in prisons; data examined by the Task Force show that a significant number of people enter the prison system with handicapping and treatable hearing problems,

and many prison work settings involve high intensity noise levels that can induce or exacerbate hearing problems.

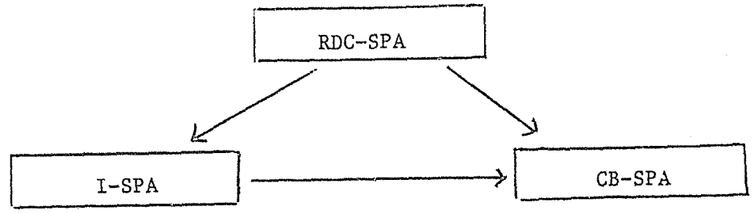
Another need exists for the services of the communication specialists that extends beyong the context of handicap and pathology. This is the interpretation to the general public of dialectal variations. Scholars in sociolinguistics are insisting that members of ethnic minority groups and their language patterns be viewed in the context of difference rather than deficiency. In penal institutions, where Black and Spanish-speaking inmates may be in the majority, differences in dialectal behavior may certainly contribute to communication barriers between minority inmates and white inmates, guards, educational and remedial specialists, and administrators. When the language of minority inmates is viewed by whites as defective, the minority inmate may also be viewed as defective; the minority inmate can be expected to feel and express resentment and hostility at such characterization. In the official report on Attica (1972), it is noted, in a review of racial factors, that the manner in which guards spoke was perceived by inmates as racial in nature. While all racial hostilities emerging in prison settings cannot be attributed to language differences, understanding of various linguistic styles in different cultural backgrounds might alleviate some tensions and misunderstandings. Prison personnel and administrators, engaging in a study of cultural language variation, might better understand minority groups whose language and life style are structured differently from their own.

This Task Force concludes that speech pathology/audiology services are critically needed as part of medical, education, and rehabilitation programs for adult prisoners if indeed there is serious intent to rehabilitate prisoners to function in the social and economic mainstream. Further, the special knowledge about cultural language variations that communications specialists have should be utilized by corrections administrators and workers to alleviate some aspects of racial tensions in prisons.

MODEL FOR PROVIDING SPEECH PATHOLOGY/AUDIOLOGY SERVICES IN PRISONS

This report describes a three-stage model for the delivery of Speech Pathology/Audiology services in prison systems. Stage I provides screening evaluations in Reception-Diagnostic Centers (RDC-SPA) to identify inmates with communication disorders. Stage II provides a treatment program within Institutions (I-SPA) for inmates with communication disorders. Stage III provides Community-Based (CB-SPA) services for persons with communication disorders who are making a transition from incarceration to adjustment in the mainstream of society. The interrelationship of these Stages is depicted in Figure 1.

FIGURE 1. Three-stage Model for Delivery of Speech Pathology-Audiology Services in Prisons



Reception-Diagnostic Center Services (RDC-SPA)

Prior to classification and assignment to a particular institution, inmates receive thorough examinations (medical, psychological, and other) in Reception-Diagnostic Centers. Speech Pathology/Audiology services should be available at this stage to provide early detection of communication disorders; this is the only stage at which all individuals entering the prison system could be efficiently evaluated.

A communication disorder may be defined as a handicapping condition which impairs a person's ability to (a) hear and/or understand speech, (b) speak, (c) read, or (d) write. Accordingly, screening evaluations are designed to identify those who are not functioning adequately in these four areas. Specifically, the Speech Pathologist/Audiologist assesses performance in functions basic to normal speech, language, and hearing.

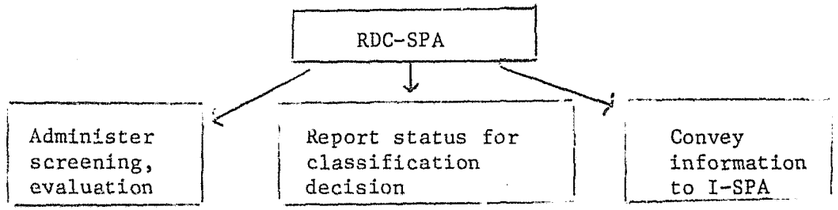
A report of the RDC-SPA evaluation should be included as one item of information which influences prisoner classification decisions. This report will offer one of three recommendations:

1. No communication disorder
2. Communication disorder present and treatment program needed
3. Communication disorder present, but other problems may be of higher priority

Finally, if it is determined that a communication disorder treatment program should be provided, the RDC-SPA will convey his observations and recommendations to the SPA located in the institution where the inmate is assigned.

In summary, RDC-SPA services will consist of three functions as shown in Figure 3.

FIGURE 3. Three Components of RDC-SPA Services



Institutional Services (I-SPA)

It is widely stated that rehabilitation efforts must be directed to the total person rather than to an isolated disorder or defect. Members of this Task Force feel that this concept may be a more critical treatment principle in a prison program than in any other clinical setting.

For multidisciplinary planning to be effective, it is necessary for each professional to have knowledge of and respect for other team members--psychologist, reading specialist, social worker, otologist, and others. One of the first tasks the I-SPA must accomplish, then, will be information-seeking and information-giving.

This Task Force is aware that a total multidisciplinary program is at present an unrealistic model for most prisons; few have enough full-time personnel (reading specialists, counselors, psychologists, etc.) to provide such services. Therefore, the I-SPA might well be expected to design and implement programs in these allied areas. This will require that the I-SPA define and distinguish between methodologies pertinent to speech pathology and those pertinent to training in communication skills basic to reading instruction and/or dialect instruction.

The I-SPA will assess the history and current nature of the inmate's communication disorder and, where possible, consult with the rehabilitation team to design a program best suited for the individual prisoner. The consensus of staff opinions following evaluation will result in variations of one of three decisions:

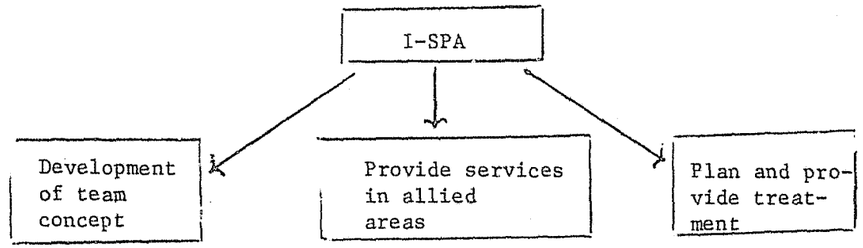
1. The inmate may have a significant communication disorder but be unable to participate at this time in a treatment program; some emotional problems, for example, prevent some people from active participation in a specific treatment program.

2. The inmate may have a communication disorder and be interested in and capable of participating in a treatment program rather specific to that disorder. In this case, the type and frequency of treatment will depend on (a) the nature and severity of the communication disorder, (b) prognosis, and (c) the immediacy of possible parole.

3. The inmate may have a communication disorder which requires multidisciplinary action--referral, consultation, joint treatment methods--on the part of the I-SPA with a remedial reading specialist, psychologist, neurologist, otologist, or others.

I-SPA services include three areas of concern, summarized in Figure 4.

FIGURE 4. Three Components of I-SPA Services



In addition, perhaps the most critical function of the I-SPA will be that of providing for the transition between institutional and community-based treatment, described in the next section.

Community-Based Services (CB-SPA)

While inmates who will be incarcerated may require rather intensive treatment and should begin a program early to increase their potential for successful release from prison, inmates who qualify for early release should be directed to community-based clinics.

The I-SPA also (1) plans for CB-SPA services for those communicatively-handicapped inmates who qualify for early release; (2) prepare inmates who have been incarcerated for some time for parole in such a manner that newly acquired communication skills will not deteriorate or provide for continuation of treatment through CB-SPA.

Sources of community-based services will be community speech and hearing clinics, college and university training program clinics, and private practitioners.

PREPARATION FOR WORK IN PRISONS

Task Force members offered observations on aspects of prisoners' characteristics that should be of interest to speech pathologists and audiologists considering employment in prisons.

Task Force members state that speech pathologists and audiologists serving individuals incarcerated for criminal acts need a strong professional background in sociology, abnormal psychology, sociolinguistics, and special education. Familiarity with counseling procedures, criminology and corrections, remedial reading and writing, programmed learning and behavioral modification techniques, adult and basic education is advised.

Understanding is needed of various ethnic groups' lifestyles and language. Also needed are willingness to work with the prison rehabilitation and educational team, including guards and paraprofessionals, and confidence in the improvability of the human condition.

Task Force members point out that a typical prisoner may well be disillusioned, distrustful, and critical of any service program offered him. He may be discouraged and require proof of the effectiveness of any remedial plan presented. He is probably acutely conscious of his impairment and often socially maladjusted because of it. He is apt to be a difficult subject for any clinician and certainly not easy material for a young or inexperienced clinician to work with.

The communicatively handicapped prison inmate may require a remedial program different from that typically associated with a specific disorder. Inmate aides, volunteers, or paraprofessionals in the rehabilitation or education staff may be most effective as communication aides. Inmates, many of whom are strongly motivated to help others with similar problems, often can become excellent aides and staff resources. Teaching machines and other forms of programmed learning appear to be popular and successful with inmates.

The majority of inmates will probably exhibit reading disabilities of varying degree. A 1969 HEW report on reading disorders states that 75% of juvenile delinquents are significantly retarded in reading. It is estimated that 25% of federal prisoners are functionally illiterate and 4% totally illiterate. Writing disabilities are also often found. Thus, programs initiated for the communicatively handicapped inmate should be coordinated with existing adult basic education programs or remedial education facilities.

SUMMARY OF TASK FORCE MEETING WITH CORRECTIONS REPRESENTATIVES*

The Task Force on Speech Pathology and Audiology Service Needs in Prisons held a working meeting on June 4, 1973 at Patuxent Institution, Jessup, Maryland, with participants representing federal and state corrections agencies and other public and private groups concerned with corrections. The morning session included the presentation by Task Force Members of information on incidence of speech, hearing, and language disorders of prison groups, discussion of tape recordings representing various types of speech and language disorders, communication concerns and ethnic minority groups, hearing impairment and its implication for prison industry, and a proposed model for delivery of speech pathology and audiology services to prisoners both in prison systems and in halfway houses and other community based programs.

After a luncheon provided by the institution and a tour of the speech and hearing clinic at Patuxent, the invited guests were asked to respond and comment on the morning's program. Many participants commented on the lack of information they had on speech and hearing disorders among juveniles who had come to the attention of the courts for a variety of reasons and made a strong recommendation that the Association seek to develop speech, hearing, and language services in juvenile detention centers and other agencies associated with juvenile offenders.

Several participants, including a representative from the League of Women Voters, indicated that support was more likely to be received for developing programs among juveniles than among adults. Many comments were made that corrections come last in state budgets, and legislators do not seriously consider rehabilitation for adult prisoners.

Several participants commented on means of implementing new programs. They discussed problems of convincing various levels within the system of the seriousness of prison rehabilitation. First, it was suggested that the inmate himself was a viable source of consumer pressure; the increasing number of legal questions being raised by inmates in federal prisons concerning hearing loss in high noise level prison industry was referred to. Second, it was suggested that state speech and hearing associations contact federal, state, and local prisons in their states. Third, it was indicated that Congress itself needed to be convinced of the need for this and other services in prisoner education and rehabilitation.

Dr. Weller, Deputy Director of Medical Services, Federal Bureau of Prisons, indicated that there was no full-time speech pathologist or audiologist in any federal penal institution. There were ten facilities that did have some form of consultation regarding hearing with physicians' assistants implementing programs. He indicated the likelihood of an increasing number of suits regarding hearing loss in prison industry and said that prison industry with its separately funded budget might be a potential source for funding hearing screening programs. Provision for hearing aids for those prisoners needing them is possible within current budgeting. Representatives of state prisons indicated that

*Meeting agenda, participants, and research persons are listed in the Appendix.

positions for speech pathologists and audiologists have been funded under medical budgets, educational specialists categories, and psychological and psychiatric consultative funds.

The need for prison administrators, teachers, inmates, and guards to know more about cultural language variation was discussed at length. Participants generally concurred that the Task Force should emphasize services and information that speech pathologists could offer in this area.

Consideration was given to the increasing acceptability by prison officials of women volunteers and women rehabilitation professionals. The officials present did not feel that training programs needed to be hesitant about bringing women students into prison settings.

Many questions were asked about means of indicating a relationship between criminal behavior and speech, hearing, and language disorders or further indicating a relationship between low recidivism rate and receiving speech, hearing, and language services. There was a discussion of the low recidivism rate at Patuxent compared to national averages. Students of the profession present remarked that they were still idealistic enough to think that the services were justified regardless of their relationship to the persons' future employability or potential recidivism.

Participants agreed that it was difficult to attract young people to correctional work and that young people tended not to stay in prison education and rehabilitation programs. Earlier introduction of students to the prison setting would be useful; also, the move away from the large institutions to community-based rehabilitation programs might make it more possible to attract young professionals. It was also stated that the general public needed to be made more aware of communication disorders and that grass roots lobbying for such services was very helpful.

Tony McCann of the National Association of County Officials said the most important problem for the Task Force to consider was how to deal with or screen the prisoner as soon as he came into the system since most prisoners were in county and city jails. He observed that no consistent pattern exists in the United States for handling juvenile offenders. He urged organizations such as the American Speech and Hearing Association to become more active in seeking early services at least at the diagnostic level as soon as an offender, particularly juvenile, had entered the system.

The need for additional information on hearing impairment among military prisoners was discussed in relation to the need for adequate hearing screening for all military personnel in all branches of the armed forces.

Several participants urged the Task Force not to focus on corrections as they now exist but to focus on corrections as they are currently developing. They foresaw that, in a transition period between the large correctional institution and the smaller community-based rehabilitation facility, there would be a scarcity of funds, making it difficult to begin new treatment programs while trying to develop new community-based centers. They indicated a definite trend to turn down the development of new types of programs in older institutions. They also pointed out that, regardless of whether the prison system was federal or state, it was difficult to get hearing aids, glasses, and other types of prosthetic aids for prisoners.

Marlene Beckman, Law Enforcement Assistance Administration, said there was a definite trend for use of existing community medical, educational, and rehabilitative resources instead of poorly duplicating services in each prison. She stated that most new ideas in corrections have focused on juveniles and recommended that we give priority to service needs in juvenile institutions. She also raised questions about prison architecture; as new facilities are being built, the need for noise abatement is not being taken into consideration.

One participant said the problem that all rehabilitation workers have is that treatment was a low priority in the correctional system, and he wished the public and legislators could be convinced that prisoners are worth helping. Serveral noted that it was difficult to get legislators to vote services for prisoners that are not available to the general public.

The participants were thanked for their information and for their time. The meeting was adjourned, after plans were made for follow-up on specific problems raised by participants.

PRIORITIES AND RECOMMENDATIONS

I. Priorities:

A. After due deliberation, consideration of available research and professional reports, and conferring with colleagues in related professions, this Task Force recommends that members and students of the profession of speech pathology and audiology seek to extend services to adult and juvenile criminal offenders and that priorities be given to the following area:

1. Information should be given to correctional, medical, rehabilitation, and educational professionals associated with prisons and to prison inmates about cultural language variation and communication and about the relationship of hearing, speech, and language disorders to educational, personal, social, and economic problems of individuals;

2. Information should be given to prison industry officials and medical administrators concerning the relationship of noise exposure to hearing impairment, the components of an adequate hearing screening and evaluative program, appropriate means of obtaining properly prescribed hearing aids, and means of reducing prison noise levels;

3. Groups planning early release programs, halfway houses, and other forms of prison reform and decentralization at city, county, state, and federal levels should be encouraged to include speech pathology and audiology services as integral parts of new medical, rehabilitative, and educational programs for juvenile and adult offenders;

4. Interdisciplinary activities should be initiated with national organizations concerned with prison reform, offender rehabilitation, and prevention of criminal behavior for the purpose of developing model programs for the treatment of juvenile offenders with learning disa-

B. Specific recommendations that follow should be considered in relation to these stated priorities.

II. Distribution of Final Report:

In addition to appropriate groups within the American Speech and Hearing Association, Task Force members requested that their report be mailed to representatives of key associations and agencies identified by the Task Force, to members of the Congressional Black Caucus, to members of Congressional subcommittees dealing with prisons and juvenile delinquency, and to participants in the June 4 Task Force meeting.

The Task Force suggests that the report abstract be made available when possible to state corrections commissioners, state directors of vocational rehabilitation, directors of treatment in state prisons, and to medical directors in federal prisons.

III. Recommendations for Contact With Other Organizations and Agencies:

A. The Law Enforcement Assistance Administration should be contacted regarding Task Force recommendations, particularly those relating to developing inservice training workshops for prison medical, educational, and correctional personnel on cultural language variation and communicative disorders. This is considered of highest priority. Some Task Force members are currently planning such a demonstration workshop at Patuxent.

B. The Medical Services Division, Federal Bureau of Prisons, should be contacted regarding further development of hearing programs in federal prisons.

C. The American Medical Association should be contacted regarding its proposed development of a national certification program for prison health services at federal, state, and local levels.

D. Every opportunity should be taken to merit expert witness before any Congressional subcommittees concerned with present and future welfare of juvenile and adult offenders.

IV. Formal Resolutions:

The Task Force prepared for presentation to the ASHA Executive Board formal resolutions concerning (a) further study of need for screening of military prisoners as part of the larger problem of securing adequate hearing evaluation for all military personnel; (b) further consideration of cooperative efforts with national groups concerned with prevention of reading and learning disabilities; (c) further study and action on speech pathology/audiology service needs among juvenile offenders; (d) further investigation of reports that prison inmates needing hearing aids do not have adequate consumer protection; (e) further study of Hearing Aid Banks as a means of providing aids to indigents.

V. Recommendations to State Associations and Appropriate Committees, Training Programs, Community Based Speech and Hearing Clinics, and Private Practitioners:

The Task Force recommends that these groups initiate formal liaison with administrative heads of state corrections systems, state departments of vocational rehabilitation, and state facilities for juvenile offenders to discuss possible implementation of diagnostic and therapeutic speech, hearing, and language services. Several members of this Task Force urged that provision of services be discussed and initiated on a paying basis. Since funding, organization, and legislation relating to criminal offenders varies widely from state to state and county to county, professional contact at the local level is essential to secure adequate speech, hearing, and language services for offenders.

VI. Consumer Information:

Members of the profession who work in prison settings are urged to prepare articles on their work for submission to prison newspapers and to

encourage inmate clients to report on their experiences.

VII. Further Information Needed:

A. The Task Force points out that limited information is available on communicative disorders among female offenders or on language pathology in prison populations.

B. Further efforts should be made, perhaps through a survey of state corrections agencies, to determine whether speech pathology/audiology services are currently available or are fundable through unexpended education specialist, health, or psychological services budgets.

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Appendix A

ABSTRACT*

American Speech and Hearing Association
Task Force Report on Speech Pathology/
Audiology Service Needs in Prisons

I. Introduction:

A. The Task Force, composed of speech pathologists and audiologists who have provided services and performed research in prisons, was charged with collecting information on the prevalence of speech, hearing, and language problems among adults in prison and the current level of speech pathology/audiology services provided in prisons, and with recommending ways to increase services in this setting.

B. Speech pathologists and audiologists are members of a profession promoting research on human communication and its disorders and provision of clinical services to children and adults who have speech, hearing, or language problems. Speech pathologists and audiologists are also concerned with the relationship of reading problems and language disability, prevention of speech, hearing, and language disorders, and educating the general public concerning cultural language variation.

C. The American Speech and Hearing Association is the certifying agent for speech pathologists and audiologists providing clinical services to the public and accredits clinical facilities offering these services.

D. The full report of the Task Force's deliberations, including a bibliography, is available upon request from the American Speech and Hearing Association, 9030 Old Georgetown Road, Washington, D. C. 20014. The Association can also provide information on its certification program, college and university training programs, and clinical service facilities. Employers may list speech pathology/audiology positions available free of charge in Association employment bulletins.

II. Prevalence of Communication Disorders Among Adults in Prisons:

A. While there is wide disparity among studies on prevalence, there is a concensus that the percentage of speech, hearing, and language disorders among prisoners is higher than the percentage found within the general population.

B. Speech pathologists working in prison settings report that the speech and language disorders they find are generally severe and require intensive remediation.

*This abstract may be duplicated for distribution to appropriate individuals or agencies.

III. Communication Disorders and Criminality:

A. A greater prevalence of communication disorders, particularly hearing impairment, is found among the poor, the neglected, and the institutionalized, regardless of the reason for institutionalization.

B. Impaired ability to communicate is associated in some individuals with poor educational performance, reading, and learning disabilities, and other special education problems.

C. Reduced job opportunities and earning power are also associated with impaired communication abilities.

D. While a direct causal relationship between criminal behavior, recidivism, and communicative disorders cannot be predicated from currently available research, it can be inferred for individuals from case histories and prisoners' self reports. Recidivism figures for Patuxent Institution, which has a full program of rehabilitation services including speech pathology and audiology, are approximately 30% as contrasted with national recidivism rate ranges of 60-80%.

IV. Current Extent of Services Provided:

A. Two federal prisons among 30 are known to utilize the services of an audiologist-consultant.

B. Fewer than 10-15 state prisons in approximately 500 have or at one time had even minimal speech pathology/audiology services.

C. City and county jails provide minimal diagnostic services of any type.

D. Too few courts ensure provisions for appropriate diagnostic screenings, use of interpreters for the deaf or non-English speaking, or in-service training for understanding cultural language variations.

V. Rationale for Providing Services:

It is unlikely that there will be any great support for providing speech pathology/audiology services to the adult incarcerated when these services are not currently made available to juvenile offenders or in many areas to the general population. Nevertheless, a case can be made for providing speech pathology and audiology services to prisoners.

A. First, there are economic considerations: Prisoners employed in high noise level prison industry are susceptible to hearing impairment, and their employer is liable for this impairment. Unsophisticated hearing testing cannot determine reliably what impairment exists prior to noise exposure or reveal those persons likely to be susceptible to noise-induced hearing impairment; Also, the

individual who has a severe speech, hearing, or language impairment may experience difficulties in getting and keeping a job while on parole. Personal-social adjustment and maximum utilization of prison educational and rehabilitative services are also lessened for the communicatively handicapped.

B. A speech, hearing, or language impairment may contribute directly to criminal behavior as evidenced in individual case histories cited by the Task Force members.

C. In relation to human values, a person who cannot communicate successfully is handicapped socially, educationally, and economically. All persons, regardless of status, are entitled to the services of this profession.

D. Better understanding by prison officials and inmates of cultural language differences could help ease some aspects of racial tensions observed in prison settings.

VI. The Relationship of Speech Pathology/Audiology Services to Other Professional Services:

Members of this profession recognize that coordinated social, educational, and medical services are needed to rehabilitate the adult prisoner. Speech pathology and audiology services should be an integral part of a total diagnostic, educational, and rehabilitative program. The individual prisoner should receive services according to his own needs and priorities; a severe stutterer, for example, may need help in understanding and controlling his stuttering before he can benefit from other services.

VII. Task Force Recommendations to Increase Speech Pathology/Audiology Services in Prisons:

A. Since a high percentage of prisoners are members of ethnic minority groups, inservice programs for prison personnel should be developed on understanding cultural language variation and communication behaviors.

B. Prison officials should give priority to providing adequate hearing assessment and hearing conservation programs in prison industry.

C. Speech pathology/audiology services should be included in any newly emerging programs of prison rehabilitation and reform, such as halfway houses and early release programs where rehabilitative services are provided in the community.

D. State speech and hearing associations, college and university training programs, private practitioners, and community-based speech and hearing centers should establish formal liaison with state corrections officials and with state prison directors of treatment programs to

discuss means of providing speech pathology/audiology services under current budgets and to plan for the inclusion of speech pathology/audiology services in future programs.

E. Contact should be initiated between the American Speech and Hearing Association and the Federal Bureau of Prisons regarding the provision of speech pathology/audiology services to federal prisoners.

F. National organizations involved with learning and reading disabilities, juvenile delinquency, etc., should cooperatively address the problem of early detection and treatment of physical, educational, and emotional handicaps among juvenile offenders.

Appendix B

PROGRAM

Task Force on Speech Pathology/Audiology Service Needs in Penal Institutions
Patuxent Institution, Jessup, Maryland
June 4, 1973

9:30 - 10:00 a.m. Participants meet at Main Gate to process clearance. Registration, Education Wing Auditorium. (Coffee, copies of pertinent research, bibliography, list of participants will be provided.)

10:00 - 10:15 a.m. Welcome: Harold M. Boslow, M.D., Director, and Arthur Kandel, Ph.D., Associate Director, Patuxent Institution
Introductions, Statement of Meeting Purpose: Sylvia W. Jones, Director of Recruitment, American Speech and Hearing Association

10:15 - 10:30 a.m. Discussion of Speech Pathology and Audiology Service Needs in Penal Institutions

Overview: Eugene L. Walle, Associate Professor, Department of Speech Pathology and Audiology, Catholic University, Wash., D.C.; Incidence Studies on Communication Problems in Penal Institutions: James Reading, Speech Pathologist, Patuxent Institution

10:30 - 11:15 a.m. Informal presentation of volunteer parolees and inmates with communication disorders.

11:15 - 11:30 a.m. Discussion: Communication Concerns and Ethnic Minority Groups: Eugene Wiggins, Ph.D., Director, Speech and Hearing Clinic, Department of Communication Sciences, Federal City College, Washington, D. C.; Hearing Impairment: Implications for Prison Industry: John Bess, Ph.D., Audiologist, VA Hospital, Atlanta, Georgia; Model for Speech Pathology, Audiology Services in Prison Systems: Curt Hamre, Ph.D., Assistant Professor, Speech Pathology, Northern Michigan University, Marquette, Michigan.

11:30 - 11:45 a.m. Tour, Educational Wing and Speech and Hearing Clinic

11:45 - 12:30 p.m. Luncheon (an automatic-color slide program will be in continuous operation following lunch while participants assemble).

1:00 - 2:30 p.m. Feedback from Participants

1. What is your reaction to the information provided and recommendations made concerning speech pathology and audiology services in penal institutions?

2. How do speech, hearing, language services relate to the rehabilitation process as you perceive it?

3. Is it possible to increase speech pathology/audiology services to inmates within existing programs?

4. Do you think additional information is needed to support Task Force recommendations to increase these services?

5. Are there other recommendations you think this Task Force should make to increase provision of these services?

6. To what agencies or persons do you think the Task Force's final report should be distributed?

2:30 p.m. Summary: Service Needs and Realistic Goals - Sylvia W. Jones

3:00 p.m. Adjournment

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Appendix D

TASK FORCE ON SPEECH PATHOLOGY SERVICE
NEEDS IN PENAL INSTITUTIONS

June 4, 1973 Task Force Meeting

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