

# **“TODAY’S HOPE FOR TOMORROW”:**

**NEW JERSEY STATE RESIDENTIAL FACILITIES FOR THE DEVELOPMENTALLY DISABLED IN THE POST-WORLD WAR II ERA**



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**“Today’s Hope for Tomorrow”:  
New Jersey State Residential Facilities for the  
Developmentally Disabled in the Post-World War II Era**

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*Cover Image:* Lawrence S. Williams aerial photograph of the Woodbridge State School (Williams 1967: Negative 98343).

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## 1.0 INTRODUCTION

New Jersey's state-sponsored programs for caring for and serving the developmentally disabled have changed dramatically over the last 70 years. Until recently, state programs relied heavily on residential facilities to house, train, and care for intellectually and physically disabled people. The history of residential facilities for the developmentally disabled in New Jersey reflects shifting ideas about intellectual and physical disabilities, the state's responsibility to its residents, and the purpose and potential of institutional architecture as an active factor in patient care. This study documents the development of New Jersey's program for the care of the developmentally disabled after World War II, with a focus on residential facilities, and traces the ways that federal and state level legislation on mental health, education, and disability have affected the shape of the state's program and its physical residential facilities.

At the turn of the twentieth century, state institutions of myriad purpose presented beautiful and stately edifices meant to please the eye of outsiders. These campuses, and the large brick edifices arranged around orderly quads, were "total institutions," intended as places where the state hoped to create "self-directed, moral, normal individuals" (De Cunzo 2006:167). At the time, however, design of facilities for the care of the developmentally disabled was not significantly differentiated from other institutions—such as asylums, prisons, hospitals, and schools. In fact, the state often cared for the developmentally disabled in conjunction with the care of other types of patients, such as the mentally ill or socially deviant. Specialized care philosophies and specialized spaces had not yet been developed.

In the pre-World War II era, New Jersey's Department of Institutions and Agencies (NJ DIA) managed the state's facilities for developmental disability, undertook research on intellectual disability, and implemented models of care that were largely custodial, even as research held promise about the potential of disabled children to learn skills that could help some become self-sufficient.

In the post-World War II era, caregivers and lawmakers alike were looking to solve problems associated with the state's developmental disability care system in the face of long waitlists, poor treatment conditions, and rapidly aging facilities. During this period an array of federal and state legislation sought to improve the lives of the developmentally disabled through an improved health-care system and a patchwork of funding mechanisms to build new hospitals, state schools, and community care centers. Parent groups in particular were instrumental in advocating for the developmentally disabled, pushing for their rights to social services and education alike.

At the same time, treatment philosophies for the developmentally disabled had evolved to focus on the needs of the patient, rather than the goals of the institution. A distinctly post-war optimism that design could actively impact care underwrote the form and features of post-war institutions. Architects, social behaviorists, and "programmers" (those who actually administered care) came together to define a theory of "psychological functionalism" which hoped to use architectural design to assist in the care program and address the specific needs of users (Knoblauch 2020).

After World War II, the stately and palatial hospital campuses of the early twentieth century were seen as cold and isolating. Care models for the developmentally disabled had not kept pace with research showing the benefits of education and training and parents pushed for more opportunities for their disabled children that took them out of permanent residential institutions. With the opening of the Edward R. Johnstone Training and Research Facility in 1955, the NJDIA recognized the need to offer educational and training opportunities for children that were not accepted by local school districts but nonetheless sought academic and vocational training.

Parents and administrators alike also agreed that regionally located, residential institutions were needed for those children who required long-term residential care. Bringing these facilities to the communities that would use them enabled families to stay close and involved in their children's lives at a moment when institutions were being destigmatized. Post-war architects of state schools utilized the theories of psychological functionalism as they designed facilities on the "human scale," creating home-like living spaces, and reducing a sense of isolation and alienation typically associated with turn-of-the-century institutions. These designs typically featured single-story cottages, floorplans designed for specific activities, and discrete buildings for ancillary needs such as group gatherings, medical care, food service, and utilities. These new designs hoped to disguise dehumanizing aspects of institutions such as the need for surveillance and the lack of personal space. New Jersey's Woodbridge State School, Hunterdon State School, and the planned but unbuilt Somerset State School exemplified the new model of psychological functionalism which flourished in the 1960s and early 1970s.

In the mid-1970s, waitlists showed no signs of abating and strong opposition to institutionalization was growing among parents and over-stretched state administrators. What seemed clear was that the institution had become the destination for any developmentally disabled child who did not fit neatly into the school system. Many residents were only mildly disabled, however, and a 24-hour residential institution was not appropriate for their needs. What followed was reform to the state's educational system and reform to the state system of developmental disability care. With an emphasis on networks of local services, the state could rely on institutions much less, or perhaps not at all. Thus began a shift toward "deinstitutionalization" on both the federal and state levels.

Deinstitutionalization was driven in part by federal legislation and funding mechanisms in the late 1970s which encouraged states to reduce the number of residential institutions, improve those that remained, and create community-based care networks that could serve people locally. In the late 1970s and early 1980s, most of the beds within the state's system were upgraded to meet the federal standards of "Intermediate Care Facilities for the Mentally Retarded" (ICF/MR). In this context, architecture became a tool to conform to federal guidelines which were intended to standardize care. The guidelines codified the human scale in square footage requirements for each resident and minimum staff-to-resident ratios, allowing caregivers to create a home-like experience through social interaction and attention, rather than the gross materiality of the living spaces.

By the early 1990s, legislation related to disability rights and court cases to uphold these rights further pushed states toward deinstitutionalization. By the 2000s, these court cases were being used by state governments to defend moves to close even well-used and liked facilities for the severely developmentally disabled. Most recently, New Jersey's move away from residential facilities for the developmentally disabled can be seen in the closure of the Woodbridge Developmental Center and the North Jersey Training Center in 2014. While residential facilities still remain in Hunterdon County (Hunterdon Developmental Center), Cumberland County (Vineland Developmental Center), Cape May County (Woodbine Developmental Center), Somerset County (Green Brook Regional Center), and Burlington County (New Lisbon Developmental Center), the emphasis once put on close proximity to parents and densely populated areas is gone (Figure 1). Many developmentally disabled patients have been placed in family homes, group homes, and larger, more remote institutions. Deinstitutionalization has allowed more and more developmentally disabled people to live in a community placement context, in the "least restrictive environments" that can accommodate their medical needs. As such, the architecture of these spaces is varied and no longer dictated by the institutional typology developed in the post-war years.

The term "developmental disability" is used throughout this document as a broad term to refer to a wide "group of conditions due to an impairment in physical, learning, language, or behavior areas" (Centers for Disease Control 2023). These conditions include both intellectual or mental and physical disabilities that tend to have a lasting impact on a person's life and can affect the ways they function on an everyday basis. A number of antiquated and offensive terms for people with developmental disabilities are mentioned throughout this document, where key sources are quoted and where the historical term is key to the context. In some cases, the term "intellectual disability" is used where state programs or research studies were focused explicitly on the effects of mental disabilities, discrete from physical impairments.

### *Project Information*

This historic context document has been compiled to contextualize the architectural and historical significance of the Woodbridge State School, which was demolished in 2021. The Woodbridge State School was in the Avenel section of Woodbridge Township, Middlesex County, New Jersey. The land on which the complex stood is proposed for commercial redevelopment. The proposed redevelopment requires a Freshwater Wetlands (FW) permit from the New Jersey Department of Environmental Protection's Division of Land Resource Protection (NJDEP-DLRP), thereby requiring compliance with New Jersey Administrative Code 7:7A.

In correspondence dated January 5, 2021, the New Jersey Historic Preservation Office (NJHPO) requested the completion of an intensive-level historic architectural survey to assess the Woodbridge State School's eligibility for listing in the National Register of Historic Places (NRHP). When the NJHPO issued this request, the complex was undergoing demolition with a majority of buildings having already been removed. On January 19, 2021, Richard Grubb & Associates, Inc. (RGA) conducted a site visit to document existing conditions of the property, including remaining extant

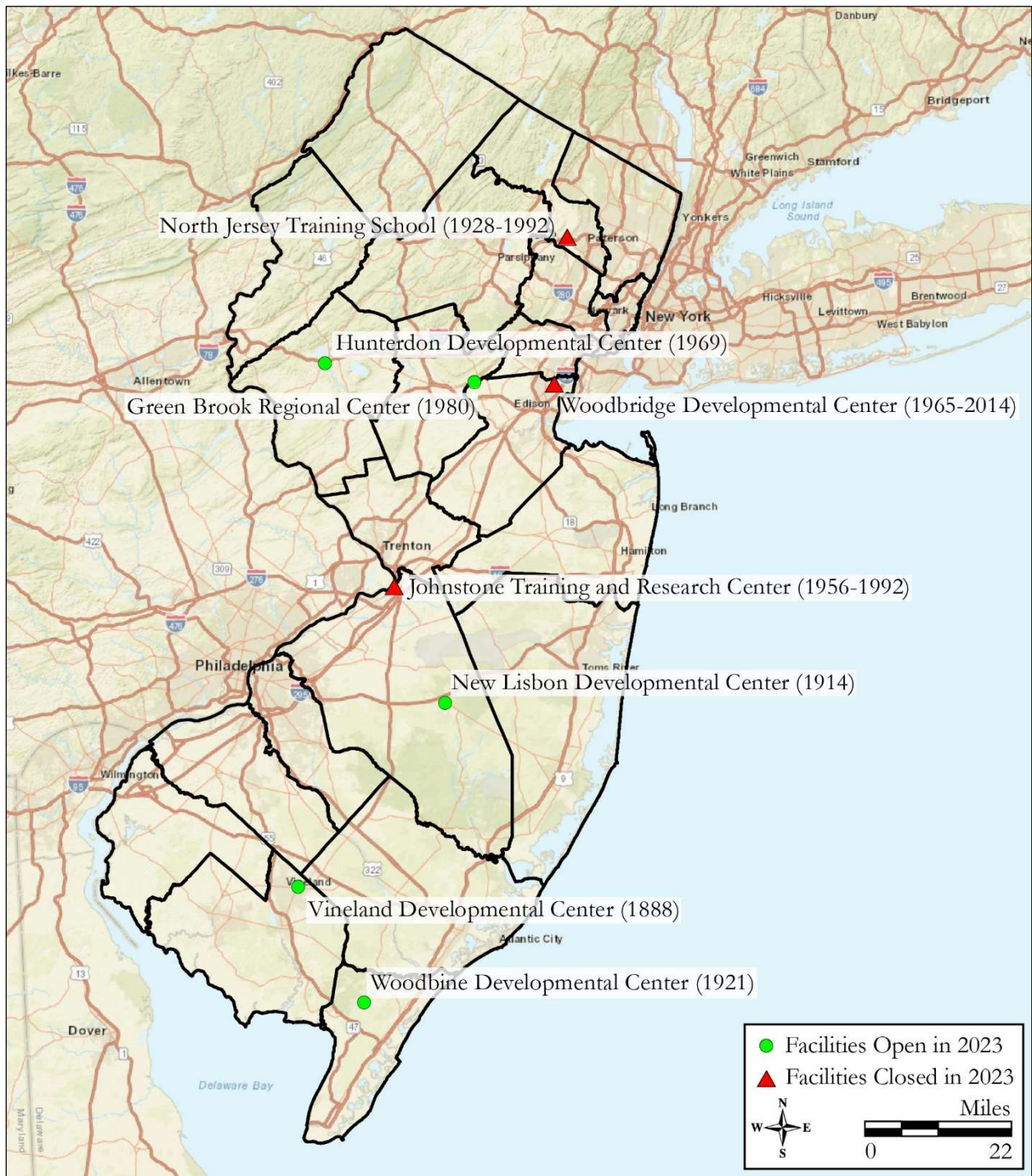


Figure 1: Map of New Jersey showing state-run residential facilities for the developmentally disabled, both present and former.

buildings, to facilitate consultation with the NJHPO regarding appropriate cultural resources requirements necessary for permit issuance. In subsequent correspondence dated January 29, 2021, the NJDEP-DLRP and NJHPO indicated that the Intensive-level historic architectural survey of the Woodbridge State School could no longer be completed, due to the demolition activities. In the absence of a formal NRHP evaluation of the Woodbridge State School, the NJHPO presumed the property is eligible for listing in the NRHP under Criteria A and C and that the demolition of the historic complex constitutes an adverse effect, thereby requiring mitigation. A list of potential mitigation items was included in the January 29, 2021 correspondence.

On February 4, 2021, a conference call was held with RGA, the NJDEP-DLRP, the NJHPO, Woodbridge Township, and Morris Avenel Associates Urban Renewal, LLC. The NJDEP-DLRP indicated that the FW permit would be issued upon receipt of permit conditions from the NJHPO. The NJHPO specified that a work plan would be required detailing the requisite cultural resources mitigation tasks for review and approval. Upon approval, the NJHPO would issue conditions and the NJDEP-DLRP would issue the permit for the proposed project. RGA subsequently prepared a Cultural Resources Mitigation Work Plan, which was submitted to the NJHPO on February 17, 2021, to satisfy the NJHPO's requirement for a work plan prior to the issuance of the permit.

On March 2, 2021, the NJDEP-DLRP issued the FW permit which included four cultural resources mitigation tasks under Condition No. 10 to address the adverse effect to the NRHP-eligible Woodbridge State School. The four mitigation tasks comprise A) Historic American Buildings Survey (HABS) Documentation of the Woodbridge State School, B) Public Accessibility of Archival Materials, C) Historic Context for State Developmental Facilities, and D) a webpage. Presented herein is the Historic Context for State Development Facilities. The other mitigation tasks are being completed under separate covers, per the Cultural Resources Mitigation Work Plan.

The property initially consisted of a complex of approximately 29 buildings known as the Woodbridge State School (later the Woodbridge Developmental Center) that was operated by the New Jersey Department of Institutions and Agencies (later the New Jersey Department of Human Services' Division of Developmental Disability). The Woodbridge State School closed in 2015 and the subject property is now owned by Morris Avenel Associates Urban Renewal, LLC.

## 2.0 DEVELOPMENT OF NEW JERSEY CARE SYSTEM PRIOR TO WORLD WAR II

### *Late Nineteenth-Century Theories of Developmental Disability*

In the mid- to late nineteenth century, ideas about the causes and preventability of developmental disabilities were underwritten by inherently racist, classist, and ableist theories of human development. Social Darwinism, progressivism—its counterpart degenerativism—and evolutionism were the dominant theories used to explain the development of observable variability throughout the human race. These theories, however, were based on a series of assumptions about the pre-determined place of groups within social and cultural hierarchies and the deterministic influence of heredity. Developmental disabilities were recognized as conditions, rather than illnesses, but a vague understanding of their relationship with heredity led many to see disability as a threat to the social order (Trent 1994:141). In this context, institutions became the permanent “locus of care and protection” for the developmentally disabled to prevent them from becoming menaces to society (Trent 1994:142–144).

Others brought a more optimistic perspective to the potential of the developmentally disabled. In the mid-nineteenth century, French physician Edouard Seguin began to study children with intellectual disabilities and theorized that a “lack of will” and stimulation resulted in “mental deficiency” (Trent 1994:16). With this in mind he theorized that training could improve the capabilities of the developmentally disabled and took steps toward the establishment of training institutions. Institutions for intellectually disabled children began as experiments in education, based on the research of people like Edward Seguin, who “proved” that through certain methods, the developmentally disabled could learn.

American psychiatrists did not fully embrace Seguin’s explanations of the causes of developmental disabilities, but his emphasis on education and training was more widely accepted. Training became an important function of institutions for the developmentally disabled in the United States, and New Jersey was a leader in the field beginning in the 1880s. New Jersey’s first institution for the developmentally disabled, the Vineland Training School for Feeble-Minded Boys and Girls (Vineland Training School), was founded in 1887 by Methodist minister Stephen Olin Garrison, as “a private school for the retarded” (Leiby 1967:74). While not a state-run facility, the Vineland Training School was subsidized by the state and had an outsized influence on the development of New Jersey residential schools for the developmentally disabled.

Following the founding of the private Vineland Training School, New Jersey opened its first publicly funded residential home for the developmentally disabled in 1888, just across Landis Avenue (NJ DIA 1966; Figures 2 and 3). This facility was named the Vineland State School for Feeble-Minded Women (Vineland State School). The impetus for the founding of the Vineland State School lay in the dual beliefs that developmental disability was a “hereditary defect” and that education could improve the ability of the developmentally disabled to live independently. Many physicians advocated for the

segregation of people with mental deficiency from the general population or even for sterilization. The Vineland State School was founded in order for New Jersey to remove developmentally disabled women from county almshouses and prevent them from reproducing (Leiby 1967:74, 103, 240). While education was one goal of the school, in reality it became a “custodial institution for pauper girls” (Leiby 1967:104). When Vineland State School was established, it consisted of one dwelling house, a barn, and outbuildings on 11.5 acres (NJDIA 1970). Over time, the state acquired additional acreage and built additional cottages.



Figure 2: 1930 oblique aerial view of Vineland Training School (foreground) and Vineland State School (background). View north. (Photograph courtesy of Hagley Museum and Library).



Figure 3: Circa-1920 general postcard view of the campus of the Vineland Training School in the early twentieth century, at center is the Maxhan “Cottage” and at the right is Garrison Hall.

#### *Vineland Training School and the Development of Psychometrics*

Vineland Training School was at the cutting edge of the architectural, training, and research trends in the field of developmental disability at the turn of the century. Philanthropist B. D. Maxhan had donated 40 acres for the establishment of the school in 1887, and its first superintendent was Reverend S. Olin Garrison. Two years later, Edward R. Johnstone became superintendent after Garrison died. The school was housed in Maxhan’s large Victorian mansion in its early years. The school’s founder, however, imagined a utopian “village” plan for the new school, where “the retarded might live and be more or less self-sustaining in a world suited to their needs and capabilities” (Leiby 1967:103). The school focused on the training of people with developmental disabilities but did not care for the severely disabled. In 1892, the school adopted the “cottage plan” in a break from the use of large dormitories. The cottage plan was characterized by residents living in multiple small houses and working together. This model became the primary approach to designing residential facilities in New Jersey for the next three decades (Leiby 1967:103). The cottage plan was used at facilities for the developmentally disabled throughout the country and was often organized according to “different functional grades, sexes, and medical conditions.” (Trent 1994:94). The “cottages” within this model, however, typically continued to be multi-storied, brick-faced buildings with the same design as earlier dormitories, though on a somewhat smaller scale.

The field of behavioral psychology has its roots in studies undertaken by New Jersey researchers at the Vineland Training School which were at once an outgrowth of eugenics and psychiatry at the turn of the century. Two key figures in this movement were Edward R. Johnstone and Henry H. Goddard. Johnstone became the superintendent of the Vineland Training School in 1903 and Goddard was his director of research at the school beginning in 1906. Along with a group of prominent psychiatrists, self-styled the “Feeble-minded Club,” Goddard and Johnstone worked to study the phenomenon of “mental deficiency” and “carry on investigations into [the] mental condition and capacity of [feebleminded] children” (Trent 1994:156).

Some professionals studying the residents at Vineland Training School were influenced by the eugenics movement. Advocates of eugenics believed that people with developmental disabilities needed to be removed from the general population and prevented from reproducing in order to promote the overall health of the human species. Their treatment philosophy was that the residents were genetically incapable of improvement and should be warehoused away from their families (Reim 2004:6–8). As noted above, the Vineland State School’s establishment was founded based on these principles.

Goddard’s research was funded by eugenicist Samuel S. Fels, and its continued funding was dependent on his ability to produce results demonstrating the correlation of hereditary human variation and intellectual differences (Trent 1994:157). He finally achieved measurable results when he came across the Binet-Simon test of cognitive ability and adapted it for his purposes. Though the original researchers cautioned that the test could not account for the “pliancy of intelligence,” Goddard looked past the changeable nature of cognitive ability and created a seemingly objective “test” of intelligence (Trent 1994:158). Vineland Training School became the proving ground for the broad applicability of the test, which quickly became the standard intelligence test used to classify children for specialized education programs. Home of what today is known as the “IQ Test,” Vineland Training School was considered a “mecca of research for special education” by local teachers and public officials alike (Trent 1994:159).

Following a 1910 meeting of the Association for the Study of the Feeble-Minded, Goddard began to formulate his psychometric grading system according to the “mental age” of patients. This system established definitions for idiots, individuals with a mental age of two years; imbeciles, individuals with a mental age of three to seven years; and morons, people with a mental age of eight to twelve years (Trent 1994:162). The creation of the “moron” grade was wholly new, and classified children who were before identified as “backward” or “slow” as mentally deficient in an official capacity, effectively doubling the projection of mental deficiency in the general population from one percent to two percent (Trent 1994:162).

Along with this grading system, Goddard popularized the notion that the intellectually disabled, especially “morons,” were responsible for a larger proportion of crime and were therefore a “social menace” (Trent 1994:163). He made the distinction that feeble-mindedness was not *caused by* social

vices. As such he opposed popular degenerativists who saw the cultural, social, and physical state of the human race as deteriorating over time, with intellectual disability being the result of abhorrent human behaviors. Goddard's "moron" concept remained mainstream for four decades, until the post-war era began to reevaluate the value of his psychometric scale in the 1950s (Leiby 1967:322–323).

By 1915 both Goddard and Johnstone had national reputations for establishing the "legitimacy of psychologists, social workers, and educators not only as service providers but also as researchers and social reformers" (Trent 1994:244). After World War I, the work of psychiatrists and psychologists diverged both in terms of their approach to developmental disorders and the spaces they chose to work in. Psychiatrists became less interested in developmental disability and moved their practices out of the state hospitals and state schools to non-residential local treatment centers. Meanwhile, psychologists put into use psychiatry tools such as intelligence tests and focused on researching behavior rather than illness within the state institutions for the developmentally disabled (Trent 1994:244).

Even as Goddard was developing his theories of mental age and grades of mental deficiency, other researchers had begun to find problems with this method of diagnosis. Dr. Henry Cotton, the leading psychiatrist in New Jersey in the early twentieth century, was developing research that cast doubt on the theory of "hereditary defect" as the cause for developmental disability. Cotton began studying the topic quality in 1912 and after four years of research "dismissed hereditary defect in favor of focal infection as the primary cause of mental disorder" (Leiby 1967:238). While researchers did not follow-up on Cotton's findings for decades, his work marked the beginning of research into preventative measures to avoid developmental disability which were not rooted in the eugenicist ideas of sexual segregation and sterilization.

#### *New Jersey Department of Institutions and Agencies*

Beginning in 1919, state programs for the developmentally disabled were administered by the New Jersey Department of Institutions and Agencies (NJ DIA).<sup>1</sup> The NJ DIA was established as an umbrella department covering multiple types of institutional care for state residents. It included the prison system, veterans' homes, the commission for the blind, the board of children's guardians, mental hospitals, state schools, and colonies for the developmentally disabled (Leiby 1967:268–270).

The organizational structure of the NJ DIA represents an example of New Jersey setting the standard for the field of developmental disability nationwide. The NJ DIA was founded with a citizen's board, which effectively brought a nonpartisan body of people together to advocate for management of the institutions in the interests of the various people served by the department. The Division of Classification and Education was organized under the new department and managed the state's institutions for the developmentally disabled: Vineland State School (1888) and New Lisbon State

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<sup>1</sup> All reports and publications of the New Jersey Department of Institutions and Agencies are on file at the New Jersey State Library, Trenton, New Jersey.

Colony (1914), while providing subsidies for the private Vineland Training School (1887). Soon after, however, the Division added more institutions to serve the state, including Woodbine State Colony (1921), Vineland State Colony (1924), and the North Jersey Training School at Totowa (1928). Prior to World War II, these were the all the residential institutions for developmental disability funded by the state.

A guiding force in the field of care for the developmentally disabled in the early twentieth century was W. John Ellis, who served as superintendent of the department from 1926 to 1945. Ellis led the NJDIA in an explicitly nonpartisan manner, which fostered excellent relations with the legislature. These relations were critical to the funding of the various institutions within the NJDIA during the difficult years of the Depression and World War II (Leiby 1967:201–217). Ellis was a vocal advocate for “mental hygiene clinics,” which were outpatient clinics of the state’s mental hospitals meant to prevent mental illness and provide community support to mental patients (Leiby 1967:232). These clinics also diagnosed children with behavioral problems and helped to identify children with intellectual disabilities (Leiby 1967:233). During his administration of the department, however, Ellis was unable to resolve ongoing staff dissension between supporters and opponents of genetic determinism. Just prior to his death in 1945, Ellis expressed an interest in innovative programs in other states which brought in research personnel from academia to recommend avenues for better care, but his death soon thereafter left any such plans unfulfilled (Leiby 1967:287).

#### *The New Jersey State Program Prior to World War II*

The classification systems developed by Goddard and Johnstone set the standards for the overall design of New Jersey’s state system for the developmentally disabled before World War II. These institutions were centralized and remote, often located in rural parts of the state, and patients with similar conditions, classifications, and risk factors were grouped together (Leiby 1967:239). As described above, Vineland Training School and Vineland State School were opened in the late 1880s and were the primary institutions for the developmentally disabled for the next two decades. Where possible, these facilities worked with community agencies and institutions, especially mental hygiene clinics, to diagnose and run training programs for those who could stay in their communities. In the first decades of the twentieth century, institutions for the developmentally disabled proliferated, and by the late 1920s, there were plans for farm colonies and community programs as the funding was not progressing at the rate that the number of residents was rising (Leiby 1967:244).

In the 1910s, the state established new facilities to accommodate state wards with mental deficiencies who did not fit neatly into the existing institutions. As the Vineland State School was exclusively for female patients, there was nowhere for developmentally disabled boys to go after they progressed through the program at Vineland Training School or were found to not qualify for services there. This changed in 1914 with the founding of the State Colony at New Lisbon (New Lisbon Colony), which became the state’s first public residential institution for boys with developmental disabilities. The New Lisbon Colony primarily accommodated “educable and trainable” boys (NJDIA 1966:96; Figure 4).

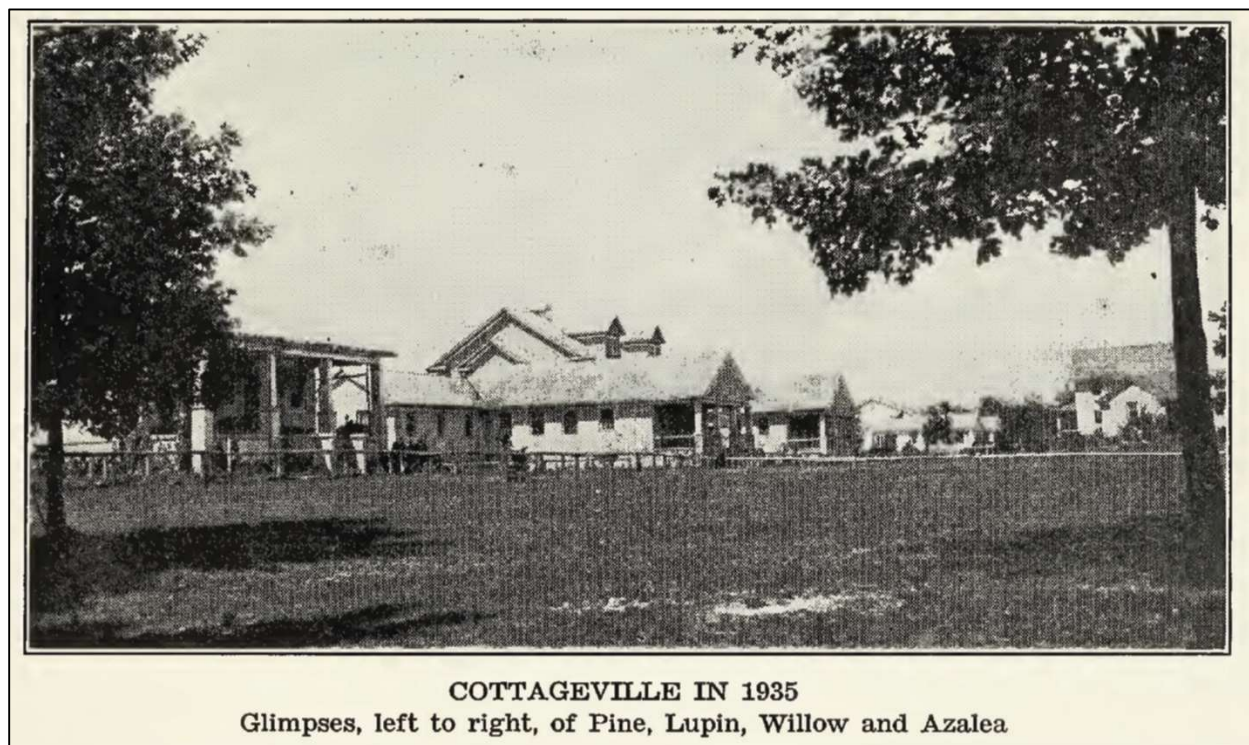


Figure 4: 1935 photograph of cottages at the State Colony for Boys in New Lisbon  
(Source: Devery 1939).

The newly founded NJDIA opened an additional facility, the Woodbine State Colony, in Woodbine, New Jersey, for the “profoundly and severely retarded” in 1921 (Figure 5). This institution took over the buildings of the Baron de Hirsch Agricultural College, which had been built in 1894 for the education of the newly established Jewish community in Woodbine and closed with the onset of World War I in 1917 (Batesel 2020). The buildings of the agricultural college had been organically arranged on the landscape. Sometime between 1924 and 1930, however, the NJDIA completely redeveloped the facility according to a “total institution” design which imposed order on the landscape. In the new design, the administrative building sat on the north side of Ocean Drive, on a semicircular driveway, facing and surveilling the school facilities and cottages which were arranged along a broad semicircular drive on the south side of the road (Figure 6). Later additions to the colony included an additional concentric semicircle beyond the first row of cottages.

The Woodbine State Colony was established as a custodial institution for boys and was not designed to train its patients for community placement. While passive “custody” was initially the treatment plan for the facility, this changed in 1924 when the Woodbine State Colony began to operate recreational activities and implement a “diversional occupation” program which sought to teach bodily self-reliance through habit formation (NJDIA 1966:97).

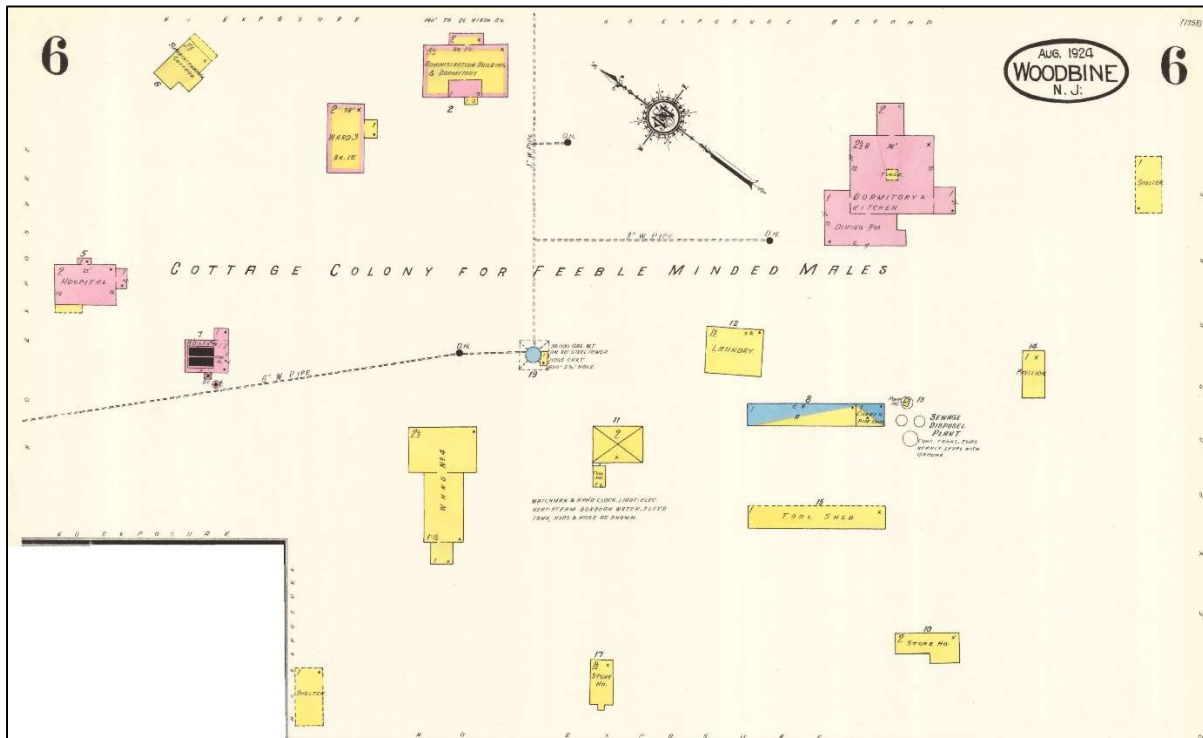


Figure 5: 1924 Sanborn Fire Insurance Map, Woodbine State Colony.

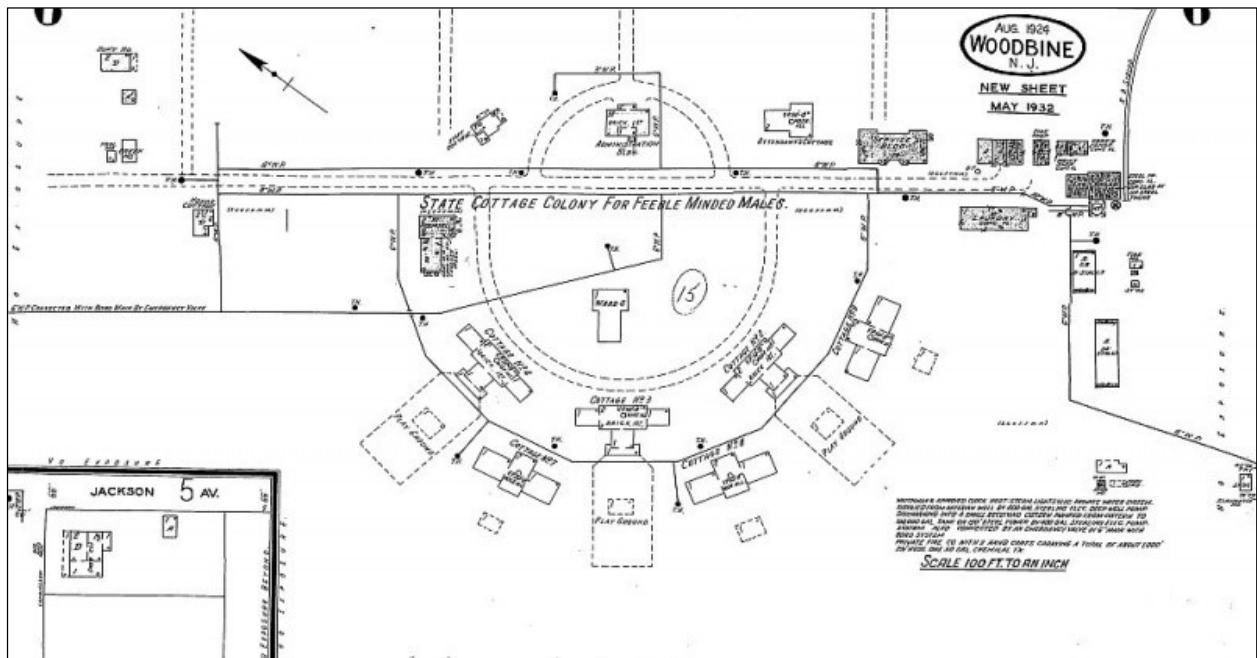


Figure 6: 1932 Sanborn Fire Insurance Map, Woodbine State Colony.

An emphasis on “diversional occupation” at Woodbine State Colony effectively launched a new approach to the care of people with severe developmental disabilities. This new care philosophy shifted the focus from assuming that the developmentally disabled were incapable of learning or self-care to asking what potential abilities they might develop with training and patience. In the 1930s, Edward R. Johnstone became superintendent of Woodbine State Colony. As the Great Depression lingered through the decade, limited funding meant reduced staffing. Johnstone thus initiated a policy of trying to train the residents to assist with their own hygiene. The prevailing philosophy that the residents had no capacity for improvement was soon challenged by the results. Patients and friendly assistants replaced the more expensive psychoanalysts. Gradually, more residents were able to dress themselves, and overall hygiene was improving. Over half of the residents were taking classes by 1940 and their teachers were being trained to work with the developmentally disabled in their local communities (Leiby 1967:242–244). The success in educating residents in self-care at Woodbine marked the end of the eugenics philosophy’s influence on care at developmental disability facilities in New Jersey.

In the first decades of the twentieth century, the Vineland State School was expanded with additional acreage and facilities such as a hospital, food service buildings, pool, school, and additional housing. The original farmhouse on that site was supplemented by four cottages in 1948, and an additional four cottages in 1956 (NJDIA 1970:2). The Vineland State Colony (also known as the Almond Road Colony) was founded in 1924, 4 miles away, and served a similar purpose, as a female-only residential institution for the developmentally disabled.

The North Jersey Training School for Girls in Totowa, New Jersey, was established in 1928 and served girls from infants to young adults (Figures 7 and 8). Programming at the North Jersey Training School focused on returning residents to the community through school and occupational training. As the facility was close to a population center, the school ran a day-placement program, finding jobs in domestic work for its students. At the time, the North Jersey Training School was the only facility for the developmentally disabled in the northern part of the state (NJDIA 1966: 97).

The nature of institutional architecture had changed since the opening of the Vineland facility. When Garrison established the Vineland colony as a private initiative, he worked with the residents to build the cottages where they would live. Additional cottages were then built when the female wing opened across the road. When the NJDIA took control over the colonies in the 1910s, the “cottages” built in the new facilities were large-scale, vertical institutional buildings modeled after academic campuses. The rectangular buildings provided dormitory style living surrounded by large acreage. These larger cottages first appeared at the New Lisbon Colony (Leiby 1967:108–109). The use of large dormitory-sized “cottages” continued in the 1920s when the State Colony at Woodbine was opened for boys (1921) and the North Jersey Training School at Totowa opened for girls (1928).



Figure 7: 1930 aerial photograph of North Jersey Training School for Girls, in Totowa New Jersey. View southeast (Source: NJ-GeoWeb 2023).



Figure 8: Circa-1930 postcard view of the campus of the North Jersey Training School for Girls.

### 3.0 NATIONAL TRENDS IN THE CARE OF DEVELOPMENTAL DISABILITY: THE POST-WORLD WAR II ERA

In the post-World War II era (post-war era), national attitudes towards developmental disability began to shift in the wake of changes to economic conditions, the shape of the American family, advances in federal investment in research and construction, and the ascendance of parental advocacy. Developmental disability came to be more accepted, and institutions were recast as havens for people with shared abilities to also share social, school, and home environments. Improvements to institutions and increased support through community placements and special education services were intended to create a network of care for the developmentally disabled. The federal government began to actively fund research into developmental disability in the 1960s, as well as the construction of new facilities. Psychiatrists, social psychologists, and architects came together to explore the potential of buildings to contribute positively to treatment plans for the developmentally disabled and mentally ill alike. Between 1946 and 1974 the subfield of “environmental psychology” sought to reduce the alienation and trauma associated with institutional settings through empirical analyses of the ways that the built environment impacts the mind and behavior (Knoblauch 2020:6–7). The prominent theory in this subfield was “psychological functionalism,” which held that form influences psychology, and designs should be shaped to fit the psyche of the user (Knoblauch 2020:7). Psychological functionalism built on the optimism of the post-war era, touting the capacity of the institutional buildings to actively encourage the psychological development or healing of their residents. This section will explore the ways that parental advocacy planted the seeds for changing attitudes toward developmental disability, the ways federal investment provided the vision and funding for these changes, and how these changes were manifest in national trends of post-war era institutional architecture for the developmentally disabled.

#### *Changes to the American Family and Parental Advocacy*

On a population level, post-war families, despite economic prosperity, had lost some of their capacity to care for developmentally disabled children. Nuclear family groups had grown to include more children on average, while suburban neighborhoods had weakened the extended family support network (NJDIA 1963:16). At the same time, the number of developmentally disabled children was growing as advances in medicine reduced premature and neonatal deaths (NJDIA 1963:17). The number of children and adults needing care in long-term facilities for the developmentally disabled was growing. In this context, institutions lost some of their taboo as parents and social welfare critics alike saw the institution as a solution to emerging economic and social problems (Trent 1994:237).

Advocacy for new and improved institutions came first from parent groups. In 1947, the initial parents’ organizations were formed to advocate for the developmentally disabled. The local chapters later coalesced into the National Association for Retarded Children (NARC) in 1953, which continues today under the name Arc. In New Jersey, parents who were interested in the improving situation at state schools and sought to improve the lives of their children in state institutions rather than simply handing them over and cutting them off gravitated toward the New Jersey Association for Retarded

Children (NJARC) (NJARC 1969). Many of the parents in NJARC were in the middle class, and they became informed critics and advocates. The parents convinced the legislature to authorize the State Commission to Study the Problems and Needs of Mentally Deficient Persons in 1950 (Leiby 1967:324–326).

Confessional literature was one tool the post-war families of the developmentally disabled used to come to terms with institutionalization and begin to advocate for improvements at these institutions. The poster-parent of the “parents’ movement” in the post-war era was Pearl Buck, a writer and member of the board of the National Mental Health Foundation, who institutionalized her daughter Carol at the private Vineland Training School beginning in 1929.

In 1949 Buck’s article, *The Child Who Never Grew*, helped to normalize developmental disability (Buck 1950). Her personal narrative described the process of diagnosis for Carol, Buck’s own dissatisfaction with most public institutions, and the exceptional leadership of Edward Johnstone in creating an institutional environment that diverged from the warehousing she had seen at other locations (Buck 1950). In Buck’s book, as in other confessional literature, the saving grace of the institution was in the vision of the individual and the personal care and homelike atmosphere that was afforded to patients. Achieving this vision, however, would require the cooperative attention and advocacy of other parents. Ultimately the attention that Buck brought to the institution, and her recognition that a homelike environment must be demanded by parents, pushed many more parents to begin to organize as they advocated for their children. Advocacy took the form of campaigns for new construction at institutions and the special education movement. Prior to this movement, mentally disabled students in public school were lumped in with “the physically disabled, and juvenile delinquents” (Trent 1994:239).

Changes to the American family and confessional literature led to the creation of family associations for support and services which helped to normalize developmental disability. These associations broadcast a singular message: “retarded children could be helped; people need not fear retarded children; with proper education and support, many retarded children could develop their potential; and, by implications, having a retarded child was nothing to be ashamed of” (Trent 1994:241).

Care providers had been projecting for generations that the developmentally disabled were educable and had been working to integrate them into society in productive ways. What made this era different, then, was the support of public institutions such as the National Mental Health Institute, the discovery of several biological rather than hereditary causes for developmental disability, and the confessional literature which had worked to normalize and destigmatize the conditions leading to developmental disability (Trent 1994:240).

Caring for developmentally disabled children was considered a strain on families. Casting the parents and families of the developmentally disabled as the victims of circumstance, medical professionals advised that families send their children away if possible (Trent 1994:241). Where parents did not send

their children to institutions, they did raise awareness and advocate for specialized education for them. From the late 1940s to the mid-1960s, special education enrollment increased 500 percent while school populations increased 70 percent (Trent 1994:242). Separate specialized education made sense at the time and was considered evidence that the state was taking developmental disability seriously and investing in the disabled. In short, developmentally disabled children required services designed specifically for the developmentally disabled (Trent 1994:243).

### *Post-War Federal Action in the Field of Developmental Disability*

Broad changes in the way that the country approached mental health and developmental disability are visible in the actions taken at the federal level by post-war presidents and Congress. Federal leadership in the field of mental health began soon after World War II. Responding to the advocacy of psychiatrists, Congress passed the National Mental Health Act in 1946, followed by the establishment of the National Institute of Mental Health (NIMH) in 1949. These measures reflected a sense of national optimism and a belief in progress that would carry through the 1950s and 1960s as the nation attempted to change its approaches to mental health (Erickson 2021). In the late 1940s and 1950s, a growing group of advocates worked with the NIMH to dramatically increase federal funding by 700% for the mental health programs during the Truman and Eisenhower administrations (Trent 1994:243). The Mental Health and Study Act of 1955 (P.L. 84-182) authorized the NIMH to study mental health and make recommendations to Congress.

Undergirding this new approach to mental health care were new avenues for funding the construction of hospitals. In 1946 Congress passed P.L. 79-725, the Hospital Survey and Construction Act. Known as the Hill-Burton Act, this legislation promised matching funds to states for the construction of hospitals, a move which helped to spur many states into action (Leiby 1967:363). The Hill-Burton act also marked the first time that federal construction programs brought together architects, administrators, public health leaders, and public relations experts as part of the planning and design process. Architects were tasked with defining a new institutional typology, of hospitals in this case, which incorporated an analysis of user behavior and its relationship to the form of the institutional building in question (Knoblauch 2020:9).

A major boost to the movement to create community centers for people with developmental disabilities took place on the federal level in the 1960s. President John F. Kennedy's Presidential Panel on Mental Retardation comprised educators, psychologists, members of the NIMH, and the American Association on Mental Deficiency (Trent 1994:244). The panel issued a report in 1962 recommending broad changes to the ways that states cared for the developmentally disabled. Foremost amongst their recommendations was to separate funding for developmental disability from mental illness as psychiatrists on the mental health lobby did not value funding disability research (Trent 1994:248). The panel also recommended that the states appoint interdepartmental boards to plan for the developmentally disabled as a means of bringing the perspective of parents as well as applicable state departments to bear on relevant issues.

Meanwhile, the Kennedy family founded the Joseph P. Kennedy Jr. Foundation (Kennedy Foundation) in honor of the family's deceased eldest son (Trent 1994:246). Part of the motivation for the foundation's focus on developmental disabilities was due to the family's history with disability. Rosemary Kennedy had suffered from an undiagnosed developmental disability and lived with severe disabilities, in part due to her father subjecting her to experimental surgery in an attempt to cure her condition (Trent 1994:247).

Congressional action on the Presidential Panel's recommendations provided funding for mental retardation research and care through the National Institute on Child Health and Human Development (NICHD). The NICHD was administered by the National Institute of Health, which represented an intentional move to separate research on developmental disability from the National Institute of *Mental* Health (emphasis added). NICHD researchers had been molded by their association with the Kennedy Foundation and that organization's focus on scientific research (Trent 1994:248). In the early 1960s, the federal government began advocating an approach to mental retardation that considered it a "health and human development problem," which could be solved through research and the application of the scientific method in a university research setting (Trent 1994:249).

One result of the report was the passage of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (P.L. 88-164), also known as the Community Mental Health Act (Knoblauch 2020:57). The law passed Congress with the backing of President Kennedy and authorized grants for states to establish mental health centers in communities with oversight by the National Institute of Mental Health. The focus on regional centers of care was a decided shift from the pattern of large, remote, residential institutions and the Community Mental Health Act represents one of the first federal moves toward deinstitutionalization (Knoblauch 2020:57). In the late 1960s, President Lyndon Johnson would continue Kennedy's campaign for improving care for the developmentally disabled as part of his "Great Society" vision for economic and social justice. Federal legislation expanding Social Security in 1965 created the Medicaid program, which would provide health insurance support for many of the low-income patients who found their way into state institutions.

The implications of this flurry of federal funding for research, education, and construction was the transformation of the field of developmental disability, the national attitude toward the condition of developmental disability, and the built environments that were constructed to care for people with intellectual disabilities.

#### *Post-War Changes to Institutional Architecture for the Developmentally Disabled*

With the founding of the NIMH and growing federal and state support for institutions for the developmentally disabled, physicians, social scientists, and architects came together to design better institutional buildings.

Social science researchers and architects alike hoped that collaboration between these fields would help to create buildings that would meet the various needs of patients with mental disabilities and mental health problems. Researchers sought to establish “a new federal typology” which could promote the prosperity of all Americans, with mental illness and developmental disability facilities effortlessly blending with other new architectural types for schools, libraries, and post offices (Knoblauch 2020:57–58).

The designs of these new institutions, however, were not uniform or even adhering to a uniform set of parameters. The desire to meet the psychological needs of patients through environmental design yielded a diversity of theories about the relationship between the two and therefore a diversity of designs (Knoblauch 2020:59). Designing “psychologically functional environments” necessarily varied with the differing knowledge and theories of the designers (Knoblauch 2020:59).

Architects began to design new facilities through intellectual collaborations with academic psychologists with progressive ideas about how to treat developmental disability, as well as practical psychologists (caregivers and superintendents) who had specific requirements as to the practical functionality of the spaces. Many researchers sought input from countries which had already reformed their institutions for the developmentally disabled, especially Scandinavian countries such as Denmark, Finland, and Sweden (Vanston 1967:148).

Spurred by the Presidential Panel’s 1962 report, American architects sought to design facilities that would meet the physical and social needs of patients, especially with regard to designing smaller facilities (no more than 500 beds) in regional, accessible locations for the convenience of families (Vanston 1967:148). In addition to these broad guidelines, architects were working from the assumption that the physical environment could enhance the program of care offered at these facilities. The buildings and designed spaces around them would themselves be “instruments of therapy” (Foxhall 1967:147). Robert Vanston, of the Department of Health, Education and Welfare, emphasized that designing facilities on the “human scale” was vitally important in order for buildings to embrace a care philosophy based on “personal dignity and a greater recognition of human values” (Vanston 1967:148). The ideals forwarded during a 1967 conference on the topic emphasized a model of care based on regional centers with small populations and homelike atmospheres.

In 1966, the United States Department of Health, Education and Welfare, Division of Hospitals and Medical Facilities issued design guidelines for buildings for the developmentally disabled. The guidelines were compiled based on input from social scientists, architects, and specialists in the care of developmentally disabled children, as well as superintendents of state institutions. The incorporation of psychological functionalism into design resulted in the articulation of a number of design principles. The central principles were related to the location, scale, and material choices which reduce the “institutional” sense of place. The authors suggested several core design concepts, including the importance of single-story buildings “for ease of access and interior circulation and to present a more intimate environment” (Vanston et al. 1966:5). Institutional complexes should utilize buildings

of modest size, and avoid “rigid uniformity” while utilizing form, material, and color to create “an informal atmosphere” (Vanston et al. 1996:5). Patios and landscaped areas were thought to enhance the sense of informality, as were recreational spaces. For residential care units in particular, “open and informal” character can help to create “the desired atmosphere of a normal home environment” as nearly as possible (Vanston et al. 1966:16). Despite these recommendations, the guidelines acknowledged that an “informal atmosphere of warmth and intimacy” may not be possible after the functional requirements to meet the special needs of patients are taken into account (Vanston et al. 1966:5). This caveat would foreshadow problems with the new design philosophy, and eventually unravel the movement to integrate psychological functionalism into architectural design.

Still optimistic about the power of architecture to help care for patients, the Architectural Institute hosted a conference in Colorado in 1967, attended by representatives from the American Association on Mental Deficiency, the American Institute of Architects, and the National Association for Retarded Children (Architectural Institute 1967). The conference represented the “first effort to bring together the two groups, programmers and architects, who have the major responsibility for effecting an improvement” in the design of care facilities for the developmentally disabled (Belinson 1967:2).

The varied architectural models that arose from collaborations between architects and physicians generally resulted in smaller institutions with a number of character-defining features (Trent 1994:251). Post World War II institutions for the developmentally disabled comprised multiple, small (accommodating 50 persons) residential buildings arranged informally across a landscaped campus. Residential buildings were typically single-story structures, with a large dayroom flanked by dormitory rooms, and a separate dining room (Trent 1994:251). The materials that predominated were tile, stainless steel, and other easily cleaned buildings materials. Some residential buildings also featured a game room or sitting room (Trent 1994:251). As the material type was dictated to architects by design specifications from caregivers, “softening” the feel of these buildings was often accomplished through color, especially in the case of tile. The landscape around the buildings was actively used in similar ways to the facility’s indoor spaces, with play and activity areas set amongst landscaped lawns.

In some ways, post-war architects were returning to the model of the 1880s, when reformers began to recognize the benefits of cottage-style dwellings, which were intended to mimic more intimate, domestic living situations. In the late nineteenth century, however, the thinking was that the institutions were custodial and should mirror a homelike experience as much as possible. In the mid-twentieth century, the return to the cottage was undertaken based on philosophical gestures to the “human scale” of this type of living situation, with the material texture and personal intimacy of the home taking a backseat to the primary needs of medical functionality.

As architectural styles shifted, so too did the size and composition of the populations at institutions for the developmentally disabled. While the populations of the institutions swelled in the 1940s and 1950s, more facilities were built in the 1960s in an attempt to relieve waitlists. The result, however, was just an ever-longer waitlist. In the period between 1946 and 1967, the nation’s institutionalized

mentally disabled population rose 65 percent, from 116,828 to 193,188 (Trent 1994:251). In just the period between 1964 and 1968, federal grants for new construction of facilities for the developmentally disabled topped \$67 million. While the numbers were rising, the composition of the institutions was also changing as more “small children and more severely disabled children and adults” became the primary class of residents over juvenile delinquents (Trent 1994:252).

## 4.0 THE NEW JERSEY STATE SYSTEM IN THE POST- WORLD WAR II ERA

After World War II, national shifts in the field of developmental disability had broad impacts on the New Jersey system. Meanwhile, state-level problems and innovations had the greatest impact on the ways state schools expanded, changed curriculum, and sought new ways to connect residents with their communities. During the late 1940s and early 1950s, state schools continued to be administered under the Division of Classification and Education, along with mental hospitals. Between 1952 and 1959, the state's program for the developmentally disabled was managed by the Bureau of Mental Deficiency, within the Division of Mental Health and Hospitals (Bureau) (NJ DIA 1966:92–93). In December of 1959, the NJ DIA was reorganized again, and the Bureau was superseded by the Division of Mental Retardation (Division) and reported directly to the commissioner of the department (NJ DIA 1961:54, 1966:93). Importantly, the 1959 reorganization permanently took the Division out from under the oversight of mental health care.

State schools for the developmentally disabled were already facing significant growth in their residential population by 1950. A statistical analysis found that the institutional population had increased by 75 percent between 1930 and 1949 (Frankel 1950). This figure continued to grow in the 1950s, and the population reached 5,702 in 1959 (NJ DIA 1963). The overcrowding and waitlists associated with these increases created demand for expansion of the system. This expansion faced state-specific financial challenges based on the bond-issue funding system, which stunted the state government's ability to be an effective leader in implementing federal guidelines for care and build the needed facilities (Leiby 1967:370). Despite the fact that each new project (or set of projects) required a public "bond issue" by which they would receive funding, several new facilities were approved and built in the 1960s.

The state's philosophy of care for the developmentally disabled changed as new researchers like Edgar Doll began to question the validity of psychometric models of grading the developmentally disabled. The NJ DIA saw a major internal reorganization, and new administrators identified problems with the existing "custodial care model" which had taken hold of the Bureau despite the education and training ideas that earlier generations had expressed. At the same time, the parent's movement in New Jersey focused on not only normalizing the institution, but rethinking how developmentally disabled people could take what they learn at institutions and become active members of their communities.

The opening of the Edward Johnstone Training and Research Center in 1955 represented one step to fulfilling the needs of both the department and the parent organizations. Designed as a campus for the teaching of practical skills and education of developmentally disabled youth, the Johnstone Center promised to prepare developmentally disabled residents for integration into their communities. The Bureau also took strides toward improving its residential programs for severely disabled patients, planning a general expansion of the Bureau's residential facilities in an attempt to catch up with the state's waitlists for these facilities.

### *Funding Changes Evolution of the NJDIA in the Post-war Era*

In the two decades following World War II, a common challenge for the field of developmental disability was the issue of funding. In New Jersey, some relief came in the form of the federal Hill-Burton Act, which provided assistance for funding of hospitals beginning in 1946. To gain funds, a state had to survey existing facilities and needs and meet standards of maintenance and operation based on licensing laws. In New Jersey, the NJDIA became the designated planning and licensing agency, not the Department of Health. The NJDIA undertook the necessary survey in 1947, and its Division of Medicine was empowered to issue licenses to private general hospitals (Leiby 1967:363). While the funding was not distributed exactly as planned, the Hill-Burton Act had pressured New Jersey into making a plan, setting state standards, and establishing a licensing authority, all of which may not have otherwise happened (Leiby 1967:364).

While these funds were helpful, federal programs explicitly focused on the research and care for the developmentally disabled would be delayed until the mid-1960s. Meanwhile, the state's system of funding new construction of institutions was based on a system of issuing bonds. In the case of New Jersey, however, the state had limited financial resources as state taxes were low, even as local and county taxes rendered the overall tax burden of individual citizens about equal with tax rates found in other states (Leiby 1967:297–298). If the state legislature authorized borrowing for construction, the general population would need to support a bond issue on the ballot. Because the approval of major state program was decentralized and lay with the will of the people, the waxing and waning of institutional construction programs closely reflects the popularity of these institutions amongst the people of the state.

Immediately after World War II, the state's schools for the developmentally disabled were operating at capacity. Overcrowding and waitlists had become a problem and shifting philosophies of care and parent groups were calling for new types of institutions and regionally available services, rather than centralized, remote institutions.

The NJDIA was experiencing similar ageing and insufficient physical plants in its other divisions and to fund the needed changes to the NJDIA system, millions of dollars for construction would be required. In 1948, the Department of Institutions and Agencies sought a \$50-million bond issue jointly with the Department of Education, but the campaign for the funding failed to get the needed votes. The following year, in 1949, the NJDIA separated its bond request from the Department of Education. A \$25-million State Welfare Building Bond Issue was approved by voters by a margin of two-to-one with the support of local committees in all 21 counties, as well as positive media coverage from newspapers and advocacy organizations throughout the state (Bates 1950:1–2). The bond issue passed easily, even as two other bond issues for public housing and a bonus for veterans failed (Leiby 1967:298–299). One of the key factors in the passage of the bond issue was the activism of parent groups that were interested in reforming the NJDIA and gaining additional services for their children.

### *Changes at the DIA*

Shortly after the passage of the State Welfare Building Bond Issue in 1950, important changes materialized in the NJDIA. Its appointed head in the early half of the decade, Commissioner Sanford Bates, was accustomed to working closely with members of the legislature to ensure their financial support for the various programs in the department. At the same time, a disharmony had emerged between the long-time employees who had been part of the work of the 1930s and newer employees who ascribed to new trends and approaches to care. A department employee who disapproved of Bates began working as an aid in the campaign of Robert Meyner, who was running for governor in 1954. Meyner was also interested in the work of the department and sided with his current aide. Once Meyner was elected governor in late 1954, Bates announced that he would retire. An acting commissioner was appointed, but he died unexpectedly after serving just four months. Then in 1955, John W. Tramburg was hired to serve as commissioner of the NJDIA. A former county school master, Tramburg entered the mental health field while working in Washington, DC, then was responsible for a reorganization of the Wisconsin Department of Public Welfare, which included child welfare programs, public assistance programs, mental hospitals, and state correctional institutions. He was working as federal commissioner of social security when he was tapped for the NJDIA post (Leiby 1967:369–376).

In 1953, the NJDIA began a reorganization which was aimed at aligning the department's structure with that of other state departments. The deputy commissioners were renamed directors, and the former divisions were renamed bureaus (Leiby 1967:378). Dr. Maurice Kott was chosen to serve as the chief of the Bureau of Mental Deficiency in 1954 with oversight of the state's institutions for the developmentally disabled. Kott saw contradictions between the state administrators, professional institution staff, and the employees on the floor of the institutions. He was particularly unhappy with some older staff who saw their job as being "good-hearted custodians" who simply kept the residents happy. Kott wanted all employees to view the residents as "people, not pets" (Leiby 1967:329). Kott would direct the Bureau, later renamed the Division of Mental Retardation, for the next 26 years. He was a fierce advocate for the intellectually disabled and was later remembered as a strong "proponent of running good institutions" (Magyar 1992). In his 1963 testimony before the New Jersey Assembly, when talking about overcrowding and the projected growth of the developmentally disabled population at state institutions, he again underscored that these were real people in need (New Jersey Assembly [NJA] 1964). Kott's perspective on the capabilities of the developmentally disabled resonated with the perspectives of parent advocacy groups.

### *Changing Philosophy of Care for the Developmentally Disabled*

New Jersey began to reevaluate the system of labels describing people with developmental disabilities in the 1940s. The prewar classification system, which had been refined by Goddard, included four classes at the lower end of a continuum of intelligence extending upwards to genius. The category of "idiot" represented people who were essentially helpless. "Imbeciles" were adults with a difficult temperament or who behaved as a child. The "feeble-minded" were people of limited mental capacity.

Goddard had added the fourth category, “moron,” to describe the uneducable and irresponsible (Leiby 1967:107). The connection of intellectual disabilities with “serious social consequences” such as unemployment, dependency, and delinquency continued into the 1940s. State schools, sometimes termed “special institutions,” were seen as a means of containing the negative effects of intellectual disability on the individuals, their siblings, their family, and their local school system (NJDIA 1943:57). This labeling system had been a convenient organizing principle for administration and classification into specialized schools but was less useful when designing programming for patients.

In 1949, the NJDIA opened the Diagnostic Center at Menlo Park. This center consciously chose *not* to use the earlier classification system. Its staff wanted to avoid the stigma attached to the system, which it identified as “descriptive” psychological terminology. In an effort to diagnose and treat the “dynamics of motivation,” the staff used interviews, projective tests, hypnoanalysis, and narcoanalysis to diagnose their patients (Leiby 1967:306). The center was run by psychiatrist Ralph Brancale and was largely focused on issuing advice to “courts and other public agencies” in an effort to solve the problems of “crime and delinquency” (Bates 1950:3). Staff at the Diagnostic Center sought to provide treatment based on a patient’s needs rather than being based on a “check list of the inmate’s deficiencies and assets” (Leiby 1967:307).

The limitations of psychometric categories and intelligence tests for the developmentally disabled were brought to light by scientists like Edgar Doll, who served as the chief psychologist at the NJDIA before becoming the director of research at the Vineland Training School from 1925 to 1949. Doll realized that “social incompetence was the practical test and that ‘intelligence’ had a social as well as biological matrix” (Leiby 1967:322). The varied labels applied to people with developmental disabilities made it difficult to understand the needs of the patient and often conflated different types of disability. The late nineteenth- and early twentieth-century search for a single cause of intellectual disability had been fruitless, and “it became clear that some people inherited poor mental capacity, but others suffered from accidents of gestation or birth” and mental deficiency itself was a symptom of other conditions, rather than a disease unto itself (Leiby 1967:322).

One effect of the vague diagnoses for people with developmental disabilities was that the services they needed were distributed among a number of agencies which often ignored their responsibility and instead focused on the needs of “normal people” (Leiby 1967:323).

The Division of Mental Retardation adopted a new philosophy in the post-war era which mirrored national optimism about the potential of developmentally disabled people. As described above, Director Kott felt in the Division’s programs and facilities should not be custodial but should embrace the potential of the developmentally disabled to learn, enjoy community, and live full lives. In the late 1960s the Division adopted the slogan “Today’s Hope for Tomorrow,” to describe this approach (NJDIA 1968a). The care philosophy in the division became one of specificity, with the programs offered at its facilities “based on the philosophy and conviction that services must be geared to recognize and realize the potential of every resident” (NJDIA 1968a:58–59).

As noted above, parent advocacy groups were the driving force behind the reform of both the flawed classification system and the disjointed network of services available to the developmentally disabled. Parents educated themselves about the needs of residents and began to influence the department's planning. Whereas under Ellis, each institution devoted itself to a different category of developmental disability, parents successfully lobbied for the creation of a broader range of services in each institution. The change resulted in some institutions becoming local in character, easing the ability of families to visit residents and contributing to improved living conditions. Parental involvement was critical to a shift in emphasis from the warehousing of residents with the bare minimum of care to a program of rehabilitation where possible to return residents to their communities. Innovative staff began to work with residents to train them to take more responsibility for their own care, an approach that promoted a sense of dignity in residents (Leiby 1967:322–330)

#### *Parents' Movement in the 1950s and 1960s in New Jersey and Community Placements*

Parental advocacy emerged soon after World War II, and interested parents accomplished major goals in the 1950s and 1960s. As noted above, Pearl Buck's experience with her daughter at Vineland Training School helped to normalize institutions in the post-war years. At the same time, with the economy rebounding and unemployment disappearing, some developmentally disabled people sought to apply for jobs that fit their skill levels and training. To the surprise of the parents, employment agencies were usually unprepared to work with them to find jobs, and the staff in these agencies were sometimes uninterested or even hostile. As a result, parents organized themselves and began to lobby for better care, services, and job placement.

At the request of parent advocates, the NJDIA created the State Commission to Study the Problems and Needs of Mentally Deficient Persons (Commission) in 1950. The Commission included two members of the state legislature, a social worker, a psychologist, and a journalist. Following a three-year study of multiple aspects of the developmentally disabled community, the Commission released its report in 1954. The report reviewed the available community services and education resources for people with developmental disabilities and restated the right of children with disabilities to receive a free and appropriate public education. The report also documented the fact that the state schools were severely understaffed, and that no specific individual in the NJDIA "had the responsibility to oversee services for the mentally deficient or to stimulate new programs" (Leiby 1967:325–327).

As a result of the commission's work, the "Beadleston Laws" were passed in 1954, which revised legislation on the education of physically and mentally disabled children (Leiby 1967:327). These laws set out new responsibilities for school boards to educate both "educable" and "trainable" children; the former term referring to children who could live more or less independent lives but would benefit from special education and the latter referring to disabled children who could benefit from self-help training in a classroom (Leiby 1967:328). The "nontrainable" children were to be cared for by state schools.

Following the report and the Beadleston Laws, the state began to make dramatic changes to the way it administered education and care for the developmentally disabled. Special education classes offered throughout the state's school system were expanded almost two-fold (from 280 to 565 between 1954 and 1956). This expansion had the indirect effect of necessitating expansion in college courses, training, and recruitment to fill teaching positions (Leiby 1967:328).

“Community care” came under scrutiny as a result of the commission's study. After the report, the Bureau also reorganized its “field services” branch which managed the care of the developmentally disabled before and after entering institutions. Three regional centers were established to manage the department's efforts to facilitate home teaching, consultation, and public information distribution (Leiby 1967:329).

Moving people with less-severe developmental disabilities into community programs changed the education and training goals of the residential institutions. The reduced number of educable residents in the state system reduced the need for academic or pre-vocational teaching at state institutions. Additionally, as the educable moved out of the facilities, they were replaced with younger patients facing more severe limitations (NJ DIA 1958:12–13). The Woodbine approach to care—which focused on activities, recreation, and personal training for self-help and self-care—spread throughout the system. This model required additional trained specialists (with higher salaries than many other staff) but conformed more closely with the needs of the residents. Because individual institutions had more job openings than applicants, they instituted their own training programs (NJ DIA 1961:55–58). Those educable residents with developmental disabilities who remained in the residential system had the option of entering the Edward R. Johnston Training and Research Center beginning in 1955.

#### *Edward R. Johnstone Training and Research Center*

In 1955, the NJ DIA opened its first new institution for the developmentally disabled in three decades. That year, Governor Meyner ordered the closure of the New Jersey Manual Training and Industrial School, a historically Black residential high school in Bordentown. The Bureau's new director, Maurice Kott, proposed to convert the buildings into a residential institution to treat developmentally disabled “persons so as to permit their return to the community in a constructive capacity” (Parnicky et al. 1967:9). The renovation was projected to cost \$1.5 million (Male 1955). The new institution was named the Edward R. Johnstone Training and Research Center to recognize the early New Jersey leader in the field of developmental disability. One goal of the facility from the beginning was to “conduct research in the field of mental deficiency” (Parnicky et al. 1967:9). In addition, however, the Johnston Center offered training for a range of people with behavioral problems, physical disabilities, and multiple disabilities. With staff that included cottage workers, teachers, psychologists, and social workers, the Johnston Center could accommodate a broad range of needs, with the ultimate goal of rehabilitating its residents for return to their local communities where their families could assist in their lives.



Figure 9: Circa-1930–1950s photograph of the grounds of the Manual Training and Industrial School for Colored Youth, which would become the Edward R. Johnstone Research and Training Center in 1955 (Source: Department of Education Records, New Jersey State Archives, Trenton, NJ).

The Johnstone Center took over the buildings of the former industrial boarding school (Figure 9). The earlier institution had opened in 1897, and the buildings reflected the needs of an educational facility rather than the needs of the developmentally disabled. Many needs of the two types of institutions overlapped. The campus was designed around an open quad, with the administration building at the head and additional buildings arranged to create an open courtyard effect. The buildings were designed in the Neoclassical style. The interiors of the dormitories had been intended for students spending a limited amount of time there, with center halls double loaded with dorm rooms. The rooms were designed to promote privacy of the residents, although they were well-lit rooms with large windows.

When Johnstone was converted into a co-educational facility for the developmentally disabled, the NJDIA undertook extensive renovations between 1956 and 1958 in order to create a sense of “campus life much like that of a college or boarding school” (NJDIA 1967a:37). The suitability of the converted facility for the developmentally disabled community was questionable. The students lived in double occupancy dormitory rooms which were meant as temporary, as they were intended to return to the community or another institution. In practice, however, the students generally did not return home for breaks or during the summer and the dorm rooms created a degree of isolation that the residents

had not been accustomed to. Long hallways with closed doors were foreboding, and creating a sense of community among the residents was difficult (Vanston 1967:148–149).

### *A New Vision for Developmental Disability in New Jersey*

While the Johnstone Center represented the Bureau of Mental Retardation's optimism about the education and assimilation of people with some developmental disabilities, the state was also working to establish progressive programs for people who would need residential care, perhaps for a lifetime (NJ DIA 1967a:v). Overcrowding at existing institutions, the destigmatization of the residential institutions, and renewed interest in state-supported developmental research and care led to a new approach to managing developmental disability in New Jersey.

In 1958, the NJ DIA developed its proposal for a new 1000-bed facility for patients with severe developmental disabilities to help alleviate overcrowding (NJ DIA 1958:13). The department proposed to redevelop a portion of the Rahway State Prison (today the East Jersey State Prison) in the Avenel section of Woodbridge Township, Middlesex County (Central New Jersey Home News, 28 January 1959:4). The selection of the site marked a distinct change in policy. Earlier facilities had mostly been located in remote, secluded areas that made it difficult for families to visit and isolated the institutions from nearby communities (Vanston 1967:148). Administrators speculated that the great distances that separated parents from their children at institutions in southern New Jersey had resulted in parents losing interest in their children (Oates 1964). The 63-acre site proposed for the institution would be accessible to the families of residents off U.S. Route 1, in a densely populated section of the state. In 1961, voters approved a bond issue (1961 Bond Issue), which committed \$13.7 million to the design and construction of the Woodbridge State School (Soda 1964:1).

The new facility promised to eliminate, if temporarily, waitlists for residential placements for the developmentally disabled. As the state's first co-ed state school, Woodbridge would alleviate overcrowding at Woodbine and Vineland state schools, which were 236 and 478 residents over capacity, respectively (Oates 1964). The waitlists continued to grow despite the department's aggressive discharge policy; between 1957 and 1960, 600 developmentally disabled patients were discharged into their communities (NJ DIA 1961:54). As a result, the percent of severely disabled patients was steadily growing. With more severely disabled patients, staff needs increased, and cottage training programs shifted toward self-care and self-help, rather than pre-vocational training and academic skills programs (NJ DIA 1961:55). Woodbridge State School was designed specifically for the severely and profoundly developmentally disabled and was envisioned as a long-term home for its residents.

As discussed above, the Kennedy administration in the 1960s provided a boost for the coalition of parents, politicians, and caregivers who sought to reform institutions for the developmentally disabled. The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (P.L. 88-164) became a major source of funding. Additional funding was made available through the 1963 Maternal and Child Health Centers Construction Act (P.L. 88-156), also known as the Mills-

Ribicoff Act. That legislation authorized money from social security for the “development of comprehensive state plans to combat mental retardation” (Vanston et al. 1966:i). The act also allocated federal funds for states to write these plans. The authors of both bills encouraged the opening of local centers to enable patients to work and live at home but still receive treatment (NJDIA 1966:9).

With these new funding sources available, in 1963 New Jersey Governor Richard Hughes appointed a Working Party on Mental Retardation (Working Party) to produce a statewide comprehensive plan for the developmentally disabled. The Working Party developed a list of services the residents needed and investigated what services were available at each institution. Advocates attended multiple meetings to add their perspective to the research; some meetings were held during the State Conference on Mental Retardation Planning.

With a clear sense of the needs of the developmentally disabled population, and the potential for construction matching funds from the federal government, New Jersey proposed a new bond issue (1964 Bond Issue). In September 1964, the New Jersey Assembly held a public hearing on the new proposed institutional bond issue which would include \$18.4 million for the construction of a center in Hunterdon County and \$4.6 million for community day care centers, and \$4 million for a new training center for children (NJA 1964; Press State House Bureau 1964). At the hearings, Maurice Kott appealed to the Assembly to pass the bond issue, as without it the state could neither take advantage of federal funding nor alleviate the 1,400-person waitlist for residential state schools (NJA 1964:36–37). Even with the approval, he warned, the waitlist would not be completely eliminated, and he suggested that one solution might be to build day care centers in each county. These centers could accommodate children who are rejected by school boards and prevent them from going on to become “institutional cases” (NJA 1964:43–44). Kott hoped that community programs such as day care centers could result in “better families, better children, and delaying institutionalization” (NJA 1964:44). Kott also proposed small group residential centers in urban communities or day programs for adults. Voters approved the institutional bond issue in November 1964 (Asbury Park Press, 4 November 1964:5).

The mid-1960s was a time of great experimentation and optimism in the field of care for the developmentally disabled. On the federal level, funding was available for the construction of new facilities where innovative ideas were undertaken. Federal funding had the overall impact of reducing the importance of institutions. Whereas earlier, each institution conducted its own research and studies with the residents, beginning in the 1960s, federal research grants were handed to universities who used the residential institutions only as a source of data. As a result, people with research interests shifted away from positions at the residential institutions. Another impact of federal funding was related to its restrictions. Federal funds were available for the construction of buildings, but no federal funds were available for staffing or maintenance. This change again had the impact of lessening the value of the older, existing residential institutions as they could not attract federal funding (Trent 1994:249–254).

After a group of parents from NJARC began to recommend that separate residential institutions serve general areas in New Jersey, the NJDIA appointed the Committee to Study the Future Type and Function of Public Institutions for the Mentally Retarded (NJDIA 1967a:iv, 1967b:22). The committee reviewed the existing “specialized approach” in which residents with similar circumstances lived together regardless of where their families lived in the state. The committee considered the assumption that with the opening of the Woodbridge State School and the impending opening of Hunterdon State School, sufficient beds would be available until 1980. An advantage of the specialized approach at the time was that professionals with specific training worked at a single institution. The committee pointed out that because only one institution at that point served residents of both sexes (Woodbridge), professionals with specific training actually worked at two different institutions. Eliminating the segregation of sexes could ease the travel of staff. Advocates of a “regional approach” focused on community care believed that residents needed the support of family members, which was facilitated by proximity. Achieving normalcy for a given resident included the ability to experience familiar surroundings in the community. The committee finally recommended that a hybrid approach should be pursued. Most residents should live near their families. In cases where specific types of staff were needed, those residents would need to live in the institution where the appropriate staff worked. With this change, New Jersey moved towards the idea of community care in both residential facilities and community clinics (NJDIA 1967a).

The results of the Governor’s Working Party were published in 1966 as the State Comprehensive Plan to Combat Mental Retardation and reinforced support for a hybridized, regional approach. This plan provided guidance on “medical, clinical, and social services, coordination, education, vocational rehabilitation, religious nurture, recreation, residential care, manpower, law, research, and public information” (NJARC 1969; NJDIA 1966). The plan articulated Director Kott’s care philosophy, which he had been implementing since the early 1950s, as therapeutic rather than custodial (NJDIA 1966:72). Where residential facilities were absolutely necessary, they would be small, located in communities, and provide care that was “therapeutic in character and emphasis, and closely linked with appropriate medical, educational, and welfare programs in the community” (NJDIA 1966:72). This plan focused specifically on creating more regional resources, including residential facilities, in order to enhance the community-based ideal of caring for the disabled. In 1968, Governor Hughes appointed a planning board to advise on the implementation of the state plan, including members of NJARC (NJARC 1969:26).

## 5.0 NEW INSTITUTIONAL ARCHITECTURE IN NEW JERSEY

As a result of the bond issues of 1961 and 1964, New Jersey was able to construct a number of new facilities and add to existing facilities for the developmentally disabled. This period of construction expansion was aimed at alleviating the state's ballooning waitlists, but the architects who brought their expertise to these projects were influenced by the critiques of traditional institutional designs and the newly burgeoning subfield of environmental psychology. These architects hoped to use the theory of psychological functionalism to design places which were unburdened by the trauma and alienation associated with institutions by focusing on the "human scale" and needs of both residents and staff in their designs. Two New Jersey residential institutions for the developmentally disabled, Woodbridge State School and Hunterdon State School, were built with these ideas in mind. A third, Somerset State School, was designed but never built. By the early 1970s, psychological functionalism had run up against the obstacles of financial austerity, increasing demands for medical and sanitary functionality, and waning optimism about the ability of architects to actively influence cases. New construction was also added to Vineland State School and the State Colony at New Lisbon to expand their capacities and improve their physical plants.

As noted above, a number of aesthetic and functional design features were incorporated into institutional buildings during the 1946–1974 period. One common element of design was an emphasis on plainness, which was thought to contribute to the predictability and comfort of a space, creating a setting in which the residents could thrive. Interior spaces were designed to be open and clear, eliminating freestanding building-systems appliances such as radiators, which were now embedded in wall recesses. Horizontal, low-rise designs were thought to allow "human-centered functions [to] communicate their purpose to the audience," so that the space could accommodate both the person and the science. The attempt to create a sense of normalcy for the residents included recognizing their humanity through a home-like physical environment. Some institutions returned to the former cottage approach, with small buildings housing a group of people with similar life circumstances (Knoblauch 2020:35–40). Each new institutional design incorporated some of these elements and explored different ways to reduce the institutional "feel" of the facility.

### *Woodbridge State School*

The Woodbridge State School opened in 1965 in the Avenel section of Woodbridge, New Jersey. This new facility was the NJDIA's first opportunity in decades to build a campus for the developmentally disabled that met mid-century theories of intellectual disability and approaches to education. Woodbridge State School was to serve as a residential facility for both ambulatory and non-ambulatory patients with limited capacity for education or training (the "severely" and "profoundly" disabled). Constructed on state-owned property originally used for limited farming activities associated with the Rahway State Prison to the north, the 65-acre Woodbridge campus would incorporate a range of innovative designs that embraced architecture specifically designed for the developmentally disabled (Vanston 1967).

The architects for the Woodbridge State School, Vincent Kling and the firm Diehl and Stein, brought a distinctly modern approach to the design of the school. Kling, a prominent member of the “Philadelphia School” of modern architecture, engaged with design theories that emphasized the human scale of design. The design of Woodbridge State School campus embodied this “human scale” through its reliance on low-profile and single-story buildings and the close-knit environment evoked by the neighborhood-like arrangement of the buildings along curvilinear paths and roads with trees screening the campus’s perimeter (Busselle 1965; Figure 10).

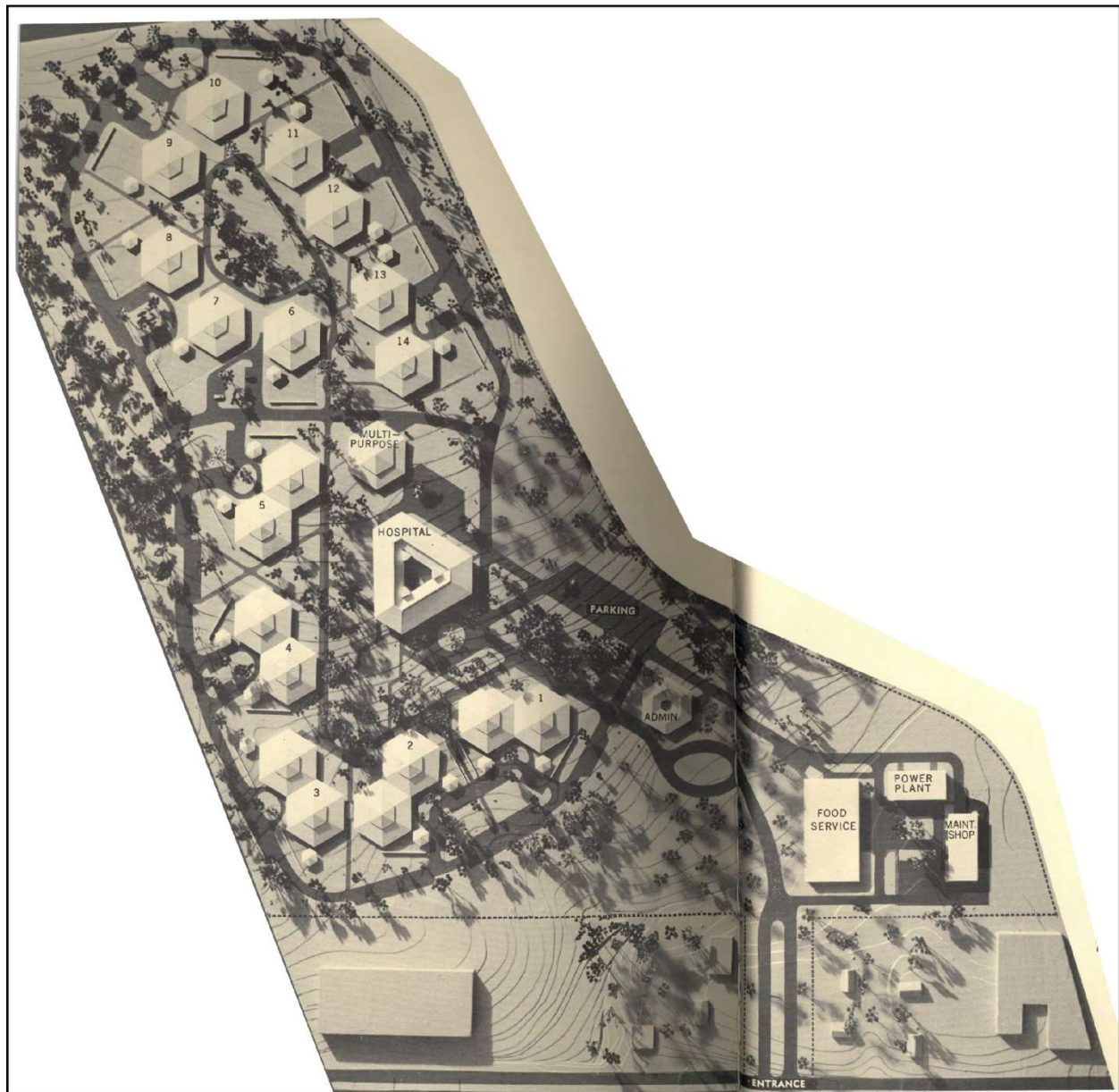


Figure 10: 1965 plan view of Woodbridge State School  
(Source: Woodbridge State School Pamphlet, NJDIA 1965).

Some other elements of design at Woodbridge were also experimental, such as the use of some flexible, multi-purpose spaces to contribute to the training of residents. The architects visited several existing campuses to examine their layout and circulation systems in preparation for the Woodbridge design. The plan for the overall campus involved placing the hospital, administration building, and multi-purpose building near the center of the campus, with the ambulatory cottages to the west and the non-ambulatory cottages to the east.

One innovation Kling, Diehl, and Stein employed was a hexagonal design motif that dominated the complex and served as a unifying element for the campus. Triangular and hexagonal forms were used in institutional design in the 1960s and 1970s by architectural masters such as Richard Neutra, as architects began to embrace asymmetry and create “flexible environments and more complex flows of space” (Knoblauch 2020:82). The triangle and hexagon gave new buildings a distinct identity and the potential to “distract from the impression of alienation or even manipulation that plagued long hospital wards” (Knoblauch 2020:82). The hexagonal shape was utilized at Woodbridge in order to facilitate ease of construction and everyday use (Figures 11–14). The design provided a highly efficient building plan for the cottages, which created an arrangement of six triangular segments radiating from the compact, central core (*Architectural Record* 1967; Busselle 1965).

As built, the Woodbridge State School campus included 29 buildings, integrated into the site’s rolling terrain. The 19 hexagonal cottages were organized into 2 loose clusters, with the 10 non-ambulatory on the east side of the complex and the 9 ambulatory cottages on the west side. The 100-bed hospital, a two-story triangular building with an open central atrium, was immediately adjacent to the non-ambulatory cottages to facilitate the easy transport of patients. A multi-purpose activity building—designed to serve as a chapel, school, and recreation center—was sited between the hospital and the cluster of ambulatory cottages. Additional buildings near the northeast entrance to the campus included the facility’s administration, food service, power plant, and maintenance shop buildings. Largely a self-contained facility, Woodbridge depended on the labor of inmates at the Rahway State Prison to help with laundry and custodial services (NJDIA 1966:23).

Each cottage accommodated 50 residents, and the six triangular segments were arranged radially around a central, shared bathroom facility (see Figures 11–14). The six segments were designed for use as: a classroom and administration area, dormitories, dayrooms, dining spaces, and service rooms for staff. A bathroom was placed at the center of each cottage for ease of access from each dormitory and the dayroom/dining room. A dedicated space for surveillance was not designed into the living arrangements, rather, the interior hallways of the cottages were short, and could allow staff to quickly move between dormitories and day rooms if needed. This design element provided a less intrusive and less visible means of surveillance.

The non-ambulatory cottages were conjoined in pairs, their service segments linked together to concentrate staff (NJDIA 1965). Each cottage was also furnished with a “quiet room” should patients need to be temporarily isolated (NJARC 1968:22). The exhaust fans and ductwork were elevated in a



Figure 11: 1965 general view of Woodbridge State School (Source: Vanston 1967).

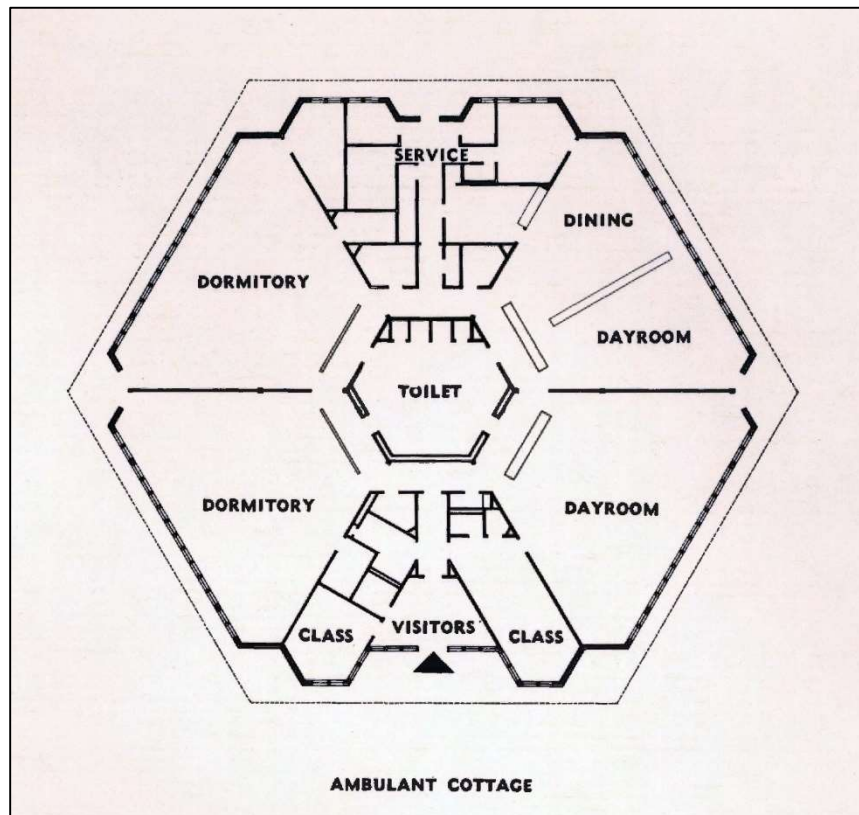


Figure 12: 1965 cottage layout for ambulant cottages at Woodbridge State School (Source: Woodbridge State School Pamphlet, NJDIA 1965).

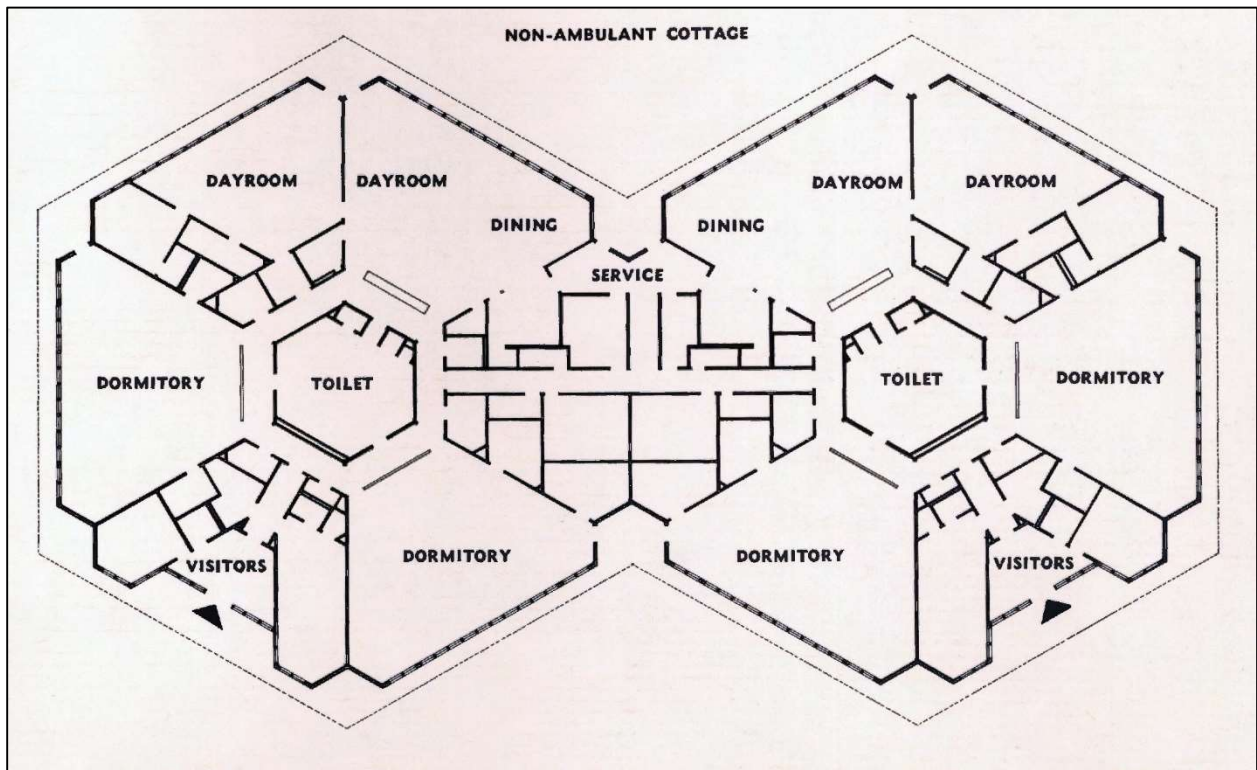


Figure 13: 1965 cottage layout for non-ambulant cottages at Woodbridge State School (Source: Woodbridge State School Pamphlet, NJDIA 1965).

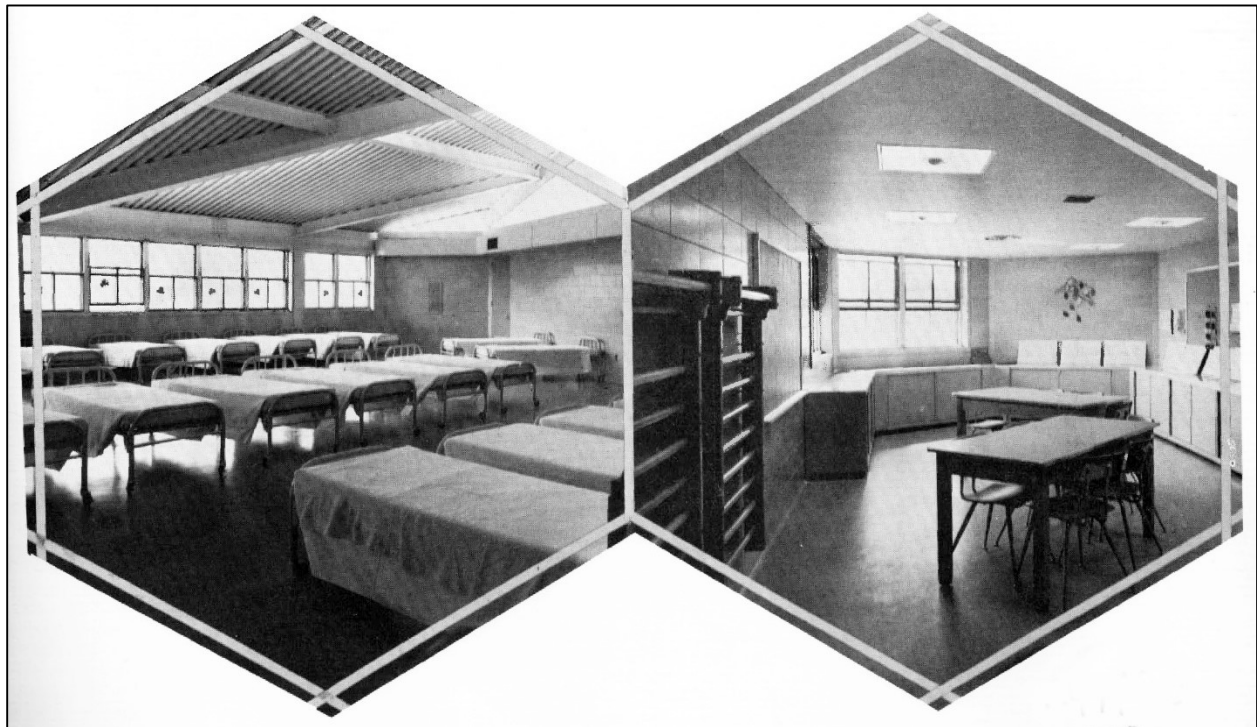


Figure 14: 1965 interior photos of Woodbridge State School cottage dormitory room (left) and a classroom (right) (Source: Woodbridge State School Pamphlet, NJDIA 1965).

small housing over the center of the main roof, which gave each cottage a unique pagoda-like appearance that softened the overall institutional appearance (Soda 1964). Stairs were excluded from the design so as not to hinder patients, and no rooms were entirely closed off so that staff views were not obscured (Oates 1964).

Adjacent to each cottage was an outdoor recreation area with hexagonal-shaped sun sheds. The sun sheds were supported by a single, central column with benches attached at the base. Each cottage's outdoor recreation area was semi-private at the "back" of the cottage, away from the internal network of walkways, but near visitor parking.

Except for the hospital, which was of concrete construction, all buildings were steel framed with brick cavity walls and capped with pitched, asphalt-shingled roofs with distinct copper trim at the eaves (*Architectural Record* 1967:150). The interiors of the buildings were outfitted with low-maintenance materials, including terrazzo floors, glazed structural tile walls, and exposed metal deck ceilings (Busselle 1965). Fireproof steel and concrete construction enhanced the safety of the buildings while tinted glass helped to eliminate sun glare for the occupants (NJDIA 1965).

The NJDIA held up Woodbridge State School as the future of residential facilities in the state. A 1969 promotional pamphlet, produced by the Woodbridge State School Parent's Association, hailed the school as the "new face" of the division and the embodiment of "Today's Hope for Tomorrow" (Woodbridge State School 1969). The language of the promotional pamphlet underscores the parents' hopes that Woodbridge would be more than a care facility for their children. The pamphlet described Woodbridge State School as "a community, a society, a small town, a place where people live" (Woodbridge State School 1969:7). With a new care philosophy and new architectural approach to residential facilities, Woodbridge had the potential to perfectly blend the ideal community living with specialized education and health care.

While the design was hailed as an innovative contribution to the field of institutional architecture, its design came under scrutiny almost immediately from the programmers at the school (*Architectural Record* 1967; Busselle 1965; Vanston 1967). The first superintendent of Woodbridge State School, David Rosen, participated in a 1967 architectural conference on the collaborative designs of institutions for the intellectually disabled (Rosen 1967). Rosen pointed out that a number of design features that were intended to reduce the institutional feel of the facility, and which might even be characterized as "luxurious," did not meet the needs of the staff in administering care, treatment, and training to the school's residents. Terrazzo floors, for example, created dangerous slipping hazards. Design features such as tile walls, radiant heating, drains, and stainless-steel tables caused Rosen to lament that "in stressing simplified maintenance and sanitation, warmth and safety have been sacrificed" (Rosen 1967:4-6).

Woodbridge's saving grace was that although the segments of each cottage were designed for specific activities, the interior spaces could be reorganized. This flexibility allowed for staff to change the buildings to meet the needs of the residents and staff. In the non-ambulatory cottages, for example, some beds were moved into the sector originally intended as a recreation area, and the middle of the bedrooms became recreation areas instead. Other sectors were reconfigured for physiotherapy and occupational therapy activities. Even with the spatial flexibility of the buildings, the staff hit the design's limitations almost immediately. Six months after the campus opened, the office space was in maximum use. The cottages had been designed without basement space or extra offices, which Rosen regarded as an unfortunate oversight as growth was inevitable.

### *Vineland State School and State Colony at New Lisbon*

Despite some of the design flaws with the Woodbridge cottages, the human-scale cottage design was seen as beneficial to the functioning of the school. The NJDIA needed to make improvements at several of its institutions for the developmentally disabled in the 1960s and early 1970s, and the human-scale, cottage approach was incorporated into several of these designs at Hunterdon State School, the expansion of the Vineland State School, and renovations at the State Colony at New Lisbon. Immediately after the construction of Woodbridge, the Hunterdon State School became the focus of attention.

Where new construction replaced existing buildings, for example, as in the case of the State Colony at New Lisbon, the new cottages were intermingled with the existing landscape (Figures 15 and 16). In 1965, 12 new cottages were built to replace outdated facilities. Each cottage accommodated 52 beds and contained recreational and training areas. A multipurpose building built at the same time served as a gymnasium and provided space for religious worship, assembly, and large group therapy (NJDIA 1966:96). Cottages were later added at the Vineland State School as well (Figure 17). While the improvements at these facilities employed the "cottage design," and were typically single-story buildings, the architectural features of the new buildings did not bear noting in architectural journals and newspapers.

### *Hunterdon State School*

Planning for the Hunterdon State School, in Clinton, Somerset County, began in 1962. That year, with the Woodbridge State School still under construction, the NJDIA's Annual Report called for a second 1,000-bed facility to address the overcrowding and waitlist problems at the state's residential facilities for the developmentally disabled. The \$18 million "new colony for the mentally retarded," the report estimated, would provide enough capacity until 1971, when a third new residential facility would be required (NJDIA 1963:15). The facility was to be built on state property in Clinton as a care, treatment, and training facility for 834 residents of both sexes (Figure 18). Like Woodbridge, it was envisioned that Hunterdon would provide cottages for both ambulatory and non-ambulatory residents. Hunterdon State School was designed to accommodate a broad range of needs for moderate to severely mentally disabled residents

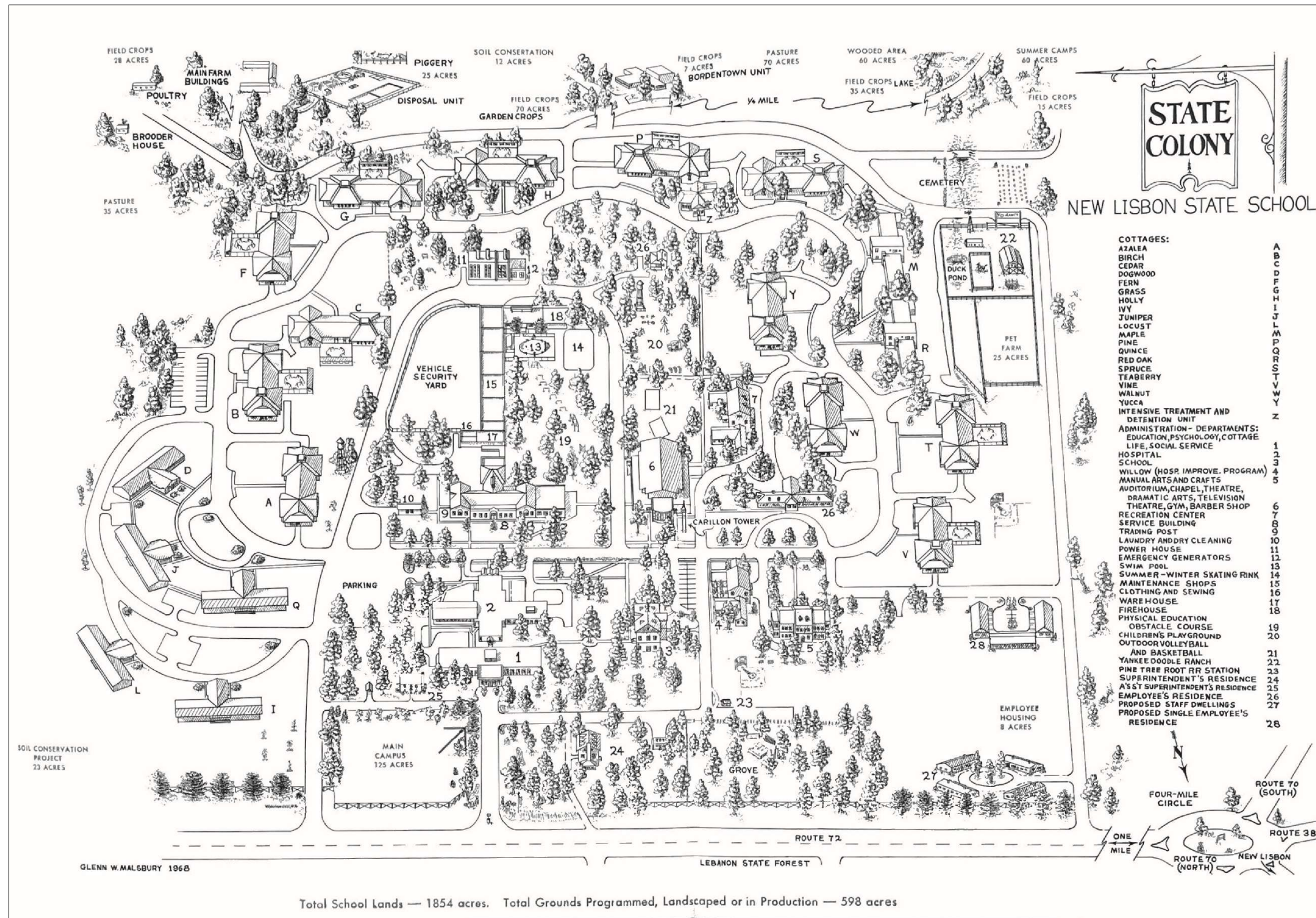


Figure 15: 1968 plans of the New Lisbon Colony, showing the planned addition of twelve new cottages, including cottages A, B, C, F, G, H, P, T, U, V, W, and Y (Source: Box 1, Department of Institutions and Agencies Collection, New Jersey State Archives, Trenton, NJ).

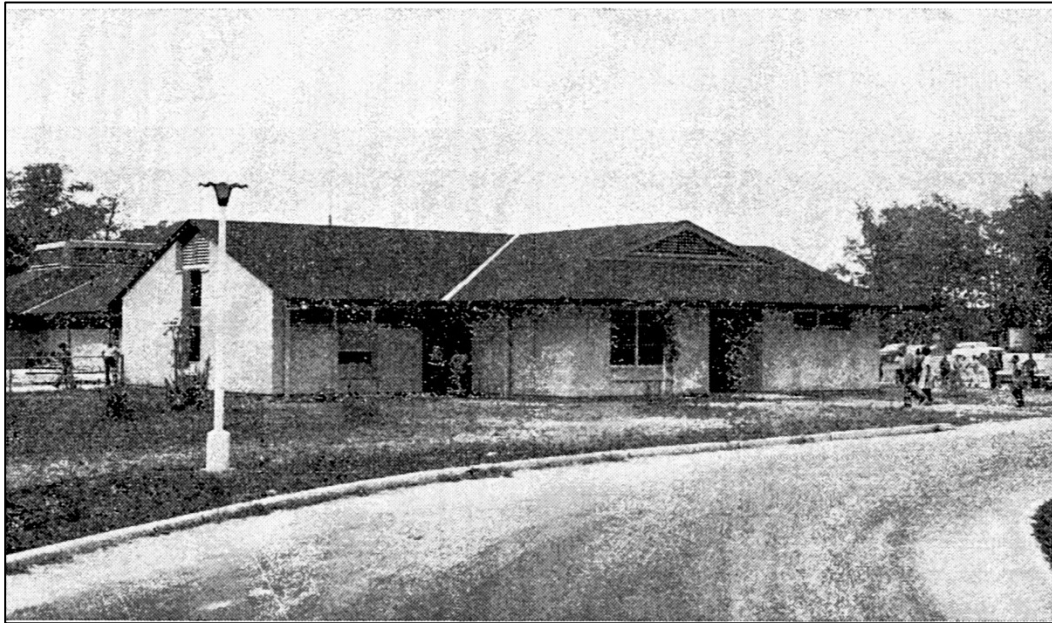


Figure 16: New cottage at New Lisbon Colony (NJDIA 1967d).

and “dual diagnosis” patients who were both emotionally disturbed and developmentally disabled. Hunterdon was designed to have a 50-bed cottage for the “emotionally disturbed” and 14 cottages for its more typical developmentally disabled residents. An innovative element of the proposed programming was a “going to school” program that would prepare appropriate residents for returning to their local school for education (NJDIA 1968a:65–66). While Hunterdon State School came to fill a vital need for the state’s developmentally disabled community, it did not receive the same level of attention and fanfare as the opening of Woodbridge State School.

The Hunterdon State School was “designed to resemble the Woodbridge State School for the Retarded” and the project was to be financed by the 1964 bond issue for institutional construction, as discussed above (Courier-News, 4 March 1967:13). Like Woodbridge State School, the new institution would rely partially on labor provided by a state correctional facility to reduce operation costs. Clinton Reformatory, a women’s correctional facility immediately adjacent to the site of Hunterdon State School, would be responsible for food preparation and some meal service (Courier-News, 4 March 1967:13).

The architectural firm Kramer, Hirsch & Carchidi of Trenton was hired to design the new facility (Gill 1968). John M. Hirsch and Harold J. Kramer had established an architectural firm in 1950, which in 1953 became Kramer Hirsch & Carchidi with the addition of Joseph G. Carchidi (McMahon 2022:8-4). The firm was prominent in Trenton during the post-World War II era of urban renewal. During this period, the firm completed a wide range of projects, including many of the city’s premier educational, institutional, commercial, and residential buildings. Some of the buildings the firm designed in Trenton included the Fuld Hospital, the New Jersey Department of Education

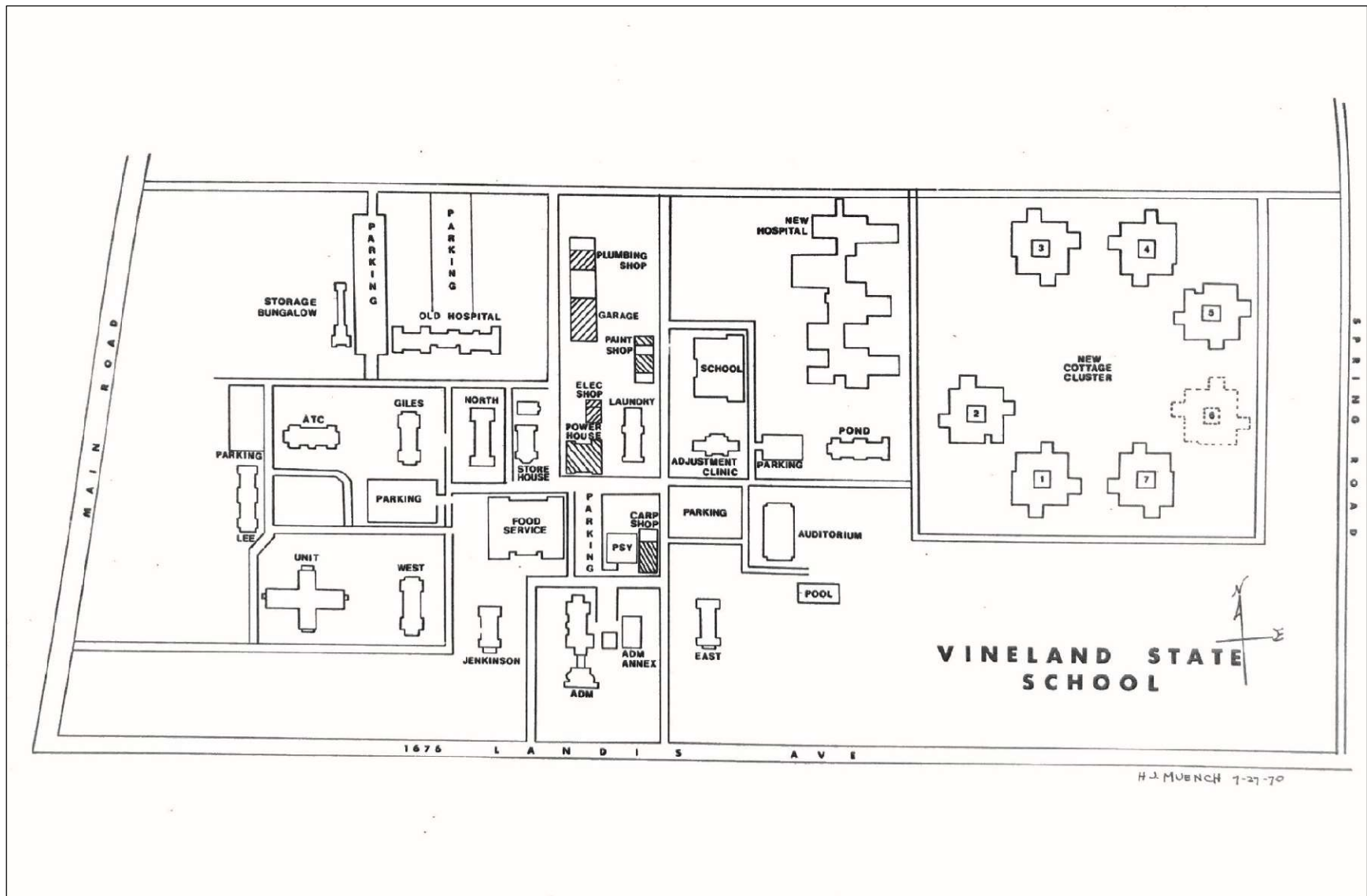


Figure 17: 1970 plan of Vineland State School, showing the planned addition of new cottages (Source: NJDIA 1970).



Figure 18: 1970 aerial photograph of Hunterdon State School  
(Source: *Trenton Times*, photographer Warren Kruse).

Buildings, the New Jersey Division of Taxation Building, and public housing complexes for the Trenton Housing Authority, such as the Miller Homes and the Kingsbury Corporation Towers (McMahon 2022:8-5). Many of the firm's designs were "high-quality modernist buildings" including some in the International style (McMahon 2022:8-5).

The site chosen for Hunterdon State School was on farmland formerly used by the Clinton Women's Reformatory. The rural character of Hunterdon County and new trends in suburban development likely influenced the design of the Hunterdon facility. In the late 1960s, Hunterdon County was seeing a surge in population growth brought on by an improved state highway system and an increase in suburban development. The county's "native" population expressed anxiety about the "creeping urbanization, haphazard planning, and erosion of what once seemed an endless expanse of open space" that the new arrivals seemed to bring with them (Gill 1969:45).

Anxiety over the dwindling rural landscape may have inspired the Hunterdon State School’s architects to adopt a design which preserved as much open space as possible. The most efficient way of achieving this objective, while maintaining the “human scale” of the buildings in the complex, was a clustered development. Clustered developments featured circular or semicircular neighborhoods with short frontages and expansive backyards, backing up to “common land” which remained open (Figure 19; Planning Advisory Service [PAS] 1960). In the 1960s, clustered residential subdivisions were heralded as a “breakthrough in suburban development” which could at once preserve the rural landscape while also creating a sense of community and togetherness (PAS 1960:1–2, 5). Another benefit of a clustered design is their economic efficiency. Clustered developments greatly reduced site engineering costs as well as costs associated with installation and maintenance of utilities (PAS 1960:14–16).

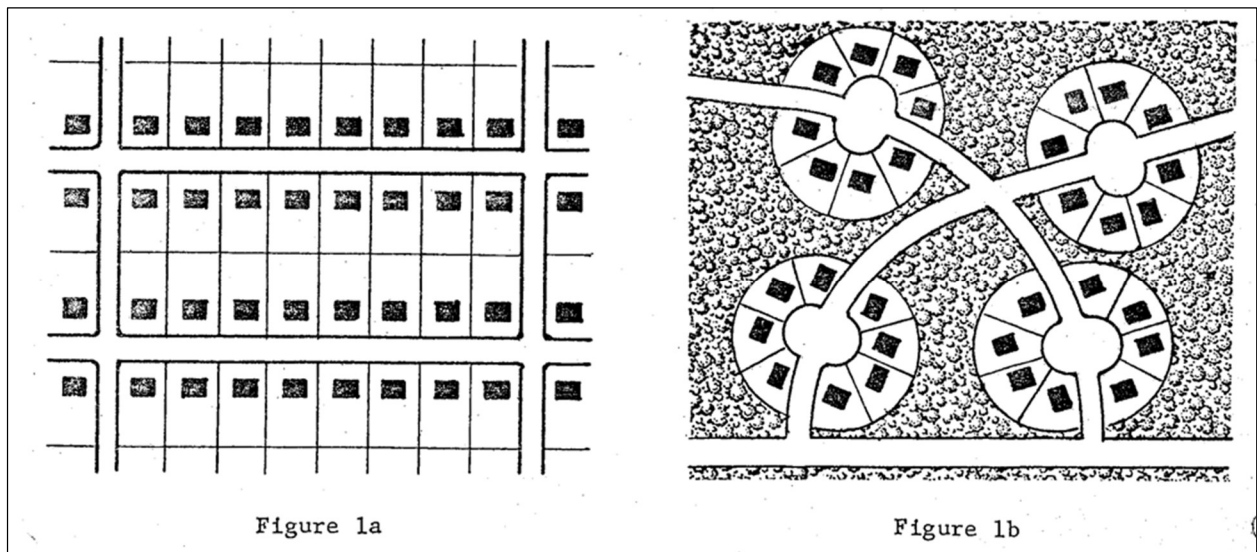


Figure 19: 1960 cluster design illustration (Source: Planning Advisory Service 1960).

Kramer, Hirsch & Carchidi’s design for Hunterdon State School appears to have been inspired by the cluster subdivision concept, with some important alterations to meet the needs of the people living there (see Figure 16). The overall design of the complex featured four large circular clusters. The central circle accommodated the administrative building, hospital, multi-purpose building, and a cottage for the emotionally disturbed around a central plaza. Three clusters of cottages were arranged around the perimeter of the central circle, with a road circulation pattern which ran around the perimeter of each cluster. Each cottage accommodated 56 patients and each cluster was designed to comprise six individual two-story cottages. One cluster was intentionally left incomplete to accommodate expansion at a later date. Unlike suburban subdivisions, where the interior of the cluster would be used for roads and parking, the Hunterdon cottages fronted on a central, shared outdoor space, with parking and roads arranged at the rear of the buildings. This design facilitated the easy regulation and supervision of all recreational spaces. The outdoor space featured shed-roofed picnic areas for each cottage and geometrically subdivided garden space. This concentration of recreational

space in the center of the clusters also contrasted with the design of Woodbridge State School, which had scattered outdoor play areas in semi-private settings at the rear of most cottages.

Continuing the practice of active collaboration between architects and programmers that had occurred at Woodbridge State School, the Hunterdon State School design involved a great deal of input from the NJDIA psychologists and other practitioners. The State Board of Control issued no fewer than 26 memoranda—amounting to more than 100 pages of instruction—to the architects of the Hunterdon State School during the design process (State Board of Control 1964). These memoranda not only delineated general needs with respect to sanitation and safety but detailed the activities and daily routines of the developmentally disabled in state institutions and the shortcomings of the designs at existing facilities (State Board of Control 1964). The design requests went into details as small as the number of screws on an outlet faceplate and the material used for baseboards, underscoring that the programmers were increasingly trying to create safe, sanitary, and easy-to-maintain environments as their first priority.

The design of the cottages was more traditionally residential compared to the hexagonal cottages of Woodbridge State School. The cottages at Hunterdon State School were two-story, mansard-style, rectangular buildings, each story featuring an oversized mansard roof with asphalt shingles. The mansard style was popular for mid-century apartment buildings as they were “relatively inexpensive to build, as only one story of masonry veneer was required, while the remainder of the wall surface was clad in roofing material” (McAlester 2015:692). The “human-scale” of the cottages was maintained by the set-back design of the second story, allowing it to be masked from view from the ground elevation. Each cottage featured a first-floor recessed entry flanked by banks of short horizontal-paned windows. Interior floor plans of the cottages were not available, but documentation associated with the facility indicates that each had six- and eight-bed dormitories, a day room, kitchen, dining area, classroom, visitor’s lounge, and outside play area (Hunterdon State School 1969:3). Additionally, project specifications indicate that each cottage had a quiet room, employee lounge with lavatory, a clinic room, and ample storage space (NJDIA 1964).

While the Woodbridge State School was hailed as innovative by contemporary architectural journals and conferences, the Hunterdon State School did not receive the same treatment. This circumstance is likely due to the relatively lower-profile status of its architects, and its more traditional style mirroring a residential apartment complex. In addition, the Hunterdon State School ran into multiple roadblocks on the way to its opening. After breaking ground on June 14, 1967, construction encountered delays as a result of a worker’s strike in the summer of 1968 and unseasonably cold temperatures in December of 1968, leading to damage to some of the half-completed cottages (Gill 1968:22). The NJDIA terminated the contract of general contractor F. H. McGraw and Company of Hartford, Connecticut in December 1968, shortly after that firm declared bankruptcy. Fidelity and Casualty of New York became the new contractor, poised to complete the final 10 percent of the job, in January of 1969 (Gill 1968:22). The Hunterdon State School finally opened in April 1969 with 14 cottages. Four

additional cottages were completed sometime between 1972 and 1984 (Nationwide Environmental Title Research 1972, 1984).

### *Somerset State School*

In the mid-1960s, the NJDIA built upon the lessons learned at Woodbridge and Hunterdon state schools and planned for an even more experimental institution, to be called the Somerset State School (Somerset). The Somerset project was initially proposed in 1966, when the state acquired surplus acreage from the federal government. The \$20 million project was expected to accommodate 1,000 patients (Bernardsville News, 6 March 1969:1). The NJDIA developed a programmatic overview of its vision for Somerset in 1967. This document opens with the proposition “Scientific evidence tends to suggest that there is a distinct relationship between design of a state school and services provided.” Key elements of the program included “homogeneous grouping by age” and “homogeneous grouping by adaptive level,” plus “the ability of the facilities to provide opportunities for the resident to feel like an individual” (NJDIA 1967c:1). Separate guidelines were proposed for two groups of residents. The “more severely handicapped,” or those whose abilities for self-care and communication were limited, would need more supervision, including assistance during meals and getting dressed. They were described as “difficult to control even with tranquilizing medication.” The group included non- and semi-ambulatory residents, requiring staff to assist with transportation to a bathroom, kitchen, or instructional area. The guidelines for the “severely handicapped” residents, those with more abilities, would also require that as many services as possible be brought to them in their cottages. All living spaces needed to be on the first-floor level, with all corners rounded to minimize accidents (NJDIA 1967c:4–5). The multi-purpose building, like that at Woodbridge, would serve educational, recreational, and entertainment needs. The building needed to have moveable partition walls to create classrooms for up to 15 residents each, a sandwich shop for visitors, an employees’ club room, and vocational training shops (NJDIA 1967c:7). A central food service building would be provided, but each cottage would have its own dining area with a small adjoining kitchen area to be used by the staff (NJDIA 1967c:8).

The design teams for Somerset were Kramer Hirsch & Carchidi and Gerber & Pancani. Gerber & Pancani was an architectural and engineering firm with offices in Newark and Florida. The firm does not have an entry in the Philadelphia Architects & Buildings database. It flourished in the 1950s and 1960s, and one of the highlights of its design career was Margate-at-Menlo Park, a garden apartment community designed in the Williamsburg Colonial style (Central New Jersey Home News, 26 June 1966:45).

The plan for Somerset called for a dense vegetative perimeter to create a buffer from its surroundings (Figure 20). The circulation system was a double loop road accessed by three entrances. Buildings servicing residents were located where the loops shared a roadbed. The cottages were L-shaped buildings attached in a zigzag manner with access to central play areas. The layout of the cottages provided dormitory space in one end, toilet and bath facilities in the center, and a “day room” in the other end with access to the service areas in the ell portion of the cottage. The cottages were designed

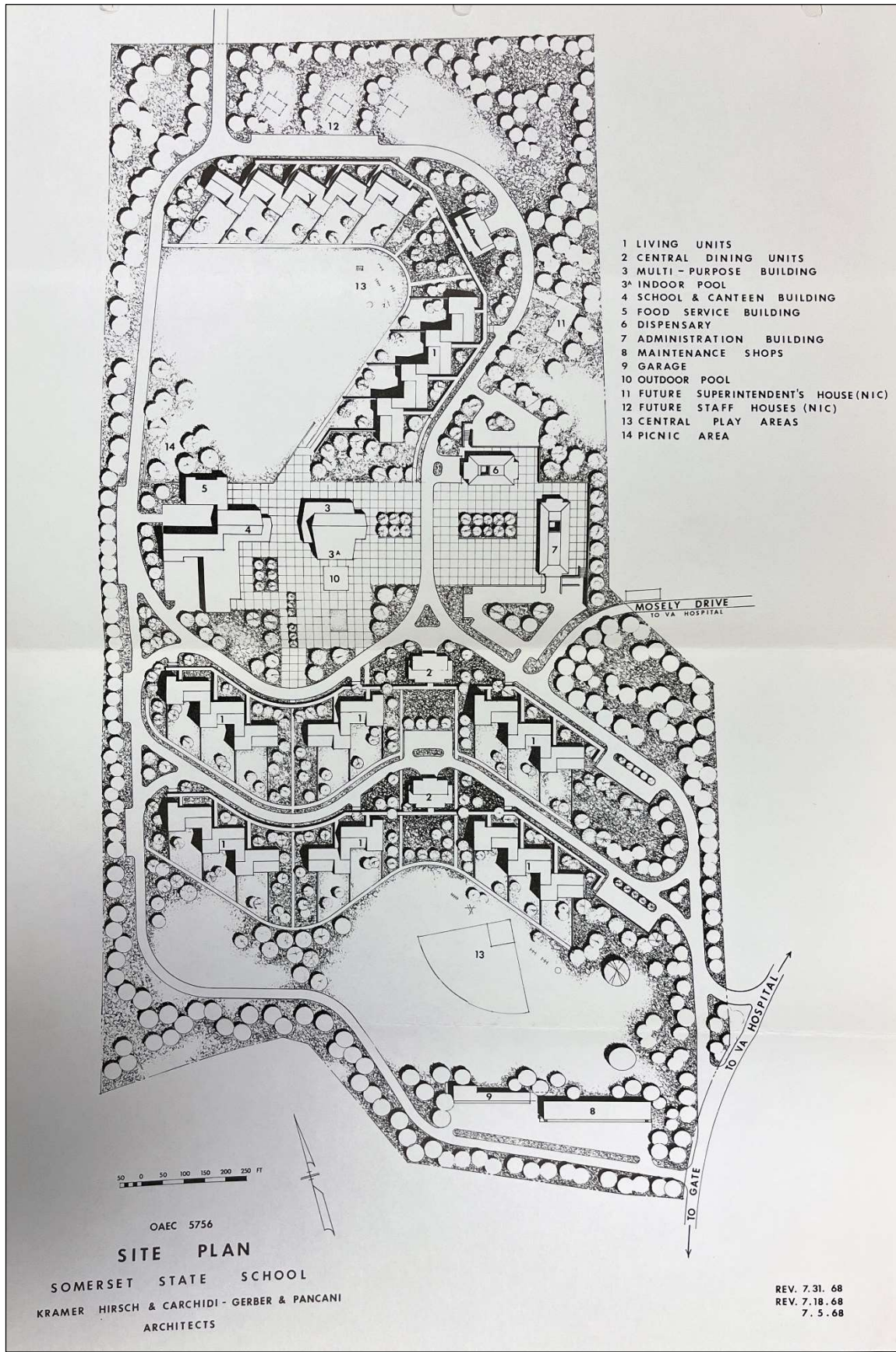


Figure 20: 1968 Site Plan for Somerset State School (Source: Box 1, Department of Institutions and Agencies Collection, New Jersey State Archives, Trenton, NJ).

to be smaller than those at Hunterdon, with a “homier” atmosphere. (Kramer Hirsch & Carchidi 1969).

Soon after the design of the Somerset State School was completed, New Jersey recognized that it would have trouble funding the ambitious project. By early 1968, the Somerset State School project had been scaled back to \$11 million to accommodate 500 patients (Bernardsville News, 6 March 1969:1; NJDIA 1968b). The goal was to build cottages containing 20 beds, with dedicated play yards outside and dedicated areas for group activities. In addition, the plan called for an infirmary, a school building, and an administrative office building (Bernardsville News, 6 March 1969:9). A Planning Report for Somerset finalized in August 1968 outlined why some design changes were made (NJDIA 1968b). The initial plans for 1,000 residents required larger buildings. After considering various alternatives, the design team proposed to reduce the size of the cottages but increase the number, so that smaller groups could be reconfigured when needed (NJDIA 1968b:6). Once the NJDIA decided to reduce the number of residents to 500, additional changes were required. If a full range of medical professions was a requirement, operational overhead for staff who were only needed sporadically for a small population was too great. Staff members thus decided to change the overall concept from a “general and regional” institution to a “satellite” institution of Hunterdon (NJDIA 1968b:7). The decision to reduce the number of residents to 500 was presented to the NJDIA in March 1968 and thereafter approved (State Board of Control 1968).

In 1968 the NJDIA drafted a bond referendum to secure money for a package of institutional construction projects that included \$8 million for the proposed Somerset State School, plus funds for the construction of new cottages at Vineland and Woodbine and funds for needed renovations at Totowa and the Johnstone Training and Research Center. The funding (if approved by the voters) would cover the first phase of construction at Somerset, providing 14 cottages with 20 beds each, plus the requisite ancillary buildings.

The referendum appeared on the ballot in November 1968 and passed easily with 60 percent support (Courier-Post, 7 November 1968:15). After the success of the referendum, the architect completed the first rough plans in July 1969, followed by the preliminary working drawings in March 1970. In the intervening two years, however, construction costs had increased over one percent every month, resulting in a new project estimate of \$10 million. The NJDIA reviewed the plans to find ways to scale them back. Since the food service building and utility buildings would be the same cost regardless of how many beds were provided, the only option was to reduce the number of beds. To keep the project on budget, the number of beds would need to be reduced to 200, but the NJDIA believed that was too few to justify the project. When it became clear the appropriated funds were insufficient to cover all the proposed projects, a legislative committee reviewed the package of projects and identified some to be set aside in order to proceed with others. Somerset was deferred, with the allocated money applied to other projects, each of which was also experiencing cost overruns (Beisert 1970). At the time when the decision was made to place the Somerset project on hold, the NJDIA estimated that the waiting list for beds in developmental disability institutions was 1,500 (Hackensack Record, 5 June

1970:3). Later attempts to resurrect the Somerset project failed, hampered by lack of public support and changes in educational policy. Cancelling the project corresponded with a shift away from full-time institutional care for people with developmental disabilities and an active shift toward day programs and placing patients back with their families. Still, the design of the institution was innovative, and some design features were characteristic of the architect's attempt to incorporate psychological functionalism into the facility.

## 6.0 THE BEGINNINGS OF DEINSTITUTIONALIZATION: CHANGES IN STATE AND FEDERAL POLICIES IN THE 1970S

After the expansion of state-run institutions in the 1950s and 1960s, lawmakers and administrators alike began to reexamine the system of care for the developmentally disabled. Seeing waitlists expand regardless of the construction boom, they asked how they could serve more people in community-based contexts and avoid or minimize institutionalization. “Deinstitutionalization” followed: a process of moving people out of residential institutions into a variety of living, working, and educational contexts.

The national shift away from state-funded residential homes for the developmentally disabled can be credited in part to the equal education movement, driven by parent advocates and educators, and the appetite for states to shed responsibility and financial burdens associated with these institutions by redistributing the responsibility to communities. The closure of these institutions did not result in the elimination of the needs of this population. While people with mild or moderate disabilities might be accommodated in a family home, apartment complex, or group home, many people with severe disabilities continued to require long-term care. The ultimate result was the dissolution of state institutions over a 40-year period, the ascendance of the private residential institution for the developmentally disabled, and group homes both public and private.

In the 1960s, public institutions for the developmentally disabled declined in popularity for a number of reasons. Exposés of the poor conditions—including overcrowding, neglect, and abuse—chipped away at the positive view of institutionalization that had prevailed in the immediate post-war era. Funding for these institutions was slashed in state budgets in the late 1960s, with politicians characterizing this choice as a move toward community-based care. These trends were seen in New York, California, Alabama, Illinois, and Pennsylvania in 1967 and 1968 (Trent 1994:255–257). Reduced budgets led to reductions in staff and further deterioration of conditions at institutions for the developmentally disabled. The imbalance between the funding for construction of facilities and the continued costs of running them (where funding stagnated or declined) led to an unsustainable system of residential institutions for the developmentally disabled. By the early 1970s, parents, politicians, and the general public seemed to agree that these institutions needed to be phased out or at the very least, reimagined (Trent 1994:259).

### *National Changes in the Educational Policies affecting the Developmentally Disabled*

One side effect of the negative view of residential institutions was an attendant skepticism about the utility of separate schools for the developmentally disabled (Trent 1994:259). Some federal legislation moved in this direction, as acts such as the Economic Opportunity Act of 1964 and the Elementary and Secondary Education Act (ESEA) of 1965, which promoted educational opportunities for developmentally disabled children within public schools. Segregated institutions were increasingly seen as “dehumanizing,” and the prospect of integrating the education of the severely and profoundly

disabled into local schools had the added benefit of providing students services close to home which resonated with the “community care” model that was becoming popular (Trent 1994:259).

The Economic Opportunity Act and ESEA helped to trigger a movement for “mainstreaming” the education of developmentally disabled children. Proponents of this model argued that labeling children “retarded” and performing IQ tests represented violence against them, and effectively pigeonholed them into a low-level of academic performance. The intellectual capacity of children was thought to be more related to the expectations set for them, which were often underwritten by the racial, class, and ableist biases of the educator (Trent 1994:260). In short, “programs created ostensibly to treat deficiency were, in fact, creating and sustaining deficiency” (Trent 1994:260).

In 1973, the American Association on Mental Deficiency changed the way it used IQ tests to classify intellectual disability and narrowed the definition of “mental retardation” from anyone with an IQ two standards of deviations below the IQ norm to one standard of deviation below the norm (Trent 1994:270). Two federal court cases further pushed the mainstreaming of special education. In 1972, the *Mills vs. Board of Education of the District of Columbia* was the first to “guarantee mentally retarded children a constitutional right to public education” (Trent 1994:260). Congress was further pressed into action after a 1972 Pennsylvania case brought to light the systematic exclusion of the developmentally disabled from public schools. That year, the case of the *Pennsylvania Association for Retarded Citizens (PARC) v. Commonwealth of Pennsylvania* ruled that the plaintiffs (13 developmentally disabled youth) were denied their rights to a free and appropriate education because their local schools made no provision for their education (Holliday 1984:36–37).

After these rulings, Congress weighed in on the educational needs of the developmentally disabled. The Rehabilitation Act of 1973 (P.L. 93-112) is considered to be the first federal legislation of its kind. The purpose of the act was to “initiate and expand services to groups of handicapped individuals.” The act’s Section 504 came to be known as the Civil Rights Act for Disabled People. Section 504 “granted a free appropriate public education” to handicapped youth, among other provisions (Holliday 1984:37–38).

Three years later in 1975 Congress passed the Education for All Handicapped Children Act (P.L. 94-142), which is now known as the Individuals with Disabilities Education Act (IDEA). This act brought together the full spectrum of people meeting the definition of “handicapped.” President Ford signed the act on November 29, 1975. The act had four components. The first mandated that “all handicapped children have access to a free, appropriate education” at public expense, including pre-school, elementary, and secondary levels. The second part identified the rights of handicapped students and their parents. The third section appropriated funding, and the fourth section outlined requirements and procedures for carrying out the act. The key difference between Section 504 of the Rehabilitation Act and the Education for All Handicapped Children Act was that the former act set forth what could not be done, while the latter authorized what the states needed to do (Holliday 1984:39–41).

Money for special education programs in public schools increased dramatically between 1976 and 1980, then slowed as the number of qualifying children decreased with closer examination of the label and the abilities of mentally disabled children. “Mildly retarded children” were relabeled as “children with learning disabilities” (Trent 1994:261). The Education for All Handicapped Children Act effectively prevented schools from barring the admission of intellectually disabled students and “insured that these children are more likely than before to get an education geared to their specific needs” (Trent 1994:267).

Also in the 1970s, important amendments were made to the 1963 construction act (P.L. 88-164), including the Disability Services and Facility Construction Amendments of 1970 (P.L. 91-517) and the 1975 Developmentally Disabled Assistance and Bill of Rights Act (DD Bill of Rights; P.L. 94-103). The 1970 law defined specific disabilities for the first time (including conditions such as cerebral palsy, epilepsy, and mental retardation), established state planning councils to look at services for the disabled, and provided grant money to universities (NJ DIA 1975). The 1975 amendment removed the law’s construction authority, established the National Advisory Council on Services and Facilities for the Developmentally Disabled, and required states participating in the grant program to establish a State Protection and Advocacy Systems [P&As] for the developmentally disabled.

#### *Changes to Education Law at the State Level*

As described above, parents’ groups had already made important strides toward equal education in New Jersey in the 1950s. In the 1970s, a series of lawsuits and congressional legislation placed further pressure on the states to speed the transition towards better local services and educational options. These efforts intersected with the equal education movement, as parents advocated for educational services for their disabled children, whether in a residential institution or in a community day facility. In New Jersey, the movement for equal education first built upon rights outlined in revisions to the state constitution made in 1947 which required that the legislature provide for a “thorough and efficient system of free public schools for the instruction of all the children in the State between the ages of five and eighteen years” (New Jersey State Constitution of 1947: Article VIII, Section IV.1).

The New Jersey State Assembly, in response to the 1967 Study Commission on Education, passed the State School Incentive Equalization Aid Law in 1970 (Echoes-Sentinel, 15 January 1976:7). This law was intended to improve educational opportunities among all school districts, by distributing state funding for operating expenses in a more equitable way. Local funding would be the backbone of the system, but supplementary state funding would be made available to less affluent districts. The law was never fully funded, however, so barriers to a “thorough and efficient” education remained for low-income districts. The law did not specifically target improving education for the developmentally disabled.

While Congress was holding hearings on federal cases in the early 1970s, the equal education movement was in its initial phase in New Jersey. On April 3, 1973, the state Supreme Court ruled unanimously in the case *Robinson v. Cahill* (also known as “Robinson I”; William Cahill was governor of New Jersey from 1970–1974). In this case, the courts ruled that the legislature needed to provide funding to meet the constitutional mandate of “a thorough and efficient system of free public schools” as had been promised in the state constitution (New Jersey State Constitution of 1947: Article VIII, Section IV.1). Parents of developmentally disabled children lobbied to ensure that the ruling applied to their children as well. The actual case related to the inequities of legislation funding public education in the state, which favored wealthy municipalities and punished poorer municipalities. The state Supreme Court ruled that the legislation violated the equal protection mandates of the federal and state constitutions and violated various provisions of the state constitution related to education and taxation. Thereafter, the Division of Mental Retardation focused its efforts on providing “Thorough and Efficient” (T&E) education for residential state schools (New Jersey Department of Human Services [NJ DHS] 1977).

In 1975 the New Jersey Legislature passed the Public School Education Act (P.L. 1975, Chapter 212) to adjust the funding of local schools in accordance with the *Robinson I* ruling. The section relating to funding of education for the developmentally disabled outlined the three types of disability in the handicapped category—the “educable mentally retarded,” the “trainable mentally retarded,” and those who were “neither educable nor trainable.” The latter category of people was excluded from public schools by the act, as they were eligible for day training (Holliday 1984:42–44). In the late 1970s, the interests of the equal education movement, advocacy for the reform of residential state institutions, and new federal funding sources converged to create dramatic changes in the state’s system for the care of the developmentally disabled.

#### *Deinstitutionalization in New Jersey in the 1970s and 1980s*

Changes to New Jersey’s Division of Mental Retardation in the late 1970s and 1980s were directly related to new federal funding sources. By converting many of the state’s residential schools into facilities that could qualify for federal funding, the Division planned to “become a predominantly community-based service system” with few or no public residential facilities (NJ DHS 1983). Also during this period, the division was renamed the Division of Developmental Disability in 1985 (NJ DHS 2009a).

Federal action in 1971 began to enable the desired shift when Congress amended the Social Security Act (P.L. 92-223). President Richard Nixon signed the law on December 28, 1971. The amendment provided for changes to social security to reduce costs, including encouraging states to establish more “intermediary care facilities” (ICF), which were a less costly alternative to skilled nursing homes (United States House of Representatives 1971:111). Importantly, the residential facilities for the intellectually disabled were eligible for the program, should states opt into the program and make the necessary upgrades to their care systems. Medicaid would provide matching funds, as long as existing state and local levels of funding were maintained (federal funds were not intended to replace state and

local funds). Intermediate care facilities for the intellectually disabled did *not* include “custodial care facilities,” so those residents in qualifying facilities had to be part of active “rehabilitation” treatments. To administer the new provisions, federal staff members produced a lengthy definition of intermediate care facilities for the mentally retarded (ICF/MR):

institutions or distinct parts thereof, primarily for the diagnosis, treatment, or rehabilitation of the developmentally disabled, which provide, in a protected, residential setting, individualized, on-going evaluation, planning, 24-hour supervision, coordination and integration of health or rehabilitation services to help each individual reach his maximum of functioning capabilities (Mental Retardation Planning Project [MRPP] 1978:i).

States were given the option of participating in the new federal Intermediate Care Facilities, Mental Retardation Program (ICF/MR Program), but facilities and services would need to meet eligibility standards to qualify for funds. A major goal of the federal funding was to reduce the institutional residential population over time, and requirements for receiving funding included reducing the number of residential patients in each facility and increasing staff ratios. Maurice Kott, still serving as Director of the New Jersey Division of Mental Retardation, examined the new federal regulations with caution, as he was not convinced the changes would enhance the quality of life for the residents. Mott anticipated that the program would have two detrimental effects. First, the program had the potential to create a hierarchy within a single facility, as initially some cottages would qualify for the money and others would not. Second, the new program had a “medical orientation” to caring for the intellectually disabled, which could conflict with the “goals of a service delivery system based on a developmental model” (MRPP 1978:iv). In his view, the rehabilitation treatments were not appropriate for many residents.

Many states were slow to opt into the program, thus federal staff collected comments from state organizations and made changes to the standards for physical plants and staffing, which were finalized in July of 1977 (NJDHS 1983:8). In 1978, New Jersey approved a plan to restructure the Division of Mental Retardation to qualify for federal aid for the Division’s programming and facilities under Title XIX of the Social Security Act (Medicaid) (NJDHS 1983:i). The restructuring of New Jersey’s system for the developmentally disabled was framed, not as an economic decision, but as a much-needed reevaluation of the benefits and drawbacks of residential facilities. As the state’s system had heretofore relied on institutional care with little community programming, without a major restructuring to *develop* community placement programs, “hundreds of mentally retarded people would have continued in living situations far more restricted than their disabilities required, hundreds would have gone unserved” (NJDHS 1983:6).

In 1978, New Jersey chose to opt into the ICF/MR program. To qualify for funding, however, the state would need to quickly survey, renovate, reorganize its system, and drastically reduce residential populations at its facilities. At the time, New Jersey’s residential institutions were operating at capacity, with waiting lists. New facilities were unlikely to come to fruition for a variety of reasons. Federal

funding was generally limited to construction-related expenses, rehabilitation of existing space, or conversion of space. The state had to provide funding for all ongoing operations expenses (NJDHS 1983:3).

The first phase of the plan involved community residential placement “for persons inappropriately placed in state schools” (NJDHS 1983:9). This was coupled with the reduction of the residential population by 40 percent, and the expansion of local day programming. In 1983, halfway through the 10-year program, a study determined that the “depopulation” of the developmental centers was nearly on target. New Jersey was projected to qualify for reimbursement of 50 percent of expenses associated with these facilities as it had met its Phase I depopulation benchmark by the 1982 deadline. The second phase of the plan to convert the remainder of state schools to intermediate care facilities was not set to be completed until 1987 (NJDHS 1983:8).

Executing the second phase of the plan was more challenging, in part because the remaining residents were increasingly those with more severe life challenges. To meet the goal of a further reduction of approximately 2,000 residents by 1989, a three-part plan was approved that would move residents to private or out-of-state institutions, “community placement beds,” or newly constructed cottages (NJDHS 1983:14). “Community placement” included a combination of adult foster care and skill development homes, group homes, and supervised or unsupervised apartments (NJDHS 1983:14). The goals of the program were progressing, opening up the possibility of shuttering some institutions within three years. The result was evaluated to be “a dramatic improvement in the quality of life and in developmental opportunities for the residents” because the staff was able to provide more assistance to the “more manageable” number of residents (NJDHS 1983:18).

Meanwhile, New Jersey’s Division of Mental Retardation was experiencing some administrative upheaval when its parent department, the Department of Institutions and Agencies, was reorganized and divided into the Department of Human Services and the Department of Corrections in 1977. When the dust settled, the Division of Mental Retardation was not fully funded as the state budget had not allocated the full amount the Division had requested. Within weeks, the New Jersey Association for Retarded Children (NJARC) filed a class action suit stating that New Jersey was violating the constitutional rights of residents in the existing institutions (Holliday 1984:51). At Hunterdon State School, the suit maintained that 200 residents had lost all education and training and that many others were receiving only three hours of programming a week (Leith 1977). Advocates for the residents organized marches in Trenton, hoping to catch the attention of Governor Brendan Byrne (in office 1974–1982), who had a daughter in one of the state institutions. They carried signs calling for equal education for this marginalized segment of society. Byrne was able to move \$7 million from other programs to help cover programmatic needs for the duration of the budget year (Morristown Daily Record, 30 March 1977:3).

The State Facilities Education Act (P.L. 1979, Chapter 207) reaffirmed the right to education for the developmentally disabled. It addressed the issues at Hunterdon State School mentioned in the lawsuit of 1977 and authorized funding for the education of the developmentally disabled (Holliday 1984:48). As such, it extended the 1975 Public School Education Act to include students in residential state facilities. The law encouraged school boards to create programs close to home for severely and profoundly disabled children. To facilitate this transition, the law granted “incentives for the placements in the least restrictive environment” to both serve the families and to increase fiscal efficiency (Holliday 1984:61). This law marked the first time that state and local educational funds were set aside for the severely and profoundly handicapped as these children had “never been associated with general education funds in the past because they were always excluded from public schools” (Holliday 1984:64).

The State Facilities Education Act and changes associated with converting these facilities into federally compliant Intermediate Care Facilities had a large impact on the staffing of residential facilities. Many children in these facilities were eligible for day training, with school-age children totaling 1,541 in 1980. Over the next few years, funds associated with the State Facilities Education Act supported the addition of dozens of new instructors to the rolls at residential facilities. At the same time, the residential facilities were reducing their populations, resulting in instructional staff to student ratios in these facilities changing from 1 to 6 in 1980 to 1 to 2 in 1983 (Holliday 1984:107–110).

The deinstitutionalization of New Jersey’s developmentally disabled population in the late 1970s resulted in the transfer of many residents to group homes. In 1977, the Department of Human Services allocated \$500,000, from the 1976 institutional bond issue, “for development by private non-profit organizations for community residences for the mentally retarded and other developmentally disabled persons” (Conohan 1978:11). Five group homes were planned, each to accommodate six to eight people, which were intended to provide a homelike environment for residents and provide some supervision. The division’s focus on group homes came at a time when it was “striving to upgrade its physical facilities for permanent residents so as to qualify for and add sufficient staff Medicaid assistance under the federal ICF/MR program” (Conohan 1978). While seven of the state schools had already received the required certification on the basis of *planned* reforms (facility improvement, increased staffing, and depopulation), they had not yet reached their target for depopulation. After fulfilling its requirements, New Jersey expected to receive \$40 million in federal support annually, which would amount to half the Division’s budget for the care of the developmentally disabled (Conohan 1978:11).

An innovative but short-lived transitional program called the Trailer Training Park was initiated at Woodbridge in 1977. Three mobile houses were brought onto the Woodbridge campus and fitted for residents. Twelve residents were chosen to live in the trailers to prepare them for moving back to their community. The residents were responsible for cooking, cleaning, and making their way to school and work. They were given freedom to decide what to do during their leisure time (NJ DHS 1977:25).

### *Residential Facilities after Conversion to ICF/MR Centers*

Woodbridge State School became known as the Woodbridge Developmental Center beginning in 1980. Though the overall population of the state system was greatly reduced, Woodbridge remained open until 2015. The conversion of New Jersey's state schools to ICF/MR program compliant "developmental centers" involved a number of architectural changes. Under the new regulations, residential wards would need to be subdivided to accommodate a limit of four persons in a room, allocate at least 60 square feet per bed, implement "barrier free design," and upgrade bathroom facilities (NJ DHS 1983:10). The conversion of state facilities resulted in a loss of capacity of 2,000 beds across 92 buildings within the system. Additionally, the overall system was reorganized so that a greater percentage of developmentally disabled beds would be in the northern part of the state, and therefore closer to the populations they were designed to serve.

New programming at Woodbridge in the late 1970s made attempts to embrace community connections and create "homelike" environments through relationships rather than through architectural form. At Woodbridge, the federal funding which came through ICF/MR program made it possible to almost double the staff of the facility from a ratio of 25 workers to 53 residents to a ratio of 48 workers to 53 residents (Miskoff 1978:A17). Many of the new care workers at the facility were parents of the residents, themselves members of the Woodbridge State School Parents Association. In addition to bringing a level of personal investment into the school itself, parents spearheaded community projects such as the opening of a store for the residents to work at and the operation of a campsite for recreational activities (Miskoff 1978:A17).

The state did not opt to upgrade all its beds to federal standards, however, leading to the very inequity that Director Kott had feared when weighing whether New Jersey should take advantage of the ICF/MR program. The difference was especially stark at Vineland Development Center, where in 1992, 461 beds were federally approved and 397 were not (Magyar 1992). At that facility, roughly half the residents still lived in dormitories with 20 residents in a room and few staff to care for and entertain them. Residents in the federal cottages were not only in small-capacity wards (four people to a room) but enjoyed "neat rooms with matching designer sheets and paintings on the walls" and additional staff with time to play games and run exercise programs (Magyar 1992). The architecture played a role in creating a homelike environment for the federal cottages by providing small-scale living quarters and personal space. Perhaps even more impactful, however, was a financial investment in additional staff and activity programming.

The requirements of ICF/MR facilities cast architectural form as an active tool in the care of the developmentally disabled primarily with respect to scale of design and its sanitary quality. The federal cottage at Vineland had the feel of a "modern hospital ward" onto which was layered the warmth which came with decorative touches and recreational activities described above (Magyar 1992).

When New Jersey opened the Green Brook Regional Center in 1980, the state's eighth facility for the developmentally disabled, the new operation took over the building once occupied by the Raritan Valley Hospital. The facility became a 118-bed facility for elderly patients who were moderately and severely developmentally disabled. The Green Brook Regional Center retained many of the hospital's medical spaces such as the X-ray and stress laboratories (Feiner 1981). The hospital organization of the space did not detract from its capacity to be a positive place for the developmentally disabled, however, and the center also offered classes in personal hygiene, reading and writing, and recreational craft workshops and games (Feiner 1981). Recently, when a flood at Green Brook forced residents to move to Woodbridge Development Center in 2010, many could not wait to return. The residents found Woodbridge less clean than their normal home, but their main complaints were the lack of privacy—the residents had to sleep six to a room and a share a communal bathroom in contrast to the en-suite bathrooms they enjoyed at Green Brook (Lampard and Lampard 2010). The modern sensibility about what made a residential facility a “good institution” had once again settled on the basics of everyday life. In this case, the scale of the building was less important than the services, cleanliness, and privacy available in a patients' immediate surroundings.

## **7.0 AMERICANS WITH DISABILITIES ACT (ADA) AND OLMSTEAD VS. L.C.**

New Jersey's state programs for the developmentally disabled continued to change in the 1990s and 2000s as landmark federal legislation and court cases expanded the rights of disabled people. Chief among these was the 1990 Americans with Disabilities Act (ADA; P.L. 101-336) and the 1999 *Olmstead vs. L.C.* Supreme Court case, which interpreted the ADA. The ADA protects people with disabilities from discrimination in workplaces, government programs, or in public accommodations. The *Olmstead vs. L.C.* case involved a pair of developmentally and mentally disabled sisters suing for their right to be put in appropriate community placement contexts based on rights outlined in the ADA (United States Department of Justice, Civil Rights Division [CRD] 2023). The court ruled in favor of the sisters. This set an important precedent that prohibited the unnecessary segregation of people with disabilities and stipulated that people with disabilities should be accommodated in the least restrictive environment which can also provide the necessary support for that individual. It wasn't until 2009, however, that the Civil Rights Division of the federal Department of Justice began to actively enforce the ruling (CRD 2023).

Meanwhile, other important legal developments occurred in New Jersey which came to intersect with federal changes. New Jersey's federally mandated protection and advocacy agency, created in the wake of the 1975 Development Disability Bill of Rights, was privatized in 1994. Thereafter the private, non-profit New Jersey Protection and Advocacy, Inc. (NJP&A) operated independently from the state government. In 2008, the group changed its name to Disability Rights New Jersey (DRNJ) and refocused its advocacy on the wide range of civil rights issues that the disabled face, not only matters of abuse in state institutions (DRNJ 2023).

In 2005, NJP&A sued the Department of Human Services for failure to comply with the 1999 *Olmstead vs. L.C.* Supreme Court decision protecting people from unjustified institutionalization (Lipka 2005). The suit alleged that New Jersey was not making enough community placements and support services available for psychiatric patients who qualified for discharge from state psychiatric hospitals. A state task force estimated that the state should have a \$200 million housing trust fund to "help relocate people from these institutional settings" (Lipka 2005). In July of 2009, the state reached an agreement with the advocacy group, with the creation of a five-year plan for discharging patients at state hospitals (NJ DHS 2009b).

Three years later, New Jersey began planning for the closure of two state developmental centers and pointed to the *Olmstead vs. L.C.* case as the reason. The state had met strong opposition to the closure of the Johnstone Center in 1992 (Magyar 1992; NJA 1991). Despite known opposition from families and advocacy groups, Governor Chris Christie actively pursued closures as a form of deinstitutionalization. In 2012 he launched the Task Force on the Closure of State Developmental Centers, which recommended closing the North Jersey Development Center in Totowa and the Woodbridge Developmental Center in Rahway (Rosenblum 2013). While families saw the move as a cost-cutting measure, Christie defended the decision as a civil rights issue, stemming from a need to comply with the 1999 *Olmstead vs. L.C.* decision and the ADA. Family members and advocacy groups

argued that these precedents do not necessarily call for closures, and the proposed closures would reduce the quality of life for severely and profoundly disabled residents (Rosenblum 2013). Importantly, Woodbridge and the North Jersey facility represented two of the four institutions located in the northern part of the state, where the large majority of the state's population continued to reside, and many severely disabled residents would be moved as much as 100 miles away from their families (Rosenblum 2013).

In February of 2013 a hearing was held on the planned closures (NJA 2013). The testimonies of families, care providers, elected officials, union members, and concerned citizens underscored that most people with a direct connection to the facilities wanted them to continue operating. Based on research into the correlation between community placements and high rates of mortality and abuse among the developmentally disabled, advocates testified that closing the facilities could compromise the emotional stability of the residents and lead to declining health or even death. Additionally, the witnesses testified to the many barriers between residents and high-quality care outside the institution. Finally, many witnesses objected to the state's choice to close the geographically convenient Woodbridge and North Jersey facilities, rather than one of the more remote centers. Thomas Yorke, an attorney for a number of developmental centers throughout the country, declared that "you're essentially telling people that they need to move their loved ones out into the community where they're at greater risk. And I guarantee you people will die as a result of that decision" (NJA 2013:26).

As residents were transferred to new facilities, advocacy groups called for reform of the system after the deaths of two men transferred out of the North Jersey Development Center into a group home in 2014 (Russell 2015). In response, the New Jersey Assembly passed a bill to halt the transfer of developmentally disabled residents to group homes without a "comprehensive closure plan," though the study called for in the bill went unfunded (S2198; NJA 2014; Kitchenman 2015). Despite opposition from family members and concerned citizens and calls for reform, the North Jersey Development Center was closed permanently in July of 2014 and Woodbridge Developmental Center was closed in December of 2014. After Woodbridge's closure, the 68-acre site was turned over to the state Department of the Treasury's Division of Purchase and Property. The developmental center buildings were demolished in January of 2021. New Jersey continues to operate development centers including Green Brook Regional Center, Hunterdon Developmental Center, New Lisbon Developmental Center, Vineland Developmental Center, and Woodbine Developmental Center. Advocacy groups continue to deny the moral dichotomy between institutional care and community care, insisting that for the more severely disabled there are clear advantages to an institutional setting where residents benefit from stable relationships with experienced staff and comprehensive centralized services (Kitchenman 2015).

## 8.0 CONCLUSION

Care for the developmentally disabled in New Jersey changed dramatically after World War II as administrators, parents, and researchers debated the merits of care in the institution versus care in the community. Before the war, the philosophy of care in state facilities was focused on the separation of the developmentally disabled from the rest of society as a social good. Most care was “custodial” as the developmentally disabled were assumed to have little ability to improve themselves. This view was never universal, however, and researchers at New Jersey institutions in the mid-twentieth century demonstrated the capacity for growth and learning for people with mental and physical disabilities.

After World War II, many of the taboos associated with institutionalization fell away in the face of these research innovations, the changing needs of the American family, and federal and state moves toward improving the lives of disabled people. Parent groups in the post-World War II era also pressed for changes to these views, while also embracing a reformed concept of the institution that respected the humanity of their children. Their lobbying set the stage for a dramatic shift in the philosophy of care towards assisting the residents to have a higher quality of life through the creation of more “homelike” environments in institutions, advocating for increased funding, calling for more community services, and demanding educational equity.

The architectural design of residential institutions for the developmentally disabled shifted after World War II, reflecting these changes. Before the war, these facilities were large, multi-story buildings with long hallways similar to hospitals, creating an impersonal and formulaic environment. After the war, architects and caretakers began to reconsider what forms would best suit the needs of the developmentally disabled. Changes within the NJDIA, including the hiring of a new Division chief to manage facilities for the developmentally disabled, helped to reshape the care system and architecture’s role in that system. When Division Chief Maurice Kott proposed the opening of the Edward Johnstone Research and Training Center in 1955, he was acknowledging the humanity and capacity to learn of many developmentally disabled children. The educational and research environment Kott hoped to create in this experimental center resonated with the academic campus feel of the New Jersey Manual Training and Industrial School, where the Johnstone Center opened.

In the late 1950s waiting lists for state schools continued to grow as the state’s population boomed and local school districts would not enroll students with developmental disabilities. At the same time, architects and social behaviorists were converging to formulate a theory of “psychological functionalism” which held that the built environment could have a positive impact on the care programs of mentally ill and developmentally disabled people. Architects began to work with professionals in the field to design new facilities, a movement called “environmental psychology.” Aspects of design during these years included human-scale architecture with cottages housing a few dozen residents each.

The expansion of the state school system in the 1960s, with the opening of Woodbridge State School and the Hunterdon State School, were the Division of Mental Retardation's answer to the pressing needs of the state's developmentally disabled population. The architectural designs of these institutions incorporated contemporary theories of psychological functionalism. Woodbridge State School sought to create a "human scale" environment with single-story structures with novel hexagon designs to avoid feelings of alienation that might be associated with an institution. At the same time, the architects incorporated a range of design features to meet the sanitation and medical needs of the staff. Hunterdon State School was designed with a similar "human scale" intent, but also took into account the rural landscape of Hunterdon County. Artfully arranged cluster developments had the advantage of creating pleasant physical environments that kept costs down, retained as much open space as possible, and served the supervisory and expansion needs of the staff.

The civil rights of people with disabilities were significantly advanced by a host of federal and state legislation that was aimed at expanding the network of care and improving the educational options available to the developmentally disabled in the 1960s and 1970s. Even as these expansions took place, the NJDIA was calling for state investment in community-centered daycare programs as a way to keep children out of institutions and get waiting lists under control.

In the late 1970s, the federal focus for care began to shift toward deinstitutionalization and movement of people into their communities. Federal programs, especially the 1978 ICF/MR Program, encouraged states to reduce the residential populations of their institutions, improve residential institutions which continued to be necessary, and vastly expand community care options and resources. In the midst of these changes, the construction program of New Jersey's Division of Development Disability was geared toward changing existing institutions to conform with federal requirements in order to qualify for matching funds. The more academic psychological functionalism theory and innovative designs of the 1960s became secondary to the basic needs of creating small-scale, semi-private living spaces, which also conformed to the medical and sanitary specifications of federal guidelines. Importantly, these guidelines retained the basic ideals of a "human scale" design—though in a sterile, mathematical way—by requiring minimum square footage per person, a maximum number of persons per room, and a minimum staff to patient ratio. The opening of Green Brook Regional Center in 1980 effectively repurposed hospital space. This center created human-scale living quarters which met the medical and sanitary needs of the patients but the "homelike" aspects of the facility were based on the social features of the environment—the large staff, activity program, and central location of the facility made the maintenance of relationships relatively straightforward.

In the 1990s and 2000s, the process of deinstitutionalization continued to shift developmentally disabled people to out-of-state institutions, distant in-state facilities, or group homes. At the same time, Congress introduced laws to expand the civil rights of disabled people, such as through the 1990 ADA. In the years that followed, a series of lawsuits led to improved civil rights for disabled people in public spaces and government institutions. A 1999 Supreme Court case, *Olmstead vs. L.C.*, reiterated the right of the mentally ill and developmentally disabled to the least restrictive living

environment which also met their needs. While well intentioned, in the case of severely developmentally disabled residents of New Jersey institutions, the resulting closures created problems. Politicians cast these closures as morally appropriate moves in light of the stigma associated with institutions. At the hearing for the closure of the Johnstone Center, the commissioner of the NJDIA asserted that “no matter how good an institution is, an institution is not a home” (NJA 1991:5). For many residents, however, their institutions *were* their homes, and the closures of two northern New Jersey institutions in 2014 were linked with negative health outcomes, and even death in the case of two former residents. The merits of the institution for the severely disabled continues to be the capacity of these spaces to create their own kind of community—with stable and comprehensive care programs close to families and friends.

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