

The Mennonite Mental Health Movement and the Wider Society in the United States, 1942-1965

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Introduction

Between August of 1942 and the end of 1945 more than 1,500 young men served in Civilian Public Service (CPS) in twenty-two United States mental hospitals and four training schools (Keeney, 1971). Mennonite veterans of this experience became deeply disturbed with the de-personalization and frequent mistreatment of patients. A core of those who went through these experiences turned to their leaders and began discussing the possibility of developing several Mennonite-sponsored, small mental hospitals focusing on a “homelike atmosphere” and “Christian care.” The CPS men and their leaders soon began interacting with--and were shaped by--movements for mental health care reform in the wider society: by the Mental Hygiene Movement of CPS, by the Mental Health Act of 1946, by the *therapeutic community* movement in the 1950s and by the Community Mental Health Centers movement in the 1960s. Operating under the umbrella of Mennonite Central Committee (MCC) this interaction gave rise to Mennonite Mental Health Services (MMHS) and six Mennonite

mental hospitals/centers that developed during the 1950s and 1960s. This paper focuses on the dual impingement of the vibrant Mennonite mental health leadership: first, from the church, and second, from the emerging wider United States mental health movement that was taking mental health care from the shadows into the community

In this paper I posit that in each decade, from the 1940s to the 1960s, a specific guiding principle helped motivate the CPSers and their leaders in their search for humane and effective mental health care. In the 1940s the over-arching search in mental health care was for humanized treatment. In the 1950s a guiding principle was the therapeutic community movement. And in the 1960s the emerging Community Mental Health Center movement became crucial.

The 1940s

By 1942, CPS units were working in state mental hospitals (Gingerich, 1949). During World War II the United States military draft made understaffing in mental hospitals critical, and because working with patients appealed to the oft-times altruistic sense of conscientious objectors, this work became an expanding focus of CPS (Keeney, 1971).

CPSers were soon noted for their recognition of the isolation and dehumanization in huge state mental hospitals. For instance, when First Lady Eleanor Roosevelt interviewed a number of CPSers at the Marboro, New Jersey State Hospital in 1943, she made the following comment about the CPSers in her periodical *My Day*: “They are a very fine group of young men, and bring a spiritual quality to their religion. In many ways, this is probably raising the standard of care given the patients” (Stoltzfus, 1943, p. 900). A significant number of administrators and staff in state mental hospitals welcomed the CPSers. Dr. O.R. Yoder, Superintendent of Ypsilanti State Hospital in Michigan, for example, wrote of his personal dilemma:

At the beginning of World War II the 3340 patients of the Ypsilanti State Hospital were cared for by a staff of 620 employees. Within a few months, due to being located within a Defense Area, the number of employees was decreased by 33% and these employees could not be replaced. A CPS unit of 50 came to work at the hospital; 25 were added later (Yoder, 1944, p. 914).

CPS had found a niche that catapulted them and their leaders into answering two questions. These were, first, how can we stop the mistreatment in state mental hospitals? And, second, shall we create a

Mennonite-sponsored mental health program after the war and, if so, what kind of program?

With reference to exposing the mistreatment practices and how they could change these conditions in existing state mental hospitals, Mennonite CPSers cooperated with the Mental Hygiene Program of CPS, an organization which grew out of a conference of Quaker leaders who met at Pendle Hill near Philadelphia. Among their other activities, they published a monthly magazine, *The Attendant*, later named *The Psychiatric Aide*. This group also promoted improved service at the attendant level, including a search for alternatives to coercion in patient care (Keeney, 1971).

When this group was expanded in 1946 it was renamed National Mental Health Foundation (NMHF). Four men were added from a Mennonite-sponsored CPS unit: Grant Stoltzfus, William Keeney, Dick Hunter and Frank Wright. At that time only Grant Stoltzfus was a Mennonite. William Keeney later became a member of the Mennonite fellowship (W. Keeney, personal communication, July 11, 1974).

Among the increased activities of the National Mental Health Foundation were preparation of legal briefs on state mental health laws, developing a model mental health law, and publishing educational materials, including a series of eight dramatizations which had been broadcast by more than 150 radio stations in the United States and Canada by the spring of 1947 (Keeney, 1971). The Foundation also documented mistreatment of patients, especially through the CPS unit of Byberry Asylum in Philadelphia. One example is the following from Frank Wright's 1947 book, *Out of Sight, Out of Mind*, published by the Foundation:

Here comes "Swifty" whispered the working patient who was helping Dave wash the mattresses on Ward C. Dave dropped his sponge in the bucket, slipped on his white coat, and stood at attention while Dr. Chalmers made his daily "round." Every day for the past seven months—except Thursdays and Sundays when he was off duty—Dr. Chalmers had walked rapidly through the hall, ignoring both attendants and patients, leaving the ward less than a minute after he had entered it—speaking to no one. But this day was different. One of the occupational therapists had taken pity on the 110 patients who usually spent every day locked up in ward C. He had brought a portable phonograph to the ward, and now he had over half the patients marching gleefully around the room in time to the music.

Surveying this scene as he entered the ward, Dr. Chalmers smirked a little and shook his head. As he passed Dave on

the way to the door, he shrugged his head in the direction of the music: "Almost like trying to put some life into a bunch of cadavers, isn't it? That O.T. man ought to waste his time some place else. Imagine! Dancing in a graveyard!" (Wright, 1947, p. 78).

Instinctively, CPSers knew that even mentally ill people deserve to dance again, at least in their hearts.

The National Mental Health Foundation worked hard to document conditions in state mental hospitals. They created a survey which informed *Life* magazine's May, 1946 publication of a shocking expose: "Our Mental Hospitals . . . A National Disgrace" (Maisal, 1946). *Readers Digest* reprinted this report in condensed form two months later (Maisal, 1946). Then in 1947 the Foundation published its own expose, Wright's *Out of Sight, Out of Mind*, about a year after he had joined the Foundation. Then a year later, in 1948, Albert Deutsch published the book that sent shock waves across the country: *Shame of the States* (Deutsch, 1948). He specifically gave credit to men from the CPS unit at the Byberry Asylum in Philadelphia for some of his information (Deutsch, 1948, p. 48). Without question, documentation of mistreatment and sometimes brutality of patients, was crucial in the exposes of the two national magazines and the two books described above.

The role of the National Mental Health Foundation and the CPSers who worked with them in their effort to change attendant care was critical also. The collaboration of these Mennonite and Quaker groups, with the simultaneous movement of the larger society, led to the crucial political achievement of the 1940s: the Mental Health Act of 1946. Mental Health care in the United States would never be the same.

The second response to conditions in state mental hospitals was for CPSers and their program leaders to face the following question: Shall the Mennonite Church create mental hospitals (or other programs) after the war, and if so, what kind of programs? In searching for a model for the first Mennonite-sponsored mental health care program, their leaders came across an example from their own membership. Bethesda Hospital in Vineland, Ontario had begun when Henry Wiebe took into his home a Russian Mennonite immigrant who was about to be deported because of mental illness. This program grew, and Bertram Smucker was sent by the early Mennonite mental health leaders to visit the Ontario program. His report of a hospital "in the tradition of genuine, warm Christian family atmosphere in contrast to the harshness of a huge state mental institution" struck a sympathetic chord with the Mennonite leadership (Smucker, 1946). Bethesda was a recurring image during the search for the initial program.

Between December of 1944 and January of 1947, nine specific actions/reports propelled MCC and MMHS toward a decision to create some kind of Mennonite-sponsored program. CPSers had experienced the thrill of being involved in creating change with human kindness. Was human kindness enough? Could volunteers carry the major load in the envisioned program(s)? Following are nine items that reveal the progression of thinking during the three-year journey towards the decision to create the first three regional Mennonite-sponsored mental health programs (there was growing sentiment among CPSers for a Mennonite-sponsored mental health program).

First, in 1944 Henry A. Fast, Director of Mennonite CPS units reported the growing sentiment among CPS men to the sponsoring body, Mennonite Central Committee (MCC), that Mennonites might want to be involved in mental health care beyond CPS (MCC, 1944). (Appropriately, the Director of Mennonite CPS was the first to report growing sentiment among CPSers for a Mennonite-sponsored mental health program.) Second, in February of 1945 the Hospital Section of MCC sponsored a symposium: Should the Churches Establish and Maintain Hospitals for the Mentally Ill (Fast, 1945)? Third, in March of 1945 Fast reported that one of the constituent groups, the General Conference of Mennonites, had taken action to cooperate with MCC to establish a mental hospital, or failing that, they would establish one themselves (MCC Executive Committee, 1945). Fourth, in May of 1945 Robert Kreider, Director of Mental Health Units of CPS, raised the possible challenge for Mennonites to sponsor a mental hospital (*Second Anniversary Review*, 1945, p. 62-63). Fifth, in June of 1945 MCC appointed a Mental Health Study Committee to study the matter (MCC, 1945). Sixth, in December of 1945 their report reflected the growing consensus that the Mennonite Church should move ahead with a mental health program. The question was: What should be the nature of this program? The Study Committee looked at alternatives to a mental hospital: possibly establishing psychiatric wards in general hospitals or “convalescent farms or homes for the mentally ill and mentally deficient” (Mental Health Study Committee, 1945). Seventh, in April of 1946 their Supplemental Report suggested smaller institutions could be sponsored by regional conferences (Mental Health Study Committee, 1946). Eighth, in October of 1946 Elmer Ediger from Newton, Kansas, the final director of CPS, who was to become a pivotal figure in initiating and developing Prairie View Hospital in Newton, proposed that a farm owned by MCC in Leitersburg, Maryland be used for a Mental Rest Home combining “Christian care in a home-like atmosphere and use of scientific therapies” (Mental Health Study Committee, 1945). (Ediger’s reference to “scientific therapies” was a caution that there was need for a professionally trained person on

the staff of the first program.) Ninth, in January of 1947 MCC decided to set up a seven-member committee to find ways to establish three Mennonite-sponsored mental hospitals in the eastern, central and western areas of the United States. With this action, active planning for the three initial health programs was set in motion.

When this decision to proceed was made, Mennonite leaders shared a "Proposal for a Mental Rest Home" with reputable and trusted mental health leaders from outside the Mennonite Church. They envisioned the farm at Leitersburg to be a post-hospital convalescent care center, which they believed to be in harmony with the "homelike" concept and to require less professional staff. (This would become the first Mennonite hospital, Brook Lane.)

They initiated a series of meetings with the National Mental Health Foundation, with whom they had worked on the exposes' of mistreatment of patients in state mental hospitals. These leaders urged them to include new therapeutic approaches rather than limiting the program to convalescent care (Jost, 1946, doc. 7). Even these colleagues in the earlier exposes, who had recognized the effectiveness of human kindness, urged them to also develop expertise in mental health care treatment. In a conversation, Robert Felix of U.S. Public Health referred to pioneering work in hospital care by Seventh Day Adventists. He suggested Mennonites might do the same in the mental health care field (Goering, 1947). Dr. Dallas Pratt, a psychiatrist on the staff of NAMH, was a bit more blunt. He felt that the Mennonite proposal sent to him assumed that persons with serious forms of mental illness could be treated with only minimal use of a psychiatrist. To him this seemed untenable (Pratt, 1947).

These meetings with Foundation staff and other trusted non-Mennonite health care experts led them to include "treatment" as an integral part of the Brook Lane program. Thus, all three elements in Elmer Ediger's Proposal in October of 1946 cited earlier: "Christian care, homelike atmosphere and use of scientific therapies," were affirmed. The first Mennonite mental hospital, Brook Lane, would begin with an active treatment program. It was hoped that the best of Mennonite culture and competent psychiatric leadership would team up to be a creative force in the mental health field. Brook Lane would set the stage for the emergence of the Mennonite mental health care movement.

The 1950s

For the Mennonite programs the 1950s constituted the decade when the concept of the therapeutic community became a guiding principle. Dr. Helmut Prager from Philadelphia and Dr. Jackson C. Dillon from

Reedley, California, at the two initial programs at Brook Lane, Leitesburg, Maryland and Kingsview, Reedley, emphasized the closely knit hospital community spirit. This approach was in harmony with the therapeutic community ideas, but was not as clearly conceptualized.

The conceptual model of the therapeutic community came into focus for Mennonite mental health leaders as they planned for the third program, Prairie View, in Newton, Kansas. Already in 1951, two years after Brook Lane opened, Elmer Ediger felt that relying entirely on the small home model of Bethesda might be constricting to the second and third institutions. He described a program that involved a whole village in mental health care in Bielefeld, and a couple of other programs as examples. The flavor of his concern comes through in the following statement: "Instead of thinking in terms of a homelike atmosphere, these suggest, we think in terms of a small-town-like atmosphere (Ediger, 1951).

Prairie View specifically sought out a Medical Director adhering to the basic principles of the therapeutic community (Ediger, 1971). They discovered and hired Dr. Thomas Morrow from Witchita, Kansas. Together, he and psychologist Harold Vogt, social workers Luella Regier and Boyd Peak, and Administrator Myron Ebersole, formulated a program that borrowed ideas from the therapeutic community concept developed by Maxwell Jones and others. The ideas of Prairie View leadership were influential throughout the other Mennonite mental health institutions via MMHS relationships, and through articles and reports they produced. (Additional articles by their staff were found in the library at Prairie View Community Mental Health Center in Newton, Kansas.)

Awareness of this concept on the part of Mennonite mental health leaders was heightened by Maxwell Jones' book *The Therapeutic Community*. His work at Belmont Hospital in England in 1947 involved rehabilitation of unemployed persons with "neurotic and personality disorders." In his thinking, the community became the focus of treatment that was oriented toward re-educating for the responsibilities of living in society (Jones, 1953).

Kingsview eventually bought into this approach with enthusiasm. In 1959, at the urging of their Clinical Director J.D. Enterline, "community meetings" were initiated with all patients and staff present. In February of 1961 Maxwell Jones spent a day with them. The "community meetings" were increased to twice daily with staff and patients. This was followed by an hour with staff only. These meetings were premised on the belief that every moment of interaction by patients with any person of the hospital community is treatment time (Davis, 1961).

The most systematic effort to spell out the relationship of the therapeutic community to Mennonite beliefs, and the implications for mental

health programs, was accomplished by Prairie View administrator Myron Ebersole. He analyzed the relationship between the Anabaptist concept of the church and the therapeutic community (Ebersole, 1961). He drew upon Morris Swartz (Swartz, 1957) to outline the key ingredients of the therapeutic community as he, Ebersole, understood them. These include the following three emphases: first, hierarchical characteristics are kept to a minimum, although the difference in staff and patient roles is not erased; second, the democratic process is emphasized in decision-making by freedom for all in "community meetings," yet, particular consideration is given to the advice of the expert; third, open and free-flowing communication is encouraged.

Ebersole believed that the concept of personal responsibility was crucial to both the Anabaptist idea of the church and the therapeutic community concept from the field of psychiatry. As he put it, "Underlying the therapeutic community is...the assumption that the individual must be understood as a relational being and that man may not be understood in individualistic terms." This he sees as a kind of parallel to the Anabaptist concept of covenanting with God as members of a community of faith who pledge their mutual faithfulness to God (Ebersole, 1961).

Ironically, his thesis was not completed until 1961 when the Mennonite-sponsored programs were moving toward the community mental health center approach that was just around the corner. But his findings were very relevant to some misunderstandings between Mennonite church leaders and the Mennonite leaders of the mental health care programs. Both were trying to discover how relationships between members of a church and relationships between patients and staff in a therapeutic community are similar and/or different. I will return to this issue when I explore the relationship of the church to the community mental health centers in the 1960s.

Another important development was the association that began between the Mennonite-sponsored programs and Dr. Karl Menninger in the late 1940s and continued for the decade of the 1950s. Based in Topeka, Kansas, this association began through Elmer Ediger and others. Even during the early stages of planning for the first Mennonite psychiatric hospital, Brook Lane, Menninger participated in a 1947 Mennonite planning session (Homes for mentally ill advisory meeting, 1947, doc. 29). A couple of years later the MMHS Coordinator announced that seven MCC personnel were in training at the Menninger Psychiatric Aide Training School at the nearby Topeka State Hospital (MCC Mental Health Services Committee Minutes of March, 1950, p. 2). The MMHS coordinator came to recognize this unit as a training center for future staff members of MCC psychiatric hospitals (MCC Mental Health Service, 1951). (Parenthetically, with the move

toward outpatient services in the 1960s the psychiatric aide role became less central in the program.)

The Menninger program also supplied three medical directors for the Mennonite Programs. In July, 1958 Giles Morin came from Menninger's to replace Helmut Prager at Brook Lane. The contrast between Morin and his predecessor is quite striking. While Prager had relied heavily on Electro Shock Treatment (EST), Morin characterized his approach as treating the "whole man," physically, psychologically and spiritually (Morin, 1960). This seemed to more nearly reflect the philosophy of the Mennonites.

In July of 1961 Mitchell Jones from the Menninger program became the second medical director of Prairie View, replacing Thomas Morrow. A third medical director coming from the Menninger program was Otto Klassen, who began to serve at Oak Lawn in July of 1962. He reflected the sponsoring denomination in at least two aspects. He was the first Mennonite medical director, and as a child care specialist he placed great emphasis on the role of the family in the development and recovery of emotional stability.

It seems clear the Menninger connection was in harmony with the move toward the spirit of the therapeutic community in the 1950s. In 1981, Karl Menninger was awarded the Presidential Medal of Freedom (the United States' highest civilian honor) by President Jimmy Carter.

The 1960s

During this decade the Mennonite-sponsored programs had two sets of relationships with which to interact: with the Mennonite Church which had given them birth; and with the wider society's mental health-related leadership, including the national community mental health center movement. This paper makes the case that this continued to be a relationship of partnership and mutual stimulation.

By the beginning of the 1960s there was significant momentum toward publically funded community-based mental health care in the United States. (This is remarkable in light of the fact that public provision for health care is still extremely controversial in this country in 2010).

The Mental Health Act of 1946 was a government initiative for research in finding answers to the lack of adequate health care. Eventually, The Joint Commission on Mental Illness and Health was established through governmental initiative.

The critical watershed for community mental health care was the *Final Report of the Joint Commission on Mental Illness and Health* (hereafter to be called *The Final Report*) in 1961. Even before it was

published ideas were being discussed among participants who were working on the document. Mennonite mental health leaders were also anticipating what the *Final Report* might call for. In 1958, three years before they came out, the MMHS minutes of April 11-12, 1958 included the following description of their next mental health care program that was to open in 1963.

In addition to some of the more traditional treatment objectives, Oaklawn included the following in their proposed program: consultation services to religious institutions and pastors, educational institutions, teachers, and welfare agencies; avoidance of duplication of services by using available community resources; coordination of local community resources in pre-marital, marital and other types of counseling; inclusion of diagnostic and treatment facilities and an adequately trained staff in the fields of psychiatry, clinical psychology, psychiatric social work, religion and general medicine. (MMHS Minutes, 1958, doc. 21).

In April, 1962 the Chairman of MMHS, H. Claire Amstutz, interpreted two developments in the Mennonite programs as moving in the direction recommended in the *Final Report*. Kingsview was actively planning to provide staff for a psychiatric in-patient service, on the grounds of and in conjunction with a general hospital at Bakersfield in the neighboring county. Amstutz saw this as being in harmony with the recommendation in the *Final Report* that the envisioned community mental health programs should associate with general hospitals and make use of existing facilities. He also viewed Oaklawn's practice of placing local community leaders on personnel and building committees as consistent with the encouragement for a broad community base in the *Final Report* (MMHS Minutes, 1962).

The serious attention given to the *Final Report* is illustrated by Prairie View's Administrator Elmer Ediger at the April 19, 1963 MMHS meeting. His report examined Prairie View's direction from the perspective of the *Final Report*. This study will note here a few excerpts to underscore the crucial impact of this document on their program. Ediger saw in that study confirmation for Prairie View's move toward a community orientation. He believed this to be in contrast to the trend of many private psychiatric hospitals. Having attended the meeting of the National Association of Private Psychiatric Hospitals the previous year, he felt many lagged behind in their community orientation.

Ediger saw the *Final Report* as laying a "base for a tremendous push coming from public opinion, American Medical Association leadership

and congressional action.” He believed the Mennonite programs would need to provide leadership in community-based programs or face isolation. He envisioned a three-county community-based organization, with Prairie View giving leadership. In light of the *Final Report*, Ediger viewed Oaklawn, which opened as a bed-less facility, as creating a welcome influence on the other Mennonite programs toward maximizing outpatient and community-based treatment, consultation, educational services, and research activities (Ediger, 1963).

The impact of the Joint Commission’s concluding document was immediate and profound. The Mennonite leaders had kept in close touch with mental health developments and were not taken by surprise. In fact, Oaklawn in particular had anticipated these developments when they opened as a bed-less mental health center in 1963 without benefit of community mental health center funds.

Again, evidence suggests that the Mennonite programs had been able to anticipate community mental health developments through their interactions with non-Mennonite professionals. In 1964 Prairie View was included in a publication by the Joint Information Services of the APA and NAMH—*The Community Mental Health Center: An Analysis of Existing Models* (MMHS Minutes, 1964). A second indication of this head start by a Mennonite program was the inclusion of Oaklawn in the April, 1964 publication by Public Health Service of HEW, *Concept and Challenge: The Comprehensive Community mental Health Center* (Public Health Service of HEW, 1964).

Evidence of Mennonite mental health leaders contributing to as well as learning from the wider mental health professions during the 1960s were two awards from the American Psychiatric Association (APA). In 1968 Prairie View received the APA Gold Award for their collaborative efforts with the local community in developing a comprehensive community mental health service. Three years later Kingview was presented with the APA Gold Award for their progressiveness as a private agency in contracting with public (county) entities for mental health services (Neufeld, 1971). In both cases there was only one Gold Award presented each year.

This discussion now turns to the emerging relationship of the Mennonite Church to church-sponsored hospitals/centers. The search for the appropriate role for the church in the hospital programs in the late 1950s and the 1960s resulted from three extra-Mennonite impingements: increasing professional influence, broadening the community base to include non-Mennonites, and in the 1960s increasing governmental involvement. This search for the church’s role in the late 1950s focused on the issue of the relationship of the hospital administrator and medical director with each other. There was also concern about a potential gap between the hospital/center leadership, on the one hand,

and the role of MCC and MMHS, the intermediary link between the local programs and the church, on the other hand.

All three hospitals had attempted to deal with the integration of the church and psychiatric concerns by a dual organizational arrangement. The administrators had begun as lay Mennonites with significant mental health care exposure. They were expected to bring concerns of the Mennonite constituency to bear on the hospital programs. The medical directors attempted to relate in a creative tension, incorporating sound psychiatric principles in the programs. The role of the church in the programs, through the administrators, seemed to be diminishing in the face of the trend toward professionally trained staff.

For Mennonites in the United States, 1963 was a year of some degree of irony. The United States Congress passed the Mental Retardation and Community Mental Health Centers Construction Act, providing public funding for community mental health centers. That same year was a time of decision regarding the role of the Mennonite Church in its mental health centers. These institutions were moving from the 1940s concept of hospitals as extensions of the church to the concept of allies of the church. They were wrestling with two questions: (1) how should the church relate to the mental health centers? Also, (2) what kind of control would be appropriate for the Mennonite Church to exercise through MCC?

In February of 1963 there was a consultation among Mennonite scholars, theologians from the Institute of Mennonite Studies, MMHS, and representatives from mental health centers. They were unable to reach an underlying philosophy satisfactory to both sides. Thereafter, there was an inclination among the center leaders to concentrate on the more pragmatic problem of providing avenues for greater mutual assistance of the church and the centers (Ediger, 1963).

A Study Committee was appointed by MMHS to seek out and recommend an appropriate role in their relationship to the centers. They opted for increased local decision-making, but also for a strengthened MMHS role that could focus on other matters more consistent with its strengths and limitations. They would stay in touch with national mental health trends, experiment with new mental health projects, explore the relationship between religion and society, interpret the program to constituent churches, and bring center representatives together for mutual stimulation (MMHS, 1964).

Two authors completed books that were related to the discussion of the relationship of the church and church sponsored mental health programs. Myron Ebersole, in his Master's thesis, sought an underlying common conceptual base for the therapeutic community and the Mennonite religious tradition. While seeing underlying commonalities,

he distinguished between the appropriate professional relationships of clients with mental health professionals, and the relationship of the emotionally troubled person and his peers in such a setting as the church. The former, hopefully, leads one to a degree of mental health that makes participation in a primary group, such as a church congregation possible, if a person so chooses (Ebersole, 1961).

Paul Peachey also warned against use of social services by the Mennonite Church for its institutional ends. He believed a distinction needed to be made between institutionally oriented activity and the primary relationships within the local congregation, which can be a "community of wholeness" (Peachey, 1963).

The events described in the above five paragraphs set the stage for a changing relationship of the Mennonite-related churches in the United States with their mental health programs. The result of the "journey" from CPS to "homelike" hospitals/centers to "therapeutic community" to community-focused mental health centers, seemed clear by 1965. This is the journey described in my dissertation, from which this paper evolved. It was treated as the end of one chapter in the Mennonite mental health care movement. Obviously, it was not the end of the movement in Canada or the United States.

In summary, in the 1960s a vigorous attempt was made to integrate evolving philosophy of the Mennonite sponsored community mental health centers with the expectations of the Mennonite Church, which had given them birth. Four aspects of this development were especially important. First, the move from serving primarily Mennonite patients to serving patients of a variety of religious and non-religious backgrounds changed the constituency base.

Second, volunteers as a significant segment of hospital staffs gradually gave way to increased emphasis on clinically trained staff. This created some consternation among a segment of the Mennonite constituency who had envisioned a "homelike atmosphere" and lay involvement as crucial ingredients of a Mennonite-sponsored mental health program. Increasingly, the encouragement from the center was for Mennonites interested in mental health care to get professional training. Volunteers continue to play a vital role in assisting those with emotional stress to become integrated into the community.

Third, sensitizing the Mennonite constituency through written media, VS, foster home care and the mental hospital/mental health care programs of informal community education such as guest speakers, raised Mennonite awareness of mental health issues. There was a trend toward organized educational and training programs with a wide variety of lay and professional trainees, especially pastors.

Fourth, there was a gradual movement for centers to gain a sense of identity as a local community program. This was fueled further in

the 1960s as the centers developed local community orientation, with non-Mennonites included on the local boards.

The mental health centers had moved gradually yet steadily from the role of being an extension of the Mennonite Church to becoming allies of the church involved in a common task in the wider society.

Conclusions

This paper proposes the following interpretation of this 23-year journey. Initially, by their actions, CPSers said clearly; “We cannot join the war effort, but we can attempt to bring healing to those who suffer in state mental hospitals.” With their human kindness they caught the attention of progressive non-Mennonite leaders in the mental health field. Heeding those voices and their own collective conscience, they established church sponsored programs with a combination of a “homelike atmosphere” and a treatment program. This movement evolved into six mental health centers. This paper contends that local communities taking greater responsibility for each center was an indication of increasing maturity.

As the Mennonite Church came to recognize that each local community had a vital stake in its community mental health center and responded accordingly, the church also was enriched. We would never lose what we had learned, and are still learning about mental health. Some Mennonites have become professionals in the field. Also, there will never be enough volunteers to walk beside those who struggle to function in the community.

Epilogue

During the recent Mental Health Conference in Winnipeg, it became clear that in Canada and the United States their community mental health care journeys were, at a very deep level, part of the same movement. The masterful presentation of (and responses to) Eden Mental Health Centre’s journey with the Mennonite-related churches in Canada made clear that in this journey they recognized the appropriate role of secular mental health related institutions while maintaining their integrity as a church-related program. It was a reminder to this author of the similar journey in the United States from 1942 to 1965.

This paper pictures the journey from the CPS days to the 1950s through to the early to mid-1960s in the United States. By that time the church-related mental health care programs found ways to walk

alongside secular public institutions springing from the community mental health center movement without “losing our way.”

Through the assistance of MCC, Mennonite Mental Health Services and mental health center leaders, the church gradually found peace with this reality.

A decade and a half before CPS, in the late 1920s, Canada gave to Mennonite mental health leaders from both Canada and the United States the dramatic example of Bethesda in Vineland, Ontario. This became a fitting image for the first Mennonite-sponsored mental health care program at Brook Lane. Bethesda in Vineland, Ontario was “homelike atmosphere” personified.

Also, since MCC and Mennonite Mental Health Services were crucial in the development of all six of our mental health care programs, it is gratifying to remember that these two organizations belong equally to Mennonite-related groups in Canada and the United States.

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