WOODBRIDGE STATE SCHOOL

MEDICAL DEPARTMENT

PHYSIOTHERAPY SERVICES

H.I.P. GRANT - 1967 - 1971

FINAL REPORT

WOODBRIDGE STATE SCHOOL
Medical Department

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H.I.P. FINAL REPORT (1967 - 1971)

APPENDIX

WOODBRIDGE STATE SCHOOL
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PHYSIOTHERAPY SERVICES

H.I.P. FINAL REPORT

I. SUMMARY

In 1966, the Woodbridge State School, then the newest of the 6 residential centers for the mentally retarded in New Jersey, requested H.I.P. assistance in establishing a program of physiotherapy services;.."The proposed program would provide a range of physiotherapy treatment from the most specialized services provided by professional staff to those which can be adequately performed by the therapy aides and cottage attendants."

Several hypotheses were advanced:

1. In order to develop the optimum potential of the 500 multiply-handicapped non-ambulant residents it is necessary to correct or ameliorate the physical defect.

2. With proper treatment, over 20% of the non-ambulant population has the potential for full or partial ambulation.

3. For those residents who are not capable of ambulation, treatment can help to relieve or prevent painful contractures, muscle spasms, decubiti, and other conditions associated with physical inactivity.

4. It is possible to develop a physical treatment team utilizing trained attendants aligned with existing professional staff, as opposed to present minimal practices.

II. NARRATIVE REPORT

A. Background

Initial statistics showed more than one half of the Woodbridge State School population would consist of semi-ambulatory or non-ambulant multiply-handicapped residents.

A review of the literature indicated the inseparable relationship between motor activity and mental activity in the developmental process. On this basis, it was felt that the total program at Woodbridge would be incomplete until it was able to "deal co-ordinately with the problems of physical, motor, and sensory defects."

B. Planning to meet the need.

1. Prior to implementation of the H.I.P. Grant, the Woodbridge State School had a treatment and training staff which was thwarted in its attempts to provide comprehensive services by (1) a gross insufficiency of professional personnel; (2) inadequate training of sub-professional staff to supplement the services of the limited number of professional personnel; (3) insufficient physiotherapy equipment.

2. Plans were made to develop therapy aides and cottage life personnel to assist in providing a comprehensive physical habilitation program.

3. Specific diagnoses of all residents having physical handicaps were completed and charted by the consultant physiatrist at the time of the submission of the grant proposal.

C. How the need was met.

1. Training of personnel.

Woodbridge State School established a supportive habilitation staff, consisting of eighteen individuals, nine of whom were in H.I.P. Grant positions.

All of these aides received 120 hours of training over a 6 week period at the Physical Rehabilitation Center of Willowbrook State School, Staten Island, New York. This training included lectures by the Physiatrist and other professional staff, as well as on-the-job training with children enrolled in Willowbrook's Habilitation Program.

In addition, in-service training classes were conducted at Woodbridge State School. These offered a wide variety of information such as: philosophy of physical medicine and rehabilitation; medical aspects of physical training; medical terminology; orthopedic bracing; sensory stimulation; behavior modification; language development; and mental retardation. Demonstration classes were held in specific techniques for range of motion; gross motor activities; application of orthopedic shoes and braces; sensory stimulation; grasp and release activities; rhythms; visual tracking; and self-help skills (e.g. feeding.) Visits to outside facilities and attendance at related conferences were encouraged.

2. Program development.

The need for physical activity, and planning to meet this need, were focal points at Woodbridge State School, from the beginning.
Initially, a program of physical training was offered by the Education Department. Teachers having specialized training in physical education, spent a half of each school day developing standard academic and pre-academic skills, and a half day in stimulating the motor skills of the non-ambulatory population.

Following screening of the non-ambulatory residents by the Physiatrist, goals were established ranging from independence to prevention of deterioration.

The school's Physiotherapy Department was at that time staffed by a Physiatrist one half day per week, and two Physiotherapists, each one half day per week. Application was made for H.I.P. assistance in 1966, and the federally funded program of Physical Habilitation for the Severely and Profoundly Mentally Retarded commenced in 1967. Two new concepts were presented in the Habilitation project:

1. Decentralization of treatment area.
2. Use of sub-professional staff, specially trained to perform specific tasks under supervision.

Historically, the acceptable method of administering physiotherapy treatment is that of using a central treatment area to which individuals requiring these services are transported. This procedure adds two factors to the criteria used in determining treatment, namely the availability of staff for transportation of patients, and vagaries of weather. Two items which should have absolutely no bearing on the determination of frequency and duration of treatment thus become prime factors.

The concept of a physiotherapy treatment area in each non-ambulatory cottage was presented in the grant proposal as a possible solution to such problems.

Utilization and training of sub-professional staff to perform specific task skills under supervision is discussed elsewhere.

3. Planning a treatment area.

a. Criteria for a physiotherapy treatment area in a cottage were established following inter-disciplinary conferences:

1) Existing space to be used, with little or no modifications.
2) Physical area adequate to accommodate equipment permitting residents to be treated in small groups.
3) Treatment area should be physically separated from other cottage activities, though not isolated.
4) Treatment area should be in proximity to cottage personnel who would provide assistance in emergency.
5) The room should be light, pleasant, comfortably warm, and free of hazards.
6) Storage should be provided for all portable equipment and supplies.
7) Secure area should be available for confidential records.

Each non-ambulatory cottage has a room which meets these specifications, and 8 treatment units were established. An additional one was created in the Maximum Care Unit of the hospital, slight modifications being made in response to the particular needs of these residents.

b. Equipment

In equipping its cottage physiotherapy areas, Woodbridge State School drew upon the experiences of professionals working with handicapped young people.

Furniture and equipment were selected to:

1) Provide environmental stimulus;
2) Enhance motor development;
3) Provide safe, new experiences;
4) Permit group activities;
5) Present no hazard to sub-professional staff;
6) Be relatively durable in an institutional setting.

Standard electro-medical modalities were located at the central Physiotherapy Clinic of the hospital, and administered by a Registered Physiotherapist on prescription of the Physiatrist.

D. RESULTS OF THE PROGRAM

Analysis of the statistical data collected at 6 month intervals during the 5 year period of the grant confirms the original hypotheses that: (1) with proper treatment over 20% of the non-ambulant population has the potential for full or partial ambulation; and (2) for those residents who are not capable of ambulation, treatment can help to relieve or prevent painful contractures, muscle spasms, decubiti, and other conditions associated with physical inactivity.

Initially (1967) eight residents were fully ambulatory. They were included in the program in order to obtain improvement in gait, and thus reduce stress on the lower extremities and the spine. It should be borne in mind that these residents were not sufficiently competent in walking skills to be housed in the ambulatory unit of the school.

At the conclusion of the H.I.P. program, 85 residents had achieved independence in ambulation, and an additional 88 residents were semi-ambulatory (ambulated with assistance.) Total physiotherapy enrollment for the duration of the grant was two hundred and eighty seven. The grand total of residents who accomplished full or partial ambulation was one hundred and seventy three, representing 36.5 per cent of the non-ambulant population of the school. and 60.3 per cent of the target group.

One hundred and seventeen residents did not achieve ambulation, but did prove the second hypothesis, since seventy seven showed improvement in developmental skills.

Over the entire period, only twenty seven residents showed no improvement, and ten regressed. It is of interest that in the latter category, 6 had severe seizures which could not be controlled; 1 suffered trauma and subsequent infection. In three cases, there was no obvious physical or medical cause for the regression.

The final hypothesis was that it is possible to develop a physical treatment team utilizing trained attendants aligned with professional staff in order to provide services to the large number of residents who could benefit from them.

The positive results of the program as outlined above were obtained by precisely this type of staff. This would appear to be ample proof of the validity of the supposition.

E. OTHER DIRECT ACCOMPLISHMENTS

1. Feeding training

The goal of independent feeding was set for a number of residents, and both Occupational Therapy and Physiotherapy Aides were assigned this training task at two meals, and at two supplementary nourishment periods. Instruction and supervision were provided to the staff by a registered occupational therapist. Results suggested that with an adequate screening and evaluation procedure, the goal of independence in feeding is a reasonable one for many individuals, however the skills, once learned, must be continually practiced and reinforced.

2. Toilet training

As a corollary to the feeding program, toilet training was emphasized. Routines were established for a selected group, and positive reinforcement techniques were used by both Occupational Therapy and Physiotherapy areas. Results suggested that the goal is a reasonable one, provided that not only consistent training but also follow-up is provided. In both programs, the element of subjectivity in recording progress made it difficult to obtain reliable statistical data.

3. Sensory stimulation

Environmental stimulus activities were introduced prior to the grant, and the additional resources of M.I.P. permitted enrichment. Following the feeding and toilet training programs, the Education Department introduced an intensive approach to Maximal Sensory Stimulation. Techniques were evolved to permit inclusion of severely limited residents, as well as the more capable. The goal was established of having each non-ambulatory resident enrolled in a program - Maximal Stimulation, Physiotherapy, or School.

The stimuli were designed to elicit responses in all sensory areas. Comparisons were used, graduating from gross difference to minute, as the resident's progress permitted. The program succeeded in "graduating" a number of participants to the recreation and education programs.

4. Surgical affiliation.

Consistent treatment and evaluation of the residents disclosed a number who, in the opinion of the Physiatrist and other Staff Physicians, would benefit from orthopedic surgery. Following the established procedures of the Division of Institutions and Agencies of the State, five operative procedures were performed during 1969-1970 at the Vineland State School. All were soft tissue procedures - tendo-achilles lengthening, and hamstring release. In order to expedite the waiting list for corrective surgery, the department utilized the New Jersey Orthopedic Hospital in addition to the aforementioned facility.

Five hundred and eighty surgical evaluations have been completed and twenty nine procedures performed involving both soft and osseous tissue. Residents are returned to Woodbridge State School within a few days, and all post-op care is given at the school.

5. Ambulatory Cottages

Referrals to the Physiatrist from other Staff Physicians resulted in the growth of an orthopedic shoe program in the ambulatory cottages. Pes planus was a common problem, as well as marked differences in structural development resulting in unequal leg length or foot size. Special shoes were prescribed and replaced as necessary, with Cottage Life staff providing interim care. For a few ambulatory residents, short term treatment was given by a Physiotherapist (usually post-trauma, or post-surgery.)

6. Orthopedic Braces

In order to obtain maximum benefit from treatment, orthopedic braces were obtained for a number of residents. Financial responsibility rested variously with the family, County Board of Freeholders, the New Jersey State Crippled Children's Commission, and/or Woodbridge State School. Procedures for obtaining the devices proved rather cumbersome, nevertheless at the time of writing, 47 residents had orthopedic braces which were being used daily.

F. INDIRECT ACCOMPLISHMENTS

1. Attendant Staff

Throughout the period 1967-1971, there has been a growing awareness on the part of the general Cottage Life staff of the many aspects of motor development, gait, and posture. Cottage personnel accepted responsibility for the follow-up of orthopedic shoes for "graduates" of the Physiotherapy program. Demonstrations were presented by an orthopedic shoe supplier, and various prescribed corrections were explained.

To a large extent, it has been possible to overcome a tendency to associate orthopedic appliances such as braces and shoes, with the Physiotherapy Aide rather than with the individual resident who wears them.

2. Interdepartmental Relationships.

In the cottages there is a cooperative atmosphere which permits maximum efforts to be directed toward achieving goals established for the residents. Shared goals have resulted in carry-over from the treatment area to the cottage dormitory and to the classroom. Regular discussions are held between teachers and a Physiotherapist regarding sitting posture, wheelchair transfers, and specific problems relating to individual residents.

The Physiotherapy Department is used as a resource in the purchase of seating equipment for the non-ambulatory units, both stationary furniture for the education area, and wheelchairs to be used by Cottage Life.

Woodbridge State School Maintenance Department has been a significant factor. Modifications of standard equipment were made, and many repairs were necessary. Problems were presented to the carpenters and metal workers who took up the challenge and, within the limits of time and material, came back with solutions and innovations.

3. Classification Committee.

The Chief Physiotherapist was appointed by the Superintendent as a voting member of the Classification Committee in 1970. In prior years, a H.I.P. program representative had been invited to attend discussions regarding specific residents. The Classification Committee (since re-named Resident Re-evaluation Committee) is one of the standing committees of the school, and is charged with the responsibility for the initial diagnostic assessment, periodic re-evaluation, and handling of Special Cases (emergency problems) of the resident population. In addition, the committee is expected to submit "pertinent recommendations concerning problems, needs, progress, and programming of residents brought to the attention of the membership." Thus the H.I.P. program was functionally integrated with the departments of the school, while being funded from an external source.

G. TERMINATION

The Physiotherapy program has demonstrated that the degree of dependence of a large number of residents can be markedly reduced by maintaining and/or increasing motility. Constant observations and evaluation was made locally by the Division of Mental Retardation. These inspections and evaluations contributed to the adoption, upon expiration, of the entire federal grant program by the Bureau of the Budget of the New Jersey Department of Institutions and Agencies.

H. Degree to which original goals were met.

1. Areas of Strength

a. Motility

As indicated by the statistical data, the original goals of ambulation and motility were met.

The grant proposal stated that "with proper treatment, over 20% of the non-ambulant population of Woodbridge has a potential for full or partial ambulation." At the termination of the grant, 36.5% of the non-ambulant population has attained this level of function.

Of the 287 residents receiving physiotherapy, 29.8% achieved independent ambulation; 30.6% partial (assisted) ambulation, and 26.8% improved in motility although they did not reach the target behavior of ambulation.

b. Staff Training

No measurement was devised specifically for evaluation of the efficacy of the training given selected attendants. The positive data on motility appears to indicate that the goal of training sub-professional staff to perform specific tasks under supervision, and to function as part of a physical treatment team was met. Of interest is the consistent motivation of the sub-professional staff, and the very low turn-over for the entire five year term.

2. Areas of Weakness

a. Quantity vs. Quality

Critical review of the preliminary plans might disclose an overly ambitious philosophy of attacking a multiplicity of problems simultaneously. For example, in addition to the daily activities of group treatment and sensory stimulation, feeding and toilet-training programs were initiated. Because of the obvious difficulties of H.I.P. staff ratio (2 per unit housing 53 residents) and time, only a relatively small number of residents participated. The cumulative data recorded suggests that while these self-help skills could be learned by a selected group, rigid follow-up was essential in order to maintain the skills.

b. Planning

Possibly the greatest weakness was disclosed when participants "outgrew" the equipment, not in terms of development, but in sheer physical size. This occurred toward the latter part of the grant period, which limited the amount of funds to offset this development. Concurrently, state budgeted funds were not available in sufficient amounts to offer a positive solution.

c. R.P.T. Evaluation Techniques

Standard Range of Motion charting was planned and attempted as a method of establishing a base upon which to measure resident progress. Several difficulties were encountered, viz.:

1) Lack of receptive communication in residents.
2) Lack of ability to follow directions (communication, IQ, or behavior.)
3) Lack of motivation to respond.
4) Lack of consistent response.

The Cerebral Palsy Evaluation Chart was then used, and was found to be a more useful tool since the major thrust of the project was toward developing motor behavior.

3. Administrative Comments.

At the outset of the H.I.P. grant program, some difficulty was encountered as to the administrative position most suitable for it. Obstacles were present in the form of the limited staff and resources available to the Medical Department. More important was the fact that the Institution was in the process of receiving its intake of patient population at the rate of 20 per week. The emphasis, medically, was toward primary evaluation, medical regimens, and the establishment of an initial medical approach to the varied medical intake. As a result, the H.I.P. program, being developmental in concept, allowed for inputs from an educational base. Upon completion of the intake and the regulation of medical programming, the H.I.P. Grant program was incorporated into the Medical Department.

III. STATISTICAL DATA

GENERAL STATEMENT

The statistical data in this study is a per calendar year measurement of motility achievement of 287 residents who participated in a H.I.P. Grant project at the Woodbridge State School. The project commenced in 1967 and terminated in 1971.

The progress of each resident was measured for each calendar year that he participated in the program. Several of the residents achieved independent ambulation earlier than others and were no longer continued in the program during the succeeding calendar years. Therefore, in addition to measuring motility achievement, the statistical data is an exclusive indicator of the number of residents who were carried over from each calendar year. It is also an indicator of those residents who were terminated from the program during any given calendar year.

In structuring a systematic approach to measuring motility achievement, the 287 residents were assigned to 6 specific categories. The criterion used for categorical assignment was based on the level of achievement that each resident had reached after termination of the five year project. The following are the categorical headings and the number of residents who achieved that level:

CATEGORY	NUMBER OF RESIDENTS
A. Independent Ambulatory	85
B. Semi-Ambulatory	88
C. Standing with assistance	42
D. Crawling	35
E. Non-movement	27
F. Regressive	10
TOTAL	287

In reading the statistical charts, a horizontal totalization (per calendar year) of the data will yield the number of residents who participated in the program (in a specific category) during that year. Example: In the semi-ambulatory category, during 1967, 72 residents participated in the program. A vertical totalization of the data was not designed to yield a valid summation of achievement. The total number of residents who were assigned to the specified category serves this purpose. (Example: 88 residents in semi-ambulatory category.)

Example of invalid summation:

Semi-ambulatory category under Code 4 (see statistical chart.)

1967 - 40 residents
1968 - 21 "
1969 - 16 "
1970 - 20 "
1971 - 20 "

TOTAL 119 residents

In the above, the total of 119 is not a valid summation of achievement because this number may include residents covered by the variables discussed in the second paragraph of this narrative.

GLOSSARY OF TERMS:

Independent-ambulatory	The resident walks well unassisted, or walks unassisted with difficulty.
Semi-ambulatory	The resident walks only with assistance.
Standing with assistance	The resident is able to stand with the support of orthopedic braces; and/or physical assistance from equipment (e.g. parallel bars), furniture or a staff member.
Crawling	The resident is able to thrust his body forward along a surface, on his hands and knees, using a reciprocal pattern.

GLOSSARY OF TERMS (cont'd.):

Non-movement	The resident has shown no developmental movement from his entry level toward walking well unassisted.
Regressive	The resident has shown negative movement away from walking well unassisted, walking unassisted with difficulty and walking only with assistance, to not walking.

IV. PROCEDURES AND TECHNIQUES

A. Initiating the physical habilitation program in a cottage.

1. Developing a treatment area.

Using the criteria developed (Section II-3) a room was selected to serve as a cottage physiotherapy room. Since all non-ambulatory units have identical floor plans, the following description is applicable to Cottages 1 through 8.

The designated area contained 963 square feet of functional space, plus a large storage closet, and was utilized informally by the cottage staff for recreational purposes. Cooperation between the Cottage Life Department and H.I.P. personnel was especially crucial at this stage since established cottage arrangements were altered in order to accommodate the new program.

2. Assignment and use of personnel.

Prior to the expansion of programs made possible by the grant, the Cottage Life Department designated staff under the direction of the Education Department to function as "Occupational Therapy Aides." In this capacity, the aides assisted the professional program of Sensory Stimulation provided by the classroom teacher. Following specific training (provided under the grant) one attendant was assigned as a physiotherapy program assistant in each non-ambulatory cottage.

3. Program planning.

Integrated programs were planned to develop in each resident the maximum in motor and sensory skills. In the early stages, both Occupational Therapy and Physiotherapy Aides presented activities in sensory stimulation, such as visual tracking, grasp and release, and auditory stimuli. As the project became more sophisticated, there grew a more obvious division, with the Physiotherapy Aides emphasizing physical treatment. In each cottage, the Occupational Therapy and Physiotherapy Aides have continued a team approach to orthopedic bracing and special shoes.

4. Selected equipment.

Each cottage therapy room was equipped with the following apparatus:

a. Exercise mats: foam rubber with washable, heavy vinyl cover.
b. Tilt table.
c. Relaxation chair.
d. Standing boxes: single place, 2-place & 4-place (large & small.)

4. Selected equipment (cont'd.)

e. Parallel bars: adjustable height; removable divider.
f. Posture mirror
g. Treatment table
h. Walkers: child; junior; adult
i. Standing stabilizer
j. Reciprocal skis
k. Run-around stool

The Central Physiotherapy Clinic of the hospital was augmented by:

a. Hydrocollator (hot-pack unit)
b. Chest pulley weights
c. Chronaxie-meter
d. Low-volt generator

5. Additional equipment

During the grant period, it was found desirable to obtain additional equipment as follows:

a. Crawlers - Kuhnen type
b. Relaxation chairs
c. Standing boxes - adult, 4-place
d. Reciprocal walking aids
e. Mat platforms
f. Tripod canes
g. Tripod crutches
h. Lofstrand crutches

6. Initial evaluation of residents

Screening of the non-ambulatory population was completed as a preliminary to the submission of the grant proposal. Subsequent evaluation was concerned with potential for ambulation or amelioration of existing physical problems, using criteria established by the Physiatrist. Habilitative measures were then prescribed for each resident enrolled in the H.I.P. Physiotherapy project.

7. Dissemination of prescriptive information.

Based on the Physiatrist's prescription, a Registered Physiotherapist planned individual treatment programs to be carried out by the sub-professional staff under supervision. The goals of treatment were discussed by the team in each case, as well as the specific techniques for achieving them. When necessary, individual instruction was given the aides not only by the Physiotherapist, but also by the Physiatrist. Finally, a written treatment program was provided the aide for each resident.

8. Grouping of residents

Group treatment served as a tool to ensure maximum exposure of each resident to corrective procedures or developmental stimuli. Homogeneous and heterogeneous groups were formed, the definition being dependent upon the priorities assigned to the criteria used. Included in such criteria were age, physical size, level of motor development, communication, social skills, behavior and type of treatment.

IV-B FOLLOW-UP

1. Resident re-examinations

Routine quarterly re-examinations were performed by the Physiatrist. In the event of special problems arising, the resident was re-examined immediately. Those who achieved ambulation and were discontinued from treatment received annual re-examinations.

2. Prescription changes

Modifications and/or changes in prescriptions were handled in the same way as new prescriptions (Section IV-A, 7.)

3. Supervision

Supervision of the sub-professional P.I.P. personnel on a daily basis was provided throughout the entire grant period by Registered Physiotherapists.

4. Evaluations by Physiotherapy Aides

A Motor Development Evaluation was compiled by the Chief Physiotherapist, based on the work of Ruth Griffiths, and the needs of the program. These were completed by the Physiotherapy Aides for each resident at 6 month intervals during the last 2 years of the grant, in addition to the H.I.P. data sheet, which was used consistently 1967-1971.

C. Evaluation of equipment used.

Item:	Durability:	Comments:
1. Exercise Mats	Excellent	Should be firm enough to provide a stable surface for standing, yet resilient enough to protect. Smooth vinyl covers are preferable since "grained leather" type is quite difficult to clean.
2. Tilt table	Excellent	Has proved a most useful tool in developing standing balance and improving posture. We required additional safety straps.
3. Relaxation chair	Excellent	Small chairs commercially available proved unstable & of poor construction. Bailey Co.(Ohio) model with solid wooden base (not tubular frame) was the most satisfactory.
4. Standing boxes (stand-in tables)	Good	4-place units were most commonly used as they conserved space and provided an environment for socialization. For larger residents, 2-place and single units were utilized at times. Frequent inspection and maintenance were found to be essential because of the excessive stress placed by our residents on door hinges & fastenings. In some cottages additional fastenings were attached for security.

C. Evaluation of equipment used (cont'd.)

Item:	Durability:	Comments:
5. Parallel bars (Adjustable height, removable divider))	Excellent	For smaller residents it would have been better to have parallel bars with standard and small diameter hand-rails instead of a single hand-rail.
6. Posture mirror	Excellent	Supplied excellent motivation when used in conjunction with parallel bars as well as free standing and ambulation (with or without assistance.)
7. Treatment table	Excellent	One cottage had a problem that the naugahyde cover of the table was frequently cut by orthopedic braces but this was an isolated experience.
8. Walkers	Good	The Housekeeping & Maintenance Depts. were instrumental in prolonging the life of some walkers (e.g. those with seats supported by webbing straps.) The biggest problem was to find large size walkers which would provide the amount of support required. Everest & Jennings Co. is now working on this problem.
9. Standing stabilizers	Good	The basic unit has excellent durability, but not so the straps & foam rubber padding, in our experience. At Woodbridge State School the stabilizers were modified & used only in conjunction with the standing boxes to counteract the tendency toward sitting.
10. Reciprocal skis	N/A	This piece of equipment was found to be impractical. (1) It was virtually impossible for 1 staff person to use it without assistance. (2) The residents did not generalize the learning. (3) Those who had flexion patterns of hip & knee joints became frustrated when they were unable to use these motions.
11. Wheeled run-around stool	Excellent	Used by staff (only) in many ways for aiding residents in standing balance and ambulation.

Additionally, it was found that the most useful forms of heat were whirlpool and hot-pack, since many residents suffered aberrations of sensory systems. Ultrasound, when administered was given at minimal dosage in terms of wattage and duration.

INDEPENDENT AMBULATORY

	M 1	1	M 2	2	M 3	3	M 4	4
1967	- -	8	XXXX XXXX - -	24	XXXX XXX	19	XXX XXX	7
1968	-	21	XXXX XXXX -	25	XXX XX	20		1
1969	X - -	21	XXX XX -	19	XXX XX -	17		0
1970	-	21	XX	31	XXXX	16		0
1971	X - - -	38	XXX XXX - -	31	XXX XXX	10		0

SYMBOLS

X = Progressive Movement

- = Regressive Movement

CODE

1 = Walks well unassisted

M 1 = Progressive or Regressive Movement

2 = Walks unassisted with difficulty

M 2 = Progressive or Regressive Movement towards or away from walking well unassisted

3 = Walks only with assistance

M 3 = Progressive or Regressive Movement towards or away from walking well unassisted and walking unassisted with difficulty

4 = Does not walk

M 4 = Progressive or Regressive Movement towards or away from walking well unassisted, walking unassisted with difficulty, and walking with assistance

SEMI - AMBULATORY

	4	M 4	3	M 3	2	M 2
1967	40	XXXX XXXX XXXX XXXX X	28	- - -	4	- -
1968	21	XXXX XXX	58	X -	0	
1969	16	XX	65	X = -	2	
1970	22	XXX XXX	63		0	
1971	20	XXXX XXXX XXXX XXXX XXX	58	X	1	-

SYMBOLS

X - Movement

\- = Regressive Movement

CODE

2 = Walks unassisted with difficulty

M 2 = Progressive or Regressive Movement toward or away from walking well unassisted

3 = Walks only with assistance

M 3 = Progressive or Regressive Movement toward or away from walking well unassisted and walking unassisted with difficulty

4 = Does not walk

M 4 = Progressive or Regressive Movement toward or away from walking well unassisted, walking unassisted with difficulty and walking only with assistance

STANDING WITH ASSISTANCE

	3	M_3	2	M_2	1	M_1
1967	29	X	0		0	
1968	29	XXXX XXXX XXXX XXXX XXX	1		1	
1969	12	X	21		0	
1970	12	XXX XX	23		0	
1971	4	XX XX	33		1	

SYMBOL

X = Movement

CODE

1 = Stands Independently

M_1 = Progressive Movement toward complete ambulation

2 = Stands with support or assistance

M_2 = Progressive Movement toward independent standing

3 = Does not stand

M_3 = Progressive Movement toward standing with support or assistance and independent standing.

CRAWLING

	3	M 3	2	M 2	1	M 1
1967	30	XXXX XXXX XXXX XXXX XXXX	1		1	
1968	14	XXXX XXXX	15		0	
1969	9	XXX X XXX	21		1	
1970	8	XX	24		1	
1971	7	XXX XXX X	25		1	

SYMBOL

X = Movement

CODE

1 = The Participant Crawls

M 1 = Progressive Movement toward standing with support or assistance.

2 = Able to move about but does not crawl

M 2 = Progressive Movement toward crawling

3 = Does not crawl or move about

M 3 = Progressive Movement toward being able to move about

NON - MOVEMENT

	4	3	2	1
1967	15	0	0	0
1968	17	0	0	0
1969	18	0	0	0
1970	22	0	0	0
1971	22	0	0	0

CODE

1 = Walks well unassisted

2 = Walks unassisted with difficulty

3 = Walks only with assistance

4 = Does not walk

PEGRESSIVE

	M 1	1	M 2	2	M 3	3	M 4	4
1967		0	XXX	4	X	2		0
1968		0		2		3		1
1969		0		1		3		4
1970		1	X	1	X	1		7
1971		0		0	X	1		9

SYMBOLS

X = Progressive Movement

CODE

1 = Walks well unassisted

M_1 = Progressive or Regressive Movement

2 = Walks unassisted with difficulty

M_2 = Progressive or Regressive Movement toward or away from walking well unassisted

3 = Walks only with assistance

M_3 = Progressive or Regressive Movement toward or away from walking well unassisted and walking unassisted with difficulty

4 = Does not walk

M_4 = Progressive or Regressive Movement toward or away from walking or away from walking well unassisted, walking unassisted with difficulty and walking only with assistance

WORKSHOPS

Montessori Workshop	1967	Douglass College
Behavior Modification	1969	Woodbridge, New Jersey
"Visual-Motor Deficits"	1968	Matheny School
American Academy for Cerebral Palsy	1968	Florida
Recreatic· and Physical Education	1968	New York City

CONFERENCES

American Association on Mental Deficiency (regional)	1968	Boston, Massachusetts
Council for Exceptional Children	1967	Trenton, New Jersey
American Association on Mental Deficiency (regional)	1971	Newark, New Jersey

PROGRAMS VISITED

Ebensburg State School, Ebensburg, Pa.	1967
Middlesex County Cerebral Palsy Centre Menlo Park, New Jersey	1967
Vineland State School, Vineland, New Jersey	1967
Children's Specialized Hospital Mountainside, New Jersey	1968
Matheny School for Cerebral Palsy Children Peapack, New Jersey	1968
Kessler Institute, Orange, New Jersey	1968
Hunterdon State School, Clinton, New Jersey	1970
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GLOSSARY OF TERMS

PHYSIOTHERAPY:

PASSIVE MOTION - To afford nutrition to muscles; train cortical pictures in mind of resident who has never moved extremity and develop kinesthetic sense.

ACTIVE ASSISTIVE MOTION - This is a progression from Passive Motion.

ACTIVE MOTION - Further progression where motion is made entirely by resident.

RESISTED MOTION - To build strength in weakened muscles and muscle groups.

BALANCE - The art of balance is required to maintain head control and the positions of sitting, kneeling, crawling, standing, and walking.

RECIPROCATION - An important phase of walking. The Cerebral Palsied child does not learn reciprocal motion as a normal child does.

PARALLEL BARS - Ambulating between bars facilitates progression toward independent ambulation.

STANDING TABLE - To stimulate muscle contractions, proprioceptor senses, and give weight-bearing to bones as well as a preventative to osteoporosis.

TILT TABLE - To get bed-ridden residents gradually into standing position and, at the same time, stimulate muscle contraction: maintain proper alignment of body segments and prepare bones for weight-bearing.

OCCUPATIONAL THERAPY:

GROSS MOTOR - Gross Motor activities stimulate the use of and assist in the development of the limbs of the body by crawling, rolling, rocking, etc.

GRASP ACTIVITIES - Grasp and release activities are taught on an individual basis. This activity is a prerequisite to the more sophisticated activities of Feeding, Dressing, etc.

VISUAL TRACKING - Lights and objects are presented to the residents to increase visual awareness and strengthen eye musculature.

EYE-HAND COORDINATION - Activities to increase eye-hand coordination and hand musculature are presented daily. Peg boards, squeeze toys and coordination boards are some of the principal materials used to promote responses.

SENSORY STIMULATION - The purpose of this activity is to establish awareness with the environment by stimulation of each of the senses: Auditory, Visual, Olfactory, Gustatory, Tactual.

GLOSSARY OF TERMS (cont'd.):

FEEDING - Each of the 17 Aides has 3 to 4 residents enrolled in the Cottage Feeding Program. As a child becomes a self-feeder, a new child requiring this training is admitted to the program. Operant conditioning techniques are used, progressing from non-feeding to self-feeding with a spoon.

TOILET TRAINING - Toilet training programs are operated in conjunction with Cottage personnel for residents who can benefit from this training. Operant conditioning techniques are used, progressing from readiness to complete self-toileting by routine.

BEHAVIOR MODIFICATION - The technique of behavior modification is used in conjunction with all of the above activities, as necessary, and as a tool to modify abusive behavior.

ARTICLES AND PRESENTATIONS

1968 Annual Meeting, American Association on Mental Deficiency; Boston, Mass.

"Physical Habilitation for the Severely Handicapped."

Donna L. Hugelmeyer, Supervisor of Instruction
Woodbridge State School, Woodbridge, New Jersey

1969 Seminar - Jersey City State College, Jersey City, New Jersey

"What's New in Cerebral Palsy"

Jerry Wyatt, R.P.T., Chief Physiotherapist
Woodbridge State School, Woodbridge, New Jersey

1968 "Summer of Fun" - a pilot program in non-ambulatory recreation

Donna Hugelmeyer and Marion Williams
Woodbridge State School, Woodbridge, New Jersey

1970 "Animal Festival"

Non-ambulatory custom fitted playground

Project submitted by Dora Carrara
Woodbridge State School, Woodbridge, New Jersey

"PHYSICAL HABILITATION FOR THE SEVERELY RETARDED"

Donna L. Hugelmeyer, Supervisor of Instruction
Woodbridge State School, Woodbridge, New Jersey

Presented at the Annual Meeting (1968) of
The American Association on Mental Deficiency, Boston, Mass.

WOODBRIDGE STATE SCHOOL - PHYSICAL HABILITATION PROGRAM

The Woodbridge State School is the newest of six residential centers for the mentally retarded in New Jersey. On its 68 acre campus, the school houses 1,000 severely and profoundly retarded residents, male and female, five years of age or older. More than half of the population consists of semi or non-ambulant multi-handicapped residents. Eight cottages and a hospital ward comprise the living setting for 500 non-ambulant residents.

During the first years of its existence the Woodbridge State School was able to offer the non-ambulant population excellent medical and personal care, but training and funds were not available to extend this program into the sorely needed area of training.

In the fall of 1966, Title I funds enabled a certified teacher to be secured for each of our 19 cottages - thus training in our eight non-ambulant cottages began. The residents in the non-ambulant cottages, as a result of multiple handicaps, presented a prime need for physical habilitation. As a result, the classroom teacher was trained to devote half of her day to physical training. This initial effort was the forerunner and basis of the program in operation today.

In June of 1967, services were expanded with the advent of Federal Funds from the Hospital Improvement Program. Nine Therapy Program Assistants positions were secured through Federal Grant funds and eight budgeted positions were allocated by the school administration. These eight budgeted positions augment the Grant staff and supply Occupational Therapy and Recreation activities.

Prior to assuming their positions, the Aides received 120 hours of training over a six week period at Willowbrook State School in Staten Island, New York. This training included a lecture by their Physiatrist and on-the-job training with children enrolled in Willowbrook's Habilitation Program. At Woodbridge State School, monthly in-service training sessions, conducted by the Physiatrist and Physical Therapists are held. Training materials are distributed to the Aides for home study and many Aides do extra reading and research to enhance their job performances. Classes are also held by the In-Service Training Department of the School, in an effort to provide the Aides with a comprehensive overview of the Woodbridge program and population. Sense stimulation, recreation activities, and an intensive orientation to mental retardation provide Aides with increased body of knowledge.

Meetings, such as the Cerebral Palsy Institute, are held at Woodbridge to disseminate information to the Aides. Periodic trips are taken to other Physical Therapy facilities in New Jersey. Out of state facilities, such as Ebensburg State School, Ebensburg, Pennsylvania, are visited by supervisors to compare notes and see other Physical Habilitation Programs function, as the result of the use of supportive personnel.

Each of our eight non-ambulant cottages and the Maximum Care Ward of the Hospital has established a Therapy Room for which the Physiatrist has ordered modern equipment, supplied through the project. The non-ambulant Cottage Life unit has been extremely cooperative in fostering and supporting this project. Four-place standing tables, parallel bars, walkers, stairs, etc., are in daily use by residents evaluated for the program. Curtains, to enhance the attractiveness of the room; television, toys and play equipment are supplied by parents, school personnel and friends, in a continuing gesture of support and interest.

Aides are responsible for putting orthopedic shoes on the residents each morning. A few residents have learned to put their own shoes on with assistance. Braces are applied each morning by Aides who have been trained by the Physiatrist in proper care and brace application.

Residents are evaluated and placed on the Physical Habilitation program by the Physiatrist, who is the Program's Medical Co-Director. Re-evaluations are done routinely on a three month basis and upon special request by Therapists, Aides, or other departments of the School. When orthopedic shoes are prescribed by the Physiatrist, the Orthopedic Shoe Manufacturer measures the children and fits their shoes in the Cottages. Braces are prescribed by the Physiatrist for residents requiring them. They are measured and fitted by the brace manufacturer. A consultant Orthopedist is called in periodically to evaluate residents for elective surgery.

At routine examinations, the Physiatrist's recommendations for treatment are communicated into a dictaphone, transcribed and distributed to the medical file, the Physical Therapists, and the Aides. The Physical Therapists implement the Physiatrist's recommendations and instruct the Aides. They also instruct the Aides in use of Therapy equipment.

The Physical Therapy Clinic in the Hospital is operated by a Physical Therapist on a three day a week basis to accommodate those residents requiring specialized treatments. Only Certified Physical Therapy personnel utilize this facility.

Ambulation training is one of the principal activities of the Aides. As you know, sitting balance is a necessary aspect of physical growth and development. In addition to the physical gains realized by the use of the standing box, other facets of the child can be developed through play, recreation and socialization. Feeding programs are conducted by both Aides in the cottage. Special feeding equipment to meet the residents' needs are provided by Federal funds.

Half-circle tables allow the two Aides to assist three children each, in a contained area. The feeding program is conducted two times a day at mealtime on a seven day a week basis. 36 residents are presently enrolled in the feeding program. Approximately four residents per month are graduated from this program.

Toilet training programs are conducted by the Occupational Therapy Aides, as is Visual Tracking. General hand manipulative activities, such as the use of peg boards, squeeze toys, etc., increase eye-hand coordination and hand musculature. Grasp and release activities taught on an individual basis are prerequisites for the more sophisticated activities of feeding, etc. Current enrollment in the Occupational Therapy program is 128 residents.

Some of the children enjoy gross motor activities, such as rocking boat action. Sensory stimulation is a program designed for residents who present severely limiting physical and mental handicaps. Their disability is of a magnitude which mandates crib or bed maintenance. The purpose of sense stimulation is to establish awareness with the environment by stimulating the senses. This segment of the retarded population most generally is the recipient of no services since the gains are thought to be unlikely or negligible at best. At Woodbridge, 107 residents are enrolled in this program, with a conviction of its worth based in the philosophy that all our residents deserve the opportunity to grow and develop. The massive problems their growth and development present spur us to find means to reach them and open lines of communication. By this means we expect to enter their world and in turn have another participant in the conscious world we inhabit.

The sense of taste is stimulated initially by sweet, sour, salty, etc., liquids applied to the tongue and lips by use of a cotton swab. As the child progresses this sense of taste is stimulated by candy, cereal, etc. Auditory sense is stimulated by the sound of squeeze toys, marraccas and other musical instruments or by the human voice in the form of babbling, cooing, and simple sentences. The sense of touch in initially stimulated by stroking the body, the use of texture blocks, and is further stimulated by the introduction of other objects. The olfactory sense is stimulated by the aroma of perfume, vinegar, alchol, foods, etc. Significant awareness has been stimulated through this activity. Colorful objects and lights help stimulate visual awareness.

Daily records are kept by each Aide on all of the children enrolled in the various programs. Every non-ambulant resident is reached by some aspect of the total habilitation program. Activities performed each day are checked off and anecdotal records are kept of any significant responses made by residents to the activities presented. As children progress to the point where the Physiatrist recommends release from the Physical Habilitation program they enter Phase II. Cottage Attendants are trained and instructed to provide carry-over to insure retention of skills learned in the Physical Habilitation program. For example, in Phase II program, ambulation training is continued in the form of walks to the Administration Building to see the fish aquariums and animal conservatory.

As a result of facets of programming, many of our non-ambulent residents are able to participate in classroom programs and special events. Parent satisfaction and pleasure is graphically reflected in resident progress. Improvements in physical capabilities ranging from small to considerable have an incalculable effect on parents and relatives. The ability to respond, to communicate, to sit, to stand or to walk opens avenues of activity long denied to handicapped persons and their families. Parents conditioned by disappointment, misinformation, false hope and despair receive our efforts with a depth of feeling difficult to describe. At Woodbridge, we operate in a climate where one resident triumph communicates itself in a buoyand manner to employees, parents and friends. The Physical Habilitation program, as a result, extends beyond the 68 acres of Woodbridge State School into the homes and feeling life of countless families.

At Woodbridge State School the challenge of the difficult, the excitement of planning, the anticipation of developing and the satisfaction of accomplishment encourages us to seek solutions where none existed before. Surely the gains noted in resident physical and mental well-being are proof and impetus to look to the future with hope, optimism and enthusiasm. What we do or do not do affects not only the mentally retarded in our care but their families and the sphere of involvement within the community. Enhancing the physical well-being and mental awareness of the residents is reflected in parent and employee satisfaction and gratification.

It is the goal of Woodbridge State School to provide each resident with services which will realize his mental and physical potential. The Physical Habilitation program is an integral aspect of a total effort, reflecting a deep and comprehensive concern for the individuals we are dedicated to serve.

"SUMMER OF FUN"

NON-AMBULATORY RECREATION PROGRAM

1968 and 1969

"SUMMER OF FUN"

A PROGRAM DESCRIPTION

By

Donna Hugelmeyer and Marian Williams

WOODBRIDGE STATE SCHOOL

Woodbridge, New Jersey

MY THANKS

PEOPLE EVERYWHERE IN LIFE
FROM EVERY WALK AND STATION,
FROM EVERY TOWN AND CITY
AND EVERY STATE AND NATION
HAVE GIVEN ME SO MANY THINGS
INTANGIBLE AND DEAR,
I COULDN'T BEGIN TO COUNT THEM ALL
OR EVEN MAKE THEM CLEAR...
I ONLY KNOW I OWE SO MUCH
TO PEOPLE EVERY-WHERE
AND WHEN I PUT MY THOUGHTS IN VERSE
IT'S JUST A WAY TO SHARE
THE MUSINGS OF A THANKFUL HEART,
A HEART MUCH LIKE YOUR OWN,
FOR NOTHING THAT I THINK OR WRITE
IS MINE AND MINE ALONE...
SO IF YOU'Ve FOUND SOME BEAUTY
IN ANY WORD OR LINE,
IT'S JUST "YOUR SOUL'S REFLECTION
IN PROXIMITY WITH MINE."

By Helen S. Rice

DEDICATED TO:

MRS. WERNER = SUPERVISOR OF INSTRUCTION
MRS. HUGELMEYER - THERAPY COORDINATOR
MR. ROSEN - SUPERINTENDENT
MR. PIRONE - ASSISTANT SUPERINTENDENT
MEDICAL STAFF
RECREATION STAFF
NON AMB. UNIT SUPERVISORS
NON AMB. H.C.T.S.
FOOD SERVICE
BUSINESS OFFICE
MRS. CARRARA - ASSISTANT THERAPY COORDINATOR
EDUCATION SECRETARIES
O.T. AIDES
MERRILL PARK OFFICIALS
PINKIE SUCH'S MATAWAN
STATEN ISLAND ZOO OFFICIALS
HOWARD JOHNSON'S ROUTE 1
KEANSBURG AMUSEMENT PARK - MR. GILHOUSE
JOHNSON PARK - EAST BRUNSWICK

FROM THE NON AMB. O.T. AND RECREATION PERSONNEL - THANK YOU VERY MUCH FOR YOUR HELP.

INTRODUCTION

This project entitled "Summer of Fun" was conducted in conjunction with the Physical Habilitation program of the Woodbridge State School funded by the federal H.I.P. Program.

The residents enrolled in this Summer Program were selected from a total of 325 residents enrolled in the H.I.P. Project. 2/3 of the residents enrolled in the H.I.P. Project are measured in intelligence within the profound level of retardation and are between the age range of 5 - 20 years.

NON AMBULATORY RECREATION PROGRAM - SUMMER 1968

The 1968 Summer recreation program for non ambulant residents was established to include Physically Handicapped residents in purposeful indoor and outdoor, physical, recreational, and esthetic activities to further stimulate and enrich their daily lives.

All children learn through their experiences, but because of mental retardation and physical disabilities, many children fail to receive the amount and variety of experiences necessary for optimum growth. Especially for these children, activities must be planned to develop interest and attitudes which form the core for the acquisition of learning fundamentals.

This program is one of physical exercises, both passive and active, swimming, indoor and outdoor games, nature walks, arts and crafts, weekly trips and special events.

The personnel for the program consisted of eight Occupational Therapy Aides, one teacher, and supervisors of vocational instruction and education.

THE SUPERVISOR'S ROLE

The Supervisors had the overall responsibility to coordinate the inter-departmental efforts to provide a multi faceted Summer Recreation Program to fulfill the non-ambulant residents recreational needs.

THE TEACHER'S ROLE

The teacher was responsible for training aides, preparing the activities and lesson plans and working directly with the aides in carrying out the activities described in the lesson plans. She made arrangements for off ground trips and accompanied as well as directed the activities on these trips.

THE ROLE OF THE AIDES

The Aides worked directly with the children in groups guiding them through each activity. Each aide was responsible for her group while on grounds or on off grounds trips. It was the duty of the O.T. Aide to make each activity as challenging and rewarding for the child as possible.

TRAINING

The first three days of the program were used for training of aides and demonstration class periods. During this time the aides were instructed in planning a lesson to suit the needs of the various groups they could work with.

Children were brought into the demonstration class and were taken through a recreational activity step by step. A question and answer period provided the aides with an opportunity to question any teaching procedure demonstrated. Using the information provided during lectures and demonstrations the aides prepared lesson plans.

SAMPLE LESSON PLAN SHEET

DATE_____ O.T. AIDE_____

GROUP_____ TIME_____

LESSON PLAN

OBJECTIVE	ACTIVITY	PROCEDURE
*WHY ARE YOU TEACHING THIS ACTIVITY?	*WHAT ARE YOU GOING TO TEACH?	*HOW ARE YOU GOING TO TEACH THIS ACTIVITY?

* QUESTION USED TO CLARIFY THE CONTENT OF THE LESSON PLANS

CHRONOLOGICAL PROCEDURES FOR DAILY NON-AMB. SUMMER RECREATION PROGRAM AND SPECIAL EVENTS ON GROUNDS

ONE MONTH PRIOR TO INITIATION OF SUMMER PROGRAM

(1) Schedule use of Swimming Pool.
(2) Arrange for water safety instruction for staff.
(3) Schedule prospective Swimmers for Physical Examinations and Medical Clearance.
(4) Arrange for Special Professional assistance i.e. Music Instructor, etc.

TWO WEEKS PRIOR TO SPECIAL EVENT

(1) Schedule use of Multi Purpose Building Auditorium or area where event will take place.
(2) Arrange for Entertainment.
(3) Arrange for Refreshments, publicity, photographs, etc.
(4) Invite parents, friends, etc.

ONE WEEK PRIOR TO INITIATION OF SUMMER PROGRAM

(1) Train Personnel in techniques and procedures to be used.
(2) Requisition Special Equipment and supplies needed.
(3) Screen residents, assign to groups.
(4) Inform all Departments of School concerned with resident programming of residents enrolled in Special Program in order to accomodate additional programming.

CHRONOLOGICAL PROCEDURES FOR SPECIAL OFF GROUNDS TRIPS FOR NON-AMB.

SUMMER RECREATION PROGRAM

ONE MONTH PRIOR TO INITIATION OF SUMMER PROGRAM

(1) Make reservations for areas to be visited.
(2) Schedule use of Bus for dates requested.

a. Schedule station wagon to follow bus if one way traveling time is more than 30 minutes from school.

b. Inform recreation supervisor of the number of wheelchairs to be locked on the bus and the number to be stored.

TWO WEEKS PRIOR TO SCHEDULED OFF GROUND TRIP

(1) Notify Food Service Department of lunches, refreshments, etc., necessary for trip, number and names of residents attending so that special diets may be prepared if necessary.
(2) Notify ambulatory unit and Head Cottage Training Supervisor of time and place of departure, date and residents attending. Stipulate if change of clothing is necessary.
(3) Secure from H.C.T.S. special information regarding medications and special diets of residents attending.
(4) Complete and submit to Director of Education a Welfare Request Form if funds are needed for the trip. (Receipts for all purchases, entrance fees, etc.. must be forwarded to Director of Education upon return from trip.)

DAY OF SCHEDULED OFF GROUNDS TRIP

(1) Upon boarding bus, to leave campus and to leave field trip areas, check each resident's name and count all residents.
(2) Check that medications and special diets, if required, lunches, etc., have been loaded on the bus.
(3) Upon departure from Campus, a list of children on the field trip must be submitted to Director of Education and Non-ambulatory Unit Supervisor.
(4) Upon return to Campus, Director of Education and Non-ambulatory Unit Supervisor should be advised of return.

SPECIAL EVENTS - SUMMER 1968

NON AMBULATORY RECREATION PARTY

SWIMMING

One of the treats the non-ambulatory residents enjoyed this summer was the swimming pool. Many of the children were afraid to go in the water the first time. But after introduction they talked about the experience for days afterward. At the end of the summer each child had learned to enjoy the pool.

SPECIAL EVENTS - SUMMER 1968

NON AMBULATORY RECREATION PARTY

MUSIC

Music classes were conducted by the music instructor on Tuesday mornings. The children were engaged in singing and rhythm instrument playing.

OFF GROUND FIELD TRIPS SUMMER 1968

PINKIES FARM:

The first field trip was taken in July to Pinkies Farm in Matawan, N.J. As the children were settled in an area near the barn the animals each were brought to them. Each child was allowed to pet the animals and ask questions about the animals. A horse show was presented for the children's enjoyment, after which they watched a blacksmith shoe a horse.

MERRILL PARK:

The trip to Merrill Park proved to be most enjoyable in that it was an all day trip and the recreational activities were divided among groups to be carried out at the park. Ball play, croquet, storytime, rides, and nature walks were some of the activities carried out.

ART SHOW:

An art show was presented to allow the children's work to be displayed. During construction of art items each child was worked on an individual basis. The art work was done using the same procedure one would use to assemble a puzzle. Parts of each picture was covered while the uncovered parts were painted or built up to leave a recessed background. Fine coordination work was accomplished using colorful yarn strips to finish pictures. Other projects were plaster of paris placques and ash trays, and articles decorated with pebbles, marbles, and sea shells.

PARTY:

During the last week of the program a party was given for all the residents enrolled in the summer program. Rock and Roll music was played and all enjoyed cake and ice cream.

HAY RIDE:

An on-grounds hayride was the culminating event of the Summer. Twenty five non amb. residents went on the hayride. Ambulatory and non-ambulatory residents attended this event. A grand performance of country and western music was given by Billy Bell and his all Western Band. The event was also attended by parents and friends of Woodbridge State School.

The children sang, clapped and danced as the band played familiar songs. The group distributed 200 records to the residents.

OFF GROUNDS FIELD TRIPS

HOWARD JOHNSON'S:

Two groups of non-amb. residents were taken to Howard Johnson's Route I Restaurant for lunch and ice cream sodas.

The groups were reminded of good table manners before the trip and two girls advanced as far as using a fork to eat lunch. Social amenities were observed throughout the trip.

STATEN ISLAND ZOO:

At the Staten Island Zoo, the children were able to see some of the animals that they had learned about in class.

KEANSBURG AMUSEMENT PARK:

The trip to Keansburg Amusement Park was truly an enjoyable one. for the children as well as the adults. Each one of the twenty-two children on this trip were taken on five rides. Some of the children were permitted to play games and came back with prizes. After the games and rides the residents enjoyed hot dogs, french fries and soda.

JOHNSON PARK:

The last trip of the summer was to Johnson Park in East Brunswick. Since the group arrived at the park during lunch time, everyone had lunch, a 15 minute rest period, and toured the grounds to see the animals and plants.

DAILY SCHEDULE SUMMER 1968

Mondays	A.M. Recreation 9:00 - 11:00 P.M. Recreation 1:00 - 3:00
Tuesdays	A.M. Recreation 9:00 - 11:00 Music 11:00 - 12:00 P.M. Recreation 1:00 - 3:00
Wednesdays	A.M. Recreation 9:00 - 11:00 Swimming 11:00 - 12:00 P.M. Recreation 1:00 - 3:00
Thursdays	July 11, 1968 - Pinkies Horse Farm July 25, 1968 - Merrill Park August 1, 1968 - Merrill Park August 8, 1968 - Howard Johnson's August 15, 1968 - Keansburg Amusement Park August 22, 1968 - Johnson's Park
Fridays	Art Classes A.M. Art - 9:00 - 11:00 P.M. Art - 1:00 - 3:00

CONCLUSION

In every child's life there should be a time for play as well as a time for learning. It was the endeavor of the recreational group working with the children to help the non-ambulatory residents enjoy a summer of both physical and educational activities.

INTRODUCTION

NON AMBULATORY RECREATION PROGRAM - 1969

The 1969 summer recreation program for non-ambulant residents was initially established in the summer of 1968 to include physically handicapped residents in purposeful indoor and outdoor, physical, recreational, and esthetic activities to further stimulate and enrich their daily lives.

All children learn through their experiences, but because of mental retardation and physical disabilities, many children fail to receive the amount and variety of experiences necessary for optimum growth. Especially for these children, activities must be planned to develop interest and attitudes which form the core for the acquisition of learning fundamentals.

This program is one of physical exercises, both passive and active, swimming, indoor and outdoor games, nature walks, arts and crafts, weekly trips and special events.

The personnel for the program consists of eight Occupational Therapy aides, one Teacher-Supervisor, and Supervisors of Occupational Therapy.

TEACHER SUPERVISOR's ROLE

The Teacher-Supervisor has the overall responsibility to provide a multi-faceted Summer Recreation Program to fulfill the non-ambulant residents recreational needs.

She is responsible for training aides, preparing the activities and lesson plans and working directly with the aides in carrying out the activities described in the lesson plans. She makes arrangements for off-grounds trips and accompanies as well as directs the activities on these trips.

THE ROLE OF THE AIDES

The Aides work directly with the children in groups guiding them through each activity. Each aide is responsible for her group while on grounds or on off-grounds trips. It was the duty of the O.T. Aide to make each activity as challenging and rewarding for the child as possible.

SUPERVISOR OF OCCUPATIONAL THERAPY

The Supervisor of Occupational Therapy has the responsibility to coordinate interdepartmental efforts.

SUMMER RECREATION PROGRAM

The Summer Recreation Program for non-ambulant residents will be held for six weeks starting July 7, through August 15th. In order to include more of the non-ambulant population, the participating residents will be grouped by level of functioning, individual physical needs and interest.

There will be six areas of concentration.

1. Passive Games - This program will include those residents showing little or no interest in participating in recreational activities. The purpose of this area will be to encourage and teach the child how to play. Games in this area will not be structured so that each child will be able to respond freely. The goal of the aide in this area will be to observe the child's behavior and be able to develop better ways to work with him and gradually present opportunities for them to work in slightly structured programs.

2. Active Games - The area of active games will include the major part of the participating non-ambulant population. The aim will be to develop awareness of one's capabilities - physically and mentally. The Aides in this area will be most concerned with projecting activities in a simple and concrete manner.

3. Art - Each group will participate in art activities ranging from finger painting to craft activities such as making molds or making leathercraft projects. Art activities will be guided by the teacher.

4. Swimming - The main goal of the aides in the swimming program will be that of safety and enjoyment in the water when working with the children. Activities such as kicking, splashing, sitting, moving around in the water, and getting the child to relax in the water will be taught.

5. Physical Education - In order to promote the physical well being of these students, a program of physical activities will be planned for each group. Activities ranging from rolling on a mat to rhythm exercises will be taught.

6. Music - This area will deal with enjoyment as well as appreciation of various kinds of music and rhythms. The children will be engaged in copying as well as creating and identifying musical sounds.

OFF GROUNDS TRIPS

Off grounds trips will be taken once a week. Children will be selected from each cottage. The purpose of these trips is to familiarize the children with outer community life.

SPECIAL EVENTS

Special events will be selected to enable the children to become a part of an environment which they are familiar with through television and motion pictures.

FIRST DAY OF TRAINING PROGRAM FOR AIDES

9:00 - 11:00 Meeting to discuss

1. Evaluation System

2. Recreation Program Requirements

    a. up to date rosters
    b. created lessons to be turned in
    c. grouping - level of functioning

3. Meetings

    a. to discuss and evaluate progress, lessons, observations and problems - called meeting each week.

4. Roster

    Swimming
    Trips - 3 children each
    Classes

5. Ideas aides might have for program

6. Field Trips

7. Selection of a special event

1:00 - 2:00 Discussion of suggested rosters - groups

TEACHING SUGGESTIONS

1. Progress slowly
2. Use repetition
3. Introduce new activities during the early part of the class
4. Be kind, firm, and patient always usinga positive approach
5. Use concrete examples - and take part, demonstrate
6. Consider individual abilities and attention spans
7. Give the children goals in which they can have some measure of success
8. Use praise as often as possible
9. Let the children compete with themselves
10. Keep up to date records

Taken from Journal of Health, Physical Education and Recreation - 1966

COTTAGES	TIME	CLASS LOAD	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
2 & 3	8:45-10:00	15 each	Games	Phys.Ed.	Music	Art	Trips
1,4,& 5	10:00-11:00	5 each	Passive Games	Passive Games		Passive Games	Trips
2 & 3	11:00-12:00	15 each	Phys.Ed.	Art	Swimming	Music & Games	Trips
6,7,& 8	1:00-2:00	15 each	Music	Art	Games	Phys.Ed.	Trips
6,7,& 8	2:00-3:00	15 each	Art	Games	Phys.Ed.	Music	Trips

"ANIMAL FESTIVAL"

NON-AMBULATORY CUSTOM FITTED PLAYGROUND

Project received New Jersey Association for Retarded Children Award - 1969

NJARC PROJECT

NON AMBULATORY CUSTOM FITTED PLAYGROUND
"ANIMAL FESTIVAL"

Woodbridge State School has in its total population of one thousand, five hundred non ambulatory residents, housed in eight cottages. These residents represent a range of physical handicap from total dependence to those who can ambulate with assistance.

Recreation and physical activity are an integral part of the daily program for these residents. This activity is conducted in the cottage by various disciplines involved in recreation, occupational therapy, physical therapy and cottage life.

Formalized outdoor activity for the non ambulatory population has consisted of walks around the campus, limited off campus trips and picnics. More structured outdoor activity has not been possible because of the lack of specific equipment designed to accommodate the non ambulatory residents. At Woodbridge State School well equipped playgrounds afford the active, ambulatory residents opportunities for physical activity and enjoyment. However, for the five hundred non ambulatory residents, these opportunities are more limited at present.

This project proposes a Non Ambulatory Custom Fitted Playground "Animal Festival" to be erected on the Woodbridge State School Campus. The Playground will serve the non ambulatory population of five hundred by providing a site for daily recreation activity throughout the clement weather season. One hundred fifty residents divided into a morning and afternoon session will be accomodated in the area. Residents will be supervised by the Occupational Therapy Aide, Recreation Staff and Cottage Life personnel.

Equipment requested for this project includes:

Heavy duty swing set with horse head and safety belt seats

9' 6" Igloo	Supply Box
Bob-a-Round	Spin Around
Picnic Tables	Animal Swing
Lady Bugg	Litter King
Buzzy Bee	Aluminum Leg Park Bench
Hansel and Gretel Playhouse	Rainbow Climber
Sand Box	Basketball backboard
Spring Horse	Strato Ride
Buckin Bronco	Animalrama
Carnival Spin Around	Assorted Games

All equipment will be fitted with safety belts and be erected at a low level to assure maximum safety. Total cost of this project is $8718.24

A Circus Tent was purchased in 1968 to provide the Non Ambulatory population with a shaded area for Occupational Therapy and Recreation activity. It is proposed that this large tent be erected on the site of the Non Ambulatory Playground in order to provide a comprehensive outdoor programming area for this large segment of the W.S.S. population.

Recreation plays a meaningful role in contributing to the growth of all individuals. For the mentally retarded, it is particularly vital as it is often the preface to more formalized learning activity. This project recognized and attempts to resolve inherent problems in providing therapeutic, enjoyable outdoor activity for the multiple handicapped. If granted, it will assist five hundred non ambulatory mentally retarded to benefit from a structured program of outdoor activity based in equipment fitted to accomodate special needs.

Submitted by: Mrs. Dora Carrara

FEEDING THE CEREBRAL PALSIED CHILD

A GOOD FEEDER CAN BE THE BEST SPEECH THERAPIST.

HOW TO CORRELATE THE FEEDING— TO THE SPEECH PROGRAM:

BEFORE ANY CHILD LEARNS TO SPEAK HE MUST FIRST LEARN TO—

CHEW

SUCK

BLOW

SWALLOW

MAKE CHILD USE LIPS TO REMOVE FOOD.

PLACE SMALL AMOUNT OF FOOD ON SPOON

DO NOT HAVE CHILD USE TEETH OR HAVE FEEDER SCRAPE AGAINST UPPER TEETH.

HAVE CHILD IN GOOD ANATOMICAL POSITION.

TELL THE CHILD TO CHEW AND IF NECESSARY MANIPULATE THE JAW IN AN UP AND DOWN MOTION

SHOW HIM HOW.

DO NOT ALLOW HEAD TO TILT BACK. THIS WILL THROW ALL SWALLOWING MECHANISM OUT OF LINE AND MAY CONTRIBUTE TO FORMATION OF REFLEXES

TELL CHILD TO MOVE FOOD AROUND WITH TONGUE

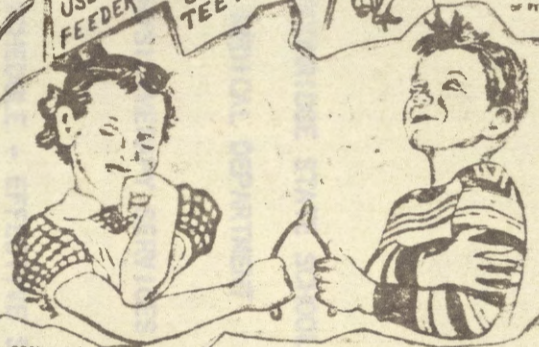
PUT FOOD ON ONE SIDE OF MOUTH

THEN ON OTHER

DO NOT PUT FOOD IN CENTER OF MOUTH.

GIVE CHILD CHANCE TO BITE OFF PIECES OF TOAST ETC.

DO NOT BREAK OFF SMALL PIECES FOR THEM UNLESS THEY ABSOLUTELY CANNOT DO THIS FOR THEMSELVES



KEEP DINING ROOM ATMOSPHERE— PLEASANT.

ALLOW THEM TO FEEL THEIR OWN THROATS OCCASIONALLY WHEN THEY SWALLOW so THAT THEY WILL BECOME CONSCIOUS OF THE ACT OF SWALLOWING.

ELIMINATE AS MUCH JAW ACTION AS POSSIBLE FROM DRINKING

ONE WAY TO DO THIS IS TO STAND IN BACK OF CHILD CUP HIS JAW IN ONE HAND & HOLD WHILE YOU HANDLE THE CUP WITH THE OTHER.

IF CHILD DRINKS FROM TUBE—

REMIND HIM TO KEEP HIS LIPS CLOSED TIGHTLY SO THAT LIQUIDS STAY IN THE MOUTH.

PRAISE THEM WHEN THEY SUCCEED

NEVER SCOLD WHEN FOOD IS PUSHED OR FALLS OUT OF A CHILDS MOUTH. THE CHILDREN CANNOT HELP A WEAK ATHETOID TONGUE OR THE OVERFLOW FROM A SPASTIC TONGUE. CONSTANTLY REMIND THEM TO KEEP THEIR LIPS CLOSED AND TO MAKE TONGUE WORK TO PUSH FOOD AROUND

CHILDREN WHO FEED THEMSELVES HAVE A BETTER ATTITUDE TOWARD EATING

KEEP TABLE TOPS AS CLEAN AS POSSIBLE IN ORDER TO INSPIRE NEATNESS— WHEN HE FEEDS HIMSELF OR WHEN YOU DO THE FEEDING.

DIRECT CONVERSATION TO THE CHILDREN

DO NOT HURRY THEM. KEEP CONFUSION AT A MINIMUM.

ALL CHILDREN HAVE PRIDE. THEY CAN BE NEAT IF— ENCOURAGED.

WHEN TWO OR MORE CHILDREN,—FEED ALTERNATELY— ONE A SPOONFUL, THEN ANOTHER ETC. THIS GIVES EACH A CHANCE TO CHEW FOOD PROPERLY. URGE CHILDREN TO CHEW BETTER. PROOF OF THE FACT THAT THEY ARE NOT CHEWING IS EVIDENCED BY VOMITING.

CHILDREN'S MENUS ARE THE SAME AS ADULTS— WHEN THERE IS A SUPPER OF SOUP FOLLOWED BY SANDWICHES, SALAD, COLD MEATS ETC, VERY OFTEN THE CHILDREN ARE OFFERED ONLY THE SOUP— THIS IS WRONG. OFTEN CHILDREN WHO EAT IN THE DINING ROOM ARE ALLOWED TO SKIP THE SOUP COURSE— ONLY THE OLDER AND HEAVIER ONES ARE ALLOWED TO DO THIS.

CHILDREN WITH SPEECH PROBLEMS SHOULD LEARN TO DRINK FROM A TUBE

TRY TALKING WITHOUT MOVEMENT OF TONGUE - LIPS - THROAT — THE BEST EXERCISE FOR MOVEMENT OF THESE PARTS ARE THE VERY ACTS OF EATING A GOOD DINNER.

PREPARED FOR USE AT THE WALTER D. MATHENY SCHOOL FOR CEREBRAL PALSIED CHILDREN PEAPACK, N. J.

DISTRIBUTED BY THE NATIONAL SOCIETY FOR CRIPPLED CHILDREN AND ADULTS, 2023 WEST OGDEN AVENUE, CHICAGO 12, ILLINOIS

WOODBRIDGE STATE SCHOOL

MEDICAL DEPARTMENT

PHYSIOTHERAPY SERVICES

TENTATIVE SCHEDULE - EFFECTIVE SEPTEMBER 1, 1971

Medical Department

PHYSIOTHERAPY SERVICES

Cottage 2 1

Therapy Program Assistant: S. WISE

7:45 - 8:00	Planning	
8:00 - 8:50	Application of braces & special shoes with assistance	
9:00 - 10:15	GROUP I PHYSIOTHERAPY & AMBULATION TRAINING	
	M. MAHON	D. LAMBERT
	C. MATSIKOUDOS	C. ASTOR
	Y. JUELL	C. MAURINO
	M. GUCKIAN	
10:30 - 11:45	GROUP II PHYSIOTHERAPY & AMBULATION TRAINING	
	R. MULLETT	S. GRUNWALD
	C. O'BRIEN	J. DONDERA
	N. SOTO	G. BILLINGSLEY
11:45 - 12:00	NOTES	
12:00 - 12:30	LUNCH	
	(OR)	
12:30 - 1:00	FEEDING TRAINING	
1:00 - 1:15	PLANNING	
1:15 - 1:30	ON DORM	
	C. RIEKER C. HALL R. BASSIN	
1:30 - 2:30	GROUP III PHYSIOTHERAPY & AMBULATION TRAINING	
	P. SCOTT	M. AVILES
	S. TAORMINA	P. HENDRICKS
	G. BOSHE	D. FIERRARO
2:45 - 4:00	GROUP IV PHYSIOTHERAPY & AMBULATION TRAINING	
	L. PRUITT	A. DEMOREVILLE
	K. BELL	E. CASHMAN
	M. FATE	
4:00 - 4:15	HOUSEKEEPING & NOTES	

PHYSIOTHERAPY SERVICES

Cottage # 2

Therapy Program Assistant: M. WADDELL

7:45 - 8:00	Planning	
8:00 - 8:50	Application of braces and special shoes with assistance.	
9:00 - 10:15	GROUP I PHYSIOTHERAPY & AMBULATION TRAINING	
	E. PROUT	J. LORENZO
	M. SERVIDIO	K. GRIFFIN
	T. SERRANO	L. DOWNEY
10:30 - 11:45	GROUP II PHYSIOTHERAPY & AMBULATION TRAINING	
	N. LAZAR	A. ROBINSON
	F. BURNS	D. BARNES
	P. LORIA	
11:45 - 12:00	NOTES	
12:00 - 12:30	LUNCH	
	(OR)	
12:30 - 1:00	FEEDING TRAINING	
1:00 - 1:15	PLANNING	
1:15 - 2:30	GROUP III PHYSIOTHERAPY & AMBULATION TRAINING	
	J. SHEEHAN	T. HEEGER
	P. WILBURN	J. O'ROURKE
	J. ZELKIND	
2:45 - 4:00	GROUP IV PHYSIOTHERAPY & AMBULATION TRAINING	
	T. McGOVERN	
	J. SVEC	
	C. HAMILTON	
4:00 - 4:15	HOUSEKEEPING & NOTES	

WOODBRIDGE STATE SCHOOL

PHYSIOTHERAPY SERVICES

Cottage # 3

Therapy Program Assistant: F. ROBERSON

7:45 - 8:00	Planning	
8:00 - 8:50	Application of braces and special shoes with assistance.	
9:00 - 10:15	GROUP I PHYSIOTHERAPY & AMBULATION TRAINING	
	D. BUTLER	B. KUNZ
	S. WILLIAMS	S. SHACHAT
	M. RASCH	T. HOLDEN
10:30 - 11:45	GROUP II PHYSIOTHERAPY & AMBULATION TRAINING	
	M. McMULLEN	S. BURNSTEIN
	C. BARD	M. SAUNDERS
	C. ACOSTA	S. BARD
11:45 - 12:00	NOTES	
12:00 - 12:30	LUNCH	
	(OR)	
12:30 - 1:00	FEEDING TRAINING	
1:00 - 1:15	PLANNING	
1:15 - 2:30	GROUP III PHYSIOTHERAPY & AMBULATION TRAINING	
	S. LINTZ	J. SERRANO
	M. GREENHILL	P. BANGHART
	M. WALDEN	D. O'DEA
	S. ZUKAUSKAS	
2:45 - 4:00	GROUP IV PHYSIOTHERAPY & AMBULATION TRAINING	
	L. GAUTHIER	D. BURNS
	L. VINEGRUD	K. PULEO
	S. FRANK	P. ZEMLA
4:00 - 4:15	HOUSEKEEPING & NOTES	

WOODBRIDGE STATE SCHOOL
Medical Department

PHYSIOTHERAPY SERVICES

Cottage # 4

Therapy Program Assistant: Q. MURRAY

7:45 - 8:00	Planning	
8:00 - 8:50	Application of braces & special shoes with assistance.	
9:00 - 10:15	GROUP I PHYSIOTHERAPY & AMBULATION TRAINING	
	M. ALSING	P. SAXTON
	D. TRAINOR	G. BOR
	J. KOURI	E. KUREK
10:30 - 11:45	GROUP II PHYSIOTHERPAY & AMBULATION TRAINING	
	V. REID	D. TENNERMAN
	J. STATON	P. CANALE
	G. MILLBROOK	C. KRUPOWICZ
11:45 - 12:00	NOTES	
12:00 - 12:30	LUNCH	
	(OR)	
12:30 - 1:00	FEEDING TRAINING	
1:00 - 1:15	Planning	
1:15 - 1:30	WILLIAM DUDNING	
1:30 - 2:30	GROUP III PHYSIOTHERAPY & AMBULATION TRAINING	
	Q. VELEZ	R. FREY
	G. GERSHIN	F. MINOR
	F. DE MAIO	G. WARNER
2:45 - 4:00	GROUP IV PHYSIOTHERAPY & AMBULATION TRAINING	
	J. RUNEBORG	J. CHACHE
	L. CULBERT	J. PIETRONICO
	D. SOLOMON	K. DE ANDREA
4:00 - 4:15	HOUSEKEEPING & NOTES	

WOODBRIDGE STATE SCHOOL
Medical Department

PHYSIOTHERAPY SERVICES

Cottage # 5

Therapy Program Assistant: M. GUYTON

7:45 - 8:00	Planning	
8:00 - 8:50	Application of braces & special shoes with assistance.	
9:00 - 10:15	GROUP I PHYSIOTHERAPY & AMBULATION TRAINING	
	M. BARR	G. WILLIAMS
	T. BASTA	J. DE MARCO
	P. GUCKIAN	R. CALMAN
10:30 - 11:30	GROUP II PHYSIOTHERAPY & AMBULATION TRAINING	
	W. ANDREWS	J. BYRD
	J. JETERS	M. QUINN
	M. NORSTROM	J. BEDELL
11:30 - 11:45	ON DORM	
	M. DOVE	
11:45 - 12:00	NOTES	
12:00 - 12:30	LUNCH	
	(OR)	
12:30 - 1:00	FEEDING TRAINING	
1:00 - 1:15	Planning	
1:15 - 2:30	GROUP III PHYSIOTHERAPY & AMBULATION TRAINING	
	M. SUSS	A. CRUZ
	J. BUYS	S. LANDAU
	D. MALISZEWSKI	W. BLANK
2:45 - 4:00	GROUP IV PHYSIOTHERAPY & AMBULATION TRAINING	
	S. EICHLER	V. SAVINO
	M. NISINOFF	R. LOTITO
	B. BAILEY	
4:00 - 4:15	HOUSEKEEPING & NOTES	

MOUDBRIDGE STATE SCHOOL
Medical Department

PHYSIOTHERAPY SERVICES

Cottage # 6

Therapy Program Assistant: L. DEVINE

7:45 - 8:00	Planning	
8:00 - 8:50	Application of braces & special shoes with assistance.	
9:00 - 10:15	GROUP I PHYSIOTHERAPY & AMBULATION TRAINING	
	M. FONZO	S. COZEWITH
	D. DIRIENZO	K. THOMPSON
	D. PAVLISKO	
10:30 - 11:45	GROUP II PHYSIOTHERAPY & AMBULATION TRAINING	
	A. DE ANGELO	B. LEVINE
	M. VERRILLI	W. WILLIAMS
11:45 - 12:00	NOTES	
12:00 - 12:30	LUNCH	
	(OR)	
12:30 - 1:00	FEEDING TRAINING	
1:00 - 1:15	Planning	
1:15 - 2:45	GROUP III PHYSIOTHERAPY & AMBULATION TRAINING	
	J. DIRIENZO	P. HOUTZ
	J. MURK	K. REARDON
3:00 - 4:00	GROUP IV PHYSIOTHERAPY & AMBULATION TRAINING	
	K. MINOR	M. KASAKOWSKI
	G. STARKEY	C. FEIST
4:00 - 4:15	HOUSEKEEPING & NOTES	

Medical Department

PHYSIOTHERAPY SERVICES

Cottage # 7

Therapy Program Assistant: S. EDWARDS

7:45 - 8:00	Planning
8:00 - 8:50	Application of braces & special shoes with assistance.
9:00 - 10:15	GROUP I PHYSIOTHERAPY & AMBULATION TRAINING
	S. ALBERTS — P. CICALA
	M. SERVIDIO — V. YEAGER
	L. ROMEO
10:30 - 11:45	GROUP II PHYSIOTHERAPY & AMBULATION TRAINING
	M. BOULDIN — J. M. COLEY
	M. PRICE — D. MC ARTHUR
	L. DE MICCA — A. LINDSEY
11:45 - 12:00	NOTES
12:00 - 12:30	LUNCH
	(OR)
12:30 - 1:00	FEEDING TRAINING
1:00 - 1:15	Planning
1:15 - 2:30	GROUP III PHYSIOTHERAPY & AMBULATION TRAINING
	V. RUNOWICZ — Y. ROBINSON
	A. TEDESCO — S. COLEMAN
	L. WILLIAMS
2:45 - 4:00	GROUP IV PHYSIOTHERAPY & AMBULATION TRAINING
	T. DE GEORGE — J. FEINMAN
	B. KITTRIDGE — R. GREEN
	M. QUINLAN — V. REED
4:00 - 4:15	HOUSEKEEPING & NOTES

WOODBRIDGE STATE SCHOOL
Medical Department

PHYSIOTHERAPY SERVICES

Cottage # 8

Therapy Program Assistant: M. BOWEN

7:45 - 8:00	Planning	
8:00 - 8:50	Application of braces and special shoes with assistance.	
9:00 - 10:15	GROUP I PHYSIOTHERAPY & AMBULATION TRAINING	
	J. CONKLIN	W. HERMANSKI
	R. LANGSTON	B. KELLY
	D. MC CREADY	A. JAHNKE
10:30 - 11:45	GROUP II PHYSIOTHERAPY & AMBULATION TRAINING	
	J. WRIGHT	T. DECKERT
	R. DE ROSE	M. HILL
	E. CAMPBELL	P. PACZINSKI
11:45 - 12:00	NOTES	
12:00 - 12:30	LUNCH	
	(OR)	
12:30 - 1:00	FEEDING TRAINING	
1:00 - 1:15	Planning	
1:15 - 1:30	J. O'BRIEN	
1:30 - 2:45	GROUP III PHYSIOTHERAPY & AMBULATION TRAINING	
	R. ESTABROOK	J. SERVINO
	G. SCHNEIDER	W. AGENS
3:00 - 4:00	GROUP IV PHYSIOTHERAPY & AMBULATION TRAINING	
	H. ARNOLD	F. BLAIR
	O. COX	
4:00 - 4:15	HOUSEKEEPING & NOTES	

PHYSIOTHERAPY SERVICES

Cottage: MAX. CARE UNIT

Therapy Program Assistant: M. TIMAR

7:30 - 7:45	Planning	
7:45 - 8:30	Feeding	
8:30 - 9:30	GROUP I PHYSIOTHERAPY & PRE-AMBULATION TRAINING	
	W. MURPHY	H. WHITE
	B. SMYLLIE	B. MENDEZ
9:45 - 10:45	GROUP II PHYSIOTHERAPY & PRE-AMBULATION TRAINING	
	S. KNIGHT	L. TORRES
	V. BERMUDEZ	K. STEFFICK
11:00 - 11:45	GROUP III PHYSIOTHERAPY & PRE-AMBULATION TRAINING	
	W. GOBLE	C. BLACKWELL
	D. WILLIAMS	
11:45 - 12:00	O. HARRIS	
12:00 - 12:30	LUNCH	
	(OR)	
12:30 - 1:00	FEEDING TRAINING	
1:00 - 1:15	NOTES	
1:30 - 2:30	GROUP IV PHYSIOTHERAPY & PRE-AMBULATION TRAINING	
	R. MORGAN	K. SAWICKI
	L. BORELLI	W. DOMINQUEZ
2:45 - 3:45	OTHER ASSIGNMENTS:	
	COTTAGE 3 - LISA THOMPSON	
	SHARON GILSINAN	
	MARION MAZUR	
	COTTAGE 5 - JAMES DAMIANO	
	FRANCIS DALY	
	HENRY D'AMATO	
	BENJAMIN SAWICKI	
3:45 - 4:00	NOTES & HOUSEKEEPING	

WOODBRIDGE STATE SCHOOL, WOODBRIDGE, N.J.

NAME _____ AGE _____

DISABILITY _____ DIAGNOSIS _____ IN ___ OUT ___

RANGE OF MOTION TEST FOR LOWER EXTREMITY

1. Anatomical position is starting position. Range is measured with cauda as 0°, cranium as 180°. Rotating motions are from the midsagittal plane as 0° to lateral plane as 180°.
2. All ranges are expressed as passive range of motion. Check muscle chart attached for limitations caused by tightness, weakness, spasm, or contracture.
3. The scale is divided into units of 10°. Range of motion is recorded by filling in area of range directly on attached sketch with date and examiner's initial.
4. Use of same sheet for subsequent tests is recorded in same color and dated accordingly.
5. Retrogression is marked by diagonal lines over area of previous test and dated.
6. If position is other than in sketch, indicate S for supine, P for prone.

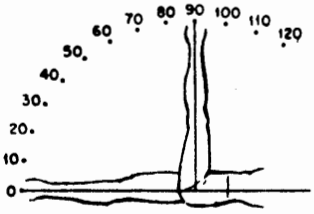
Hip

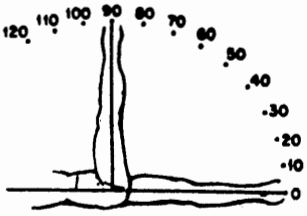
Flexion (straight knee) 0-90
Flexion (bent knee) 0-115-125
Extension 0-10-15
Extension and lumbar-spine 0-15-45

Limitations

Flexion (straight knee)

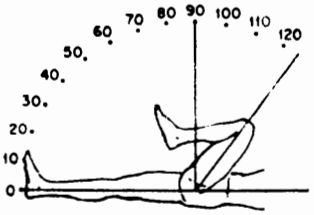
	L		R	
	Fl.	Ext.	Fl.	Ext.
1				
2				
3				
4				

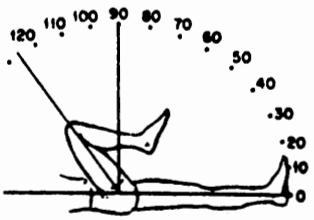




Flexion (bent knee)

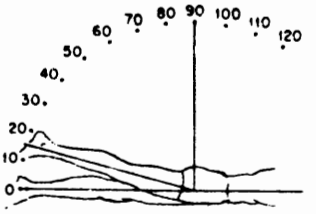
	L		R	
	Fl.	Ext.	Fl.	Ext.
1				
2				
3				
4				

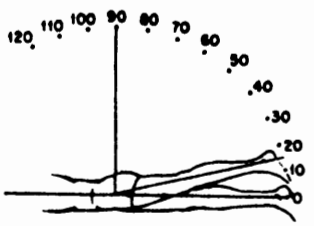




Extension

	L		R	
	Ext.	E&L	Ext.	E&L
1				
2				
3				
4				



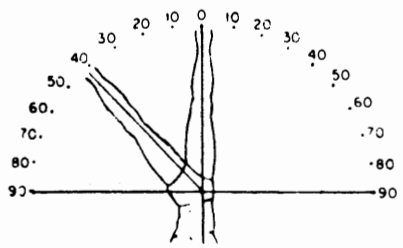


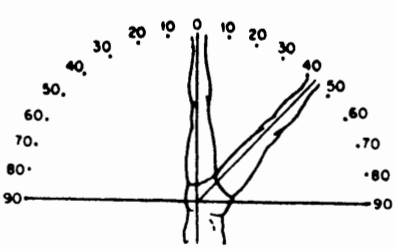
Hip

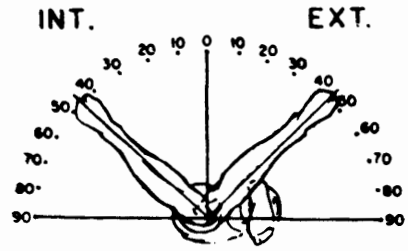
Abduction 0-45
Adduction 45-0

Limitations

	L		R	
	Abd.	Add.	Abd.	Add.
1				
2				
3				
4				





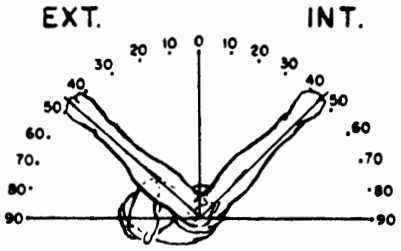


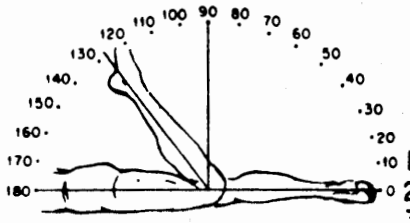
Hip (bent knee prone)

External rotation 0-45
Internal rotation 0-45

Limitations

	L		R	
	Int.	Ext.	Int.	Ext.
1				
2				
3				
4				



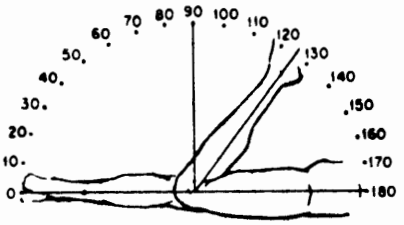


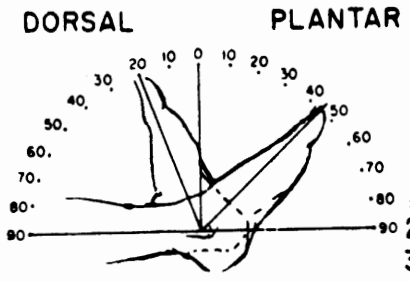
Knee

Flexion (prone) 0-120-130
Extension 130-120-0

Limitations

	L		R	
	Fl.	Ext.	Fl.	Ext.
1				
2				
3				
4				



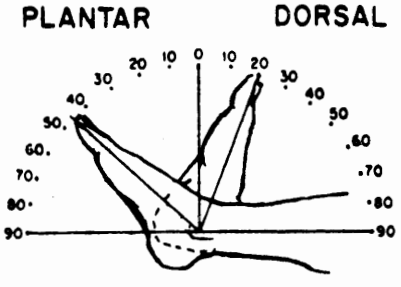


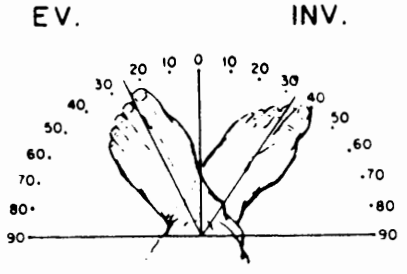
Ankle

Flexion 0-20
Extension 0-45

Limitations

	L		R	
	Fl.	Ext.	Fl.	Ext.
1				
2				
3				
4				



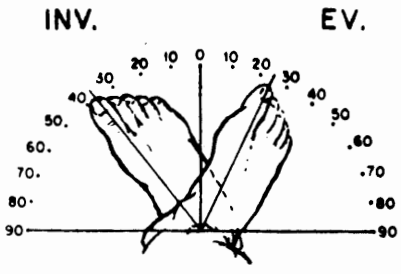


Foot

Eversion 0-25
Inversion 0-35

Limitations

	L		R	
	Ev.	Inv.	Ev.	Inv.
1				
2				
3				
4				



PHYSICAL THERAPIST	COMMENTS	DATE
1.	1.	
2.	2.	
3.	3.	
4.	4.	

Patient's Name _____ Chart No. _____

Date of Birth _____ Name of Institution _____

Date of Onset _____ Attending Physician _____ M. D.

Diagnosis:

LEFT								RIGHT			
				Examiner's Initials							
				Date							
				NECK	Flexors	Sternocleidomastoid					
					Extensor group						
				TRUNK	Flexors	Rectus abdominis					
					Rt. ext. obl. Lt. int. obl. } Rotators	Lt. ext. obl. Rt. int. obl.					
					Extensors	Thoracic group Lumbar group					
					Pelvic elev.	Quadratus lumb.					
				HIP	Flexors	Iliopsoas					
					Extensors	Gluteus maximus					
					Abductors	Gluteus medius					
					Adductor group						
					External rotator group						
					Internal rotator group						
					Sartorius						
					Tensor fasciae latae						
				KNEE	Flexors	Biceps femoris Inner hamstrings					
					Extensors	Quadriceps					
				ANKLE	Plantar flexors	Gastrocnemius Soleus					
				FOOT	Invertors	Tibialis anterior Tibialis posterior					
					Evertors	Peroneus brevis Peroneus longus					
				TOES	M. P. flexors	Lumbricales					
					I. P. flexors (1st)	Flex. digit. br.					
					I. P. flexors (2nd)	Flex. digit. l.					
					M. P. extensors	Ext. digit. l. Ext. digit. br.					
				HALLUX	M. P. flexor	Flex. hall. br.					
					I. P. flexor	Flex. hall. l.					
					M. P. extensor	Ext. hall. br.					
					I. P. extensor	Ext. hall. l.					

Measurements:

Cannot walk	Date	Speech
Stands	Date	Swallowing
Walks unaided	Date	Diaphragm
Walks with apparatus	Date	Intercostals

KEY

5	N	Normal	Complete range of motion against gravity with full resistance.
4	G	Good*	Complete range of motion against gravity with some resistance.
3	F	Fair*	Complete range of motion against gravity.
2	P	Poor*	Complete range of motion with gravity eliminated.
1	T	Trace	Evidence of slight contractility. No joint motion.
0	0	Zero	No evidence of contractility.

S or SS Spasm or severe spasm.
C or CC Contracture or severe contracture.
* Muscle spasm or contracture may limit range of motion. A question mark should be placed after the grading of a movement that is incomplete from this cause.

LEFT							RIGHT			
				Examiner's Initials						
				Date						
				SCAPULA	Abductor	Serratus anterior				
					Elevator	Upper trapezius				
					Depressor	Lower trapezius				
					Adductors	Middle trapezius Rhomboids				
				SHOULDER	Flexor	Anterior deltoid				
					Extensors	Latissimus dorsi Teres major				
					Abductor	Middle deltoid				
					Horiz. abd.	Posterior deltoid				
					Horiz. add.	Pectoralis major				
					External rotator group					
					Internal rotator group					
				ELBOW	Flexors	Biceps brachii Brachioradialis				
					Extensor	Triceps				
				FOREARM	Supinator group					
					Pronator group					
				WRIST	Flexors	Flex. carpi rad. Flex. carpi uln.				
					Extensors	Ext. carpi rad. l. & br. Ext. carpi uln.				
				FINGERS	M. P. flexors	Lumbricales				
					I. P. flexors (1st)	Flex. digit. sub.				
					I. P. flexors (2nd)	Flex. digit. prof.				
					M. P. extensor	Ext. digit. com.				
					Adductors	Palmar interossei				
					Abductors	Dorsal interossei				
					Abductor digiti quinti					
					Opponens digiti quinti					
				THUMB	M. P. flexor	Flex. poll. br.				
					I. P. flexor	Flex. poll. l.				
					M. P. extensor	Ext. poll. br.				
					I. P. extensor	Ext. poll. l.				
					Abductors	Abd. poll. br. Abd. poll. l.				
					Adductor pollicis					
					Opponens pollicis					
				FACE:						

Additional data:

WOODBRIDGE STATE SCHOOL, WOODBRIDGE, N.J.

NAME _____ AGE _____

DISABILITY _____ DIAGNOSIS _____ IN ___ OUT ___

RANGE OF MOTION TEST FOR UPPER EXTREMITY

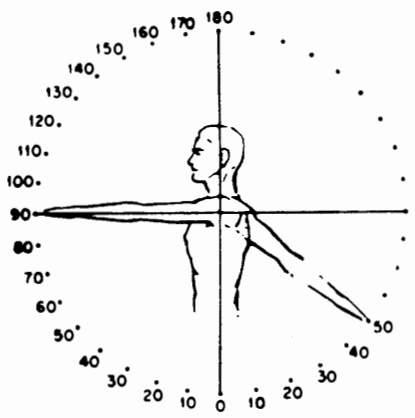
1. Anatomical position is starting position. Range is measured with cauda as 0°, cranium as 180°. Rotating motions are from the midsagittal plane as 0° to lateral plane as 180°.
2. All ranges are expressed as passive range of motion. Check muscle chart attached for limitations caused by tightness, weakness, spasm, or contracture.
3. The scale is divided into units of 10°. Range of motion is recorded by filling in area of range directly on attached sketch with date and examiner's initial.
4. Use of same sheet for subsequent tests is recorded in same color and dated accordingly.
5. Retrogression is marked by diagonal lines over area of previous test and dated.
6. If position is other than in sketch, indicate S for supine, P for prone.

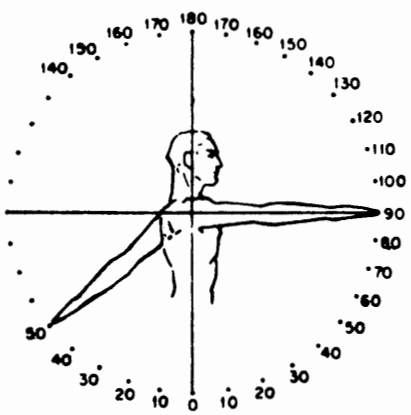
Shoulder

Flexion	0- 90
Flexion and rotation of scapula	90-180
Extension and rotation of scapula	180-90
Extension	90- -50

Limitations

	L		R	
	Fl.	Ext.	Fl.	Ext.
1				
2				
3				
4				



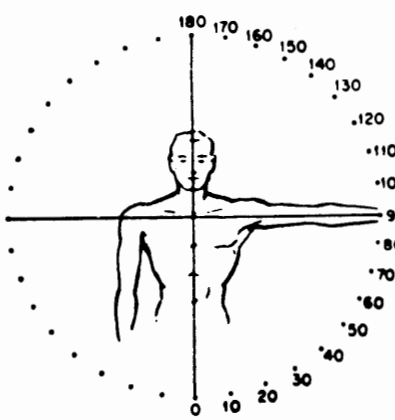


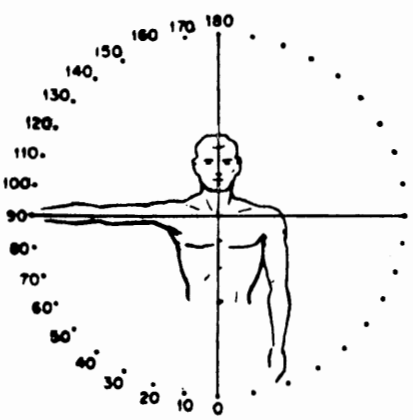
Shoulder

Abduction	0- 90
Abduction and rotation of scapula	90-180
Adduction and rotation of scapula	180- 90
Adduction	90- 0

Limitations

	L		R	
	Abd.	Add.	Abd.	Add.
1				
2				
3				
4				



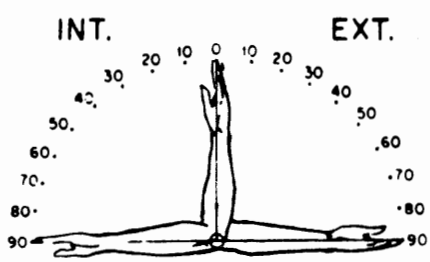


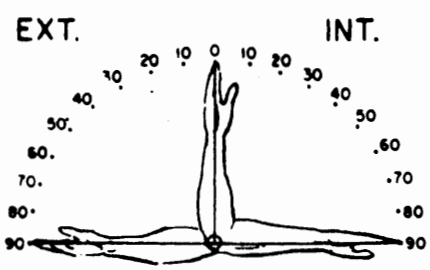
Shoulder Rotation

Elbow flexed	90°
External rotation	0-90
Internal rotation	0-90

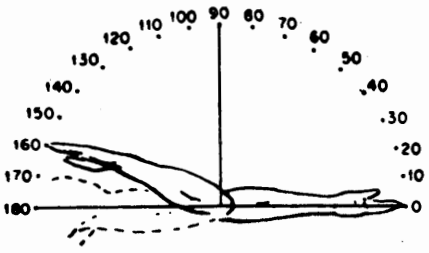
Limitations

	L		R	
	Int.	Ext.	Int.	Ext.
1				
2				
3				
4				





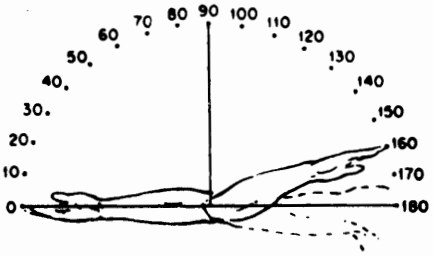
Elbow



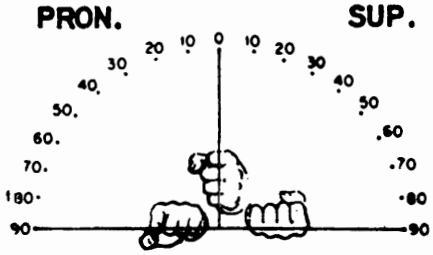
Flexion 0-145-160
Extension 160-145- 0

Limitations

	L		R	
	Flex.	Ext.	Flex.	Ext.
1				
2				
3				
4				



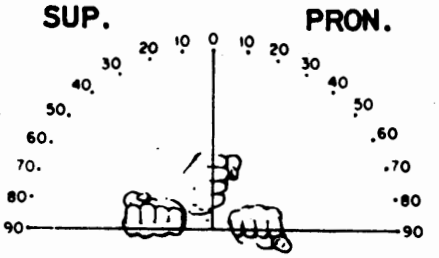
Radio-ulnar



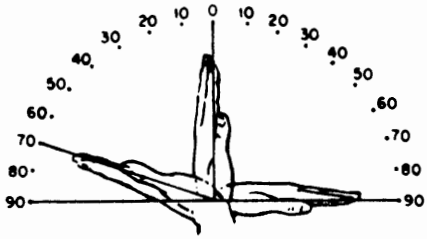
Pronation 0-90
Supination 0-90

Limitations

	L		R	
	Sup.	Pron.	Sup.	Pron.
1				
2				
3				
4				



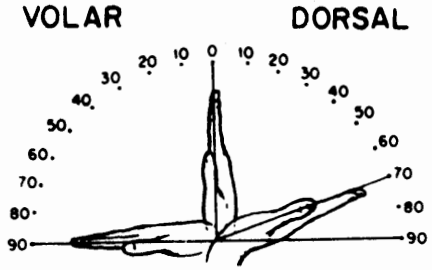
Wrist (flexion)



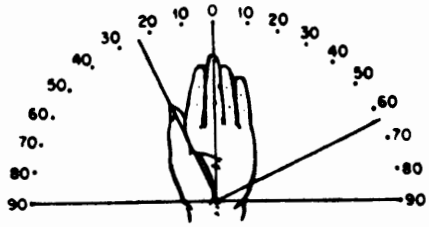
Dorsal flexion 0-70
Volar flexion 0-90

Limitations

	L		R	
	Dor.	Vol.	Dor.	Vol.
1				
2				
3				
4				



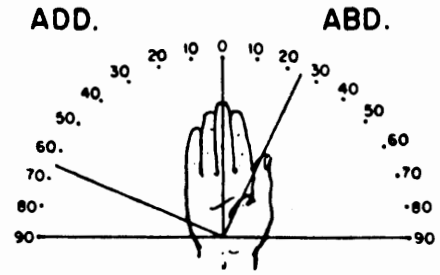
Wrist



Abduction 0-25
Adduction 0-55-65

Limitations

	L		R	
	Rad.	Uln.	Rad.	Uln.
1				
2				
3				
4				



PHYSICAL THERAPIST	COMMENTS	DATE
1.	1.	
2.	2.	
3.	3.	
4.	4.	

PHYSICAL HABILITATION PROGRAM

RESIDENT_____ COT. NO._____ DATE_____

I. LEVEL OF INTELLIGENCE

0 No Retardation
1 Level I (68-83)
2 Level II (52-67)
3 Level III (36-51)
4 Level IV Severe (20-35)
5 Level V Profound (Less than 20)
6 Unknown

II. ADAPTIVE BEHAVIOR

0 No retardation
1 Level I (high)
2 Level II
3 Level III
4 Level IV
5 Unknown

III. FEEDING

1 Complete Self Feeding
2 Eats with a spoon with assistance
3 Eats with fingers
4 Cannot feed self
5 Must be tube fed

IV. SOILING

1 Independently Clean
2 Indicates Needs
3 Clean by Routine
4 Soils Night
5 Soils Day
6 Soils Day & Night

V. WETTING

1 Independently Clean
2 Indicates Needs
3 Clean by Routine
4 Wets Night
5 Wets Day
6 Wets Day & Night

VI. MOTILITY

(A) Ambulation

1. Walks well unassisted
2. Walks unassisted with difficulty
3. Walks only with assistance
4. Does not walk

(B) Standing

1. Stands independently
2. Stands with support or assistance
3. Does not stand

(C) Crawling

1. Crawls
2. Able to move about but does not crawl
3. Does not crawl or move about

VII. COMMUNICATION

1. Speaks well (phrases or sentences)
2. Speaks poorly (some words)
3. Babbles
4. Gestures well (Makes needs known)
5. Gestures poorly (gestures at times)
6. No apparent communication

LOCOMOTOR DEVELOPMENT SCALE

For Use in Woodbridge State School Physical Habilitation Program

NAME_____ COT._____ DATE_____ EXAMINER_____

ORTHOPEDIC DEVISES_____ MENTAL AGE_____ CHRONOLIGICAL AGE_____

MOTOR AGE		A	B	C	D
1 Month	1. Lifts chin when lying in prone position 2. Holds his head erect for a few seconds				
2 months	1. Lifts head when lying in prone position. 2. Kicks feet when lying down.				
3 months	1. Lifts head up slightly when in dorsal position. 2. Rolls side to back.				
4 months	1. Back firm when held in sitting position. 2. Lifts head and chest when lying prone. 3. Holds head erect continuously.				
5 months	1. Lifts head and shoulders when in dorsal position. 2. Can roll from one side right over to the other.				
6 months	1. First crawling reaction - pushes on hands, draws up to knees, etc. 2. Sits with slight support.				
7 months	1. Can roll from back to stomach. 2. Can roll from stomach to back. 3. First stepping reaction (a) moves feet alternately as if dancing when held up.				
8 months	1. Tries vigorously to crawl, using both hands and feet. Crawling II. 2. Sits alone briefly.				

MOTOR AGE		A	B	C	D
9 months	1. Stepping reaction (b) feet now go definitely one in front of the other.				
	2. Can turn self around when left lying on the floor. Crawling III.				
	3. Can be left sitting on the floor.				
	4. Crawling IV - makes some progress backwards				
	5. Crawling IV - makes some progress forwards.				
10 months	1. Stands when held up.				
	2. Sits in a chair.				
11 months	1. Can pull up from the floor by grasping furniture.				
	2. Can stand holding on to furniture.				
	3. Crawling V - (a) Creeps on hands and knees. (b) Gets about freely by some other method, i.e. bear walk				
12 months	1. Side-steps around play-pen, furniture, etc. holding on.				
	2. Can walk when supported.				
	3. Can walk when led, both hands held.				
	4. Can walk when led, one hand held.				
13 months	1. Can stand alone.				
14 months	1. Can walk alone.				
	2. Can kneel on the floor and balance in this position.				
17 months	1. Climbs into a chair.				

KEY

A - Performs activity normally

B - Performs activity slowly or in an awkward fashion

C - Performs activity with difficulty

D - Beginning Activity

COTTAGE_____

DATE ADMITTED ON PROGRAM_____

PHYSICAL THERAPY AIDE REPORT

AIM OF PROGRAM:

TREATMENT OUTLINE: DATE_____

PROGRAM CHANGE: DATE_____

PROGRAM CHANGE: DATE_____

PROGRAM CHANGE: DATE_____

PROGRAM CHANGE: DATE_____

PROGRAM CHANGE: DATE_____

1/24/68 - 500 Cc:
HIP Program

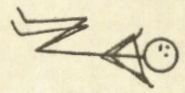
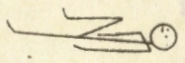
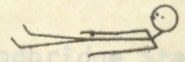
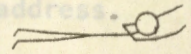
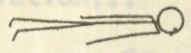
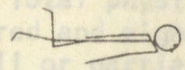
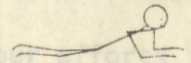
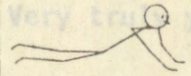
(Reverse side for Aide to write notes)

TABLE 1

CEREBRAL PALSY ASSESSMENT CHART

BASIC MOTOR CONTROL

Name:_____ Birthdate:_____ Diagnosis:_____

Test Postures and Movements	Examiner:	Name: Date	Name: Remarks	Name: Date	Name: Remarks	Name Date	Name Remarks
Supine 1. Hips and knees fully flexed, arms crossed, palms on shoulders.							
2. Hips and knees fully flexed. (a) Extend right leg. (b) Extend left leg.		R. L.		R. L.		R. L.	
3. Head raised.							
Prone 4. Arms extended beside head. Raise head in midposition.							
5. Arms extended beside body, palms down.							
6. (a) Flex right knee, hips extended. (b) Flex left knee, hips extended.		R. L.		R. L.		R. L.	
7. Trunk supported on forearms, upper trunk extended, face vertical.							
8. Trunk supported on hands with elbows and hips extended.							
Sitting erect 9. Soles of feet together, hips flexed and externally rotated to at least 45°.							
10. Knees extended and legs abducted; hips 90°–100°.							

State of New Jersey

WOODBRIDGE STATE SCHOOL
WOODBRIDGE 07095

LOUIS R. PIRONE
SUPERINTENDENT

TELEPHONE
201 636 - 3400

March 28, 1972

RETARDATION

DEPT. OF

Maurice G. Kott, Ph.D., Director
Division of Mental Retardation
169 West Hanover Street
Trenton, New Jersey 08625

RE: 19:R5 H.I.P. R20-02102

Dear Dr. Kott,

Enclosed are two copies of the Woodbridge State School Medical Department, Physiotherapy Services H.I.P. Grant - 1967-1971 Final Report. As directed by the Department of Health, Education and Welfare, 10 copies have been forwarded to their New York address.

The initial request for Federal funds had as one of its hypotheses "...With proper treatment, over 20% of the non-ambulant population has the potential for full or partial ambulation..."

At the conclusion of the H.I.P. Program, 85 residents had achieved independence in ambulation, and an additional 88 residents were semi-ambulant (ambulated with assistance.) Total physiotherapy enrollment for the duration of the grant was two hundred and eighty seven. The grand total of residents who accomplished full or partial ambulation was one hundred and seventy three, representing 36.5 per cent of the non-ambulant population of the school, and 60.3 per cent of the target group.

Again, we sincerely appreciated your efforts for the adoption of the Grant by the State.

Very truly yours,

Louis R. Pirone
Superintendent

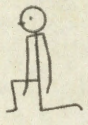
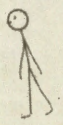
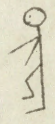
Lawrence E. Pratt
Medical Services Administrator

LRP:LEP:je
Enclosures (2)

TABLE 1—Continued

CEREBRAL PALSY ASSESSMENT CHART
BASIC MOTOR CONTROL

Diagnosis: _____ Birthdate: _____

Examiner: / est Postures and Movements		Name: Date	Remarks	Name: Date	Remarks	Name: Date	Remarks
ing over edge of right knee. left knee.		R. L.		R. L.		R. L.	
neck straight (not ded). on knees. on hands.		a b		a b		a b	
g, upper trunk erect, xed: ht hip. t hip.		R. L.		R. L.		R. L.	
g upright, hips ex- head in midposition, sides.							
kneeling: weight on knee. kneeling: weight on knee.		R. L.		R. L.		R. L.	
own, toes not clawed, pointing in same direc- toes, hips fully flexed, line with trunk.							
nd components of g, correct alignment.							
and trunk aligned over d leg. Both knees ex- d. ght leg forward. ft leg forward.		R. L.		R. L.		R. L.	
weight on one leg in ance. hift weight over right leg. hift weight over left leg.		R. L.		R. L.		R. L.	
strike. Rear leg extended externally rotated, heel . Both knees straight: ight heel strike. eft heel strike.		R. L.		R. L.		R. L.	

PHYSIO THERAPY SERVICES AT W.S.S.

Johnny Fields, a Cottage 5 resident, was first examined by Dr. Mark Friedman, Physiatrist, in June, 1967.

Finding: "Unable to walk due to contractures"

The Physiatrist's physiotherapy prescription was carried out by Mrs. Mattie Guyton, Therapy Program Assistant, with much success.

By June, 1969, John was independently ambulatory and treatment was discontinued. Presently, he is a resident in semi ambulatory Cottage 2

The aid of the Physical Habilitation federally funded grant for the past five years, has enabled John and forty four other residents to progress, graduate from the program and participate in other activities.

Woodbridge State School

MEDICAL DEPARTMENT
PHYSIOTHERAPY SERVICES

PROGRESS DAY

SUNDAY, OCTOBER 17, 1971 **2:00 P.M.**

JOHNNY FIELDS

"When I first arrived at the School, I saw a resident, John, who seemed to just exist sitting in a butterfly chair. When the Hospital Improvement Project grant was received for a physical therapy program, John was enrolled. He learned to stand and walk independently. I often sit and watch John and think of the before and after results and how much the P.T. program has done for him, not to mention all the other residents like John. Some have graduated from our program and are walking independently now. Physical therapy is a meaningful factor in their lives. Without it, there would be too many little Johnnies just sitting around."

Mrs. Mattie L. Guyton, T.P.A.

LOUIS R. PIRONE
Superintendent

ALLEN SWEET
Assistant Superintendent

PROGRAM

Introduction.....Mr. Larry Pratt, Medical Services Administrator

Welcome.....Mr. Louis Pirone, Superintendent

Remarks.....Mr. Larry Pratt, Medical Services Administrator

Remarks..Mr. David Chick, President, W.S.S. Parent Association

Remarks.....Mr. Joseph Curtin, Parent

Presentation of Certificates

Refreshments

Music.....Tina Koonze

PHYSIOTHERAPY STAFF

Mark Friedman, M.D. .....*Physiatrist*

THERAPY PROGRAM ASSISTANTS

Mae Timar.....*Max. Care*
Sadie Wise..... *Cottage 1*
Mary Waddell..... *Cottage 2*
Flora Roberson..... *Cottage 3*
Queen Murray..... *Cottage 4*
Mattie Guyton ..... *Cottage 5*
Laura Devine..... *Cottage 6*
Sarah Edwards..... *Cottage 7*
Myrtrice Bowen ..... *Cottage 8*
Dora Carrara .....*Co-ordinator*
LaVerne Griffin..... *Secretary*

Frank Mulvihill, R.P.T. .....*Consultant Physiotherapist*
Catherine Ratliff, R.P.T. ..... *Consultant Physiotherapist*
Jean Shirreffs, R.P.T.....*Chief Physiotherapist*

LIST OF P.T. GRADUATES – 1967–1971

Bains, Randy
Banas, Joyce
Barnes, James
Bauer, Barbara
Branch, Melvin
Burrell, James
Calabrese, Mark
Colon, Pedro
Cooper, Darryl
Curtin, Joseph
D'Amato, Henry
Dirienzo, Gerard
Dupre, Gary
Eaton, John
Ferrara, Karen
Fields, John
Flammer, Michael
Gilsinan, Sharon
Gowers, Richard
Green, Diane
Hanay, Mark
Harrington, John
Hendricks, Gloria
Hill, Kevin
Hoag, Joann
Hoagland, William
Holly, Frank
Kelly, Sally Ann
King, John
Kraus, William
LaPlaca, Ronald
Loerch, Michael
Longbottom, Leroy
Lotito, Robert
Malek, Edward
Martinez, Howard
Maze, Beverly
McMann, William
Minton, Robert
Moller, Stephen
Morvay, Carol
Nemeth, Joseph
O'Brien, Diane
O'Rourke, John
Peters, Mary
Phillipshek, John
Pollison, Joseph
Ruppert, Arthur
Sapone, David
Schwartz, Gary
Silbert, Cynthia
Sorrentino, Vincent
Stanton, Ann
Stanton, Theresa
Thompson, Lisa
Tremble, Richard
Ward, Stephen
Washington, Joseph

H.I.P. GRANT

WOODBRIDGE STATE SCHOOL

WOODBRIDGE, N.J.

FEDERAL GRANT AWARDED WSS

5 YEAR 1/2 MILLION FOR PHYSICAL REHABILATATION

NEWS RELEASES 1967

the WOODBRIDGE state school nev

VOL. II, NO. 2

MARCH, 1967

FEDERAL GRANT AWARDED WSS

5 YEAR 1/2 MILLION FOR PHYSICAL REHABILATATION

Mr. David Rosen, Superintendent, Woodbridge State School, received official word from U.S. Representative E.J. Patten of an award of nearly half million dollars to develop a demonstration project at the State School.

Continued

The program will provide for the physical rehabilitation of severely retarded multiply handicapped residents. Approximately half of the 1000 youngsters residing at the school are suffering from a variety of neurological and physical defects. In many cases the severity of defects prevent these residents from walking and participating in other treatment and training activities available at the School.

The award, granted by the National Institute of Mental Health, Public Health Service, Department of Health, Education and Welfare, amounts to $93,896 for the first years operation. The project is expected to extend over a five year period.

Funds from the grant will be used to correct physical handicaps enabling the mentally retarded youngsters to benefit from further training. Specialists in the field of physical rehabilitation will be hired. Equipment designed to assist in rehabilitating the physically handicapped will be purchased.

In order to develop the optimal potentialities of many of the multiply handicapped children, it is first necessary to correct the physical defect. The benefit of classroom social and self help training cannot be fully realized until their physical condition is improved.

The extent and type of services will depend upon individual needs. In some cases, it is realistic to think in terms of full or partical ambulation as an attainable goal. In other cases it may be possible to provide some relief from painful contractures, muscle spasms and bed sores. Through the resources of the grant and with existing resources, an effort will be made to extend services to all residents in the non-ambulant cottages and in the maximum care ward of the hospital.

Implied in the term "Habilitation" is the total treatment of the childs complex and multiple needs; physical, educational, social, and emotional. To be successful, the whole child will be treated. Although much of the work of the project will involve direct physical therapy, therapy itself is merely one part of the total habilitation process. As in the case of all programs at Woodbridge, the effectiveness of this program will depend in large measure on the support it receives and the manner in which it is integrated into other treatment and training services. The "Team Approach" concept must be more then an idea; working together towards the objective of meeting the individual childs needs must be a reality.

Continued

Woodbridge State School News: "Federal Grant Awarded"

Because of the importance of this type of program to nearly half of the Woodbridge residents, a portion of Federal Title I funds were used during the past year to establish a program of Physical Habilitation in the non-ambulatory cottages.

The progress made, through the capable and energetic leadership of Miss Donna Carroll has provided an excellent beginning. The program has developed so greatly in such a short time that it is reasonable to say that Woodbridge is doing much more for the physically handicapped child than most other institutions in the country. When the resources of this grant are added to that which is already underway, Woodbridge State School will provide prototype services for the multiply handicapped mentally retarded which will set the pace for other institutions to follow..

Dr. Maurice Kott, Director, Division of Mental Retardation, encouraged Woodbridge State School officials to apply for the grant and provided guidance which was instrumental in receiving the award.

The project, will be co-directed and implemented by Mr. Richard C. Ziegler, Assistant Superintendent and Dr Scialabba, Medical Director. Mr. Ziegler noted, "Woodbridge State School will be among the first to provide an intensive program of physical rehabilitation for residents in need of such services. It is my hope that the five year project will demonstrate the value of total rehabilitation of these handicapped residents. In supplying treatment and training therapies, it will complete the spectrum of services offered residents of Woodbridge State School."

Woodbridge State School is the newest of the six residential facilities for the mentally retarded in the State of New Jersey. It houses 1000 severely and profoundly mentally retarded children and adults. Under the leadership of Mr. David Rosen, Education, Training and Medical programs geared to realize the potential of every resident who are in progress.

PHYSICAL THERAPY AT WSS

Aide placing braces on resident

Aide assisting in feeding

Aide assisting resident on parallel bars

A DAY IN THE LIFE OF A PHYSICAL THERAPY AIDE

Physical Therapy Aides undergo four weeks of training at the Willowbrook State School in Staten Island, New York. Their training includes lectures and demonstrations dealing with training activities, ambulation training, methods of teaching feeding and occupational therapy. After the training period, they return to Woodbridge State School and are assigned to a non-ambulatory cottage. Once their schedule is established, an average day proceeds as follows.

On arrival in the morning, the P.T. Aides first job is feeding children in her feeding group. The group consists of 3 to 4 children who have reached a point where they are ready to learn self feeding. The P.T. Aides function in the feeding program is to train the children to hold a spoon, to feed themselves, to drink from a cup unassisted and master acceptable table manners. The feeding program is continued at lunchtime with the same group of children. When these children become self feeders, the P.T. Aide will select another group of 3 to 4 residents who are ready for the program.

As the day progresses, the Aides cover the following areas: Sense Stimulation involving 15 to 20 residents who because of severe physical and mental handicaps are confined to cribs or beds. The P.T. Aide stimulates these children with auditory, visual, ofactual, and tactual stimulation. She talks with the children and gives them personal contact in order to develop increased awareness in their surroundings.

Continued

Teacher's aide directing... occupational therapy

Another area of the P.T. Aide's day is Occupational Therapy. She takes 5 or 6 children in an Occupational Therapy group where she trains them to use their upper extremities, arms and hands by manipulating puzzles, coordination boards, stringing beads, grasping on to objects and playing wheelchair basketball.

Many of the P.T. Aides have a period in the day devoted to assisting the teacher in giving physical training exercises to larger children and/or children who are difficult for the teacher to manage alone.

In the morning, the Aide is responsible for putting the orthopedic and corrective shoes on all the children in the program. She also puts braces on those children for whom they are prescribed.

Another duty is conducting a physical training period where she works with a small group of children who are ready to ambulate and provides them with ambulation training practice standing in the standing box, walk on parallel bars and free run in their walkers.

Physical Therapy Aides are instructed in P.T. techniques by Dr. Mark Friedman, Physiatrist, and work under his direction. Miss Donna Carroll regularly checks on their skills and progress.

The Physical Therapy Aide at Woodbridge State School has enhanced the Education Program in the Non-Ambulatory cottages. With their assistance, the Education Program is presently an extensive an comprehensive one.

NEWS RELEASES 1968

Maximal Stimulation Program

Mrs. Rachel Floyd, Maximal Stimulation Aide, conducting her program with resident in Dorm Cottage.

The Maximal Stimulation program, conducted daily, serves non-ambulatory cottage residents who are not yet reached a developmental level to participate in more structured programs.

Picture Credit - Gene Schneider

The Maximal Sensory Stimulation program is primarily concerned with activities to motivate environmental awareness.

As an example, the sense of touch is developed by giving experiences of rough, smooth, hard, soft by the worker moving his hand across cardboard, wood, cotton, etc. Residents are usually seen in groups of six for thirty minutes. Residents are also seen at bedside. At present each worker has five groups for Sensory Stimulation.

Following stimulation, discrimination activities commence. This program begins with gross discrimination of sizes, shapes and color and proceeds to finer discrimination as he progresses.

The Maximal Stimulation Program promotes awareness through Sensory Stimulation techniques, Activities of Daily Living, Recreational activities and Specially Prescribed activities.

Play is very important because it gives a child a means of expressing himself. His world revolves around play and is vital to growing up and to the development of social character. We therefore, have two obligations in planning meaningful recreation for the mentally retarded..

1. To motivate and expose the disinterested to many forms of recreation in order to help them participate in those activities best suited to their needs.
2. To offer participation for as many as can benefit.

MORE NEXT MONTH--------

November, 1968

WSS Employee Suggestion Award Winner

Mrs. Bemiece Valentine, State Suggestion Award winner.

Picture Credit - Gene Schneider

Mrs. Bemiece Valentine, Housekeeping Department, is the winner of a New Jersey State suggestion award.

The award was presented for the design of a diaper type posture support. The support, designed and made by Mrs. Valentine, was a cooperative effort with Mrs. Jean Sheriffs, Chief Physical Therapist, Physical Habilitation Project.

The support is designed in a hour glass shape and fits around the child like a diaper. The impetus for its development was the need presented by a particular resident in Oriole Cottage. To date, number have been made for use in the Cottage Life Department.

Mrs. Valentine began her employ at WSS in January, 1968 in the hospital. In September, 1968, she transferred to the Housekeeping Department as a Seamstress.

NEW MEMBER OF PHYSICAL THERAPY DEPARTMENT

Mrs. Myrtrice Bowen, former recreation assistant, has joined the Physical Therapy Services area, announced Mrs. Jean Sheriffs, Chief Physical Therapist.

She assumed the duties of Therapy Program Assistant and is at work in the federally funded Hospital Improvement Project Physical Habilitation program.

After an initial training period Mrs Bowen was assigned to Cottage 8 where she is responsible for carrying out programs of exercise and preambulatory activities prescribed by Dr. Mark Friedman, Physiatrist.

NEWS RELEASES 1969

the WOODBRIDGE state school new

Chief Physical Therapist Joins Project Staff

Mrs. Jean Shireffs has joined the WSS staff as Chief Physical Therapist in the Hospital Improvement Project Physical Habilitation program.

Mrs. Shirreffs will provide professional supervision of the Therapy Program Assistants at work in each of the eight non ambulatory cottages and in the Maximum Care Ward of the Hospital.

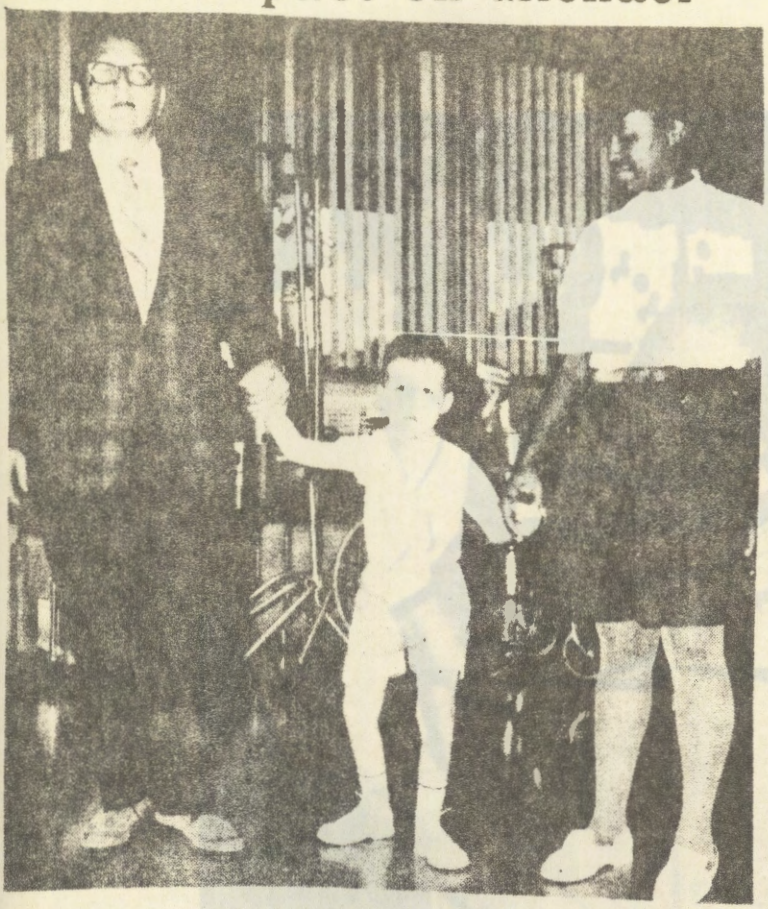
Mrs. Shireffs has served in various professional capacities with United Cerebral Palsy of Union County, has conducted a private practice, has served as admissions team member of the Occupational Center of Union County, has co authored Pointers for Parents and Programmed Instruction

Mrs Shireffs has been a Physical Therapy consultant at WSS for the past 15 months. Prior to the formal inception of the federally funded Physical Habilitation program, she provided professional knowledge in the assessment of need and planning for fulfillment of need in the form of todays wide reaching program".

Mrs. Shireffs noted, "I have as my goal the improvement of residents general physical condition, the cultivation of of neuromuscular potentials and to effect an atmosphere of achievement in the residents and in the aides working towards their improvement."

CARE & PROFESSIONAL ATTENTION

Their Impact on Michael



Dr. Mark Friedman, Physiatrist, Michael and Mary Waddell, Therapy Program Assistant, practicing newly developed skills.

In 1967, Michael, a resident of the Maximum Care Ward of Woodbridge State School Hospital, was first evaluated for the Hospital Improvement Project Physical Habilitation Program.

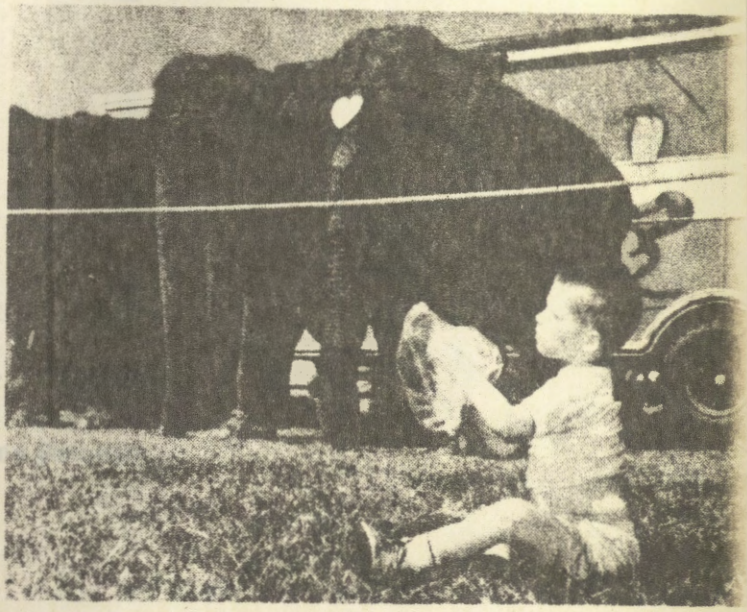
The Physiatrists report following examination stated in part that Michael had weakness in all extremities; was fourteen years of age and looked about two years of age. He could stand and ambulate with assistance although very weak from from constant regurgitation. "I feel that if this boy is stimulated enough he can improve his ambulation and his strength considerably".

Range of motion exercises and ambulation training were recommended and a treatment plan initiated.

By the end of 1967, Michael had improved in ambulation, although he still required assistance. He had gained approximately ten pounds and was stronger. He continued to participate in the habilitation program and was given additional training in self feeding.

In May, 1969 Michael was transferred to Cottage 5, a semi-ambulatory cottage and continued in the physical therapy program there.

On August 19, 1969, the Physiatrist discharged Michael from the Physical habilitation program. Michael can function well in a cottage setting, has increased social abilities in addition to improved ambulation skills. His total weight gain has enhanced his general well being and permits him to benefit from group life in Cottage 5.



Michael at the circus. His growth and development is a source of pleasure and satisfaction to the school.

Picture Credit - Gene Schneider

Mrs. Mattie Guyton, Therapy program Assistant, conducting therapy program in Marlin Cottage.

Picture Credit - Gene Schneider

NEWS RELEASES 1970

PHYSICAL THERAPY GRANT RENEWED FOR 1970—1971

Page 4

Therapy Program Assistants; Top row, left to right, Mrs. Ratliff, Registered Physical Therapist, Aides, Miss Murray, Mrs. Timar, Mrs. Bowen. Bottom row, left to right; Mrs. Guyton, Mrs. Waddell, Mrs. Devine, Mrs. Edwards

Dr. Mark Friedman,

Miss Q. Murray, Therapy Program Assistant, at work with resident. Miss Murray's reaction to her work appears on this page.

Continued

Physical therapy is helpful in many kinds of diseases and disabilities. With the aid of physical therapy, a disabled person can regain a constructive and creative life.

Many different kinds of physical equipment, exercises and self help devices are used to help the disabled person. Exercise helps to maintain or improve body functions and posture It increases muscle tone strength and endurance Some exercises can be done by the patient himself; others require the assistance of the doctor or therapist. Mechanical devices such as parallel bars, pulleys weights and many others.

Self help devices such as splints, braces, crutches and wheel chairs help disabled persons perform their daily living activities Doctors and therapists train persons to use these devices and to develop confidence in accomplishing daily tasks

Since I started on the P.T. program, I found much to my satisfaction and extreme gratification that 90% of the residents responded to therapy. As I come to work each day, I look forward to my job. It is indeed a great experience to work in the the therapy field and to know that you see such great progress in the patients that you work with.

Q. Murray
Therapy Program Assistant

Louis R. Pirone, Superintendent, announced the renewal of the Hospital Improvement Program Physical Habilitation grant for the 1970 1971 year.

The Physiotherapy program was conceived in November, 1966 by David Rosen and Richard Zeigler, Superintendent and Assistant Superintendent at that time. The program began under the supervision of Mrs. Donna Carroll Hugelmeyer on a pilot basis using attendants and teachers trained in Physiotherapy techniques. With the encouragement of Dr. Maurice G. Kott, Director, Division of Mental Retardation, WSS applied for federal assistance which was granted in January, 1967.

The physiotherapy program is conducted in each of the eight non ambulatory cottages and the Maximum Care Ward of the Hospital by a Therapy Program Assistant. Initial training of the Aides was conducted at Willowbrook State School, Staten Island, N.Y. The program was initially administered under the auspices of the Education Department and consisted of both Physical and Occupational Therapy services. The Physiotherapy program is now under the Medical Department and operates with Larry Pratt, Project Co-Director and Dr. J. Silva, Project Medical Co-Director. The Occupational Therapy program continues to operate under the Education Department and lends assistance to the Physiotherapy program

Dr. Mark Friedman, Physiatrist and Program Medical Co-Director has offered program leadership since its inception in 1966. All program services are directed by Dr. Friedman. His recommendations are implemented by the Chief Physiotherapist Mrs. Jean Shirreffs and the part time Physiotherapists, Mrs. C. Ratliff and Mr. F. Mulvihill who instruct the Physical Program Assistants. Mrs. Dora Carrara serves as coordinator to the aides and assists in grant administration

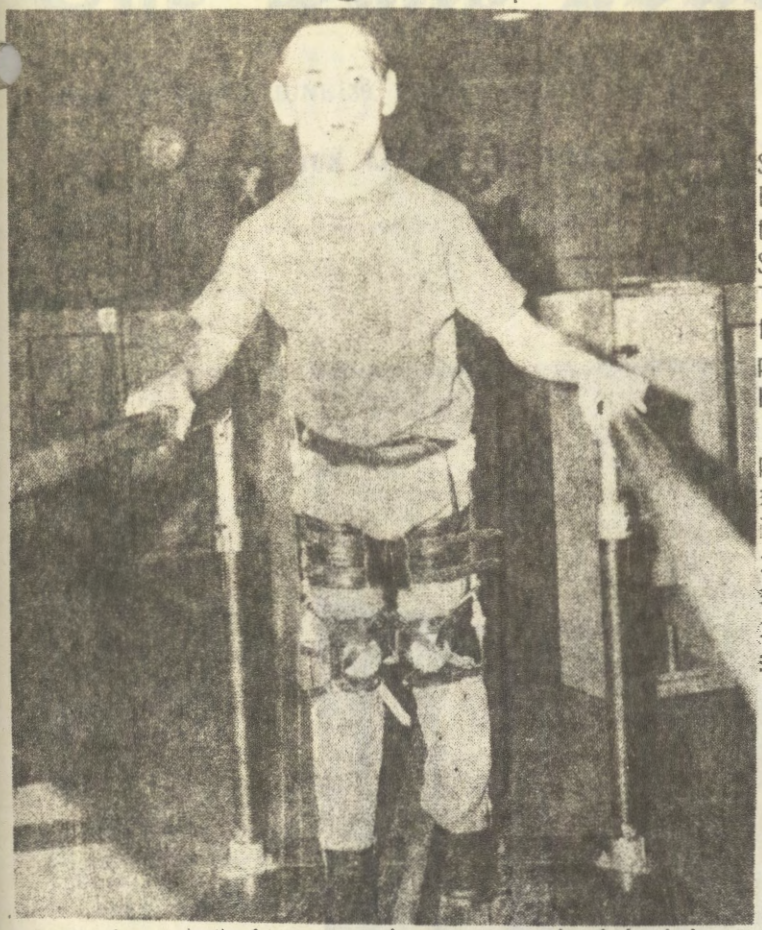
The Physiotherapy program consists of three areas. (1) The application by physiotherapists of modalities such as heat and hydrotherapy for specific conditions (2) Stimulation of motor development by means of passive, assisted and active exercise and balance training (3) The use of passive exercise and positioning to enhance circulation and prevent or reduce contractures. The program makes provision for the use of special equipment such as chairs, walkers, braces, splints and orthopedic shoes

Monthly in service training classes are conducted by the Physiatrist, Project Therapists and the Adult Training Department. Aides are encouraged to attend meeting, institutes and to visit outside facilities to increase their knowledge and enhance their job performance.

Extensive records of resident progress are kept and reported to the Federal Government at six month intervals. To date, 199 residents enrolled in the program have shown improvement in mobility, feeding and communication and 49 residents have progressed in ambulation (walking) to the point where they no longer require physiotherapy services.

Inherent in the Physiotherapy program is the belief that the potential for increased motor development and the improvement of posture exists in a large segment of the schools non ambulant population Fulfillment of this potential is largely dependent on the aciitities provided by the Physiotherapy program. The high level of success is due in no small measure to the attitude displayed in a Therapy Program Assistants comment, "I look forward to my job. It is indeed a great experience to work in the therapy field and to know tha you see such great progress in the residents

James and the Physiotherapy Program



James has received many services as a result of the federally funded Physio Therapy program. **Picture Credit Gene Schneide**

When James, a resident in Cottage 6, was examined by Dr Mark Friedman in November, 1966, the findings were that he was unable to walk due to contractures of the knees.

The Physiatrist's prescription for intensive physiotherapy was carried out. Follow up examination after three months showed improvement due to greater range of motion. The degree of spasticity however, remained severe and medication was recommended to reduce the muscle tightness. In addition, a series of special injections was given

This treatment successfully decreased the amount of spasticity but not enough to enable James to walk. An orthopedic consultation was arranged in October, 1967 and the opinion given that surgery might make it possible for the resident to ambulate.

James continued his treatment in the H.I P. program in Cottages 6 and 8 and arrangements were made for surgery to be performed at Vineland State School In April, 1969, at Vineland, hamstring release was performed bilaterally with good results. Braces were secured to maintain maximum range of motion in the legs. James was re-enrolled in the cottage H I.P program and has made consistent progress

department member

Mrs. Sadie Wise former Sensory Stimulation worker in the Education Department has joined the Physiotherapy Services area She has assumed the duties of Therapy Program Assistant in the federally funded Hospital Improvement Project Physical Habilitation

After an initial orientation period, Mrs. Wise has been assigned to Cottage 1 where she is responsible for carrying out programs of exercises and pre ambulatory activities prescribed by Dr. Mark Friedman, Physiatrist.

After surgery, it was necessary for James to learn new muscle patterns for balance and movement Positions of legs and trunk had a new 'feel' which made standing and exercising difficult for quite awhile. During this time, Mrs. Ratliff and Mr. Mulvihill, Physiotherapists and Mrs. Bowen and Mrs. Bostic Therapy Program Assistants in Cottage 8 were helping James to help himself. The Red Letter Day for all was January 27, 1970 when James, aided by his braces, stood alone and took his first independent steps.

'Yes, there is still much work to be done, progress still to be made; in fact some people might not even consider James short steps to be 'walking'' But. wearing his braces, he stands tall and is beginning to move around as he wills it. That's a good feeling in a mans life'., concluded Mrs. Dora Carrara.

Mrs. Jean Sheriffs, Chief Physio Therapist and Mrs. Myrtrice Bowen, Therapy Program Assistant, apply James braces.

PHYSIOTHERAPY SERVICES AT WSS

The vision of a Physio Therapy program accompanied Mr. David Rosen on his journey from Vineland State School to Woodbridge. As Superintendent, he shared with staff, his experiences with this type of activity. In short order, residents were evaluated, progneses made, and a proposal submitted for a federally funded program.

While the School's project was being reviewed by the Deoartment of Health, Education and Welfare, the nucleus of the Physio Therapy Department was created utilizing State funds. Using previous studies and evaluations of WSS residents as a base, it was hypothesized that possibily up t 30% of the non ambulatory population, could, with treatment, become independently ambulatory.

On Sunday, October 4, 'Advancement Day' recognized the progress of fifty residents who have achieved independence and/or improved in balance and gait, to the point where physiotherapy is no longer required

Although the major emphasis is on the development of balance and walking skills, the needs of other residents are considered also. In some instances, the goal is to maintain a reasonable range of motion in the joints, so that routine care in the cottage is made easier for the staff and more comfortable for the residents.

Rehabilitation services are provided to residents who have suffered traumatic injuries such as fractures and lacerations, as well as to those who have had operative procedures performed at Woodbridge State School.

Ambulatory residents are evaluated if they give evidence of difficulty in walking, or of poor foot conformation. When appropriate, orthopedic shoes, assistive devices, or treatment programs are recommended.

Continued

The strength of the Physiotherapy Department lies in its nine specially trained Therapy Program Assistants. Most were already working with the residents as Cottage Life employees when the HI P Grant began. After an initial period during which teachers spent half a day performing specific exercise programs, the combined OT PT program was launched. The aides received training not only at Woodbridge State School, but also at Willowbrook School, Staten Island, and at Middlesex Rehabilitation Hospital, N.J. Occupational Therapy and Physical Therapy Aides worked together in applying special shoes and braces to residents, in establishing feeding and toilet training programs, and worked independently in their areas of specialty.

Physiatrist, Dr. Mark Friedman, has been in charge of the program since its inception. He performed initial evaluations assisted in preparing the Grant proposal, and made arrangements For special training for the Therapy Program Assistants He re-evaluates residents routinely, prescribes all treatments, and is a source of encouragement to all in Physiotherapy Services.

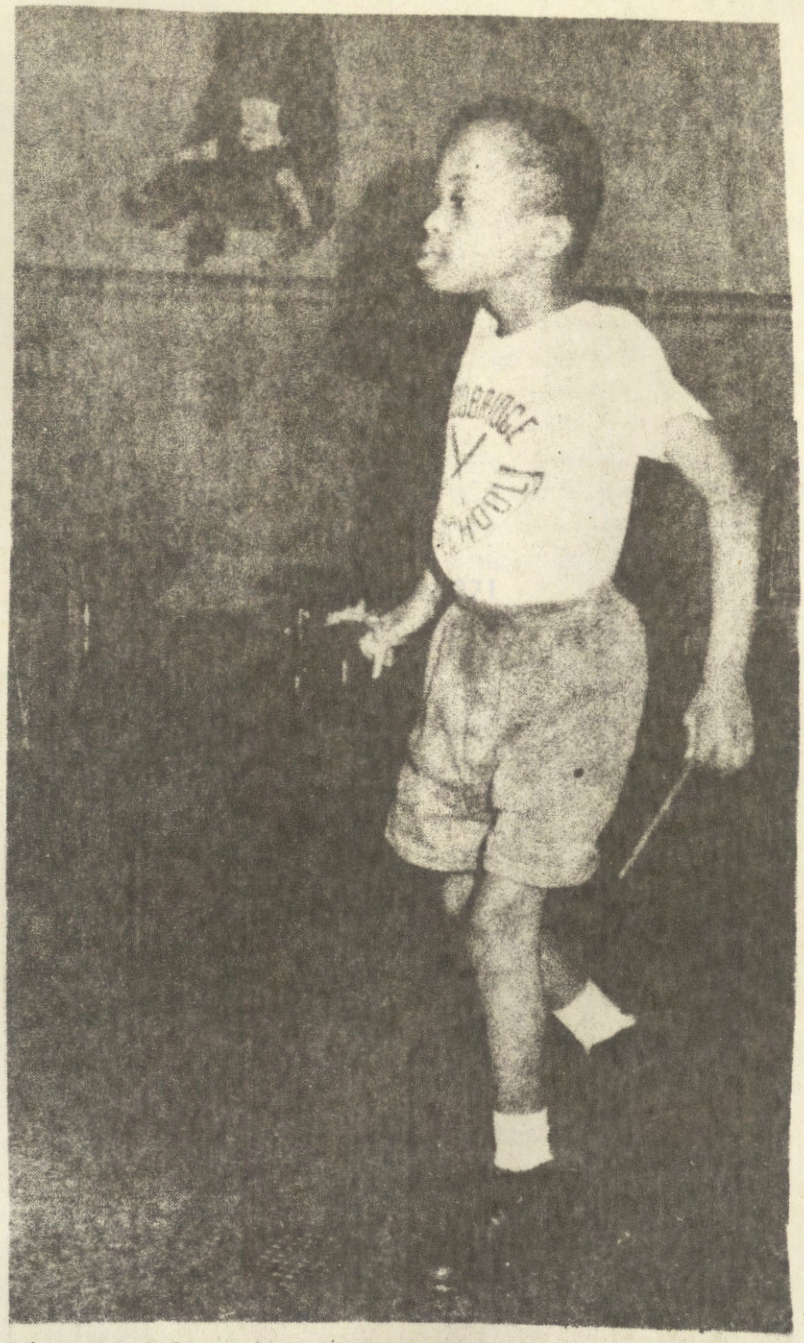
Two consultant Physiotherapists, Mrs. Catherine Ratliff, R.P.T., and Mr. Frank Mulvihill, R.P.T., have given professional guidance to supportive HIP personnel throughout the Grant. In addition, they administer specially prescribed treatments to residents.

Nine Therapy Program Assistants are assigned the non-ambulatory areas as follows:

Mrs. Sadie Wise - Cottage 1
Mrs. Mary Waddell - Cottage 2
Mrs. Flora Roberson - Cottage 3
Miss Queen Murray - Cottage 4
Mrs. Mattie Guyton - Cottage 5
Mrs. Laura Devine - Cottage 6
Mrs. Sarah Edwards - Cottage 7
Mrs. Mytrice Bowen - Cottage 8
Mrs. Mae Timar - Maximum Care Unit

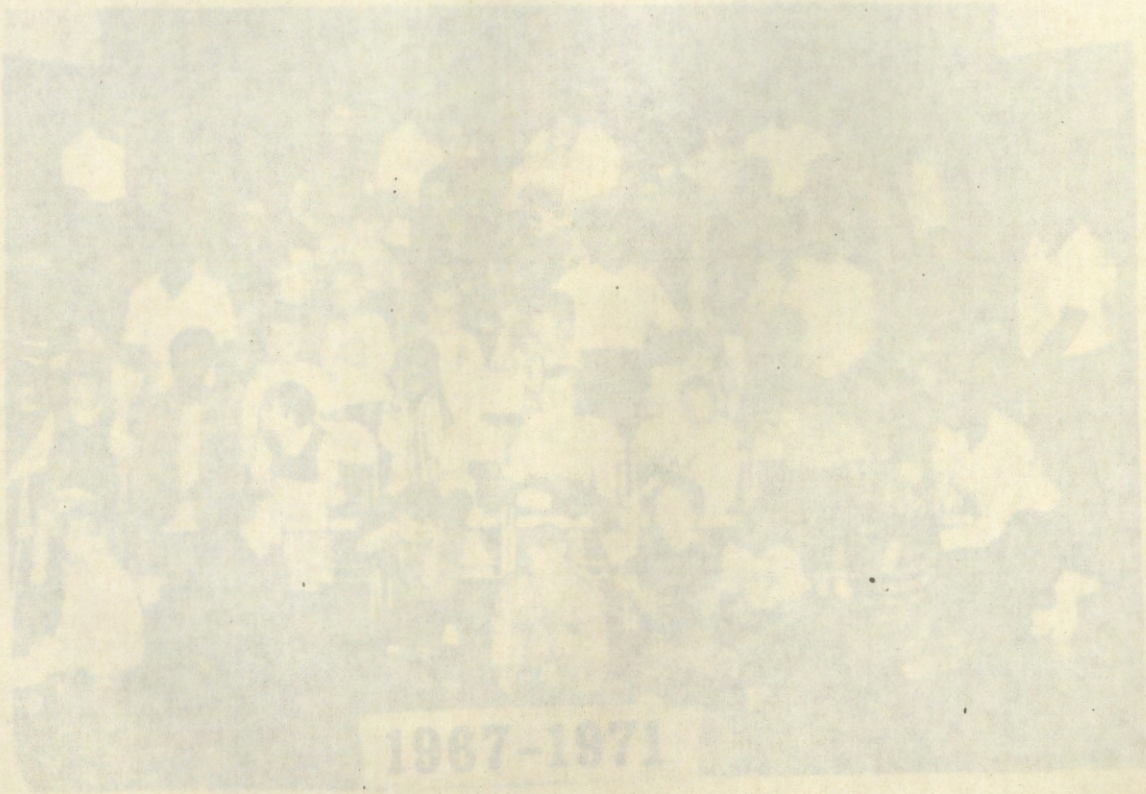
Mrs. Dora Carrara serves as coordinator and also assists the Chief Physiotherapist in compiling statistical and narrative reports as required by the Department of Health, Education and Welfare. She similarly aided Miss Donna Carroll (Now Mrs. Donna Hugelmeyer) in the earlier years of the HIP Grant.

Currently, the Chief Physiotherapist is Mrs. Jean Sherreffs, R.P.T.



A recent graduate of the Physio Therapy program. It was mentioned recently that this boy used to just exist, sitting in a butterfly chair. In the physical therapy program, he learned to stand and walk. 'I Often sit and watch him and think of the before and after results and how much the program has done for him'.

NEWS RELEASES 1971



Woodbridge State School News

PHYSIO THERAPY SERVICES PROGRESS DAY

On Sunday, October 17, at 2PM the Hospital Improvement Program Progress Day will be held in the auditorium.

The day will recognize sixty residents who have achieved independence and-or improvement in balance and gait to the point where physiotherapy is no longer required.

Dr. Mark Friedman, Physiatrist, has been in charge of the federally funded program since its inception.

Two Consultant Physiotherapists, Frank Mulvihill, R.P.T. and Catherine Ratliff, R.P.T. under the direction of Mrs. Jean Shirreffs, R.P.T., Chief Physiotherapist, have given professional guidance to supportive HIP personnel throughout the grant.

Residents gather with physio therapy staff for Progress Day ceremonies. Five year federally funded Physio Therapy program will be continued with state support.

Continue

The strength of the Physiotherapy Department lies in its nine specially trained Therapy Program Assistants.

The provision of their valuable service is assisted by the cooperation of the Maximal Stimulation and Cottage Life staff.

Therapy program assistants are: Mae Timer, Maximum Care, Sadie Wise, Cottage 1; Mary Waddell, Cottage 2; Flora Roberson, Cottage 3; Queen Murray, Cottage 4; Mattie Guyton, Cottage 5; Laura Devine, Cottage 6; Sara Edwards, Cottage 7; Myrtrice Bowen, Cottage 8; Dora Carrara, Coordinator; LaVerne Griffin, Secretary. Max Stimulation Workers are: Rachael Floyd, Cottage 1; Annette Wallace, Cottage 2; Genever Vinson, Cottage 3; Martha Oxendine, Cottage 4; Lorraine Benbow, Cottage 5; Loretta Sharp, Cottage 6; Mary Gray, Cottage 7; Mary Murphy, Cottage 8:

The Progress Day program featured:

Introduction - Mr. Larry Pratt, Medical Services Administrator

Welcome - Mr. Louis R. Pirone, Superintendent

Remarks - David Chick, WSS Parent Association President

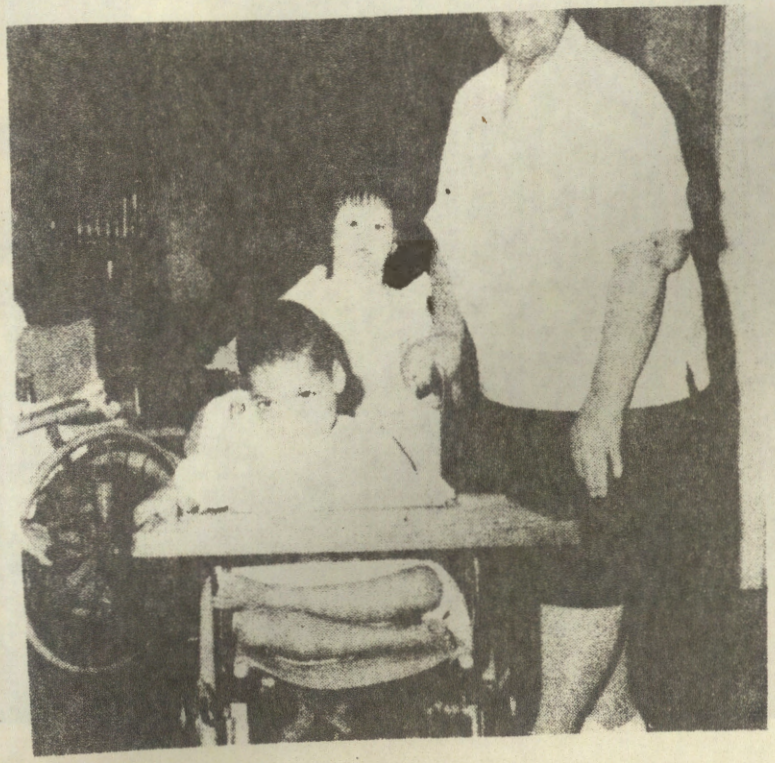
Remarks - Mr. Joseph Curtin, Parent

Music by: Mrs. Tina Koonce

Certificates were presented to: Kevin Hill, James Barnes, James Burrell, Joseph Curtin, Mark Calabrese, Gerard DiRienzo, John Fields, Frank Holly, Mark Hanay, William Hoagland, John King, Leroy Longbottum, Michael Loerch, Stephen Moller, Howard Martinez, John Phillipshek, Stephen Ward, Joseph Nemeth, Vincent Sorrentino, Pedro Colon, Arthur Ruppert, Karen Ferrara, Diane Green, Lisa Thompson, Mary Peters, Diane O'Brien, John Eaton, Henry D'Amato, Richard Tremble, Robert Lotito, Ronald LaPlaca, Richard Gowers, Robert Minton, William McGann, John Harrington, Carol Morvay, Beverly Maze, Sharon Gilsinian, Gloria Hendricks, Joyce Banos, Sally Ann Kelly, William Kraus, Gary Schwartz, Joseph Pollison, Darryl Cooper, Melvin Branch, Randy Baines, Gary Dupre, David Sapone, Joseph Washington, John O'Rourke, Joann Hoag, Barbara Bauer, Ann Stanton, Theresa Stanton.

The impact of the total program can be summarized by the comment of Mrs. Mattie L. Guyton; 'When I first arrived at the School, I saw a resident, John, who seemed to just exist sitting in a butterfly chair. When the Hospital Improvement Project grant was received for a physical therapy program, John was enrolled. He learned to stand and walk independently. I often sit and watch John and think of the before and after results and how much the P.T. program has done for him, not to mention all the other residents like John. Some have graduated from our program and are walking independently now. Physical Therapy is a meaningful factor in their lives. Without it, there would be too many little johnny's just sitting around'.

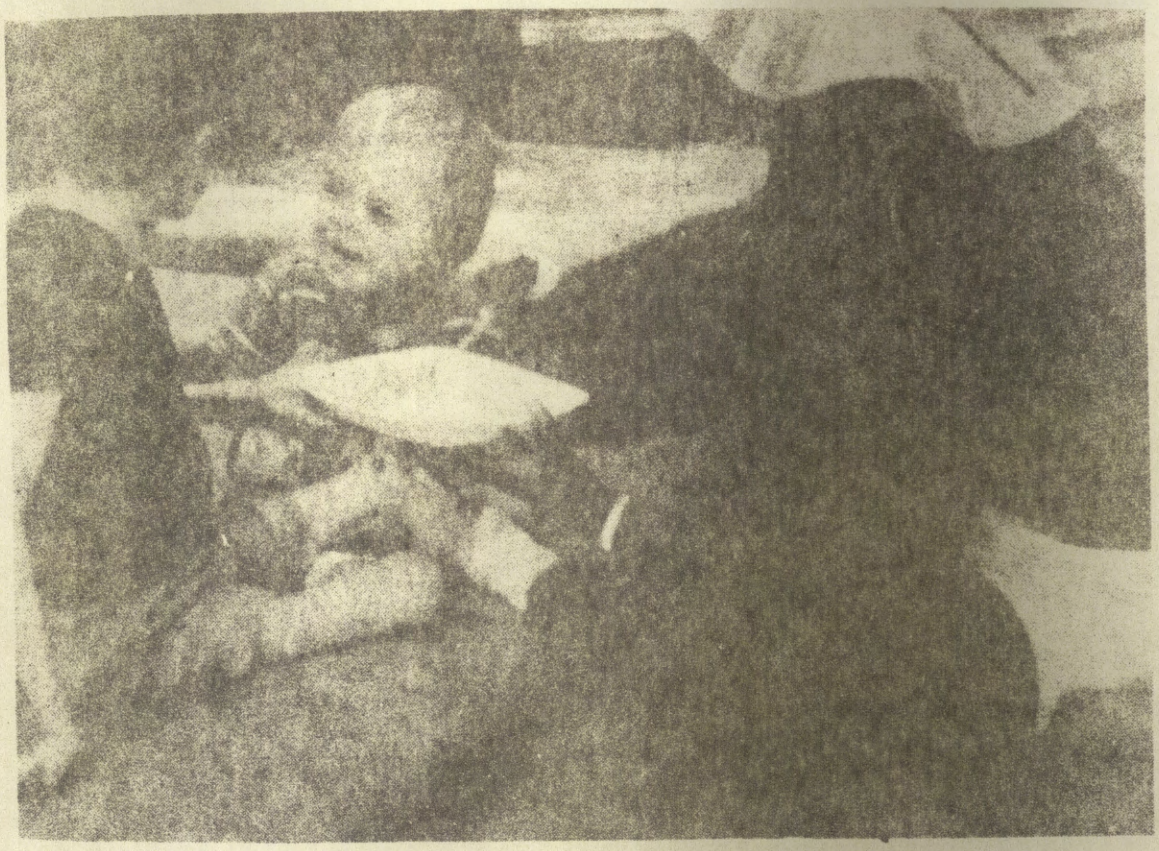
MAXIMUM CARE .....A Very Special Home



A dynamic physical therapy program pays very real dividends which are measured in terms of the over-all growth, development and progress of the residents enrolled.

Picture Credit - Gene Schneider

summertime 1971 summertime 1971



Some people have all the luck. They get to eat first.