MENNONITE CENTRAL COMMITTEE MENTAL HEALTH SERVICES
The Establishment of Three Mental Institutions

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CURRICULUM STUDIORUM

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INTRODUCTION

The purpose of this thesis is to study the establishment and growth of three mental institutions administered by the Mennonite Central Committee Mental Health Services whose headquarters are in Akron, Pennsylvania.

Events which led to the formation of this administrative body and the subsequent establishment of a mental hospital program were recorded by Melvin Gingerich[1] in his history of Mennonites in civilian public service during the war years 1940-1945. John Unruh[2] in a history of the Mennonite Central Committee, reported a few of the early developments of the Mental Health Services project.

Since no history has been written of the development of these three hospitals to date, it is hoped that this study may serve as a preliminary report for future historians.

The establishment of mental hospitals fits into a cultural trend. A study of the historical background of mental hospital growth in America as recorded in the Encyclopedia Americana, showed a rapid increase of psychiatric

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1 Melvin Gingerich, Service for Peace, A History of Mennonites in Civilian Public Service, Akron, Pennsylvania, Mennonite Central Committee, 1949, p. 213-250.

2 John D. Unruh, In the Name of Christ, A History of the Mennonite Central Committee and Its Services, 1920-1951, Scottdale, Pennsylvania, Herald Press, 1952, p. 310-318.

facilities in the latter part of the nineteenth century and during the twentieth century. By 1912 every state had one or more state supported mental institutions and by 1939 the number had increased to 351 with a patient capacity of more than 500,000.

Improved psychiatric facilities and services came largely from within the institutions by the prosecution of physicians and psychiatrists. Laymen became increasingly aware of the problems of mental illness and mental health through the efforts of such persons as Dorothea Dix and Clifford Beers. The mental hygiene movement instigated by Beers had far-reaching effects in the organization of community mental health programs.

In keeping with these preliminary considerations, the survey of literature included articles which appeared in the 1948-1954 issues of the Mental Hygiene and American Journal of Psychiatry dealing with current trends in hospital administration, staffing and treatment emphasis. The following are articles which the writer found to be of significance in these areas. The Modern Mental Hospital by Paul Haun,[3] a North Carolina psychiatrist, placed the maximum mental hospital capacity for efficient operation at 1500. Haun also stressed

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3 Paul Haun, "The Modern Mental Hospital," American Journal of Psychiatry, Vol. 109, No. 3, September 1952, p. 163-167.

the importance of strategic hospital location and the need for more adequate personnel rather than additional physical facilities. Leslie Osborne[4] Wisconsin Division of Mental Hygiene Director and professor of psychology at the Wisconsin State Medical School, also upheld this view-point. Osborne further stressed the idea of maximum freedom as opposed to confinement and locked doors and the growing acceptance of the team approach where everyone who contacts the patient is an important member of the therapeutic team. Finally Osborne stressed the importance of establishing a community related hospital.

As pointed out by George Stevenson[5] Medical Director of the National Association for Mental Health, the community related aspect of mental health has been neglected. In the past the hospital location was one of isolation and it has been only in the last half century that the importance of home environment and follow-up care of the discharged patient was considered.

This fairly recent emphasis on adequate follow-up care probably accounts for the gradual increase in the

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4 Leslie Osborne, "Functional Design of Psychiatric Hospitals," American Journal of Psychiatry, Vol. 109, No. 2, August 1952, p. 140-142.

5 George S. Stevenson, "Dynamic Considerations in Community Functions," Mental Hygiene, Vol. 34, No. 4, October 1950, p. 531-546.

number of patients in foster homes.[6] An increase of approximately 1500 mentally ill being cared for in this way was reported for the period 1951-1953.

Another possibly less publicized but apparently effective rehabilitative method is described by Louis Reich,[7] Assistant Superintendant of the Butler Hospital in Rhode Island, as an in-between institution operated by laymen for patients well enough to be discharged from the mental hospital but not ready to return home.

Daniel Blain[8] American Psychiatric Association Medical Director, lists the objectives of the Mental Health Program as (1) hospitals and clinics, (2) treatment techniques, knowledge and technical equipment, (3) personnel. Here again it is pointed out that these first two objectives are available but personnel is lacking. He also stressed the importance of an all out educational program in secondary schools.

A recent trend noted to help solve the mental hospital staffing problem is that of training psychiatric aides, attendants and technicians to supplement the general shortage

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6 Walter Barton, "Review of Psychiatric Progress, Out Patient Psychiatry and Family Care," American Journal of Psychiatry, Vol. 110, No. 7, January 1954, p. 533-534.

7 Louis Reich, "The Halfway House: The Role of Layman's Organizations in the Rehabilitation of the Mentally Ill," Mental Hygiene, Vol. 37, No. 4, October 1953, p. 615-618.

8 Daniel Blain, "A New Emphasis in Mental Health Planning," American Journal of Psychiatry, Vol. 109, No. 2, February 1954, p. 702-704.

of psychiatric personnel. Walter Baer[9] an Illinois psychiatrist reported the existence of 135 such training schools, offering courses of one week to nine months in length.

Although private mental hospitals for the most part offer adequate individual psychiatric care, the facilities are limited and expensive. A study[10] made in 1947 showed ten states without facilities, six with less than one hundred patient capacity, twenty-six with one hundred to nine hundred and ninety-nine and six with facilities for one thousand or more patients. The average rate was $70 a week with an additional $25-$50 weekly medical charge.

A State Program of Mental Health, by Frank F. Tallman,[11] Ohio State Commissioner of Mental Hygiene, indicated the trend in treatment of extensive use of electro-shock, insulin therapy and prefrontal lobotomy which decreases the period of hospitalization. The importance of locating a hospital near a community where medical services are available and where

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9 Walter H. Baer, "The Training of Attendants, Psychiatric Aides and Psychiatric Technicians," American Journal of Psychiatry, Vol. 109, No. 4, October 1952, p. 291-295.

10 Irene Sherman and Harry Hoffman, "Facilities in Private Mental Institutions," American Journal of Psychiatry, Vol. 106, No. 4, October 1949, p. 268-269.

11 Frank F. Tallman, "A State Program of Mental Health," Mental Hygiene, Vol. 32, No. 2, April 1948, p. 271-278.

the mental hospital can become as much a part of the medical community as a general hospital, was also stressed by Tallman.

A survey reported by Feiga Gross[12] showed excellent results produced by the intensive use of electro-shock treatment.

A study of the effectiveness of psychotherapy for the aged[13] reported a note of hopefulness in that area.

Several trends pointed out by the references cited are (1) a shorter period of hospitalization as a result of newer methods of therapy, (2) a growing awareness of the mental hospital as a part of the community in which it is located, (3) need for more adequate staffing rather than additional physical facilities, and (4) maximum freedom as opposed to confinement for the mentally ill.

The recent interest among the Mennonites in establishing their own mental institutions fits in with this general trend of improving facilities and services for the mentally ill and actively promoting mental health.

The first chapter of this paper presents the historical background of the Mennonite Church and the activities of the

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12 Feiga Gross, "Survey of First Two Years of Electro Shock Treatment in a Large Private Hospital," American Journal of Psychiatry, Vol. 109, No. 1, July 1952, p. 32-35.

13 Alvin I. Goldfarb and Helen Turner, "Psychotherapy of Aged Persons," American Journal of Psychiatry, Vol. 109, No. 12, June 1953, p. 916-921.

Mennonite Central Committee, which is composed of representatives from various branches of the Mennonite Church in America.

This Committee organized in 1920 primarily as a foreign relief agency continues to function in this capacity. Another area of activity was the administration of Mennonite civilian public service camps during World War II. In this period approximately 1500 of the Mennonites in civilian public service worked in state mental hospital units. The interest in this work aroused among the men by their hospital experiences spread to the Mennonite Central Committee constituency and in time led to the formation of the Central Committee Mental Health section and the establishment of three small mental institutions.

Chapter II is concerned with initial study of the problem of establishing church mental hospitals and the active planning and administration of these hospitals. As pointed out in this chapter, the basis for establishing church hospitals was a desire to contribute actively to the care of mentally ill, although actual experience in psychiatric work among Mennonites had been mainly at the attendant level.

The last three chapters trace the developments of the individual hospitals located at Leitersberg, Maryland,

opened in November 1948; Reedley, California, opened in February 1951, and Newton, Kansas, opened in March 1954.

A primary consideration in tracing the development of these Mennonite mental institutions is an understanding of the historical background of the Mennonite Church.

CHAPTER I

ACTIVITIES OF THE MENNONITE CHURCH

To clarify the development of the Mennonite Central Committee Mental Health Services which culminated in the establishment of three small hospitals for mentally ill, it is necessary to first familiarize the reader with the origin of Mennonites and various activities of the Church which led to the development of this program.

1.- Origin of the Mennonite Church

The Mennonite Church[1] was founded in Zurich, Switzerland in 1525 by a group of Bible students, commonly called Anabaptists, led by Conrad Grebel. Anabaptism maintained an unbroken course in Switzerland, Holland, South Germany and Austria throughout the sixteenth century and has continued to the present in the Mennonite movement. The outstanding leader of the group was the Dutch Menno Simons, active from 1536-1561.

Among the doctrines[2] stressed by these people were the separation of church and state, and nonresistance.

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1 Harold S. Bender, "The Anabaptist Vision," reprinted from The Mennonite Quarterly Review, April 1944, Goshen, Indiana, Mennonite Historical Society, 1949, p. 8.

2 Guy F. Hershberger, War, Peace, and Nonresistance, Scottdale, Pennsylvania, Herald Press, 1946, p. 80-88.

Although they believed the state was necessary to keep order in a society not totally Christian, they also believed that the Christian should not use force or take human life as a soldier in the army or as a magistrate in the civil government. Bender enlarges this concept when he writes:

> The focus of the Christian life was to be not so much the inward experience of the grace of God, as it was for Luther, but the outward application of that grace to all human conduct and the consequent Christianization of all human relationships.[3]

Persecution for their religious and social views frequently caused entire Mennonite communities to migrate. By the middle of the sixteenth century, Mennonites from Holland had migrated to northwest Germany. Those who remained in Holland eventually lost their nonresistance and it was only in the last decade that an active interest in this doctrine has been revived through association with American Mennonites.

In the seventeenth century many Swiss Anabaptists migrated to southern Germany, France, and as early as 1683, a few families migrated to Pennsylvania to form the first Mennonite settlement in America. By the end of the eighteenth

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3 Bender, Op. cit., p. 14.

century there were some 7000 Mennonites in eastern Pennsylvania. The Mennonites from Switzerland and southern Germany continued to emigrate to America during the nineteenth century. Some of these in turn moved to Canada, mainly into southern Ontario.

Toward the close of the eighteenth century when conscription became a universal practice in Europe, those Mennonites who took their nonresistance most seriously again left their homes, this time to settle in southern Russia and also later in Siberia, where they had been promised religious freedom and exemption from military service.

The Russian government maintained this policy until 1870. In the five years from 1870-1875, 15,000 Mennonites emigrated from these areas to the prairie regions of Canada and the United States. Alarmed by this large exodus, the Russian government allowed the remaining Mennonites to engage in civilian service as an alternative for military service. The coming into power of the Bolsheviks[4] after the Russian revolution in 1917, precipitated the second large scale emigration from Russia. During the years 1922-1930 approximately 29,000 Mennonites left Russia to settle in Canada, Paraguay and Brazil. They were aided somewhat in

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4 Hershberger, Op. cit., p. 153.

this emigration by the American Mennonites who more actively sponsored the establishment of their settlement in South America.

In the most recent emigration from Russia[5] to the Americas in the years 1945-1950, the American Mennonites took the responsibility for the emigration and establishment of more than 11,000 Mennonite refugees.

At present there are approximately 500,000 baptized members[6] of the Mennonite Church in Europe and America. Those who remained in Russia[7] after 1917 suffered increasing hardships. In the fall of 1920 the American Mennonites formed a Central Committee representative of various branches of the Mennonite Church in America, primarily to aid the Mennonites left destitute by the Russian revolution.

2.-Foreign Relief Service 1920-1954

The Mennonite Central Committee[8] became a permanent organization in September, 1920. The forming of a committee,

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5 John D. Unruh, In the Name of Christ, A History of the Mennonite Central Committee, Scottdale, Herald Press, 1952, p. 178.

6 Bender, Op. cit., p. 8.

7 Unruh, Op. cit., p. 16.

8 Ibid., p. 319-331.

representative of various Mennonite groups in North America, was an attempt to strengthen the total relief program of the Mennonite churches, by combining the efforts of the individual relief organizations. Seven church groups were represented when the Committee was first organized. Since that time the number has increased so that at present twenty-two representatives are appointed to meet at least once a year. Those church groups which support the work of the Committee are entitled to appoint one representative for every body of 25,000 members or less. The individual groups determine the length of service and the method of selection of their appointees. If it so desires the Committee may appoint two members at large.

The Central Committee annually elects an executive committee of seven members. The main office of this Central Committee was located in Scottdale, Pennsylvania for the first fifteen years of activity until it moved to Akron, Pennsylvania in 1935. Some time later several regional offices were opened; the three which are still functioning are Kitchener, Ontario, opened in October 1944; Reedley, California, opened in June 1948; and Newton, Kansas, opened in 1952.

The Committee's first relief project[9] was the distribution of clothing and food during the three years running from October 1921 to the end of the summer of 1924. It also helped Russian Mennonites to emigrate to the Americas. Later, mainly in the years 1930-1938, the Committee aided in the establishment of Mennonite refugees in Brazil and Paraguay.

The second large scale foreign relief endeavor,[10] beginning in 1940, again took the form of emergency relief projects to war damaged countries. To these were added children's homes, old people's homes, reconstruction units, refugee camps, community health education, medical clinics and hospitals, depending on the particular needs of the communities in which Mennonite Central Committee workers were stationed. The personnel in these units consisted mainly of young people from various Mennonite groups who volunteered for one, two or more years of service.

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9 Hershberger, Op. cit., p. 144-153.

10 Unruh, Op. cit., pp. 45-50, 57-59, 65-69, 75-97, 102-125, 112-121, 125-139, 145-153.

This type of emergency relief work is being continued at present in such countries as Korea[11] and Palestine.[12] However in those places where the acute need is past, as in certain areas of Japan[13] and Germany,[14] the trend is in favor of community centers where self-help projects, such as sewing rooms, shoe repair shops, reading rooms, and youth activities are carried out.

The history of the Mennonite Central Committee service can at this point be divided into three periods. From 1920-1924 it was concerned with Russia famine relief. For the next five years, 1925-1930, it was comparatively inactive, but from 1930-1938 the Committee was engaged in establishing the new Mennonite settlers in South America. The third period began with the outbreak of World War II in 1939 when again emergency relief projects were carried

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11 Dale Nebel, "Progress of M.C.C. in Korea," from the Far Eastern Relief Notes, reprinted in the Gospel Herald, Scottdale, Pennsylvania, Mennonite Publishing House, Vol. 46, No. 35, September 1, 1953, p. 840, Col. 1, 2.

12 M.C.C. News Service, "M.C.C. Weekly Notes," Gospel Herald, Vol. 46, No. 34, August 25, 1953, p. 818, Col. 2.

13 Ibid., p. 818, Col. 2,3.

14 Unruh, Op. cit., p. 153-160.

out. In this third period,[15] a new field was entered when in 1940 the Mennonite Central Committee took over the administration of civilian public service.

3.-Mennonites in Civilian Public Service

In his history of Mennonites in civilian public service, Gingerich[16] expresses the principle of non-resistance in these words:

> Refusal to participate in war is only part of the doctrine of nonresistance. It is based upon the concept that the Christian loves all men including his enemies. "If thine enemy hunger, feed him; if he thirst, give him drink." Throughout the history of the church this scriptural admonition has been its ideal.

In keeping with this theological tenet, approximately 5,000 Mennonite men[17] served in civilian public service during the war years of 1940-1945. This number comprised 39% of the total civilian public service population in the United States. The Friends, Brethren and Mennonite churches all administered their own civilian

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15 Melvin Gingerich, Service for Peace, A History of Mennonite Civilian Public Service, Akron, Pennsylvania, Mennonite Central Committee, 1949, p. 84.

16 Ibid., p. 17.

17 Ibid., p. 85-86.

service camps. They also assumed the responsibility for supervising conscientious objectors from churches not sympathetic with the nonresistant stand. These service camps were under the directorship of Federal Selective Service which assigned the projects to be carried out by the men.

During 1941, the first year of civilian public service,[18] the men in Mennonite camps engaged in soil conservation, forestry service, game reserve work and nursery projects. By the following year, arrangements had been made with Federal Selective Service to allow civilian service men to engage in special projects such as dairy farm service, training schools, public health service and mental hospital work. Of these special projects, the mental hospital work made the greatest impression, not only among the men who served in these units, but also among the Mennonite Central Committee constituent groups. Since this paper is concerned primarily with the development of the Mennonite Central Committee mental health services, the mental hospital work is the only aspect of civilian public service which will be discussed.

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18 Ibid., p. 85.

At the peak of the program,[19] 900 men were serving in twenty-five mental hospital and training school units. These latter were institutions for mentally retarded children. By December 1945, more than 1500 men[20] and a number of wives had worked in state mental hospitals under the administration of the Mennonite Central Committee.

Something of the spirit and work of these people can possibly be shown by quoting a few excerpts from various hospital unit publications. From Marlboro, New Jersey:

> In the early part of 1945, the unit was expanded to a total of 100. By this time the major portion of the hospital attendant staff was made up of C.P.S. men and their wives. (...) Increased unit strength made it possible to assign C.P.S. men to vacant positions other than that of attendant. Special skills were utilized. There was a physician, a social case worker, an accountant, a craftsman, and there were laboratory technicians and dairymen.[21]

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19 Robert Kreider, "The Opportunity of the Church," Anniversary Review, Mental Hygiene Number, Harrisburg, Pennsylvania, C.P.S. Unit 93 publication, May 1945, p. 62.

20 Gingerich, Op. cit., p. 246.

21 "Background of CPS Unit No. 63 at Marlboro," P.R.N., Marlboro, New Jersey, C.P.S. Unit No. 63, (no date), p. 52.

In the Norristown state hospital publication we read:

> Tending patients with loving kindness has in many instances changed conditions on the ward. (...) To work on the ward has not been an easy job for most of the fellows, for many of them have had to work hours and days that should have been free (...) very few men have complained.[22]

An outgrowth of the civilian public service hospital experience[23] was the Mental Hygiene Program which was concerned mainly with better care for the mentally ill. This project created wide-spread interest among hospital superintendents and church leaders. In 1946 it became the National Mental Health Foundation. Its sponsors for that year included Mrs. Franklin D. Roosevelt, Pearl Buck, Harry Emerson Fosdick and others. In the fall of 1950 the National Mental Health Foundation, the National Committee for Mental Hygiene and the American Psychiatric Foundation joined to form the National Association for Mental Health whose headquarters are in New York.

Two books published as a result of the civilian public service survey of conditions in mental hospitals are Out of Sight-Out of Mind, by Frank L. Wright, Jr., who

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22 "Ward Service," Files, Norristown, Pennsylvania, C.P.S. Unit No. 66, (no date). p. 35.

23 Gingerich, Op. cit., p. 247-248.

worked in a Mennonite Central Committee mental hospital unit; and Forgotten Children, dealing with the mentally retarded, by Grant Stoltzfus who worked in the Mental Hygiene Program.

Robert Kreider, at present a member of the Faculty of Arts, Bluffton College, Ohio, who was director of the hospital units, summarized what had been learned from this hospital experience in terms of what it could mean to the Mennonite Church. Kreider[24] wrote in essence that civilian public service men made good attendants even though they came to the hospital without previous experience. It was learned too that there is no better treatment for mental illness than Christian concern and friendship. The men saw that the soul of an institution must be found in the men and women who serve in it. There was an awareness of the difficulty of translating beliefs into action in a non-Christian environment. These considerations, along with the impersonality and imperfections of state hospitals, awoke the men to the possibility of establishing a private church-supported hospital.

Kreider concluded the article by stating that the Mennonite Central Committee should be actively concerned about mental hygiene. The Church should think seriously

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24 Robert Kreider, Op. cit., p. 62-63.

of establishing mental institutions. It was also suggested that the establishment of psychiatric wards in conjunction with Mennonite general hospitals would be a good way to begin this work.

Interest in caring for mentally ill grew among the Mennonite church groups. As early as 1944[25] the Central Committee organized summer service units to serve in state mental institutions. These units were composed of women who wished to volunteer for service comparable to the work being done by the drafted men. Mental hospital units composed of men and women have continued to function in this capacity since the war years.

These hospital units were part of a larger Mennonite Central Committee administered voluntary service program[26] in which young people served for a period of three months, one year or more in such places as mental hospitals, general hospitals, camps for underprivileged children, medical clinics and refugee camps.

Although the Mennonite Central Committee was organized primarily as a foreign relief agency, it later developed a variety of services at home as well as abroad.

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25 Unruh, Op. cit., p. 296.

26 Ibid., p. 297-309.

These developments may help the reader to better understand the interest and spirit of service which led the Mennonites to seriously consider the establishment of their own mental institutions.

CHAPTER II

MENNONITE CENTRAL COMMITTEE MENTAL HOSPITAL PLANNING AND ADMINISTRATION

Service in mental hospitals had created an interest among the Mennonite churches toward establishing their own mental institutions. In June 1945, the Executive Committee appointed P.C. Hiebert, H.S. Bender and Robert Kreider to serve on the Mental Hospital Study Committee formed to investigate this problem.

Four months after its appointment,[1] the new committee proposed a plan of study to the Executive Committee. The stated objectives of the plan were (1) to ascertain the extent of mental illness and mental deficiency among the Mennonite and Brethren in Christ churches, (2) to investigate the type of institutional care which could best be provided, and (3) to determine whether these institutions should be administered by individual church groups or by the Mennonite Central Committee.

After endorsement of the plan by the Executive Committee, the Study Committee proceeded to send questionaires to 1,070 Mennonite and Brethren in Christ congregations. Some of these findings are shown on Table I.

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1 Unruh, Op. cit., p. 310-311.

TABLE I.-

Special Care Cases in the Mennonite Central Committee Constituency[2]

Classification	In Institutions	Cared for at Home	Totals
Both Groups	370	865	1235
Mentally Ill	302	365	767
Mentally Defective	68	500	568

2 Ibid. p. 311.

The Study Committee also investigated several existing church-operated mental institutions and psychiatric departments in general hospitals.

Although the data in Table I was compiled from only 670 of the 1,070 questionaires sent out, it was estimated that the total number of mentally ill and mentally deficient in the Mennonite Central Committee constituency would be less than 1500, which was comparable to the percentage of mentally ill among the general population of the United States. Very few questionaires[3] were returned after the initial statistical data had been compiled. The questionaire also indicated that 319 of the congregations favored establishing their own institutions. The 1945 report[4] concluded that the Mennonite Central Committee was not ready to establish full-fledged psychiatric hospitals because of the expense, which was estimated at $5,000 per hospital bed, and because of the lack of trained personnel within the church groups.

The report did urge the consideration of establishing psychiatric wards in the Mennonite general hospitals and

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3 Mental Hospital Study Committee, Supplementary Report, to the Mennonite Central Committee, April 6, 1946, p. 1.

4 Homes-for-Mentally-Ill Planning and Advisory Committee, Minutes, Appendix I, Chicago, Illinois, January 25, 1947, p. 3.

the possibility of operating rest homes for mentally ill and mentally deficient patients. It was further suggested that in co-operation with the psychiatric wards and rest homes there should be foster home care programs. After additional research and study into the church's role in mental health, the Study Committee confirmed its earlier report and in February 1946, added the following recommendations.

First, the Church[5] should stress the contribution of religious faith to mental health through its schools and publications, and its ministers should be encouraged to become equipped and competent in the field of counseling and pastoral psychiatry.

Second, investigation should be made into the possibility of interesting former civilian public service men with hospital experience, in providing foster home care for mentally ill.

Third, as the Committee had been especially impressed by the work being done at the Mennonite Brethren hospital in Vineland, Ontario, it suggested the establishment of several small institutions, sponsored by regional conferences.

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5 Mental Hospital Study Committee, Op. cit., p. 4-5.

Finally, the Church should maintain a live contact with the National Mental Health Foundation, through her schools, mental hospital service units, nurses' and doctors' associations and hospitals.

At this early stage of planning, representatives from the West Coast and Midwest areas had asked the Mennonite Central Committee to establish mental hospitals in their respective regions. However the first tangible development of the hospital program occured in September of 1946 when Orie O. Miller[6] of the Executive Committee proposed that the 105 acre farm near Leitersberg, Maryland, which had been purchased by the Central Committee as a civilian public service project in 1941, be retained for the location of a rest home for Mennonites needing psychiatric care. The proposal was accepted with the request that Miller draw up a possible plan for the operation of the home. Such a plan was later presented to the Committee by Elmer Ediger, the first director of Mental Health Services.

At its meeting in January 1947, the Central Committee, after adopting a resolution to continue work in this field, more specifically recommended planning in terms of three small hospitals located in the East, Midwest, and West Coast

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6 Unruh, Op. cit., p. 312.

areas, the appointment of a hospital advisory committee, and the holding of the Leitersberg property for the location of the Eastern hospital.

E.C. Bender, Titus Book, Henry R. Marten, Orie O. Miller, Paul Nase, H.A. Fast and Harold Sherk, with the last two mentioned serving as chairman and recording secretary respectively, were appointed to serve on the hospital committee. This committee was called Homes-for-Mentally-Ill Planning and Advisory Committee until 1950 when it became the Mental Health Service Committee.[7]

Past experience of Mennonites in the psychiatric field had been limited largely to the level of aides and attendants in state hospitals, a therapeutic role[8] which had become increasingly important. Because of this limitation in trained personnel, it was necessary to employ outside professional psychiatric assistance to develop an early effective treatment program. However the Committee planned to encourage interested Mennonite young people to

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7 Elmer Ediger, "Report to the Homes-for-Mentally-Ill Planning and Advisory Committee," Minutes, Chicago, Illinois, March 17, 1950, Section III, p. 1.

8 Walter H. Baer, "The Training of Attendants, Psychiatric Aides and Psychiatric Technicians," Journal of Psychiatry, Vol. 109, No. 4, October 1952, p. 291-295.

enter psychiatric fields of training. Also because of this limitation, the Mennonite Central Committee[9] did not at the beginning concern itself with a particular philosophy of treatment but it did desire to control the patients' environment. The psychiatrist as medical supervisor was to have a large measure of freedom in establishing his own treatment program and therapeutic measures.

The organizational chart in Figure I shows the interrelations of the various offices and committees connected with the mental hospital program.

The larger administrative body responsible for the operation of the Central Committee hospital program[10] was the Akron Mental Health Services office which under the Executive Secretary was responsible to the Executive Committee.

The Mental Health Service Committee acting in an advisory capacity was responsible to the Executive Committee and was concerned with (1) professional adequacy, (2) overall and respective area budgets, (3) constituency interests, (4) major policies such as wage patterns and patient rates, and (5) expansion planning. This committee composed of

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9 Delmar Stahly, Report to the Mental Health Study Conference, Chicago, July 1953, p. 2-3.

10 Homes-for-Mentally-Ill Planning and Advisory Committee, Minutes, Chicago, March 17, 1950, attachment 3, p. 1-3.

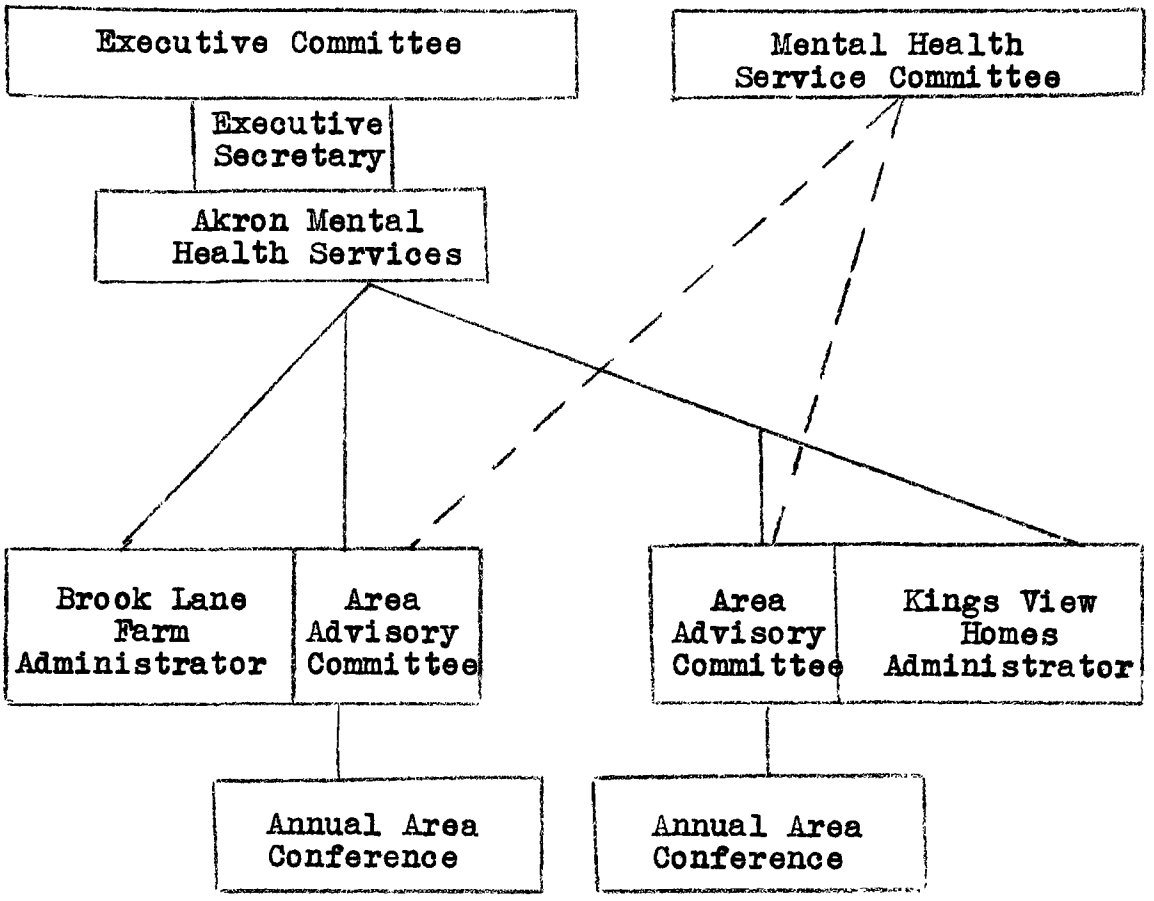

Figure 1.

Interrelation of Administrative Offices and Advisory Committees[10a]

10a Ibid., p. 3.

A third institution, Prairie View Hospital, Newton, Kansas, was established four years after this concept of interrelations had been developed.

seven members appointed for a two year period by the Executive Committee met annually.

The administrators of the respective hospitals and area advisory committees working in co-operation, were responsible to the Akron, Pennsylvania Mental Health Services Office.

Members of the area advisory committees were appointed by the Executive Committee for a two year period. The hospital administrators and an Akron office representative served as ex officio members. The committee met as frequently as necessary but at a minimum of every three months. It also called an annual area conference for the Central Committee constituency to offer general information and receive suggestions. Reports of all meetings were sent to the Akron Mental Health Service Committee.

In December 1952 Mental Health Services Incorporated[11] was established to act as a trustee holding the Central Committee mental hospital property. At this time the Mental Health Service Committee was resolved and its members became board members of the incorporation. The function of the Advisory Committees remained unchanged.

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11 Mental Health Services, Incorporated, Minutes, Chicago, December 12, 1952, p. 1-2.

The interest in establishing Mennonite mental institutions first aroused by the civilian public service hospital experiences developed into a concrete project with the appointment of the Hospital Study and Planning Committees. The plan of establishing three small hospitals as authorized by the Central Committee at its January 1947 meeting, was implemented by the development of various administrative offices and advisory committees, generally responsible to the Executive Committee.

By the spring of 1947 less than two years after the appointment of the first Hospital Study Committee a site had been chosen for one hospital and tentative plans were being made for the establishment of two more institutions. In the same year construction was started on the first hospital located near Leitersberg, Maryland.

CHAPTER III

BROOK LANE FARM A HOSPITAL FOR ACUTELY MENTALLY ILL

The Executive Committee chose the farm near Leitersberg, Maryland,[1] as the site for the first Mennonite Central Committee mental hospital mainly because the Central Committee already owned this land. Also because of the limited experience in this field, the Executive Committee favored the idea of establishing the first hospital in the Eastern area comparatively near the Akron office, where its development could be more closely guided.

In addition to these factors the institution at this location was fairly accessible to the large number of Mennonites living in the Eastern area, although the hospital was also intended to serve non-Mennonite patients from the community. There were no other institutional facilities for mentally ill in the immediate district, however there were two state hospitals and several private hospitals within one hundred miles of Brook Lane Farm.

The Mennonite hospital administration[2] planned, with the utilization of a number of voluntary service workers to

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1 Personal Correspondence of the Author, letter of Delmar Stahly, Mental Health Services Director, dated April 13, 1954.

2 Homes-for-Mentally-Ill Planning and Advisory Committee, Minutes, Chicago, April 13, 1947, p. 2.

provide standards of care and treatment comparable to those maintained at other private mental hospitals at less cost to the patient.

In October 1946 Elmer Ediger presented to the Executive Committee, the first plan for the operation of the Leitersberg hospital, later called Brook Lane Farm.[3] These recommendations formulated after further investigation of the Study Committee's suggestions and recommendations, were modified several times before a working plan was finally developed.

Of the church-operated mental hospitals[4] investigated by the original study committee, the Mennonite Brethren hospital at Vineland, Ontario was thought to have the type of program which could best be carried out at the Leitersberg institution with the limited trained personnel available among the Mennonite churches.

The Vineland hospital situated on a seventy-five acre farm served an average of nineteen chronic mentally ill patients. The informal Christian atmosphere provided good therapy. Many of the patients assisted with the routine work about the hospital and farm. In this type of large

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3 Homes-for-Mentally-Ill Planning and Advisory Committee, Minutes, Chicago, October 11, 1947, p. 1.

4 Mental Hospital Study Committee, Op. cit., p. 3.

scale foster home care only a small staff and low capital were needed for efficient operation.

The proposals for Leitersberg, Maryland,[5] favored generally the establishment of an institution patterned after this Vineland hospital in its Christian atmosphere, good attendant care and low cost. In addition to providing good custodial care, Brook Lane Farm was to utilize modern technical services. More specifically Ediger's report made the following recommendations.

Of the total twenty beds, one half should be for the accommodation of chronic mentally ill and the remainder for acutely mentally ill.

Since the institution could hope to have a psychiatrist available only part-time, the report suggested taking on transfer or parole, patients from state hospitals who had been acutely mentally ill but who had already received initial treatment and were ready for a rehabilitation program.

Personnel in addition to the part-time psychiatrist, should include; a former civilian public service man with hospital experience, as administrator, a registered nurse with some psychiatric training and experience, and a farmer

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5 Elmer Ediger, "Findings to Date," Report to the Mental Hospital Advisory Committee, Chicago, January 25, 1947, Appendix IV, p. 2.

preferably with previous hospital experience, to supervise much of the rehabilitative labor.

This idea of an in-between institutional service was not altogether new, however very few such homes were in existence. According to Louis Reik,[6] assistant superintendent of Butler Hospital, Providence, Rhode Island, Lake Ranch at Cuttingville, Vermont andinstitution of this type, is widely patronized by New England psychiatrists for patients well enough to be discharged from the hospital but not ready to return to their homes. Operated by laymen, such an institution fosters an atmosphere of health rather than illness yet provides a protective environment for the patient.

Further recommendations of Ediger's report were that expenses of the institution above farm income should be covered by the patients' families. Where this was not possible the individual conferences should assume the financial responsibility for patients of their groups. The cost was estimated at less than $3.00 a day per patient.

Therapy could take the form of rehabilitative occupational therapy available on the farm and in the community. Hydrotherapy might be included at the beginning

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6 Louis Reik, "The Halfway House; The Role of Laymen's Organizations in the Rehabilitation of the Mentally Ill," Mental Hygiene, Vol. 37, No. 4, October 1953, p. 615-618.

of the hospital program with electroconvulsive therapy, commonly called electro shock treatment, to be added as soon as facilities were available.

Later, when the National Mental Health Foundation[7] strongly advised complete segregation of chronic and acutely ill patients, it was decided to concentrate on patients with reasonably hopeful prognoses.

These plans for the Leitersberg hospital were presented for criticism in interviews with H.K. Petry,[8] superintendent of Harrisburg, Pennsylvania State Hospital, George H. Preston,[9] Commissioner, Division of Mental Health, State of Maryland, Robert H. Felix,[10] Maryland Mental Hygiene Division, United States Public Health, and John C. Whitehorn,[11] head of the Psychiatric Department, director of Phipps Clinic, Johns Hopkins Hospital, Baltimore, Maryland. Generally, they agreed that one hospital should be established on an experimental basis in co-operation with state and private hospitals. Several of these men who had had experience with Mennonites

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7 Ibid., Appendix V, p. 4.

8 Ibid., Appendix VII, p. 5.

9 Ibid., Appendix VIII, p. 5-6.

10 Ibid., Appendix IX, p. 6.

11 Ibid., Appendix X, p. 6-7.

in civilian public service hospital units, were most encouraging in the confidence they placed in the ability of the Mennonite Central Committee to carry out a mental health program.

Preston particularly approved of an in-between service and anticipated no difficulty in having patients paroled from Pennsylvania to Maryland.

Felix' first reaction was that patients should rather be admitted directly from their homes to avoid hospitalization in a state institution, however he did agree that the proposed plan was a way to begin.

Whitehorn disapproved of an in-between service on the basis that it would make no technical contribution to the field of psychiatry and because it would be difficult to later change to an active treatment program after having developed this type of service. He also disapproved of establishing a hospital in an area as inaccessible to medical services as the Leitersberg farm which was situated nine miles from Hagerstown, Maryland, the location of the nearest general hospital.

This viewpoint is supported by Paul Haun[12] a North Carolina psychiatrist, who also stressed the difficulty of staffing an isolated institution.

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12 Paul Haun, "The Modern Mental Hospital," American Journal of Psychiatry, Vol. 109, No. 3, September 1952, p. 163-167.

The Akron Mental Health Services however hoped to provide a restful, therapeutic environment in this farm setting. At this early stage staffing the Leitersberg hospital did not seem to present a problem.

The interview with Petry of the Harrisburg State Hospital clarified the legal implications of admitting patients to a mental hospital.

In view of these findings as reported by Ediger, the Mental Hospital Planning and Advisory Committee[13] at its first meeting January 25, 1947, recommended that (1) the Leitersberg hospital be set up as an experimental project, (2) facilities and treatment be provided for the moderately ill type of patient, (3) the maximum period of hospitalization be six months, (4) the maximum cost per patient be $3.50 per day, (5) the patients' families take the financial responsibility; where this is not possible the individual conferences or congregations assume this responsibility, and (6) Paul Nase and Titus Book be appointed as advisors to the Akron office in matters pertaining to the Leitersberg project.

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13 Homes-for-Mentally-Ill Planning and Advisory Committee, Minutes, Chicago, January 25, 1947, p. 2.

Three months later the Committee added the following recommendations:[14] (1) a one year contract be made for the services of Helmut Prager, private psychiatrist, Baltimore, Maryland, on the basis of approximately two days a week, (2) facilities be provided for the acutely mentally ill, (3) the main house and cottages be remodelled during the summer of 1947 to provide a homelike atmosphere, and (4) the institution be opened in the fall of the same year.

In July a letter from the Akron Mental Health Services Office regarding the Leitersberg project, informed the Advisory Committee of plans being drawn up for the erection of a new building for patient housing and the appointments of Delvin Kirchhofer as administrator and Helen Moser, later Mrs. Kirchhofer, as supervisory nurse for the institution. These two were later sent by the Mennonite Central Committee to Chestnut Lodge, a private hospital near Baltimore, Maryland for a three months' period of interneship.

At a meeting in May 1948, the Committee[15] suggested that hospital rates be set at $4.50 per day for Mennonites,

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14 Homes-for-Mentally-Ill Planning and Advisory Committee, Minutes, Chicago, April 19, 1947, p. 2.

15 Homes-for-Mentally-Ill Planning and Advisory Committee, Minutes, Chicago, May 22, 1948, p. 1-2.

$5.50 for non-Mennonites and a flat rate for each electro shock treatment. Before the hospital opened the rate[16] for Mennonites was changed to $5.00 per day, and in December 1950, the rates[17] for all patients were raised to $6.00 a day, which still compared favorably with other private hospitals where the average weekly rate was $100.

The construction of the new hospital building delayed the opening of Brook Lane Farm[18] until October 31, 1948. The first patient was admitted in January 1949. At this time the staff numbered twelve. Most of these workers had had previous training in state or private hospitals.

It was estimated[19] that nine persons would be sufficient to provide proper care for ten patients and fifteen would be needed when the hospital was operating at its 23 patient capacity.

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16 Homes-for-Mentally-Ill Planning and Advisory Committee, Minutes, Brook Lane Farm, Hagerstown, Maryland, October 20, 1948, p. 2.

17 Delmar Stahly, Report to Mennonite Central Committee, December 27-28, 1950, p. 3.

18 Delvin and Helen Kirchhofer, "Progress in the Church's Mental Health Program," Mennonite Community, Mental Hygiene Issue, Scottdale, Herald Press, April 1950, p. 11.

19 Stahly, Op. cit., p. 3.

Unique features[20] of this institution were the freedom of unlocked doors, the homelike atmosphere where patients and staff ate together in a common dining room and spent many hours together in recreational activities such as volley ball, hiking and picnics. As well as being urged to take part in planned activities, patients were encouraged to help staff members with work in the house and on the farm.

As they ate, worked and played together, so also staff and patients shared in the same religious services.[21] Morning devotions around the breakfast table started the day. After breakfast there was a period of organ music in the chapel, more recently changed to evening hours; this was more specifically for patients than staff. Wednesday evenings ministers from the community were invited to speak to both groups. On Sunday mornings a simple devotional service was conducted by staff members.

Facilities at Brook Lane Farm did not allow for adequate segregation of different types of illness. This was found to be somewhat of a handicap, especially when very disturbed patients were admitted.

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20 Kirchhofer, Op. cit., p. 11, 29.

21 Mental Hospital Administrative Personnel, Discussion Notes, Chicago, May 27, 1953, p. 6-7.

In its first year of operation the hospital admitted approximately 100 patients of whom 30% were Mennonites. The majority were diagnosed as schizophrenics, manic-depressives, and involutional melancholias, with an occasional senile, alcoholic, drug addict and psychoneurotic. The hospital was operating at its full capacity of twenty-three patients[22] for the first time in January 1950, with the increase almost entirely from the Mennonite Central Committee constituency. As shown in Table II this fact was altered with the gradual increase in patient population.

The average period of hospitalization[23] was six weeks. Although patients were returned to their homes as soon possible, many of them continued to take electro-shock treatment periodically for several months after discharge from the hospital. This short period of hospitalization was considered helpful not only from the financial viewpoint, but also in minimizing the difficulty of readjusting to home environment.

Brook Lane Farm acquired a reputation for being a treatment hospital where most of the patients received electro-shock treatments. In defence of this program,

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22 Delmar Stahly, Report to the Executive Committee, January 14, 1950, p. 2.

23 Mental Health Service, News Release, Akron, December 1953, p. 2.

TABLE II.-

Brook Lane Farm Admissions 1949-1953[24]

Year	All Categories	Mennonites	
		N	%
1949	97	29	30
1950	165	38	33
1951	249	87	35
1952	205	33	16
1953	224	35	15
'49-'53	940	222	23.6

24 Mental Health Service, News Release, Akron, December 1953, p. 2.

Prager[25] expressed the opinion that although this type of treatment was not the final answer to mental illness, it did in many cases make a difference between allowing a patient to suffer a deep depression for months possibly ending with suicide, or administering shock treatment and seeing at least an apparent recovery and a degree of future happiness for the patient.

By the end of 1951 the administrative staff[26] was aware that Brook Lane Farm was no longer distinctive as a rapid-turnover treatment center since this type of program had become increasingly common.

Statistics from Brattleboro Retreat,[27] a 700 patient private hospital in Vermont, showed excellent results from the use of electro shock treatment. Over a two year period, of the 249 patients who received shock treatment, 46.8% recovered and were discharged, 48.2% had improved, and of these 43% were discharged. The remaining 6% were unimproved.

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25 Brook Lane Farm Advisory Committee, Minutes, Brook Lane Farm, November 1, 1951, p. 2.

26 Mental Health Service Committee, Minutes, Chicago, November 23, 1951, attachment 7, p. 2.

27 Feiga Gross, "Survey of First Two Years of Electro Shock Treatment in a Large Private Hospital," American Journal of Psychiatry, Vol. 109, No. 1, July 1952, p. 32-35.

Brook Lane Farm statistics were inadequate to draw a comparison. Of the total 940 admissions[28] shown in Table II approximately 80 were readmissions. The slight decrease in patient population in 1952 was probably due to the opening in the previous year of a hospital in Lancaster County, Pennsylvania, operated by the Mennonites of that area. This would also account for the decrease in Mennonite patients.

With the Central Committee constituency interest in the Mennonite hospital program, the hospital administration had not anticipated difficulty in staffing the institution, however this did become a problem. Although Mennonite young people[29] especially those who had worked in mental hospitals in summer service units, were becoming interested in training for various psychiatric positions, they were not necessarily willing to work in a church hospital which involved considerable financial sacrifice. A few of the persons who took psychiatric aide training in the Menninger School at Topeka, Kansas, did work in the Mennonite Central Committee hospital program.

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28 Mental Health Services, Incorporated, Minutes, Chicago, December 18, 1953, attachment 1, p. 1.

29 Stahly, Op. cit., p. 1.

The current instructional program[30] for Brook Lane Farm staff includes a series of twelve to fourteen orientation classes for new workers and semi-weekly conferences of key hospital personnel with the psychiatrist.

The personnel problem was due partly to the fact that the Central Committee[31] had never developed a long term service concept among its workers. Many persons were willing to serve for three months or a year on a voluntary service basis of maintenance and $10 a month, but did not consider remaining on the staff for an extended period of time as salaried workers. This rapid staff turnover did not allow for improvement in service through experience or adequate instruction for new workers without previous hospital training. The encouraging aspect of this part of the problem was that the few long term workers could hardly become stagnant with this constant influx of enthusiasm and new ideas.

It was hoped that in time Brook Lane Farm would have thirteen salaried staff members and four to six voluntary service workers. However, much of the time there were approximately the same number from each group. Later, with

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30 Mental Hospital Administrative Personnel, Op. cit., p. 3.

31 Ibid., p. 1-2.

an increased patient population, the staff[32] numbered as high as twenty-six for an average of twenty-nine patients.

In September 1950 a counseling therapist, J.D. Goering[33] was added to the permanent staff. This was found to be a decided improvement especially since the psychiatrist spent such a limited time at the hospital. Goering interviewed the patients shortly after their arrival at the hospital; any additional interviews were usually initiated by the patient. His contacts with the patients' families were valuable in understanding the patient and in helping both parties to readjust to normal living. Because there was no social worker, Goering also assisted in occupational placement of discharged patients when necessary. Usually these persons continued therapeutic counseling with him on an out patient basis.

By May 1951, when the patient census[34] had on occasions reached thirty and for several months had been almost consistently higher than the twenty-three bed capacity for which the hospital was licensed, plans were made for the

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32 Brook Lane Farm Study Committee, Minutes, Akron, October 1, 1953, p. 1.

33 Mental Health Service Committee, Minutes, Chicago, December 1, 1950, attachments, Minute 7, p. 1, Minute 8, p. 1-2.

34 Mental Health Service Committee, Minutes, Chicago, May 25, 1951, attachment 1, p. 1-5.

expansion of patient housing facilities. This increase was due largely to the fact that Prager had become less selective in admissions and the recognition among lay people and doctors in the community, of the work being done at Brook Lane Farm.

The first expansion plans[35] proposed were remodelling of the staff women's dormitory for convalescent patients and making housing available for staff in a house situated on the highway at the end of the hospital driveway.

When this plan was not approved by the Maryland department of health, it was decided to make several more patient rooms[36] available by changing the location of the offices and visitors reception room from the hospital to the building then being used as a recreation room. It was suggested that recreational facilities could be set up in the second storey of the barn. Later a large room[37] on the lower floor of the barn was renovated for this purpose. Additional patient housing was to take the form of a six-bed wing with sound-proofed rooms for very disturbed patients,

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35 Ibid., attachment 2, p. 1.

36 Mental Health Service Committee, Minutes, Chicago, November 23, 1951, attachment 2, p. 1-3.

37 Mental Health Services, Incorporated, Minutes, Chicago, December 12, 1952, attachment 3, p. 2.

The first part of this plan[38] which had been carried out by June of 1952, raised the hospital's capacity to 29 beds.

An increased number of patients demanded larger occupational therapy quarters. This was accomplished by remodelling the farm maintenance shop, which was housed in the same building, so that the entire space was available for occupational therapy activities.

Excavation for the hospital wing[39] began in the late fall of 1952. The number of beds for the new wing was increased from six to ten. This addition[40] which would increase the capacity to thirty-nine beds, was to be completed in the early part of 1954. The main purpose for adding the wing was to provide segregation facilities which would allow for the treatment of a greater variety of mental illnesses.

At the invitation of the hospital administration, Rudolph Depner,[41] Director of Hospital Inspection and Licensure for the State Department of Mental Hygiene, appraised Brook Lane Farm services in the summer of 1952. No specific

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38 Mental Health Service Committee, Minutes, Chicago, June 13, 1952, attachment 1, p. 1.

39 Mental Health Services, Incorporated, Minutes, Chicago, December 12, 1952, attachment 3, p. 2.

40 Mental Health Services, Incorporated, Minutes, Chicago, December 18, 1953, attachment 1, p. 2.

41 Mental Health Services, Incorporated, Minutes, Chicago, June 13, 1952, attachment 1, p. 4.

recommendations were made by Depner. A year later the Brook Lane Farm administration consulted Robert Felix, Chief of the National Institute of Mental Health, concerning future expansion plans. At Felix' suggestion Riley Guthrie, Mental Hospital Advisor of the Institute of Mental Health, Community Service Branch, conducted a thorough survey of the hospital's existing facilities and services. Guthries report[42] included the following recommendations.

Community needs should be studied to determine further expansion facilities, extension of community services and intensification of the treatment program.

Greater emphasis should be placed on active therapy, including psychotherapy, directed activity therapy and social adjustment.

The office of vocational rehabilitation and other state welfare agencies should be interested in the placement, assistance and after care of discharged patients.

Better clinical records should be kept, clinical conferences recorded and regular seminars should be held for all employees engaged in the psychiatric care and treatment of patients.

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42 Riley H. Guthrie, Report of Survey of Brook Lane Farm, Maryland, July 1953, p. 1-7.

Better liason with the local general hospital should be established, and consultants in the various medical specialties should be appointed.

Suggestions regarding personnel were that (1) a resident full-time psychiatrist and social worker, additional registered nurses and at least a part-time clinical psychologist should be employed. Key personnel should be permanent salaried workers. Organized in-service training should be instituted especially for ward personnel.

The report also suggested (1) expansion of laundry, kitchen and dining room facilities, (2) improved accommodation for employees, (3) more adequate fire protection and (4) the possibility of having the house and barn replaced.

A number of these recommendations were put into effect within a few months after the survey.

Although the idea of patients and staff living together[43] was not generally favored, it was felt that strong points of the Brook Lane Farm program[44] were the intimacy of interpersonal relations between staff and patients and the naturalness of rebuilt farm buildings in a rural setting. Plans for future

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43 Leslie A. Osborne, "Functional Design of Psychiatric Hospitals," American Journal of Psychiatry, Vol. 109, No. 2, August 1952, p. 142.

44 Mental Health Services, Incorporated, Minutes, Chicago, December 18, 1953, attachment 5, p. 2.

expansion were to maintain this atmosphere by never expanding the existing unit to serve more than fifty patients.

During its five years of operation, the hospital[45] has been under the satisfactory supervision of the psychiatrist, Helmut Prager. The treatment program had in the last year moved toward therapeutic counseling with somewhat less emphasis on electro-shock treatments. Two physicians, Travis Wells of Johns Hopkins Hospital, Baltimore, and Bruno Radauskas of Spring Grove, Maryland State Hospital, had almost entirely taken over the administration of shock treatments, leaving Prager free to interview more of the hospitalized patients and out patients.

With the resignation of Delvin Kirchhofer in the fall of 1953, the counselor J.D. Goering temporarily assumed administrative duties, which cut his counseling and social work to a minimum.

Near the end of 1953, Prager engaged a psychologist to come to Brook Lane Farm three times a week to assist in the psychotherapy program. As well as relieving Prager of some routine responsibility, it was hoped this plan would improve the psychotherapy program and make possible more adequate clinical records.

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45 Ibid., attachments 1, p. 1, 5, p. 2.

These arrangements were to be continued tentatively until a resident psychiatrist could be added to the staff. It was planned that a resident or almost full-time psychiatrist should be available when the new wing opened in 1954. The hospital would however continue under its present supervision.

Additional future plans for Brook Lane Farm[46] are that a social worker should be added to the staff as soon as one is available, to serve in the field of patient-family relations and in time to establish a foster home care program among Eastern area Mennonites. Also the institution should eventually offer a more adequate program for out-patients, either at the hospital or in Hagerstown under the direction of the resident physician.

The plan of a home for the moderately mentally ill had grown into the establishment of an active treatment hospital where everyone from the farmer to the psychiatrist played an important part in the rehabilitation of the patient.

The concept of considering everyone who comes in contact with the patient an important part of the therapeutic team is becoming more widely accepted. This was emphasized at the Mental Health Service study conferences[47] held during

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46 Mental Health Services, Incorporated, Minutes, Chicago, December 18, 1953, p. 4.

47 Mental Health Service, Study Conferences, Chicago, July 6, 1953, First session, p. 8.

the summer of 1953. The importance of this approach was also upheld by Osborne[48] in his paper "Functional Design of Psychiatric Hospitals."

During 1953 Brook Lane Farm formed a closer relationship with other mental hospitals[49] by joining the Association of Private Psychiatric Hospitals, in the spring of that year. Plans were also made to join the American Hospital and State Hospital Associations. At this time it was agreed that the main office should establish a membership in the Mental Hospital Section of the American Psychiatric Association.

Brook Lane Farm which had been set up on an experimental basis had soon after it was opened, established a fairly effective treatment program for acutely mentally ill. A research project being carried out at present by Melvin Kohn, a sociologist from the National Institute of Mental Health, may give an indication of the effectiveness of the Brook Lane Farm treatment program[50] as compared to those of other mental hospitals in Maryland. The study is limited

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48 Osborne, Op. cit., p. 142.

49 Mental Health Services, Incorporated, Minutes, Chicago, December 17, 1953, p. 3.

50 Personal Correspondence of the Author, letter of Delmar Stahly, Mental Health Services Director, dated April 30, 1950

to patients diagnosed as schizophrenic or manic-depressive from the city of Hagerstown, who had been hospitalized for a period of time during the years 1949-1951.

In its five years of operation, the hospital administration and medical supervisor were constantly endeavoring to improve and broaden the scope of the existing services as facilities and adequate personnel were available.

Before the first hospital was in operation, plans were being formulated for the establishment of a second Mennonite mental institution. However actual construction on this hospital located at Reedley, California did not begin until the fall of 1950.

CHAPTER IV

KINGS VIEW HOMES
A REHABILITATION AND TREATMENT CENTRE

The West coast Mennonite Central Committee constituency[1] particularly the Mennonite Brethren group, had expressed an interest in the early establishment of a Central Committee administered mental hospital in that area. Both the choice of a hospital location and the type of program to be developed at Kings View Homes, the second Mennonite mental institution were determined largely by the West coast Mennonites rather than by the Akron administration as was the case for Brook Lane Farm.

Although the West coast Central Committee constituency was quite widely scattered, the largest Mennonite congregations were in or near Reedley, California, which made this a logical location for the new church institution.

The Executive Committee received the first specific request for the establishment of a mental hospital in this area, through the board of a Mennonite Brethren Home for the Aged in Reedley. This board was especially aware of the need for an institution for senile patients who could not be cared

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1 Personal Correspondence of the Author, letter of Delmar Stahly, Mental Health Services Director, dated April 13, 1954.

for in an old people's home. There was also considerable pressure for the establishment of this type of hospital. These considerations led to the early concept of a home mainly for chronic mentally ill including senile and mental deficients.

Although the hospital program began with the care of chronic mentally ill it was modified to include acutely mentally ill soon after the institution opened. A foster home care program was also developed.

Influences which contributed to a change in the admission policy were the attractiveness of the rapid turnover treatment program of Brook Lane Farm and the requests of local doctors for accommodation and treatment facilities for acutely mentally ill. There was a state administered mental hygiene clinic[2] in Fresno, several miles from Reedley but there were no facilities for acutely mentally ill[3] within 150 miles of Kings View Homes.

To facilitate planning for the West coast institution the Executive Committee appointed a three man area study committee. In April of 1947 this committee presented tentative plans for the hospital to the Homes-for-Mentally-Ill

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2 George N. Thompson, "Psychiatric Progress in California," American Journal of Psychiatry, Vol. 109, No. 10, April 1953, p. 777.

3 Mental Health Service Committee, Minutes, Chicago, December 12, 1952, attachment 4, p. 6.

Planning and Advisory Committee.

In view of these suggestions the Advisory Committee[4] made the following recommendations.

First, the West coast home for mentally ill should begin as a rest home for long term care of chronic mentally ill, mentally deficient, and such acutely ill as could be given adequate treatment.

Second, patients from all religious groups should be served with preference for admission given to those from the Central Committee constituency.

Third, initial accommodation should be for thirty patients with eventual capacity for one hundred patients.

Fourth, the hospital should be located in California within reasonable distance of a Mennonite community.

Fifth, a full-time hospital administrator should be appointed as soon as possible, to be responsible to the Advisory Committee for the study of legal and medical requirements of other similar institutions, and recommendations regarding exact location, approximate expenses, size and tentative building plans.

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4 Homes-for-Mentally-Ill Planning and Advisory Committee, Minutes, Chicago, April 19, 1947, p. 1-2.

Finally, the hospital staff should be composed of a permanent group of well-qualified workers for key personnel positions and volunteer workers to serve as attendants and helpers for terms of service not less than one year.

In May 1948, Arthur Jost[5] later appointed hospital administrator, reported that when the California Mennonite churches were contacted for solicitation of funds and lectures had been given to familiarize the congregations with the Mental Health Service program, sufficient interest was shown to warrant proceeding with plans for the establishment of a hospital. By fall of the same year the Committee obtained permission from the County Commission to purchase a forty-three acre farm[6] located near Reedley, California as the site of the new hospital.

Building plans[7] presented to the Advisory Committee in October 1948, which had been drawn up to include a treatment unit for acutely mentally ill were modified to agree with the original concept of a thirty bed hospital for the chronic mentally ill. Progress on this new project continued rather

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5 Homes-for-Mentally-Ill Planning and Advisory Committee, Minutes, Chicago, May 22, 1948, p. 2.

6 Homes-for-Mentally-Ill Planning and Advisory Committee, Minutes, Chicago, October 20, 1948, p. 3.

7 Ibid., p. 2.

slowly with actual construction not beginning until a year later. Dr. Frank F. Tallman, California State Mental Health Commissioner and P.C. Hiebert, Mennonite Central Committee Chairman were the main speakers[8] at the ground-breaking ceremony held on November 20, 1949.

With the beginning of hospital construction the administrator made regular reports[9] to the State Mental Hygiene Department in view of obtaining an operating license. Representatives sent by this department expressed satisfaction with the project and a license was issued in the spring of 1951.

During the process of construction[10] H.R. Martens, D.C. Krebiehl, Abe Ens, S.E. Eicher and Arthur Jost served as a building committee. Also in this early building stage, a more active interest in the project was aroused among the churches by the appointment of additional representatives from the various conference groups to serve on the West coast hospital advisory committee.

During the spring and summer of 1950, the West coast churches were again contacted for fund solicitation and

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8 Delmar Stahly, Report to Executive Committee, Akron, January 14, 1950, p. 1.

9 Mental Health Service Committee, Minutes, Chicago, May 25, 1951, attachment 3, p. 4.

10 Mental Health Service Committee, Minutes, Chicago, March 17, 1950, attachment 1, p. 1-3.

further interpretation of the Mental Health Services. Brook Lane Farm experiences were cited to show the desirability of establishing a church-operated mental institution.

At its December 1950 meeting, the Mental Health Service Committee[11] recommended that 50% of the thirty-two bed capacity of Kings View Homes should initially be utilized by patients as they applied irrespective of area, church affiliation or classification, with the assumption that these admissions had met acceptable behavior and medical conditions. After this number of patients had been admitted, the West Coast Advisory Committee should set quotas for West coast, non-West and non-Mennonites.

The Mental Health Service Committee also made the following recommendations. (1) Patients were to be admitted for a thirty day trial period. (2) Four beds should be set aside for treatment cases. (3) A social service section should be established to rehabilitate the chronic mentally ill patients either to their own homes or foster homes. (4) The services of Jackson C. Dillon, private psychiatrist and Reedley Mental Hygiene Clinic Director were to be engaged for one half day a week and for cases of emergency. (5) Rates

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11Mental Health Service Committee, Minutes, Chicago, December 1, 1950, p. 1-2.

for chronic patients were to be $4.00 a day and for active treatment cases, $10.00 a day. Fee policies[12] were revised in the fall of 1953 at which time a basic daily rate of $8.00 was established with extra charges for special care. (6) Hospital personnel should have living quarters awayfrom the hospital site.

The Committee also suggested the possibility of helping in the rehabilitation of patients who received shock treatments in state and private hospitals.

The type of program being developed for this second hospital emphasized the social service aspect of psychiatric work in contrast to the rapid-turnover treatment program at Brook Lane Farm where there was very little follow-up care.

A formal hospital dedication service[13] was held on February 11, 1951, and the first patient was admitted several weeks later. The patient population[14] increased slowly so that by the fourth month of operation the census was fifteen; a total of nineteen patients had been admitted. Until the fall[15]

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12 Delmar Stahly, Report to Executive Committee, Akron, September 26, 1953, p. 1,2.

13 Delmar Stahly, Report to the Mennonite Central Committee, Chicago, December 27-28, 1950, p. 3.

14 Mental Health Service Committee, Minutes, Chicago, May 25, 1951, attachment 3, p. 1.

15 Mental Health Service Committee, Minutes, Chicago, November 23, 1951, attachment 4a, p. 2.

of the year the hospital operated with an average of twenty patients.

Due to the continued low census and as previously mentioned, the repeated requests of local doctors for permission to admit acutely mentally ill patients, and the apparent success with these patients at Brook Lane Farm, more acute treatment cases were admitted. However the primary interest was still the rehabilitation of chronically ill patients.

There had been some success with senile patients who had been considered completely hopeless, but this type of service[16] was recognized as no longer being altogether distinctive.

A report from the Tomah, Wisconsin Veterans' Administration Hospital Geriatric Ward,[17] pointed out that to show sincere kind consideration in dealing with even very confused patients and allowing them to do simple manual tasks had had hopeful results. Some of these patients were even rehabilitated to foster homes.

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16 Mental Health Service Committee, Minutes, Chicago, November 23, 1951, attachment 7, p. 2.

17 Raphael Ginzberg, "Geriatric Ward Psychiatry, Techniques in the Psychological Management of Elderly Psychotics," American Journal of Psychiatry, Vol. 110, No. 4, October 1953, p. 296.

Another study of elderly persons with disordered behavior usually associated with senile psychosis, in a New York Home for Aged and Infirm Hebrews,[18] showed that not all these patients had significant brain damage but rather suffered from psychological or somatic handicaps which resulted in frustration, a feeling of helplessness and fears. Brief psychotherapy produced favorable results in a number of cases.

The Kings View Homes social worker[19] had spent considerable time becoming acquainted with the people of the community, speaking to various church groups and contacting individuals interested in providing foster home care for chronic mentally ill patients.

Statistics[20] available from six states showed a slow but gradual increase in the number of patients cared for in foster homes. These states reported 6,201 in 1953, as compared to 5,617 in 1952 and 4,937 in 1951.

To clarify the program of Kings View Homes, it might be well to review the psychiatrist's report written approximately a year after the hospital opened.

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18 Alvin Goldfarb and Helen Turner, "Psychotherapy of Aged Persons, Utilization and Effectiveness of Brief Therapy," American Journal of Psychiatry, Vol. 109, No. 12, June 1953, p. 916-921.

19 Martha Lee Yoder, Report to the West Coast Board of Directors, Kings View Homes, April 26, 1952, p. 1.

20 Walter E. Barton, "Review of Psychiatric Progress, Family Care," American Journal of Psychiatry, Vol. 110, No. 7, January 1954, p. 534.

As stated in this report,[21] therapeutic objectives included a high standard of routine care and a careful study of each patient, with the aid of medical, neurological, psychiatric and psychological examinations. Local doctors and clinics co-operated in giving admission medical examinations and routine examinations for patients receiving electro shock treatments. An increasing number of selected patients had received shock treatments since the beginning of 1952.

The patients' activity program, in addition to the orthodox hand crafts, included such activities as athletics, picnics, movies, shopping trips, berry picking, canning fruit, helping with routine work in the hospital and on the farm. In some cases male patients were employed on nearby ranches. Several patients took organ or piano lessons.

Religious activities[22] took the form of daily morning devotions conducted by staff members, and bi-weekly services supplied by local church groups. When possible patients attended local churches with staff members.

Because of the importance of the activity program, early in 1952 plans were drawn up for a new occupational

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21 Jackson C. Dillon, Report to the West Coast Advisory Committee, Kings View Homes, Reedley, California, April 26, 1952, p. 1-5.

22 Ruby Friesen, Report to Kings View Homes Advisory Committee, Kings View Homes, April 26, 1953, p. 1.

therapy building. This building[23] was still under construction at the end of 1953.

Although the psychiatrist lamented the shortage of registered nurses and the lack of trained personnel in general, he did commend the spirit and motivation of the staff members.

To supplement the practical knowledge gained by working with mentally ill patients, the psychiatrist[24] gave weekly lectures and assigned reading material to the staff. This later became a weekly clinical session[25] where individual cases were discussed. When time permitted, one of the nurses gave a series of lectures on nursing care to new workers.

By June of 1952, the admission policy[26] had been changed to admit practically all Mennonite patients. Non-Mennonites were restricted to young chronics and acutely mentally ill. Approximately one third of the beds were being used for active treatment cases.

The census rose to a fairly constant twenty-eight. Table III shows the number of admissions to Kings View Homes per year.

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23 Mental Health Services, Incorporated, Minutes, Chicago, December 18, 1953, attachment 2, p. 1.

24 Mental Health Service Committee, Minutes, Chicago, May 25, 1951, attachment 3, p. 6.

25 Mental Hospital Administrative Personnel, Discussion Notes, Chicago, May 27, 1953, p. 3.

26 Mental Health Service Committee, Minutes, Chicago, June 13, 1952, attachment 2, p. 2.

TABLE III.-

Kings View Homes Admissions 1951-1953[28]

Year	All Categories	Mennonites	
		N	%
1951	46	18	40
1952	73	26	36
1953	96	12	23
'51-'53	215	66	32

28 Mental Health Service, News Release, Akron, December 15, 1953, p. 2.

Several factors contributed to an increased interest in the hospital program[27] among the doctors and lay people of the community. In an effort to integrate psychiatric and medical services, Dillon served on the staffs of several local hospitals, which also created a better understanding between Kings View Homes and these general hospitals.

Mental health institutes sponsored by Kings View Homes were well attended. Local People also showed their interest by assisting in the work at the hospital on a part-time volunteer basis.

Finally, members of the Kings View Homes staff were instrumental in organizing a mental health society in Reedley.

As noted by Table III the number of admissions increased slowly each year with a slight decrease in the percentage of patients from the Mennonite Central Committee church groups. These factors probably can be explained by the increased community interest.

Due to the reticence of some persons to seek assistance at a mental hospital, an office to be used by Dillon and counselor Raymond Cramer several hours a week, was opened

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27 Mental Health Services, Incorporated, Minutes, Chicago, December 18, 1953, attachment 2, p. 1-5.

in the Mennonite Central Committee regional office in Reedley. Cramer, especially interested in counseling people with religious problems, joined the hospital staff on a half-time basis in the fall of 1953. The psychiatrist by this time spent at least three half days a week at Kings View Homes.

Present plans for expansion of hospital facilities[29] are to build a forty bed addition for active treatment cases, to be ready for operation early in 1957.

At the time Brook Lane Farm joined the Association of Private Psychiatric Hospitals, it was recommended that Kings View Homes[30] should also become a member of this Association and of the American Hospital and State Hospital Association.

At the request of Kings View Homes administration[31] the National Institute of Mental Health is making arrangements to send a representative from its San Francisco office to conduct a critical survey of the hospital's present services.

In its three years of operation Kings View Homes had served mainly in the area of rehabilitating chronic mentally

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29 Mental Health Services, Incorporated, Minutes, Chicago, May 28, 1953, p. 2.

30Mental Health Services, Incorporated, Minutes, Chicago, December 17, 1953, p. 4.

31 Personal Correspondence of the Author, letter of Delmar Stahly, Mental Health Services Director, dated April 30, 1954.

ill patients to non-institutional life by development of the foster home care plan. In the last year the emphasis shifted somewhat to a more active treatment program. This trend will likely continue with the addition of the unit for acutely mentally ill.

With the first two hospitals in operation, plans were developed for the establishment of a central area hospital, in keeping with the initial concept of three Mennonite Central Committee mental institutions. This third hospital located near Newton, Kansas was the culmination of years of planning guided by the experiences of Brook Lane Farm and Kings View Homes.

CHAPTER V

PRAIRIE VIEW HOSPITAL FOR ACTIVE TREATMENT CASES AND NON-INSTITUTIONAL GUIDANCE SERVICES

Mennonites in Kansas[1] had for years been interested in caring for the mentally ill of their own churches. Even before the experiences of civilian public service men in state mental hospitals during World War II had awakened the larger Central Committee constituency to the possibility of establishing their own mental institutions, the Kansas Mennonites had investigated this area by consulting their state hospitals. These people, many of whom were of the groups which came to America from Russia during the years 1920-1930, were influenced by the recollection of mental hospitals established by their ancestors in Russia.

Despite this early interest in caring for their own mentally ill, it took the stimulation of the civilian public service hospital program to produce concrete plans for a mental institution in the central area.

Although as early as 1947 representatives from Newton, Kansas[2] expressed a desire to co-operate with the Central

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1 Delmar Stahly, "Prairie View Hospital-A Step Forward," Mennonite Weekly Review, Newton, Kansas, Vol. 31, No. 45, November 5, 1953, p. 11, Col. 1.

2 Elmer Ediger, Report to Homes-for-Mentally-Ill Planning and Advisory Committee, Akron, July 1947, p. 2-3.

Committee in establishing a hospital in that region, the general community support did not seem strong enough to warrant proceeding with such a plan at this time.

The financial burden of developing the first two hospitals also delayed the building of a third institution for several years.

This delay allowed for a study of the existing Mennonite hospital programs, which brought a more mature understanding to the planning of Prairie View Hospital.

In July 1953 study conferences were held at Chicago, Newton, and Philadelphia. In each of these conferences, Mental Health Service staff and Mennonite educators, professional men and ministers contributed toward a search for principles to guide the church hospital program.

The following concepts formulated at these meetings were summarized by Delmar Stahly, Mental Health Services Director since 1949.

> The M.C.C. should have a staff training program formalized and centered within its own institutions but drawing on outside resources. Follow-up care and follow-up records of discharged patients must be extended. A church program should involve research in the field of mental illness and mental health as well as self-study of our own program. The field of prevention must be faced. The mental health program has a large field in the education of the wider church constituency.[3]

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3 Mental Health Services, Incorporated, Minutes, Chicago, December 18, 1953, attachment 5, p. 1.

This period of waiting and preparation also included constituency and community mental health education[4] by means of lectures, mental health institutes, and literature. By the time Prairie View Hospital opened in March 1954, the project was well accepted and supported by the non-Mennonites and Mennonites in the community.

The concept of mental illness as a community concern had gained recognition through the Mental Hygiene movement instigated by Clifford Beers early in the twentieth century. The idea of the mental hospital as a community related project is fairly recent. Frank F. Tallman[5] the present California State Mental Health Commissioner, in A State Program of Mental Health, indicated that the mental hospital should be as much a part of the medical community as a general hospital. Osborne[6] cited previously, stressed the importance of linkage with community life and services before, during and after hospitalization.

As early as 1948 the Mental Health Service Committee began investigating possible locations[7] for a mid-West area

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4 Delmar Stahly, Op. cit., Col. 2,3.

5 Frank F. Tallman, "A State Program of Mental Health," Mental Hygiene, Vol. 32, No. 2, April 1948, p. 272.

6 Osborne, Op. cit., p. 141.

7 Homes-for-Mentally-Ill Planning and Advisory Committee, Minutes, Chicago, May 22, 1948, p. 2.

hospital. The first plan, that of purchasing a county old people's home near Newton, did not materialize when on further investigation it was discovered that the property would not be available for some time.

General plans[8] were for the early appointment of a hospital administrator and the purchase of a hospital site as soon as sufficient funds had been solicited for Kings View Homes.

No further steps were taken in the central area hospital planning until the beginning of 1951 when a committee[9] was appointed to study the problem. This Committee which met semi-annually, took the form of the following sub-committees: (a) Central Area Program, (b) Site, Building and Facility, (c) Finance and Promotion, and (d) Interim Non-Institutional Services and Personnel. Elmer Ediger, Waldo Hiebert, H.S. Andres, and Daniel Kauffman, respectively served as chairmen of these committees.[10] From the Executive Committee of the Mennonite Central Committee, H.A. Fast and P.C. Hiebert served as ex officio members.

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8 Delmar Stahly, Report to Mennonite Central Committee, Chicago, December 27-28, 1950, p. 4.

9 Mental Health Service Committee, Minutes, Chicago, May 25, 1951, p. 3.

10 Ibid., attachment 5, p. 1.

The latter two along with those committee members who lived within reasonable proximity of the building site formed an Advisory Committee to more actively promote the project.

The state of Kansas had been designated as the general area for the location[11] of the mid-West hospital. After thorough investigation of three sites, a forty acre farm near Hesston, a forty acre farm near Hillsboro and eighty acres of land one mile east of Newton, the property near Newton was chosen as the most suitable hospital location. The accessability of the Bethel Deaconess General Hospital facilities in Newton was a deciding factor in this choice.

Prairie View Hospital[12] as the new institution was named, was envisioned as a cottage style institution[13] with each of five buildings housing twenty patients. The initial plant would have central facilities for sixty patients with operations beginning after the completion of two cottages. The eventual plan was for five units to accommodate one

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11 Mental Health Service Committee, Minutes, Chicago, November 23, 1951, attachment 6, p. 1-2.

12 Mental Health Services, Incorporated, Recommendations, Chicago, December 12, 1952, p. 1-2.

13 Elmer Ediger, "Envisioning a Central Area Mental Health Service Program," Memorandum to Akron Mental Health Office and Central Area Subcommittee, September 12,1951, p. 1-9.

hundred patients of which sixty should be active treatment cases and the remainder chronic mentally ill.

Parallel to the institutional service, noninstitutional services, such as foster home care, guidance clinic, and community mental health education were to be developed. Although the Mental Health Service Committee preferred the development of a predomintely noninstitutional program in the central area, the Mennonite Central Committee constituency seemed more ready to accept an institutional type program where those who were obviously mentally ill could be helped. However the Committee hoped an educational program on a community rather than merely a Mennonite basis, would aid the development of a wholesome attitude toward mental illness and an awareness of the importance of seeking aid before hospitalization was necessary.

Tentative plans also included a training program for Mennonite Central Committee hospital personnel in connection with these central area services.

In June 1952 Myron Ebersole[14] was appointed administrator for the central area mental health project. Prior to this appointment Ebersole had been director of the Mennonite Central Committee relief program in Jordan.

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14 Mental Health Services, Incorporated, Minutes, Chicago, June 13, 1952, p. 2.

With the beginning of hospital construction[15] in the fall of 1952, the subcommittees were resolved and a steering committee was appointed to assume major responsibility for further development of the program. Serving on this committee were Elmer Ediger as chairman, Daniel Kauffman, Vice-chairman and Waldo Hiebert, secretary. The Central Area Advisory Committee continued to function in its original capacity. During the construction stage Ebersole[16] frequently consulted with the State Health Department, the mental hospital licensing body in Kansas.

The concept of beginning operation with a forty bed institution[17] was retained, however instead of twenty bed cottages the first unit was a one-storey building with a forty bed capacity.

In general cases for admissions[18] were to be selected from applicants who in the opinion of the administrator and medical director, could be helped by the Prairie View staff and facilities. This included acutely mentally ill and others

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15 Mental Health Services, Incorporated, Minutes, Chicago, December 12, 1952, attachment 6, p. 1.

16. Personal Correspondence of the Author, letter of Delmar Stahly, Mental Health Services Director, dated April 30, 1954.

17 Mental Health Services, Incorporated, Minutes, Chicago, December 12, 1952, attachment 1, p. 2.

18 Mental Health Services, Incorporated, Minutes, Chicago, December 18, 1953, p. 2.

who had been ill for some time but for whom rehabilitation appeared to be possible.

Patient fees and charges[19] for combined hospital and medical services were estimated at $75 per week. If the hospitalization period continued beyond two months the cost would probably be no more than $55 per week.

Thomas Morrow and F. Carter Newsom private psychiatrists[20] from Wichita, Kansas, were engaged to serve as staff psychiatrists, the former as medical director.

Hospital services[21] were to be patterned after those of Brook Lane Farm and Kings View Homes with the addition of insulin shock treatment.

The Central Area Committee had anticipated non-institutional services in the form of a child guidance centre[22] by March 1953, but contrary to earlier expectations, suitable personnel was not available at that time.

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19 Delmar Stahly, Report to the Executive Committee, Chicago, February 27, 1954, p. 1.

20 Mental Health Services, Incorporated, Minutes, Chicago, December 18, 1953, attachment 9, p. 1.

21 "Prairie View Hospital," Mennonite Central Committee Service Bulletin, Vol. 8, No. 1, March 1954, p. 5.

22 Mental Health Services, Incorporated, Minutes, Chicago, December 12, 1952, attachment 6, p. 1.

More recent plans[23] resulted in the purchase of a house in Newton to be used as a family guidance center, beginning with adult individual and group counseling with the idea of later moving also into the field of child guidance. The group counseling was to be developed especially for refugees living in the Newton area, many of whom had serious personal adjustment problems. Some of these people had already been contacted.

The guidance centre work will be under the direction of Harold Vogt, clinical psychologist, who will also assume major responsibility for carrying out the therapeutic counseling program at Prairie View Hospital.

Tangible results of community and Mennonite Central Committee mental health education were the $5000 raised in a fund drive by the Newton Chamber of Commerce and the hospital furnishings and equipment supplied by the central area Mennonites and Brethren in Christ churches.

The hospital dedication[24] services were held on March 14, 1954. Main speakers for the occasion were Milton Kirkpatrick, Director of Greater Kansas City Mental Health

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23 Mental Health Services, Incorporated, Minutes, Chicago, December 18, 1953, attachment 4, p. 1-4.

24 "Hospital Dedication," Mennonite Weekly Review, Newton, Kansas, Vol. 32, No. 11, March 18, 1954, p. 1, Col. 1,2, p. 3, Col. 1.

Foundation, and C.N. Hostetter, Jr., president of Messiah Bible College, Grantham, Pennsylvania and present chairman of the Mennonite Central Committee. The first patient was admitted the day after the formal dedication of the institution.

The initial hospital staff[25] consisting of seventeen persons was to be increased to approximately twenty-five by June 1, 1954. By this time they hope to be serving about twenty-five patients.

The planning for this central area mental health project indicated an awareness of the limitations of the services offered at the two Mennonite Central Committee hospitals already in operation.

Brook Lane Farm with a thirty-nine patient capacity had developed a rapid turnover treatment program by the use of electro-shock therapy, however insufficient trained personnel did not allow for adequate follow-up care. The shortage of clinically trained staff members also resulted in limited patient records which will possibly handicap carrying out research into the effectiveness of the program. The location of the hospital, nine miles from Hagerstown, Maryland where the nearest medical services are available

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25 Delmar Stahly, Report to the Executive Committee, Chicago, February 27, 1954, p. 1.

is somewhat of a drawback. This isolation probably has also retarded community acceptance of the services offered at Brook Lane Farm. An attempt is being made to develop a more adequate psychotherapy program for in-patients and out-patients.

Kings View Homes in California which had started as a rehabilitation and foster home care program for chronic mentally ill, had shifted its emphasis somewhat in its third year of operation to include facilities for the care and treatment of acutely mentally ill; however two-thirds of its twenty-nine beds were still reserved for the accommodation of chronic mentally ill. This hospital was from the time it opened more actively related to the community than Brook Lane Farm, partly as a result of community mental health education and a more strategic location, but also because of the nature of the services offered by Kings View Homes.

Plans for Prairie View Hospital a forty bed institution, are to develop a rehabilitation and treatment centre for acutely mentally ill and for chronic patients who possibly can be rehabilitated. In addition, noninstitutional services in connection with the hospital program, are to take the form of a family guidance centre, beginning with adult individual counseling and group therapy, and later moving also into the area of child guidance. Community mental health

education over an extended period of time in this central area has resulted in the active support and apparent acceptance of both these institutional and noninstitutional services.

At this stage of operation, it is too soon to evaluate how much more effective the Prairie View Hospital services will be from the beginning than those offered by the two older hospitals. However the concrete plans for a noninstitutional preventive program in co-operation with the hospital services, and the community acceptance and support of the project would indicate a more valuable contribution to the total field of mental health.

SUMMARY AND CONCLUSIONS

The Mennonite Central Committee Mental Health Services during the years 1948-1954 established three small mental institutions with an aggregate patient capacity of one hundred and eleven. By the fall of 1953 the first two hospitals operating with a combined capacity of seventy-one, had admitted 1155 patients. Although a primary consideration in establishing church hospitals was to provide care and treatment for mentally ill from the Central Committee constituency, only 28% of the admissions were from these groups.

These statistics which show a fairly rapid turnover of patients would indicate that a valuable contribution is being made to the field of mental health. However the actual effectiveness of the program has not been investigated partly due to the limited number of clinically trained staff members.

The deficiency in follow-up care was especially true of Brook Lane Farm which had developed a rapid turnover treatment program with the use of electro-shock treatment. In five years of operation this thirty-nine bed hospital had admitted 940 patients.

The twenty-nine patient capacity West coast hospital was gradually developing a fairly effective rehabilitation and foster home care program for chronic mentally ill. The emphasis during its third year of operation shifted somewhat to include

the care and treatment of acutely mentally ill, however two-thirds of the beds were still reserved for chronic patients.

The third hospital with the advantage of five years of planning guided by the experiences of the two existing hospitals had developed a fairly clear concept of its institutional treatment and noninstitutional guidance services. However it is too early to predict the effectiveness of this program.

A general weakness in the program was the rapid turnover of hospital personnel as the result of the employment of volunteer workers who usually served only for three months to a year. There was also a lack of continuity of service among the key staff members. This rather serious handicap did not allow for the establishment of adequate personnel training programs within the institutions.

A significant feature of these Mennonite hospitals was the family atmosphere achieved by the free intermingling of patients and staff members.

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A short exposition of the beliefs and doctrines of the early Mennonites or Anabaptists as they were called, furnished historical data for this paper.

Ediger, Elmer, "Findings to Date," Report to the Mental Hospital Advisory Committee, Chicago, January 25, 1947, 7 p.
This report supplied information on contacts made by the Mennonite Central Committee with Maryland State Health officials, investigation of existing church mental hospitals and the subsequent proposals for Brook Lane Farm.

Report to Homes-for-Mentally-Ill Planning and Advisory Committee, Akron, Pennsylvania, July 1947, 3 p.
This report contained information on proposed hospital personnel.

"Envisioning a Central Area Mental Health Service Program," Memorandum to Akron Mental Health Service and Central Area Program Subcommittee, Newton, Kansas, September 1951, 9 p.
Most of the concepts proposed in this report for the third Mennonite Central Committee hospital were retained and are included in this paper.

Guthrie, Riley H., Report of Survey of Brook Lane Farm, Maryland, July 1953, 7 p.
An evaluation of Brook Lane Farm facilities and services, made by a representative from the National Institute of Mental Health. Guthrie's objectivity produced fair criticism although he may have been comparing this hospital to a large state institution.

Hershberger, Guy F., War, Peace and Nonresistance, Scottdale, Pennsylvania, Herald Press, 1946, 415 p.
A detailed presentation of the doctrine of non-resistance as adhered to by the present day Mennonites and by their forefathers. This book was valuable in furnishing information which clarified later activities of the Mennonite Church.

Homes-for-Mentally-Ill Planning and Advisory Committee, Minutes, Chicago, Illinois, January 1947-March 1950, 6 meetings.
This committee which acted in an advisory capacity to the Mental Health Services Director and the area advisory committees, met at irregular intervals during the period January 1947-March 1950. The minutes of these meetings were a most valuable source in tracing the development of the Mennonite hospital program.

Kirchhofer, Delvin and Helen, "Progress in the Church's Mental Health Program," Mennonite Community, Mental Hygiene Issue, Vol. 4, No. 4, April 1950, p. 10-11, 29.
Written by the administrator and supervisory nurse of Brook Lane Farm approximately a year after the hospital opened, this article gave the writer some insight into the daily hospital routine.

Kreider, Robert, "The Opportunity of the Church," Anniversary Review, Mental Hygiene Number, Harrisburg, Pennsylvania, C.P.S. Unit 93 publication, May 1945, p. 62-63.
This article by the director of the civilian public service hospital units is an excellent summary of the work done by the men in these state hospital units, in terms of what the Church as a whole could do.

Mental Health Service Committee, Minutes, Chicago, December 1950-June 1952, 4 meetings.
This committee had originally been called the Homes-for-Mentally-Ill Planning and Advisory Committee and functioned in the same capacity.

Mental Health Services, Incorporated, Minutes, Chicago, December 1952-December 1953, 3 meetings.
This corporation was formed in December 1952 and became the Mental Health Services advisory body, at which time the Mental Health Service Committee was resolved.

Mental Hospital Study Committee, Supplementary Report, to the Mennonite Central Committee, April 6, 1946, 5 p.
Suggestions for a church hospital program were included in this report submitted by the Study Committee which carried out the initial investigations of the problem.

Personal Correspondence of the Author, letters of Delmar Stahly, Mental Health Services Director, dated April 13, and April 30, 1954.
These letters supplied information which had not been included in the Advisory Committee minutes concerning the early planning stage of the last two Mennonite mental hospitals.

Mental Health Services, News Release, Akron, Pennsylvania, December 1953, 5 p.
A news sheet printed periodically for persons among the Mennonite Central Committee constituency interested in the progress of the church mental hospital program. This issue contained statistics on patient admissions.

Stahly, Delmar, "Prairie View Hospital-A Step Forward," Mennonite Weekly Review, Newton, Kansas, Vol. 31, No. 45, November 5, 1953, p. 11, Col. 1-3.
This brief history of events leading to the establishment of the third mental hospital provided valuable background material for this paper.

Unruh, John D., In the Name of Christ, A History of the Mennonite Central Committee, Scottdale, Pennsylvania, Herald Press, 1952, 404 p.
A comprehensive history of activities of the Mennonite Central Committee which supplied historical background for this paper and also a few of the early developments of the mental hospital program.

APPENDIX 1

MENTAL HEALTH SERVICES LITERATURE

APPENDIX 2

ABSTRACT OF

Mennonite Central Committee Mental Health Services[1]

The American Mennonites first became actively interested in contributing to the care and treatment of mentally ill through the experiences of a number of their young men who worked in state mental hospitals. This paper is concerned with the development of three mental hospitals which were the outgrowth of this interest. The hospitals were established at Leitersberg, Maryland, November 1948, Reedley, California, February 1951, and Newton, Kansas, March 1954.

The Eastern area hospital with a thirty-nine patient capacity developed a rapid turnover treatment program by the use of electro-shock treatment. In its five years of operation the total number of admissions was 940.

The twenty-nine bed institution on the West Coast established a rehabilitation and foster home care program for chronic mentally ill. In its third year of operation facilities were added for the care and treatment of acutely mentally ill. However two-thirds of the beds were still reserved for chronic

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1 M.A. Thesis presented by Lucinda G. Martin, in 1954, to the Faculty of Arts of the University of Ottawa, 83 pages.

patients. In three years the total number of admissions was 215.

The forty bed central area hospital offered services similar to both these hospitals with additional noninstitutional services under the direction of hospital personnel.

Main weaknesses of the Mennonite mental hospital program were its limited number of clinically trained staff members and the rapid turnover of the hospital staffs in general caused by the employment of numerous short term volunteer workers. This in turn handicapped the development of adequate personnel training programs within the institutions.

The main feature of these hospitals was their informal homelike atmosphere where patients and staff members mingled freely.

By Love Serve One Another — Galatians 5:13

A Program of Mental Health Service

IN THE NAME OF CHRIST
for the
CENTRAL AREA

- **HOSPITAL** — Homes for the mentally ill
- **COUNSEL** — referral service concerning family or personal problems
- **MENTAL ILLNESS PREVENTION** — assistance for those interested

. . two merging streams . .

the Old World river

Russian Mennonites had their own mental hospital serving Mennonites and non-Mennonites. Immigrants to America have long deplored the lack of church institutions to serve the sick in mind. Some groups have made surveys and conferred with institutional leaders in an effort to continue that heritage of concern.

the newer torrent

More recent impetus came at the close of World War II. Fifteen hundred young men served as "aides" on state hospital wards in the Alternative Service program administered by the MCC. Wives of CPS men and auxiliary units of Mennonite girls helped establish this as a field of Christian service. Individuals, congregations, and Mennonite conferences encouraged the church to establish and operate mental hospitals.

the Mennonite Central Committee Called

Single conferences felt unqualified to enter the field. Several of them asked the Mennonite Central Committee to take the lead in determining the need and interest among our own church groups. Through a survey of Mennonites of all groups all over the United States, it was learned that Mennonites required the service of psychiatrists and mental hospitals to about the same extent as did other Americans.

This meant that **one out of every ten Mennonites** should require help and treatment; **one out of twenty** should at some point in his life be hospitalized for mental or nervous difficulties. The **NUMBER ONE** health problem of the nation was also the **NUMBER ONE health problem of Mennonites.** Fifty per cent of all hospital beds were filled with mental cases and we were using our share.

A majority of the responding ministers urged that the church established its own mental hospitals. On January 3, 1947, the members of the Mennonite Central Committee officially representing the separate Mennonite groups authorized a new mental hospital program involving the building of three institutions. The East and West areas were to have relatively small institutions until the large and centrally located **third** hospital would be possible.

and now . . . central area

Once or twice a year since 1947, church leaders from the middle west states near to Kansas have met with Mennonite Central Committee workers to discuss plans. With the completion of the second MCC hospital in 1951, the way became clear for more concrete action. A stable and continuing committee representing ten groups of Mennonite, Amish and Brethren-in-Christ constituencies was founded. With the advice and encouragement of these men, a site has been secured and an architect engaged to produce building plans.

questions arose . . .

Whence would come professional personnel?

Were Mennonite psychiatrists available?

Would ex-CPS men continue to serve in our mental hospitals?

Would additional Mennonites enter the mental hospital field?

youth will serve

There has been an unparalleled response from young people now that the field is opened to them. Year-around state hospital units of Mennonite youth operate at Topeka, Kansas; Philadelphia, Pennsylvania; Stockton, California, and Roseburg, Oregon. Additional units in five to ten state and provincial mental hospitals are opened for ten weeks each summer. Canadian young people have caught the vision and are making this a development of all Mennonites in North America. And forty staff members are serving continually in the two Mennonite Central Committee mental hospitals now in operation.

youth will train

An increasing number of young people are studying and training in specialized courses. Mennonite churches are producing psychiatrists, psychiatric social workers, psychiatric nurses, and psychologists. Some of these will serve in state and provincial hospitals. Others will establish private practices. Many, however, are requesting—yes—demanding a church program in which to serve.

why a Christian hospital?

There is a growing awareness among medical men of the place of **love** in the treatment of the mentally ill. Aides are being taught that this feeling of **love** is essential for the success of the treatment. Text books are being rewritten in terms of this comparatively new discovery in the old profession of psychiatry. This is really not a new idea, for psychiatrists and psychologists have recognized this truth, but they had no qualified workers to build a program upon. Christians have long taught and lived this truth, and Christian love is the center of Christian service in institutions. At this late time, we are learning that our Christian love, if real, has a field for expression in our own mental hospitals.

1951 **MCC MENTAL HOSPITAL**
West Coast Area
Reedley, California

Kings View Homes

Jackson C. Dillon, M.D., Psychiatrist
Arthur Jost, Administrator

CAPACITY
32 patients

PROGRAM
Rehabilitation of long-term cases
—to home and family
—to foster homes
Treatment of acute cases

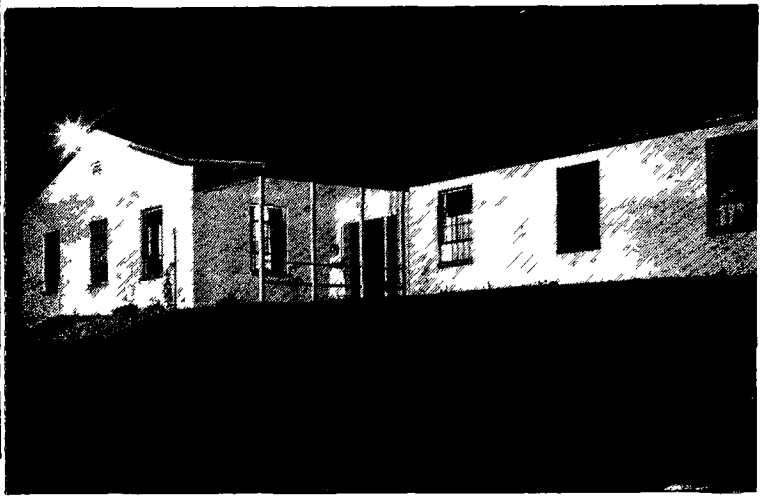
The **second** MCC mental hospital was dedicated in **February**, 1951 and accepted patients immediately **Emphasis** was placed upon patients who had been ill for some **time**, but who could be helped by relatively long-term care The program developed to fit the newer concept of hopefulness for so-called "chronic" cases of mental illness

Astonishing results indicate that only half of those admitted require continuing hospitalization Beds are being turned over regularly and new cases of acute types are now being admitted for treatment The result of combining Christian care with sound psychiatric services have exceeded the hopes of the West Coast constituent groups

The hospital continues to be available for long-term care of selected patients It serves the constituency from states as far east as Ohio and from many of the intervening Mennonite communities

"And He sent them to preach the Kingdom of God and to heal the sick" —LUKE 9 2

MCC MENTAL HOSPITAL 1949
East Coast Area
Hagerstown, Maryland



Brook Lane Farm

Helmut Prager, M.D., Psychiatrist
Delvin Kirchhofer, Administrator

AVAILABLE
27 beds for acute cases requiring immediate treatment

PLANNED EXPANSION
6 additional close security rooms

This **first** MCC mental hospital was dedicated in 1948 and accepted patients in January 1949 In three years of operation with 23 regular occupancy beds, services increased as follows

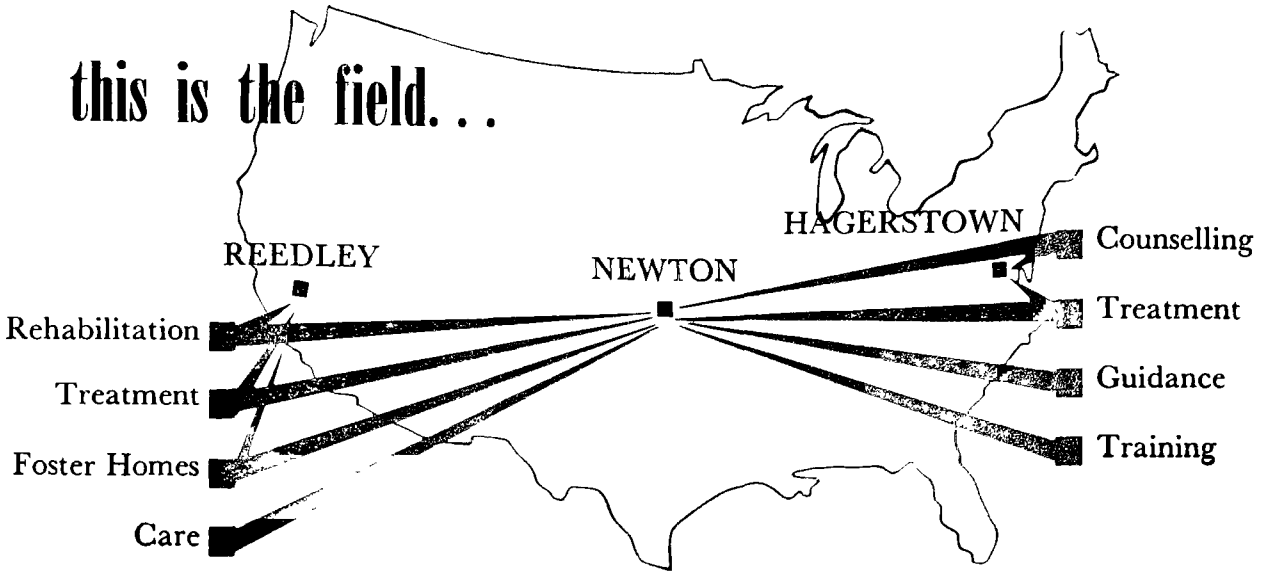
1949	96 admissions	Average census—10
1950	164 admissions	Average census—17
1951	228 admissions	Average census—26

One-fourth of those served in 1949 came from MCC constituent groups Now about one-third of the much greater number of cases are coming from supporting church groups Mennonite, Amish, and Brethren-in-Christ church members from the Atlantic Coast westward to Kansas are making increased use of the treatment hospital

Brook Lane Farm encourages relatively short-term periods of hospitalization The average length of stay is 37 days per patient Its reputation is one of offering Christian service to those in need Its light, indeed, shines forth as a witness of love in the name of Him who first loved us

"For all the law is fulfilled in one word, even in this; thou shalt love thy neighbor as thyself" —GALATIANS 5:14

this is the field...



the goal

PREVENTION — of mental illness through easing of the tension of modern day living.

HEALING — of those who have nervous, emotional or mental disorders.

HOMES and Home-like Institutions — for those who need special care, protection from themselves, or a sheltered environment.

the task

Understand the Nature of Mental Illness.
There should be no more personal guilt or family shame connected with mental illness than with physical illness It concerns a diseased condition of the emotional system and requires the help of a doctor as does influenza, pneumonia or cancer. Some illnesses are quite serious while others are minor; either may require hospital care for a time.
Learn What a Hospital can Do
The purposes and results of a mental hospital are quite similar to those of a general hospital with physical illnesses. Both serve us when we need special treatment or care. Sometimes hospitalization is quite brief, and at other times for an extended period of time. The patient may recover completely, or he may require further attention at a later date. We look to a mental hospital for help in the same manner that we approach a general hospital.
Believe in recovery and **accept** the restored patient as the normal individual that he is.

the means

MODERN, EQUIPPED HOSPITAL
Up-to-date therapies
Meeting qualifications for State Certification

RURAL HOME-LIKE ATMOSPHERE
Small Building Units
Pastoral Surrounding
Family-like Relations

CHRISTIAN STAFF
Fully trained and accredited
Christ-Centered Individuals
Inspired by **Love** to Serve

your means

A goal of $200,000 has been established for building the first two units of twenty beds each. The cooperating church groups are contributing toward this estimated cost. Your personal interest and gifts are earnestly solicited. Give through your own Church or Conference Treasurer. Information is available from your Conference representatives listed on the back of this folder.

this is the plan...

BUILD NOW: 40-bed hospital in two units for initial operation.

Present building plans call for a third unit to add to beds to serve 60 patients.

Site is being planned for an eventual total of 100 beds in five building units.

your representatives

General Conference Mennonite

H J Andreas — 412 S E Second St Newton Kansas
Edmund J Miller — Moundridge, Kansas

Mennonite Brethren

Waldo Hiebert — Hillsboro Kansas
A W Epp — Fairview Oklahoma

Mennonite

H A Diener — R F D No 2 Hutchinson Kansas
Daniel Kauffman — Hesston College Hesston Kansas

Krimmer Mennonite Brethren

A L Friesen — Inman Kansas

Evangelical Mennonite Brethren

J E Wiens — Meade Kansas

Brethren-in-Christ

R I Witter — Navarre Kansas

Old Order Amish

John D Yoder — R F D No 1 Hutchinson Kansas

Church of God in Christ, Mennonite

Albert Unruh — R F D No 6 Box 61 A Montezuma Kansas

Conservative Amish Mennonite

Elmer Swartzendruber — Kalona Iowa

Emmanuel Mennonite Congregation

G J Rempel — Meade Kansas

Mental Health Service Committee

George Classen (Representative ex officio)
331 N 30th St Kansas City Kansas

MCC Executive Committee Members of Central Area

P C Hiebert (Representative ex officio) — Hillsboro Kansas
Elmer Ediger (for H A Fast) — 722 Main St *Newton Kansas*

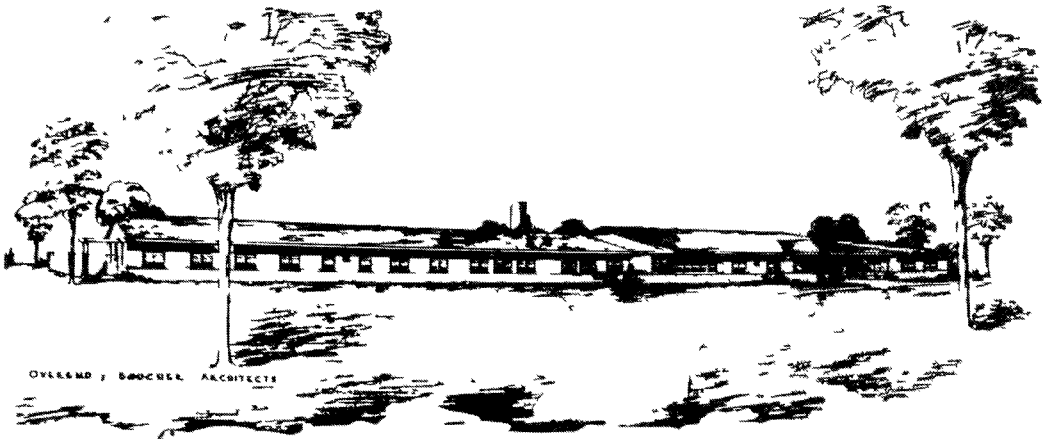
for further information

consult your Conference representative, or address your inquiry to

MENNONITE MENTAL HEALTH CENTER
314 Main Street
Newton, Kansas
Telephone 1208 Newton

or

MENNONITE CENTRAL COMMITTEE
Mental Health Section
Akron Pennsylvania



for a program of Mental Health Service

Prairie View Hospital

Newton, Kansas

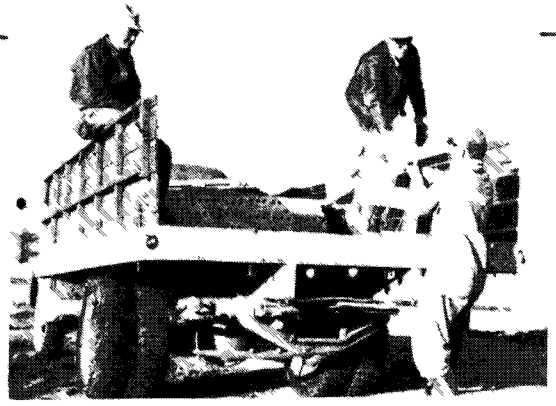
Inasmuch as ye have done it unto one of the least of these my brethren ye have done it unto me

planning

Leader Center The Steering Committee representing ten groups of Mennonites work very closely with Myron Ebersole administrator toward the development of Prairie View Hospital

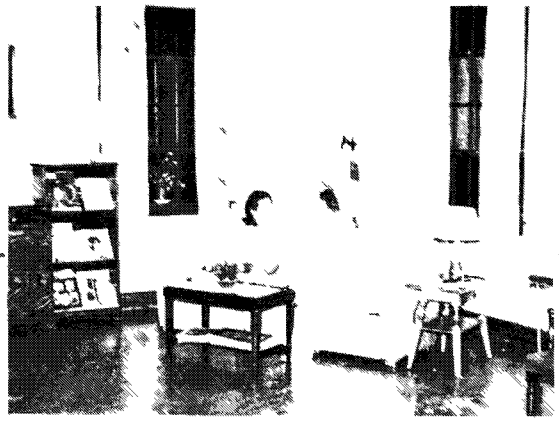
building

Stone upon Stone Nearly a quarter of a mile of outside walls A Voluntary Service Unit is helping with construction under the supervision of Frank Roupp a member of the brotherhood



contributions

Over 50,000 brick have been hauled by interested brethren In addition to funds for the building churches contribute labor and voluntary hauling of materials



services

Serving the Mentally Ill In the Name of Christ will soon be a reality at Prairie View This hospital will serve Mennonites and others

the vision

During World War II, Mennonite young men serving in mental hospitals discovered *a neglected field of service* Because they were interested in serving they were able to make a vital contribution Mental illness is the number one health problem in America! Furthermore, emotional and nervous problems are found all around us *Trained Christian personnel and adequate facilities can help greatly to alleviate this situation.*

All of this has prompted the Mennonite Central Committee to plan for three small hospitals to carry on a program of Christian service for the mentally ill *Brook Lane Farm* near Hagerstown, Maryland, with 29 beds has served more than 700 patients since January, 1949! *King's View Homes* at Reedley, California, with 32 beds has been successfully serving those who need relatively longer periods of hospitalization and those of the shorter "acute" cases as well All three hospitals operate on a non profit basis Fees are charged to cover operating expenses

prairie view

To serve the central area of the United States Prairie View is being built as an up-to-date psychiatric hospital It is being built in a rural setting and will be furnished to provide *homelike surroundings* A fully trained staff motivated by *Christian concern and love* will strive to create *family-like atmosphere* These will give opportunity for the interpersonal contacts which are the "medicine" for the treatment of the mentally ill

Construction is well underway on the new hospital which is made up of two buildings in "T" formation, connected by a covered corridor The beginning units will care for 40 patients The buildings are of one-story, brick veneer construction Central facilities including the offices, kitchen and heating plant are being built to take care of later expansion to 60 and ultimately 100 beds

Prairie View will serve the *acutely ill* who need a *relatively short period of treatment* Plans are also made for treatment of some whose illness is of a more "chronic" nature and will respond to *longer rehabilitative treatment* Counselling will be available for outpatients Plans are being developed for *guidance services for children and parents* with problems of "nervousness"

our part

An avenue has been opened for us to contribute to this recovery The job has been started—let's see it through!

pray

The success of this undertaking will depend upon the extent to which we depend upon the power of Him in whose name we serve

a new attitude

Mental and nervous illnesses should be accepted as physical illnesses are accepted, and mental hospitals as general hospitals Understand and accept the restored patient as the normal individual he is

projects

Room furnishings and equipment will be provided by women's groups and others If you are interested, contact Mennonite Mental Health Services

give

At least $200,000 is needed for the present construction Send contributions through your conference channels or to the address given below

Mennonite Mental Health Services
P O Box 78, Newton, Kansas

By this shall men know . . if ye love one another.

KINGS VIEW HOMES

Operated to

give full psychiatric care within feasible price range—base rates are $8.00 for room, board, laundry and nursing care —

: the best diagnostic and treatment resources of area – demonstrate that each staff member under the supervision

: psychiatrist is essentially a therapist – serve and respect the worth of each individual personality regardless

e, creed, age or illness.

e a Christian environment where positive worship of God is encouraged.

ı a farm environment where the recreative resources of nature are recognized – where fruits and vegetables
me grown and where the adjacent river offers recreation.

ings View Homes is built entirely with gifts; it is operated in part with labor

volunteered by trained personnel because of Christian love and concern.

Licensed – California Department of Mental

Hygiene – registered with the American

Medical Association.

Offering individual and group psychotherap

electro convulsive therapy

occupational – recreational therapy

day care and family placement

social service

rehabilitation

LOCATION

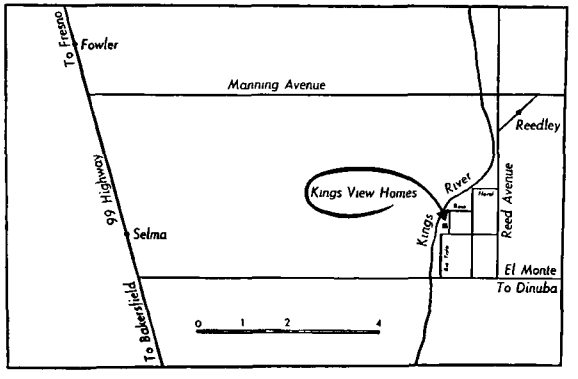
Kings View Homes is located about 2 1/2 miles southwest of Reedley and about 7 miles northwest of Dinuba. It is adjacent to the Kings River.

Admission arrangements can be made by writing to:

KINGS VIEW HOMES
P. O. Box 631
Reedley, California

or phoning: 454 Reedley
6-5831 Fresno

ARTHUR JOST, Administrator
JACKSON C. DILLON, M.D., Medical Director



Kings View Homes is a 30 bed psychiatric hospital. Accomodations are designed for psychotic and psychoneurotic patients.

Operated by the Mennonite Mental Health Service, Inc. of the Mennonite Central Committee, Akron, Pennsylvania.

KINGS VIEW HOMES

"Overlooking the Kings River"

Reedley, California

PSYCHIATRIC SERVICES

The only private psychiatric hospital in the San Joaquin Valley offering a full diagnostic and treatment program.

Visiting Hours

Wednesdays, Saturdays, and Sundays
2-4 P.M.

Mondays and Thursdays
7-8 P.M.

Pastors and clergymen are encouraged to call on members of their own confession or group.

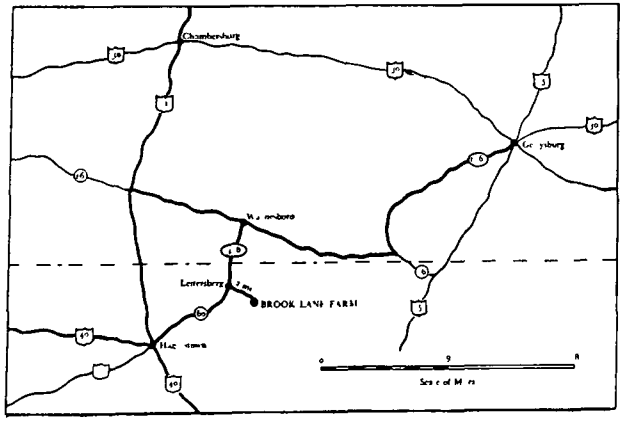
Visits on days or hours not listed above would interfere with other aspects of the treatment program. Special arrangement can be made for visitors from a distance.

Simple devotional services are held twice weekly in the hospital chapel for interested patients, guests, and staff members. Wednesdays at 7:30 p m and Sundays at 9 a.m. are the hours.

* * * *

Location

Brook Lane Farm is located about two miles southeast of Leitersburg, Maryland, a small village midway between Hagerstown, Maryland, and Waynesboro, Pennsylvania.



Admission Procedures

Requests for help are considered by the psychiatrist and the administrator in consultation. If Brook Lane Farm does not have room or the specific treatment facilities required, patients are referred elsewhere.

Address inquiries to:

Delvin Kirchhofer, Administrator
BROOK LANE FARM
Route No. 5
Hagerstown, Maryland
Hagerstown 5339

or:

Helmut Prager, M. D.
1308 Eutaw Place
Baltimore 17, Maryland
MAdison 2070

Brook Lane Farm

A Hospital

for those with

Emotional Problems

HAGERSTOWN, MARYLAND
Psychiatrist, Helmut Prager, M. D.
Administrator, Delvin Kirchhofer

Purposes

- To employ advanced techniques and therapies in a Christian and home-like environment.
- To utilize a rural setting for its creative and recreative healing powers.
- To provide attendant care by individuals who have a call to serve in the spirit of love.
- To make available personalized attention on a non-profit basis.

* * * *

Scope of Facilities

- Diagnosis and specialized treatment with modern therapies individually prescribed and administered by an accredited psychiatrist.
- Semi-private rooms for 23 active treatment and observation patients; isolation when necessary.
- A full resident staff of Christian workers professionally trained for counseling, nursing-attendant care, and therapeutic patient activities.
- Examination or treatment without hospitalization by arrangement.

FOR PEACE OF MIND — MENNONITE CENTRAL COMMITTEE — IN THE NAME OF CHRIST

Administrative Agency

Brook Lane Farm is owned and administered by the:

Mennonite Central Committee
Mental Health Service
Akron, Pennsylvania

The hospital operates under license from the Department of Health of the state of Maryland.

* * * *

Rates

The cost of caring for patients at the hospital is $6 per day.

This rate includes board, room, laundry, and therapeutic care and services of attendant-nursing staff.

Separate charges are made for psychiatric and medical treatment services rendered.

Historical Concepts

The idea of Brook Lane Farm grew out of the experiences of Mennonite young people in state mental hospital service. They were impressed with the manner in which ill persons responded to loving care and consideration on the part of stable and competent psychiatric aides and nurses. Thus was conceived the plan for a Christian institution in which the highest degree of commitment to service would be combined with a steadily growing professional competence.

Brook Lane Farm was established in 1948 for patients requiring immediate relief from acute emotional or mental disturbance. The farm is central to the program as an environmental factor rather than for its agricultural potential. Nestled in the foothills of the Blue Ridge Mountains, the hospital combines an atmosphere of restful security with the freedom of open hills, fields, and lanes.

The Mennonite Central Committee operates a second mental hospital near Reedley, California, and is planning a third for the Central Area of the United States. It sponsors summer and year-around service units in state and provincial mental hospitals of the United States and Canada. Thus is continued the service that inspired the hospital program and that assures a growing source of trained personnel.