An Ethos of Faith and Mennonite Mental Health Services

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Introduction

A number of papers in this symposium have examined the painful sequelae of personal encounters with depression or other mental health issues – loss of hope and alienation from one's family, one's closest community, one's church. The topic of this paper has its roots in almost the exact opposite – the coming together of a people from the church to confront difficult challenges of responding to such issues by reaffirming (or relearning) old wisdoms emerging from their ethos of faith; and, in the coming together, the whole (to steal a gestalt expression) became much greater than the sum of its parts.

Before beginning, a few words about what informs my approach to the subject. I'm a lapsed psychologist! To be more specific, 'lapsed' from the type of psychology I was educated in. I was educated in the view that psychology was a discipline aspiring to do 'real science' – with 'real science' defined as research conducted within a positivist paradigm using experimental and quasi-experimental research designs, and where the researcher sought to test theories without bias and independent of values other than the search for knowledge. To propose that one might enquire into an 'ethos of faith' within this paradigm was about as close to sacrilege as one might get.

The problem, of course, is that constructs like 'faith' and 'values' reflect attributes that are quite intangible and unobservable – hence, fundamentally immeasurable in a direct sense. While I was reasonably good at the positivist style of research, I also was convinced that if one wanted to understand decisions people made, and their behaviour, one couldn't escape coming to the conclusion they were inherently mediated by 'values'. The positivist notion of being 'value free' made little sense. Further, that the construct of 'faith', as we Mennonites commonly understand it – not just faith as a vague confidence that something will work out; rather, that there is a God, and we have a mission to fulfill as a people of God – that 'faith' could not be cavalierly set aside as wishful thinking or a 'bias.'

Systems theory was in its infancy during my graduate studies, and provided a way to think beyond the constraints of reductionism. Amongst the seminal thinkers of the time I encountered Kenneth Boulding, a rather extra-ordinary economist.[1] One quote attributed to him that caught my eye was: "Mathematics brought rigor to Economics. Unfortunately, it also brought mortis." This echoed my sentiment about psychology.

In a 1956 book titled *The Image: Life and Knowledge in Society*, Kenneth Boulding[2] argued that it is the 'image' one has of what is possible that shapes behaviour, shapes what one does – whether the behaviour of an individual, of a group of people, of an organization, or even of a country. By 'image' he meant the accumulated knowledge and understandings a person had. This notion of 'image' captured me then, and has done so through my career of pursuing 'ideal seeking' systems. It is within this notion of 'image' I put the construct of 'faith' – and, by extension, how 'values' and knowledge come together to guide behaviour. In turn, this conceptual context shapes the understandings I've come to on the Mennonite Mental Health story.

Role of Faith in Development of Mennonite Mental Health Services

That Mennonite development of mental health services in the post-World War II (WWII) period was an intentional expression of faith in action cannot be doubted. The experiences of Conscientious Objectors (COs) working in state hospitals during that war as described in other papers in these sessions and elsewhere,[3] created an awareness within the larger Mennonite community not only about the dire conditions within those institutions, but also a concern that better forms of care and treatment should be available to its adherents and others experiencing serious forms of mental disorder. As early as 1944 a proposal was put forward to the Emergency Relief Board of the General Conference

of Mennonites that serious consideration be given to establishing a Mennonite mental health institution, a resolution agreed to in 1945. A similar motion was adopted by the conference of Mennonite Brethren in 1946.[4] Henry A. Fast, one of the key actors in promoting these resolutions, later recalled:

> Our dedication to the principle of nonresistance by itself did not inspire concern for the mentally ill. It did help to intensify our care about people and give meaning, direction and quality to the way we worked with the mentally ill (Henry A Fast, 1972).[5]

These resolutions from two of the largest of Mennonite conferences prompted the Mennonite Central Committee (MCC) to undertake a study on whether or not to set up mental health services which, in turn, led to a 'master plan' to develop a series of centres in the United States– one on the east coast (Brooklane), one in the west (Kings View), one in the central plains (Prairie View) and one in the mid-west (Oaklawn). A fifth, also in California (Kern View), was eventually added.[6] The first three of these began under the administrative auspices of MCC, with local advisory groups; but, within a relatively few years the administrative responsibility was devolved to local boards which, in turn, were linked together and to MCC through Mennonite Mental Health Services – a council comprised of an equal number of centre representatives and members from the church constituency at large. I've commented on the genius of this early structural arrangement elsewhere.[7]

Similar motivations, of the church extending its ministry, underlay the development of another three mental health centres – in Lancaster County (Philhaven), in Bucks County, Pennsylvania (Penn Foundation) and in Southern Manitoba (Eden), and are easily documented.[8] These three also joined MMHS over time.

Towards an assessment of faith in practice

While the founding of these centres clearly was an act of a faith community, whether and how Mennonite/Anabaptist faith is (or was) expressed in the services themselves is a little more challenging to demonstrate. It is difficult to claim that services provided by Mennonite mental health centres are distinctive or unique as contrasted with other equivalent centres if judged on criteria such as services or programs provided, training and experience of personnel, who they serve or the kinds of issues addressed – at least that was the case when I

was involved and, I expect, is still the case. But, these are the 'tangible' kinds of indicators that 'bean counters' dearly like, and largely are relevant only to easily describable externalities of programs.

Not so easily assessed are the qualitative dimensions of such enterprises – of what the experience of people receiving services is, of what the working environment for personnel is like, of what the image (there's that word again) of these programs is in the public square. Such attributes fundamentally reflect individual and corporate values, and can only be assessed in such terms, an argument initially put forward in the disability field (e.g. Wolfensberger, 1972)[9] and later adopted in management and organization theory as well.[10] Today, North American governments, businesses and human services commonly set out statements of their 'values' – ostensibly as guideposts to follow in pursuing their 'mission', and against which they might be judged.

But, the simple articulation of a set of values, whether by a human service or an enterprise of some kind, does not mean they necessarily are put into practice. To illustrate, consider McDonalds, the international hamburger empire. One of the reasons for its success has been attributed to diligent pursuit of its four key values: 'Quality,' 'Service,' 'Cleanliness' and 'Value.'[11] Most of us probably would agree these are reasonable values for a food service enterprise. The 'acid test' of their efficacy, though, is whether we (as consumers of food) would have the same confidence in how McDonalds acts on these values as we might in an alternate 'best practice' place of food preparation where we know from experience these values also apply – say, the kitchens of Mennonite households, our mothers' being the first that come to mind. The fundamental question is: which of the two kitchens – McDonalds' or your mother's – would you have greater confidence in, with respect to consistently putting such values into practice? My guess is most would say the latter. The difference is in how these values are seen in relation to practice. For McDonalds these values are *aspirational* – a way of setting standards and, on occasion, of measuring whether or not a franchisee is living up to implied expectations. For my mother, these were *internalized standards of practice* – an 'image' that, if not lived up to, was something of a disgrace. In Boulding's words, our mothers have an 'image' of the desired outcome consistent with such values that guides their every decision, while people not so inculcated are bound to have 'images' that only partially identify with the values in routine decision making.

In like fashion, it has become common for mental health services to set out values statements. One typical public mental health agency set its values out as: 'Respect,' 'Recovery,' 'Quality,' 'Education' and 'Care.' And a university-based mental health centre set out its values with terms such as: 'Excellence,' 'Innovation,' 'Commitment,'

'Collaboration' and 'Education.' It's notable that there are differences between public and university-based services in how they articulate their values – reflecting something of the context within which they operate. In both cases, though, the fundamental question is "to what extent the expressed values are aspirational, and to what extent an internalized part of practice?" The reality is, such a question has been rarely if ever assessed; but, my observation is that, in the main, these value statements are essentially aspirational.

This difference between aspirational as contrasted with internalized values lies at the heart of gaining some understanding of how a mental health service is perceived and experienced by users of such services, by staff or by the public. And, by implication, they provide a conceptual framework for discerning whether Mennonite mental health services are similar to or different from services provided by others. One might reasonably expect that values consistent with Mennonite/Anabaptist perspectives of faith, if internalized by a sufficient number of personnel, might well lead to differences in how these services are experienced by service users or by personnel or perceived in the public square as contrasted with centres where similar values essentially are aspirational in nature.

Regrettably, neither I nor anyone else I am aware of has sought to contrast Mennonite and other mental health services in these terms, though there is anecdotal evidence suggesting that at least some of the MMHS centres are perceived as preferable. Nor am I aware of a systematic attempt to articulate what seem to be the common faith related values that characterize Mennonite services, let alone determine whether they are internalized in practice. The remainder of this paper is directed towards that end.

Values of Mennonite Mental Health Services

In preparation for another paper last year[12] I examined what one might infer as being the values expressed by Mennonite services – from the very first one in Russia (Bethania) to those in North America. The approach used was characteristic of critical analysis techniques involving reading of available source literature, repeated reflection on the content and nature of the various conversations over the years of my involvement with MMHS and fellow Mennonites involved with mental health and other human services, and contrasting the tentative ideas arrived at.

Nine of the most prominent and common of the values along with exemplars of supporting evidence are identified below, grouped in two categories: seven that speak to service development and day-to-day

provision of mental health services, and two that speak to leadership. Others might have been articulated, but these 9 were the most common. To test their validity, the final step was to compare these themes with findings from a partially related study.

Core values related to developing and providing services

The following seven values pertain to the development and provision of mental health services.

Mutual Aid: Mennonites/Anabaptists have a rich history of practicing mutual aid in a manner similar to that of the early church as set out in several letters by the Apostle Paul,[13] where the community comes to the aid of the person or family experiencing a significant trouble or loss. Documentation from all MMHS centers indicates mutual aid to be the driving concern for their founding – providing aid to the community of faith, as it is sometimes referred to. That said, it should be noted that such services weren't kept exclusive. All centres, from Bethania in Russia to those part of the MMHS in North America and the Paraguayan Mennonite mental health facility *Eirene*, almost immediately extended their services to include people in need from other faith and cultural backgrounds. This dual emphasis – serving Mennonites, serving others – was reflected in the following MCC policy statement (May 3, 1947): "that the concept of services to be rendered be approached by MCC here also in the same spirit as in its other services, having due regard to the needs *of all men* but *especially of the household of faith*."

That didn't mean the church committed itself to pay for services of 'the household of faith' or anyone else in an ongoing way. Orie Miller, Exec Secretary of MCC at the time, stated the mandate as: "(1) MH facilities would be built with church funds but (2) the program itself would be self-supporting" (cited in Jost, 1982, p. 268).[14]

Christian Compassion and Love. This second value expressed by two related terms speaks to the motivation of personnel for being involved in mental health services. Both terms reflect a sympathetic consciousness of others' distress together with a desire to alleviate it, and arise out of a tradition of seeking to live a life of discipleship. The term 'Christian compassion' was used in literature that describes the services of both *Bethania* in Russia and *Bethesda* in Canada, and the term 'compassion' continues to be noted as a value in present day mental health services such as *Eden Health* in Manitoba, *Oaklawn* in Indiana, *Prairie View* in Kansas and *Philhaven* in Pennsylvania. 'Christian love' was the term used to describe the work of COs in mental hospitals and, later, was seen as a primary motivating value

in developing of MMHS centers. In practice, the value from early on was expressed in terms of developing a 'total milieu' with a Christian emphasis. The first Medical Director of Brooklane spoke about the importance of "Christian Living" and the impact that staff had on people served: "I don't see this as ritualistic but more fundamental, incorporating the concept of love, understanding, tolerance and empathy. Each and every member of our organization has a very definite moral obligation in this respect." (cited in Myers, 1983, p. 67.)[15] At the Penn Foundation the founding Plan prepared by Norman Loux and others in 1955 emphasized: "this would, in essence, be a mission endeavor, extending the hand of Christ and love." (Cited in Hoeflick, 1982, p.147.)[16]

Respect for Dignity of the Person. The phrase 'dignity of the person' as an expressed value is relatively recent in origin, largely arising in the 1970s and '80s in the secular context when disability advocates pursued development of service approaches that were sensitive to individual needs and interests. There is an argument to be made, though, that this value was at least an implicit, if not explicit, part of how personnel sought to relate to people receiving services provided by earlier Mennonite mental health or disability agencies. The theological view that each person is a child of God, no matter what their condition or state of life, has deep roots in Anabaptist tradition. One can infer the presence of such a value in the work by Mennonite COs in mental hospitals during WWII. These were young men and, later, a few women, by and large raised on farms, with little or no training or experience relevant to working in large mental hospitals. Yet, as documented in a recent book on the CO experience by Steven Taylor,[17] they gained a reputation of being able to make small positive changes to life on the wards by showing genuine interest in the persons they served. It is reasonable to argue that an implicit understanding of the distraught, naked, long stay inmates of mental hospitals as each a 'child of God' characterized the understanding of these untrained COs seeking to make such individuals' lives just a little bit better.

This value continues to be present as a characteristic of MMHS services, reflected in statements like the following: "Patients or clients are viewed with 'a deep kind of sensitivity and caring about human values…the humaneness"; (Melvin Funk); "instead of being treated with the 'custodial mechanisms that dehumanize the individual,' the person is treated with dignity and respect." (Robert Carlson) (Cited in Neufeld, 1983, p. 247.)[18] Elmer Ediger, one of the MMHS founding directors, wonders whether this emphasis may be a heritage from the Quakers and the 'moral treatment' tradition.[19] This is plausible since the moral treatment philosophy was widely embraced in the early 19th century, but it also is conceivable that this view emerged independently

within the Mennonite community. The greatest direct influence on Bethania in Russia which had a similar emphasis in its programming was from the Bethel institution in Germany where a number of personnel were trained (see below).

Community. The communal ethic is widely recognized as a defining characteristic of Anabaptists. Various writings as well as personal observation identify a number of practices in the various Mennonite mental health services that seem consistent with this ethic: placing emphasis on building relationships, trusting others to do 'what is right', sharing resources, seeking to build consensus whenever possible, 'servant leadership' and so on. Such behaviors are particularly notable in literature describing the way that Mennonite CO programs were operated[20] as well as in contrasts of Mennonite CO programs with those sponsored by other groups[21]. More recently developed programs continue to strive for a communitarian emphasis, both in their internal programs (transdisciplinary teams, with blurring of lines between professions, were evident within the MMHS and other centers well before they became accepted within the public sector MH programs), as well as in their relationship to the sponsoring Mennonite community and the larger geographic communities within which they exist.

Integrity and Ethical Rigor. An emphasis on integrity and ethical rigor is evident in literature on the earliest Mennonite mental health services to the present. There was an obvious commitment to provide services in such a way that it is above reproach, and to doing what is right and being trustworthy in all relationships. The presence of this value is best demonstrated by testimonials from outside sources. For example, one noted psychiatrist-educator from the New York state mental health system who became familiar with MMHS centres observed: "The staff…whether they were Mennonite or not – were approaching their jobs with a commitment and dedication which I have found to be unique to the programs of the MMHS…although the words were the same, the music was different …. Whether Mennonite or not, personnel were approaching their jobs with a dedication and commitment I have found unique to MMHS."[22]

Pursuit of High Quality Programs by incorporating Knowledge-based Evidence with Values. Leaders planning for mental health services invariably sought not only to have their faith expressed, but also to develop programs based on the best sources of knowledge at the time. *Bethania* was modeled on the Bethel institution at Bielefeld, Germany, a mental asylum begun by Friedrich von Bodelschwingh.[23] While it seems probable that what attracted Russian Mennonites, at least in part, was the argument by Bodelschwingh and other Lutheran clergy that the church could better run asylums than the state, a position vigorously opposed by psychiatrists of the day,[24] it also is clear

their principled approach to treatment led to a very fine reputation of service over the years. In the 1940s, for example, Bodelschwingh's Bethel was amongst few German psychiatric facilities that opposed the Nazi euthanasia policies.[25] In North America the MMHS centres were preceded by careful study of leading programs in Europe and North America by an MCC Mental Health Study Committee in the years 1945 and '46.[26] In both these cases, as well as more recent Mennonite services of which I am aware, the intent was to seek out the best available knowledge and meld such evidence with Mennonite/Anabaptist values as a framework for services.

Peace and Justice. Principles of non-resistance and/or pacifism, at the heart of Mennonite/Anabaptist theology, served as guiding values in a new way for personnel in early mental health services. For COs the issue wasn't 'war' and 'injustice' in the classic sense of conflict between peoples or nations; rather, the issue was one of violence and neglect faced by people with mental disorders. The young farm COs found that physical and sexual abuse of patients was not uncommon, but far more common was the immense neglect in wards of grossly over crowded institutions where there often was only one paid attendant for 100 to 200 'patients'. According to Steve Taylor's recent study, somewhat different strategies were used to confront such systemic practices, depending whether COs were of Quaker or Mennonite background. Those of Quaker background gravitated towards active public advocacy, including public exposés of abusive conditions in such national media as *Life* magazine and others, and prompted development of a highly effective advocacy organization in the USA known as the National Mental Health Foundation.[27] Mennonites felt that tackling systems change was too complex and would not change conditions very easily, and so decided instead to see about changing conditions in small ways on the wards during the war, and on the war's conclusion to set up their own small mental health facilities. Value statements on peace (i.e. non-violence) and justice (promoting the common good) continue to be present in values expressed by current Mennonite mental health programs, sometimes expanded to emphasize programming that focuses on peace within families.

Values Pertinent to Leadership

Not so prominent but never-the-less present in the various programs are two values related particularly to the leadership of mental health programs.

Leadership in Tune with Anabaptist/Mennonite Values. In all mental health and related programs one can't help but be impressed by

the effort to ensure that personnel at various levels of their organization can identify with the Anabaptist/Mennonite perspective on faith and its values. All MMHS services sought to have people in leadership positions who understood the faith perspectives of the sponsoring constituencies, ideally showing their capacity to be 'servant leaders' (that is, placing the program interests above personal interest in a Christ-like manner). Certainly there were people of other faith persuasions in senior positions as well as some who undoubtedly had no professed faith, or the occasional leader might express greater self-interest than was considered desirable; but, that was not the preference. If programs were located in cities or towns with a substantial Mennonite/ Anabaptist presence, finding personnel with these desired perspectives was easier to accomplish than when that was not the case. It proved a particular challenge for the earliest MMHS administrative leaders to find psychiatrists, psychologists and other clinical personnel with Mennonite/ Anabaptist backgrounds, some more than others. [28] There simply were very few to draw from at the time.

The MMHS experience also suggests that if a program had difficulty in finding and retaining key executive and clinical leaders with Mennonite/Anabaptist values, almost invariably its linkage with the sponsoring community seemed to deteriorate with consequent negative impact on their internal social cohesion and ability to deliver quality programs. That most Mennonite mental health services in the USA have survived and thrived for a period of up to six decades in what surely is one of the most turbulent of human service environments anywhere, with almost none either closing or leaving their Mennonite connections, is a tribute to their ability to retain key leadership, many of whom continue to relate to each other through Mennonite Health Services (MHS). In Canada similar efforts are made by mental health and disability programs to ward off forces of secularization by seeking to continue their links to their MCC or other Mennonite sponsors.[29] It is just such a commitment to ensuring its leadership is committed to an Anabaptist/Mennonite values framework that, in my judgment, has been a key to maintaining Mennonite services that continue to be broadly and publicly recognized for their high quality

Pragmatic Division of Leadership Functions. It is useful to remember that the dominant leadership model for mental health services in North America and Europe up until the 1970s was for the senior psychiatrist to be the hospital director. Mennonite programs were amongst the earliest to separate administrative leadership from professional leadership. This was, in part, a pragmatic decision; and, in part, it reflected some skepticism about the motives of psychiatrists as leaders of mental health programs. Such skepticism was evident amongst Bodelschwingh and other Lutheran clergy in Germany, whose

programs were developed in opposition to the dominant professionally led psychiatric programs of the time, and seems to have been embraced by leaders of *Bethania*. A similar model became the norm for MMHS centres when they were developed. Through their CO experience North American Mennonites observed that, despite often-expressed concern by lead psychiatrists about lack of good programs or conditions in mental hospitals, there seemed to be either little effort or ability to change hospital conditions, contributing to the obvious conclusion that psychiatrists seemed not necessarily in the best position to exercise leadership for change – perhaps they might even be compromised. There was also a pragmatic concern. Mennonite constituency leaders were interested in having someone in leadership who could devote energy to building the program in a cost effective way and in exercising leadership in a way that the constituency had confidence would reflect its values. It is not surprising, then, that administrative leaders of the first MMHS centres all had personal experience as COs, and thereby the credibility to launch the first mental health services. In contrast, it wasn't until the late 1960s and early '70s that the public sector in North America began to experiment with similar division of labor in mental and general health systems.

A Contrast of Values in Two Different Contexts

A question to consider is whether the values identified above as reflective of Mennonite/Anabaptist mental health services are consistent with statements of values others might derive from examining the evidence. In the absence of any previous similar analyses an approximation might be gained by contrasting the above values with those derived from a related area of activity.

During the course of writing I discovered one such study, a paper presented in 2003 at a meeting of the American Public Health Association with a goal that in part was similar to this paper; namely, to identify values and ethics that inform the practice of faith-based (international) development practitioners. The study by Yoder, Redekop and Jantzi[30] involved a thematic analysis of written responses to questions on their approaches to international development by 20 Mennonite/Anabaptist development practitioners. Eight values were identified and are contrasted with those already presented in Table 1.

It is immediately evident that though there are some differences in wording, there is substantial similarity between the two listings. Five of the values from both lists appear substantively the same, differing slightly in wording or in their application in the two different contexts (mental health service provision vs. development practice). For two

values in each list there was no immediately obvious opposite. This may reflect somewhat different emphases in the two kinds of practice, or it could reflect the nature of bias introduced by either or both authors. Finally, one value from the development practice list was partially related to two values from the mental health service list – again, this could be interpreted in several ways.

VALUES

	Mental Health Services	**Development Practice**
1	Mutual aid	Mutuality
2	Christian compassion and love	Authenticity
3	Respect for dignity of person	People centeredness
4	Community	Service (?)
5	Integrity & ethical rigor	Integrity/Honesty
6	Pursuit of high quality programs through knowledge and values	
7	Peace and Justice	Peace
8		Justice
9		Humility
10	Leadership in tune with Mennonite/ Anabaptist values	Service (?)
11	Pragmatic division of leadership functions	

Table 1.   A comparison of values derived from study of mental health service contexts with values derived from a study of development practices.

The extent of similarity gives confidence to both sets of observations. Such differences as there are lend themselves to exploring further the extent to which the two lists of values are similar, and in which ways they are different. Indeed, it would not be unreasonable to find most values as applied by Mennonite/Anabaptist practitioners of any kind to be held in common, with only a few unique to the particular intent of the program or service or context within which it derives its legitimacy.
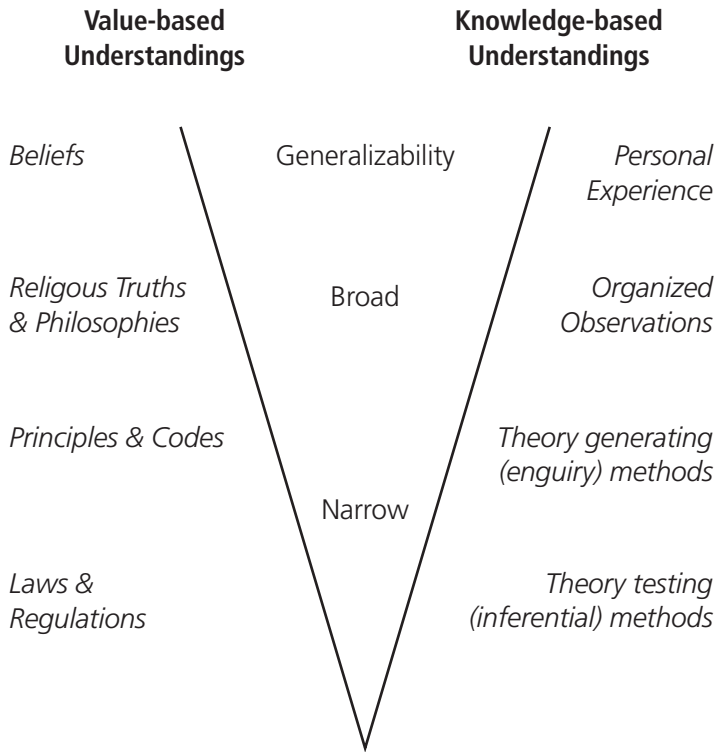
Conclusions

Several conclusions might be drawn from the foregoing. First, an argument can be made (and, I suggest, sustained) that Mennonite mental health services have, to a substantial degree, managed to instill an ethos of faith into their practices as expressed in the values just articulated. Though one can't conclusively demonstrate that so doing has made them substantively different from others, there is reason to believe that they may well be. As per my earlier comments, who amongst us would argue with terms such as 'respect' or 'recovery' or 'quality' or 'commitment' as useful guideposts by which mental health services should be judged. But, good as they are, for many mental health services such values are more a statement of aspiration than they are statements describing how services are in fact provided. Even when such values frame an evaluation of services (a rare experience), or if there is good congruence between the values and how such services might be judged, they don't quite get at the sense of at least some of the values that express the Anabaptist/Mennonite perspective as presented in this paper. There is overlap, but there also is something more, something deeper that describes what Mennonites have sought.

Second, what seems to characterize our collective Anabaptist/Mennonite approach is a balanced consideration of faith-based values on the one hand, and knowledge gleaned from various research traditions on the other, as contrasted with placing the predominant priority on either. I have long argued that any and all decisions one makes involve consideration of both *values-based* and *knowledge-based* understandings of whatever the decision is about. A heuristic to help think about the inter-relationship of values and knowledge is provided in Figure 1. Values-based understandings range from broad understandings of worth as articulated by the major religions and philosophies (including philosophies of science) to more narrowly defined and specific laws and regulations. In the same way, knowledge-based understandings range from broad, loosely organized and defined experiences to narrowly defined, organized observation such as undertaken in theory testing research methodologies. In between there are many degrees of specificity. This Vee heuristic lends itself to understanding that both knowledge claims and values claims vary in their degree of specificity and generalizability. The more specific, the more certain one's conclusion about a given phenomenon, but also the less generalizable to other contexts or phenomena; and, *vice versa*.

In presenting this heuristic to policy or research audiences,[31] there invariably is considerable interest. However, such interest tends not to be followed up with action except as and when a particular program might be in the midst of some operational crisis, or where leadership

is particularly interested in pursuing some significant change. In Mennonite/ Anabaptist contexts the Values/Knowledge balance of the Heuristic seems to have a better fit.

Value-based Understandings   **Knowledge-based Understandings**

Beliefs   Generalizability   *Personal Experience*

Religous Truths & Philosophies   Broad   *Organized Observations*

Principles & Codes   *Theory generating (enguiry) methods*

                          Narrow

Laws & Regulations   *Theory testing (inferential) methods*

Figure 1. Sources of Evidence in Shaping our Futures - The "V" Heuristic

Third, and finally, I'm left with the question of what these attributes of our collective being, if they are sustained, contribute to the world at large and how that might help improve opportunity and life for people experiencing mental health issues. In putting this question forward, I'm mindful that MMHS centers emerged at least partly with the encouragement of highly recognized psychiatrists and others of non-Mennonite or Anabaptist background who suggested that "Mennonites might have a special contribution to make."[32] Such confidence was vindicated in a relatively short period of time. National recognition was given to three MMHS centers in the 1960s for their leadership as model community mental health centers – not bad for agencies that sought to counter societal evils by engaging in personal acts of love and caring.[33]

There are other contributions one might cite. In the end, though, our 'ethos of faith' would suggest that it doesn't matter very much whether we've made a contribution to the world at large. If they have, fine and good. What really matters is whether we've made a difference to the lives of the people around us.

Notes

1   Kenneth Boulding moved beyond the bounds of his discipline, making important contributions to the fields of political science, sociology, philosophy, and social psychology. And, during World War II, he had become a committed pacifist and devoted Quaker.

2   Boulding, Kenneth (1956). *The Image: Knowledge in Life and Society*. Ann Arbor, MI: University of Michigan Press.

3   See, for instance: Keeney, William (1982) "Experienced in Mental Hospitals in World War II", *Mennonite Quarterly Review, LVI (1) (January)*, 7 – 17; and, more recently, Steven J. Taylor (2009), *Acts of conscience: World War II, mental institutions and religious objectors*, Syracuse, NY: Syracuse University Press.

4   See, Neufeld, Vernon (1982) "The Mennonite mental health story", *Mennonite Quarterly Review, LVI (1) (January)*, 18 – 31; and, Neufeld, Vernon (1983). "Mennonite mental health services". In, Neufeld ,Vernon H. (Ed.), *If we can love: The Mennonite mental health story*, Newton, KS: Faith and Life Press, Ch. 2, pp. 31 - 56.

5   Fast, Henry A (1972). "Beginnings of Mennonite Mental Health Services", unpublished address, Meeting of MMHS at Prairie View, Newton KS, October 7.

6   Chapters on the history of each of these centres are presented in Neufeld ,Vernon H. (Ed.) (1983), *If we can love: The Mennonite mental health story*, Newton, KS: Faith and Life Press.

7   Neufeldt, Aldred H. (1983). "MMHS in Perspective". In, Neufeld ,Vernon H. (Ed.), *If we can love: The Mennonite mental health story*, Newton, KS: Faith and Life Press, Ch. 15, pp. 283 – 294.

8   Ibid.

9   Wolfensberger, Wolf (1972). *The principle of normalization in human services*. Toronto: National Institute on Mental Retardation.

10   The importance of unspoken values are at the heart of a sizable number of the types of vignettes presented by Peters and Austin in their 1985 book *A passion for excellence: the leadership difference* (New York: Random House).

11   For a brief McDonalds History see the URL: http://www.mcdonalds.ca/pdfs/history_final.pdf. Retrieved 10 June 2009.

12   Neufeldt, Aldred H. (2009). "Scientific knowledge and Mennonite/Anabaptist values in mental health". Presented in the Mental Health Practitioners Workshop, Mennonite World Conference, Asuncion, Paraguay, July.

13   See texts such as 2 Corinthians 8; Philippians, and 1 & 2 Thesalonians.

14   Jost, Arthur (1983). Private Centers and Public Funding. In, Neufeld ,Vernon H. (Ed.), *If we can love: The Mennonite mental health story*, Newton, KS: Faith and Life Press, Ch. 14, pp. 267 – 282.

15   Myers, Evangeline B. (1983). "Brook Lane Hagerstown, Maryland". In, Neufeld ,Vernon H. (Ed.), *If we can love: The Mennonite mental health story*, Newton, KS: Faith and Life Press, Ch. 3, pp. 57 – 76.

16   Hoeflich, Charles, H. (1983). "Penn Foundation Sellersville, Pennsylvania." In, Neufeld ,Vernon H. (Ed.), *If we can love: The Mennonite mental health story*, Newton, KS: Faith and Life Press, Ch. 7, pp. 145 – 154.

17   Steven J. Taylor (2009), *Acts of conscience: World War II, mental institutions and religious objectors*, Syracuse, NY: Syracuse University Press.

18   Neufeld, Vernon H. (1983). Providing clinical and other programs. In, Neufeld ,Vernon H. (Ed.), *If we can love: The Mennonite mental health story*, Newton, KS: Faith and Life Press, Ch. 12, pp. 239 – 249.

19   Ediger, Elmer M. (1983). Roots of the Mennonite mental health story. In, Neufeld ,Vernon H. (Ed.), *If we can love: The Mennonite mental health story*, Newton, KS: Faith and Life Press, Ch. 1, pp. 3 – 28.

20   Chapters in Neufeld (Vernon H. Neufeld (Ed.), *If we can love: The Mennonite mental health story*, Newton, KS: Faith and Life Press) speaking to the early history of MMHS reflect these kinds of orientation.

21   See Taylor, *op cit*.

22   Wilder, Jack F. "The words were the same, the music was slightly different." In, Neufeld ,Vernon H. (Ed.), *If we can love: The Mennonite mental health story*, Newton, KS: Faith and Life Press, Ch. 18, pp. 309 – 312.

23   Krahn, Cornelius. "Bethania Mental Hospital (Chortitza Mennonite Settlement, Zaporizhia Oblast, Ukraine)." Global Anabaptist Mennonite Encyclopedia Online. 1953. Global Anabaptist Mennonite Encyclopedia Online. Retrieved 10 June 2009http://www.gameo.org/encyclopedia/contents/B48436.html.

24   Engstrom, Eric (2004). Clinical psychiatry in imperial Germany: A history of psychiatric practice. New York: Cornell University Press, pp. 179 – 181. Retrieved 29 June 2009 from: http://books.google.ca/books?id=C1JYNnBLMqQC&pg=PA179&lpg=PA179&dq=Bodelschwingh,+mental&source=bl&ots=QJUm9_8cny&sig=u2_dmWkixYU4wsbhNwZKXvHV-uE&hl=en&ei=1K9HSqzZCsGFtgewpKmnDw&sa=X&oi=book_result&ct=result&resnum=3.

25   Lifton, Robert Jay (1986). *The Nazi doctors: Medical killing and the psychology of genocide*, pp 90 ff. Retrieved from The Mazal Library and the Holocaust History Project, 28 June 2009 at: http://www.holocaust-history.org/lifton/LiftonT090.shtml.

26   Ediger, Elmer M. *op. cit*.

27   Taylor, *op. cit.*, provides a particularly good account of this in a number of sections in his book.

28   See descriptions of center histories in Neufeld, *op. cit*.

29   Supportive Care Services in British Columbia is a recent example of an MCC sponsored program that was spun off to independent status. In the process of being spun off, both Board and Staff of this disability program sought to ensure their connection with the Mennonite constituency would remain strong despite the bulk of funding coming from public sources.

30   Yoder, Richard A, Calvin Redekop and Vernon E. Jantzi (2003). "Ethics, values and development: Anabaptist/Mennonite perspectives." Paper presented at the 131st Annual Meeting, American Public Health Association, November 18.

31   For example, Neufeldt, A.H. (2004). What does it take to transform mental health knowledge into workplace practice? Towards a theory of action, *Healthcare Papers: New models for the new health care, Vol. 5 (2) Special Issue*, pp. 118 – 132. See URL: http://longwoods.com/hp/5-2MentalHealth/HP52Mental.pdf.

32   Ediger, *op. cit.*, p. 27.

33   Taylor, *op. cit.*, p. 395.