CHAPTER 8
Socially Active Mennonitism and Mental Health

The Origins of Kings View Homes

You people have unique care.
—Dr. Jackson Dillon, psychiatrist, on Mennonites, 1951

Beginnings

Immediately in postwar California, flush with the success of the Civilian Public Service (CPS), there was an expanding array of social relief efforts through the local Mennonite Central Committee (MCC) and churches. The institutional presence of Mennonites was growing at a rapid rate. As with CPS, the institutional expansion of California Mennonites articulated a sense of identity and drew them nearer to society’s political structures. An especially poignant example of this development is the creation of Kings View Homes (KVH), a mental health hospital in Reedley. Although California health care in the early twentieth century was, in part, defined by curative sunshine, soon the application of scientific principles dominated health care delivery, and we see both in the early sanitarium. As the twentieth century advanced, health care, by necessity, became a professional activity, and despite the compassionate and religious motivation behind KVH, religion seemingly disappeared.

The flurry of Mennonite activity in the first postwar decade was part
of a larger Californian response to changing times. Related directly to a rapid expansion of suburban developments, Californians were building at a quick pace. As the state’s population continued to rise quickly, communities were built with schools, houses of worship, and other religious institutions anchoring them along with parks and shopping malls. The 1950s was also a decade of tremendous expansion for religious infrastructure, with many seminaries, houses of worship, and social services built. Within California, all this building, including massive school, community college, and university construction—coinciding with expanding networks of highways—was supporting old-time residents and the vast number of newcomers. Within this swirl of optimism and activity the Mennonites too established a significant presence in churches, schools, and community service organizations.

Emerging directly from the CPS experience was an ambitious undertaking to establish Mennonite mental health hospitals throughout the country. In California, Arthur Jost headed this project, and it signaled a larger irony: the rise of a “secularized” Mennonitism. Henry Schmidt, Mennonite Brethren seminary professor and president, observed that the twentieth-century experience was largely one of “reluctant involvement,” where tensions between “continuity” and “discontinuity” were typical. These tensions were found in attempts to maintain Mennonites’ particular ethical religious expression, geographic isolation, and cultural separation. However, they accepted such citizenship demands as voting and, increasingly, military service, or at least lost some compulsion to avoid them. In so doing, Mennonites grew in their acceptance of “patriotic nationalism,” and we see this in such projects as KVH and its social, religious, and cultural motivations.

As early as 1937, the Mennonite Brethren Pacific District Conference (PDC) discussed mental health care. They believed that mental health care was necessary for some, but as a medical practice, it was largely biased against religion. Despite this concern, when they visited the state hospital in Stockton in 1938, they felt welcomed and were encouraged to sing and preach to fellow Mennonites.

The real momentum to establish a center for mental health care developed from CPS, when many Mennonite CPSers were stationed in mental health hospitals. Scholars have linked CPS involvement in mental health institutions during World War II with postwar Mennonite socio-religious activism. During World War II, approximately 1,500 Mennonite men served
in mental hospitals, and many reported that the mentally ill lived in deplorable conditions.\(^5\)

In the mid-1940s, MCC studied mental illness among Mennonites and discovered that more than one thousand American Mennonites suffered some form of it. Mennonite leaders, such as Arthur Jost, considered the general apathetic attitude toward the mentally ill an indictment against the Mennonites. As West Coast Mennonites took initiative on this issue, the significance of people like Jost grew.\(^6\)

The PDC made recommendations in 1946: “We see a very definite need for a mental institution. We feel that we are not equipped to receive such cases; also, our license of operation is for a Home for the Aged only. Therefore we recommend that the conference take some definite action toward the establishment of such [an] institution in connection with MCC.”\(^7\) The PDC added and approved a clarification in the original minutes that the Home for the Aged (a Mennonite Brethren senior care facility created in 1942) and the future mental institution remain separate.\(^8\)

By the following summer, the Mennonite Brethren Committee of the Home for the Aged, voted unanimously to support the mental hospital and “co-operate to the fullest extent possible.”\(^9\) After exploring the possibility of opening a mental hospital in California, Elmer Ediger of the planning committee reported that a psychiatrist in Los Angeles supported the project: “He feels that the psychiatrically validated ‘spiritual’ ministry should distinguish the Mennonite institutions for [the] emotionally ill.” Furthermore, “Discussion regarding the philosophy of a Mennonite institution was helpful, however, he, not having had first hand institutional experience but only clinical office work, could not help too much in the field of suggestions regarding the nature of the institution policies and staff.”\(^10\) That fell to a proven Mennonite Brethren administrator, Arthur Jost.

Before his involvement in mental health, Jost had been the administrator of the Home for the Aged in Reedley, which he left in 1953 to devote more time to KVH.\(^11\) When Jost filed the first report of the “M.C.C. Mental Hospital Project,” his narrative framed the mental health issue in terms of the secularization of mental health care, mistreatment of patients, Mennonite inaction, and specific Mennonites suffering at mental health institutions. Jost introduced his report with a telling statement: “Our modern day of secularization and strife seemingly has led many of us [Mennonites] into a deeper appreciation of our Christian privileges.” By this statement, Jost indicated that secularization, while creating a host
of problems in society, provided a place to enact religious convictions. He then listed various groups in the Mennonite constituency that had institutions built to serve them. These institutions included schools and senior care facilities. Those who suffered from mental illness, however, went to state institutions, where standards of care were questionable.  

No longer, argued Jost, could Mennonites claim innocence regarding the treatment of the mentally ill or that mental illness did not afflict their own people: “Today we know that there is nothing magic about mental illness; it is largely a cause and effect relationship which is no respecter of persons. Today we know that medical care together with kindly treatment and intercessory prayer, which is possible only in Christian institutions, can restore many of them to mental and spiritual health.” Jost tied the de-mythologizing of mental illness as nothing “magical” to the spiritualizing of its care as “kindly” and “intercessory prayer” which only “Christian” institutions could provide. He navigated between two sets of concern: the spiritual concerns of Mennonites and the medical concerns of professional health care.

Jost took care to highlight the problems of the secular institutions: “There is no segregation from the evil influences often rampant in these [state] institutions.” Furthermore, he reported that the treatment of patients was often deplorable if not violent. Finally, Jost described, albeit anecdotally, the treatment of Mennonite sufferers of mental illness in state or other private facilities in tones that suggested dark malevolence: “I have seen a Mennonite sister . . . who was imprisoned in a cage like a beast and her agony was indescribable. A Mennonite brother, who with his religious utterings incensed the attendants, was choked until unconscious. Recently I was shown the ward where our own brother, a minister to whom our conference owes a great debt, was kept in an unusually clean room yet where he was crowded into a godless, lonely environment.”

The language Jost used depicted men and women, leaders and laity, as suffering mental illness exacerbated by facilities that caged them like beasts, persecuted them for religious utterances, or at least kept them in a lonely godless environment. Jost reminded his audience of the evangelistic possibilities and suggested that such ministry was a “fuller Christian service” necessary for earning the church respect in the local community: “Although this work is directed particularly to those who are of the household of faith, we want to consider this as a type of missionary service which we can be rendering in a very special way.”
Construction

On May 3, 1947, MCC authorized the construction of KVH, with Jost as its administrator, and the creation of a committee, made of representatives of the West Coast Mennonite constituency, to run it. In fall 1949, construction began on a forty-three-acre plot, and in March 1951, KVH opened its doors. Patient activities included music and farming, which generated income for KVH. Kings View Homes, though planned as a long-term care facility before its opening, set aside four beds for acutely mentally ill patients. Thus, Kings View Homes was also known as Kings View Hospital.

The KVH program enjoyed the support of the Mennonite Brethren Church, whose Board of General Welfare and Public Relations in January 1950 passed the following resolution: “Kings View Homes. Work on this project has been started. The Churches on the West Coast are making special drives to finance the building of these homes. We are pleased to hear that the work is progressing and are thankful for the efforts of the Pacific District Conference in this regard. We are urging our churches to support this worthy cause.” Not only churches supported the cause, but other Mennonite Brethren agencies, such as the Committee for Bible Camps, saw potential in working with KVH.

Support from the local community, however, was not as readily forthcoming. In two letters to Elmer Ediger, of MCC in Akron, Pennsylvania, Jost described local resistance. Initially, he characterized local concerns as typical: “The community here around our property just like thousands of other American communities has many questions regarding the mental hospital.” Jost assured Ediger that “neighbors with Mennonite American or German backgrounds have responded well,” and that opposition was essentially the orchestration of one couple, Mr. and Mrs. Peloin. Mr. Peloin, an apparently influential man in Reedley, worked to persuade people to vote against KVH. He offered as a compromise that KVH reconstitute itself as an “Old People’s Home.” Though accurate in the short term, as KVH began treating chronically ill patients, many of whom were elderly, Jost argued it was dishonest to have promoted the facility to the State of California and the Mennonite constituency as a mental health hospital and then proceed as an elder care facility.

Of particular concern for Jost was the local Armenian population: “It is
unfortunate that the Armenian people, who band together just like Mennonites on an issue, do not favor the project.” Jost thought that Armenians were planning to attend the local meetings with “an unnecessary number [of participants].” He also believed that Peloin’s motivation was influenced by his own desire to buy the same plot of land. Peloin, however, attributed his opposition to the hospital to his wife’s fears: “She is afraid of all mentally ill, except those that cannot walk.” If the vote went against KVH, Jost had a second option: find land in an area populated primarily by Mennonites in a school district with few, if any, Armenians.

In a letter dated April 8, 1948, on the eve of the vote, Jost informed Elmer Ediger that, despite some struggle to win local approval, it would be forthcoming: “[It’s] utterly preposterous that people make so much ado about nothing.” He hinted that part of the problem was their pacifist background: “the price to pay for our stand during the last war.” Three years later, H. R. Martens, on the KVH Advisory Committee, concluded that “hostile opposition” to the hospital was shifting to “acceptance” as local uncertainties regarding KVH subsided.

Throughout 1948, the struggle to generate Mennonite support continued, and responsibility to educate local Mennonite congregations fell to the MCC Peace Committee. Throughout the experience, Jost linked evangelical piety and social action. For himself, the challenges in moving KVH forward were also a spiritual matter: “The project as a whole is moving slowly and with great difficulties at some points. With the expression of interest which I contact continually and with the way in which developments have taken place we feel the Lord is definitely leading, but we have also experienced a greater dependence on Him leaving the whole matter in His hand.” He concluded that church support came largely from educational visits, not fund-raising visits, with particularly large turnouts in Upland and Reedley. To demonstrate the project’s fiscal viability, Jost proposed that KVH be built primarily with voluntary Mennonite labor. Demonstrating the project’s social responsibility, Jost explained that KVH was a response to society’s tendency to cast the mentally ill aside. Thus, Jost wove together evangelicalism and social activism into whole cloth.

At the ground breaking, on November 20, 1949, Jost had mixed feelings. Though he had some success promoting KVH to Mennonites, non-Mennonites were less enthused: “We were somewhat disappointed that not more members of the community (non-Mennonite) were present.” There was a measure of success on another front, as MCC had always hoped...
that the hospital would be a venue of inter-Mennonite cooperation. By 1952, KVH reported that “only three churches were uninterested” and that Mennonites were asking more questions about mental health care and considering KVH “their mental hospital.” Nonetheless, Jost acknowledged, “we realize that this project does not inherently register the sense of urgency that foreign relief and refugee projects do.” Working to bring mental health into the same realm of Mennonite consciousness as foreign missions and refugee work, supporters of KVH were most frustrated with fund-raising. They complained as late as 1950, “we as yet have not received enough contributions to assure completion of the Kings View Homes building.”

Despite these frustrations, KVH served an important symbolic function of inter-Mennonite ecumenism, though run almost entirely by the Mennonite Brethren. Their geographic isolation from the main anchors of American Mennonitism in the eastern states made the symbolic function of inter-Mennonite cooperation possible. Jost observed, “In the past we have frequently stressed the importance of the [Mennonite Central Committee West Coast Regional Office] center on the West Coast as a symbol of our combined effort. The mental hospital is entering into that same function and I continue to believe that it is important particularly because of our distance to Akron.”

Kings View Homes was also important in mediating a growing relationship between the Mennonites and California society. At the opening ceremony, Dr. Frank Tallman, of the California Department of Health, representing the governor, thanked the Mennonites and encouraged them “to go forward in their program for the mentally ill.” KVH was a church-run institution but not overtly religious in its presentation. Even the name was symbolic of this, for despite its apparent Christian imagery, Jost explained, KVH was named after the Kings River.

The county commissioner found KVH’s location acceptable: “The selected site was a bit isolated although only two and half miles from town on the edge of a thickly populated Mennonite community.” The site encompassed forty-three acres with fruit trees and fertile soil: “The soil is some of the best in the San Joaquin Valley and is capable of producing any of the crops native to central California.” Modernist architecture, simple, practical, and prebuilt, became common in 1945 as Californian suburbs and housing construction ballooned, and here this architecture was a point of pride for Mennonites: “The building is strictly modernistic in
design and yet every effort has been made in both design and construction to keep costs on the lowest possible plane."35 Construction lasted from January 29, 1950, to February 1, 1951, using prefabricated materials and donated labor, both of which kept costs down for a church organization on a tight budget. The industry journal Mental Hospitals praised KVH as a model for low-cost construction, and denominational leaders such as P. C. Hiebert recognized Jost’s administration of KVH as “efficient administrative work.”36 Now it was time to hire a doctor.

**Religion and Health Care**

Following World War II, when the plan to create a Mennonite mental health program emerged, no Mennonite psychiatrists existed. From the start, Jost and Ediger pursued “active treatment rather than merely custodial care” and the best of progressive mental health treatment.37 Staff initially came from the wider community, though “great care was used to secure a staff sympathetic to Mennonite Christian concerns.”38 KVH, therefore, employed non-Mennonite psychiatrists, who naturally enough wielded considerable influence on the hospital’s early development, posing some challenges and interesting recommendations.

The first KVH psychiatrist, Dr. Jackson Dillon, encouraged the hospital to adopt a Mennonite religious element: “Our hospital doctor is of the very best and understands our Mennonite faith. Recently Dr. Dillon was asked to appear before the Executive Board as to future guidance for the Hospital Staff. Dr. Dillon gave us a very encouraging report stating that others give good medical care. But you people have unique care, and something that I call extra which is a healing ministry in itself. We should have been pleased had he used the word Christian instead of the word unique, but doctors like to use more of a medical term.”39 According to Jost, non-Mennonite doctors were perceived by some Mennonites to “approach all problems with an experimental eye,” which “debulk[ed] old customs.”40 The “old customs,” likely of a religious nature, were also replaced by Mennonites with a concern for efficient, rational, and modern administrative practices.

In its first twenty years of operation, KVH grew from a small psychiatric hospital to a mental health center serving a population of more than 400,000 in five counties. It established a reputation for its efficiency and rational delivery of service, as in the following praise found in Hospital and
Community Psychiatry: “Its [KVH] experience demonstrates that a private organization can effectively deliver services usually provided by government agencies.”

From the beginning, Jost worked closely with state officials in the creation and running of the facility. In a conference Jost, Dr. Frank Tallman, director of the California Department of Mental Hygiene, concluded that he wanted to start a National Mental Health Foundation (NMHF) chapter in California in order to include MCC in the establishment of an “attendant training program.” Tallman explained that an NMHF chapter in California would “unify the uncoordinated Californian agencies” and that NMHF was more oriented to mental health than existing general health agencies and therefore had better resources and funding for mental health. MCC’s contribution to the training curriculum, through Jost, “would not be on the technical level but in terms of attendant attitudes and experience on the level of ‘personal relationships.’”

In his relationship with Tallman, Jost worked to build closer relation-
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ships with the California government. Jost wrote to Tallman, “We would like to discuss further with you the possibility of such units and the part we might have in the development of such as well as in reaping the benefits such a program might have toward our own mental health activities.”

It became a fruitful relationship. By the mid-1950s, Jost’s administrative team situated KVH on an increasingly vague boundary between Mennonite religiosity and California society.

Jost had his start in mental health work while in a CPS unit in Provo, Utah. In a 1943 letter to the Christian Leader, the official publication of the United States Conference of Mennonite Brethren Churches, he wrote, “In this field we saw avenues of unlimited service to humanity; we saw in it a similarity to the kind of service Jesus had in mind when He commands us to serve ‘the least of these.’ . . . We realize that we are dealing with souls, although sick and irresponsible, they are and deserve to be treated as such.” By the time Jost took the reins of KVH, he had undergone his own shift in focus. A decade later, he described KVH for the Mennonite Encyclopedia in clearly less religious terms: “The present services include full psychiatric care, medical workup in conjunction with local general medical facilities, outpatient care, and foster home care. All types of mental patients are admitted.”

Jost was not alone. Jim S. Gaede, chair of the Board of General Welfare and Public Relations, also navigated this boundary in accepting the position of psychiatric social worker at KVH for two reasons: “to be true to Christ and to be true to myself.” Gaede worked in his denomination’s psychiatric hospital as a trained psychiatric social worker in a fashion that was authentic to himself—as an individual.

Moreover, hospital administrators gauged their growing success by local and professional acceptance, especially as their workers increasingly spoke at professional meetings. By 1962, however, Mennonite leaders expressed concern over the decline in the number of Mennonite nurses. They feared the Mennonite constituency at the hospital might be completely replaced by secular outsiders. Ironically, the increased success of efforts to reach out to the wider community, so enthusiastically embraced and pursued by hospital administration, threatened to alienate the very constituency that sponsored them.

In the early 1960s, when plans were established to build a second Mennonite mental health hospital in Bakersfield, significant changes in the Mennonite social position in central California made development
possible. In the case of Bakersfield, local experts invited the Mennonites to construct a hospital ward near the Greater Bakersfield Memorial Hospital. The invitation even came with government funding and a rent of one dollar a year for fifty years. These planners of the Bakersfield hospital stressed that no money, only personnel and expertise, were required of the Mennonite constituency. The Bakersfield medical community considered such a hospital necessary, and the Mennonites considered it an opportunity to provide services in a California region with a large Mennonite population; they could “enlarge their witness.” The new facility in Bakersfield was located “on grounds adjacent” to the Memorial Hospital of Greater Bakersfield. Mennonites quickly seized the opportunity to purchase the land out “of fear that one of the other hospitals in the area, particularly the Catholic hospital, will ‘beat them to the punch.’”

When the Mennonite Mental Health Services Board approved the expansion of KVH into Bakersfield, in 1963, the language used in the announcement was more generic than specifically Mennonite. The new hospital was to be “love centered.” The citizens of the State of California had accepted the work at KVH and its “effectiveness of a psychiatric treatment program, which is motivated by a philosophy of life with love as its central theme.” One patient wrote, “The Mennonites and their way of love is what we all need.” In the context of mental health care, Mennonitism seems to have been understood often enough as “love-centered psychiatric therapy,” or more generally, “the therapeutic effect of Christian love.” Christian faith and an ethereal, generic-sounding “love” were considered efficacious.

In summer 1963, the builders of the Bakersfield Hospital waited for approval from state and federal government grants. The denominational Board of General Welfare and Public Relations announced that this new hospital “will be owned and operated by the Mennonite churches, [though] the identification with the larger community general hospital will be very close.” Ultimately, this project, by which Mennonites served society and their own constituency, would not clearly mark Christian and Mennonite identity, but would work comfortably with “secular” society. On the cover of the October 16, 1966, Kern View Hospital dedication bulletin was an American Flag and a Christian Flag with crossed staffs alongside a picture of the United States Capitol in the lower left corner; the entanglement with American Civil Religion seemed complete.

Mennonite engagement with mainstream culture and society, as ex-
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emplified by the mental health program, was clearly articulated in the Bakersfield hospital proposal. The proposal stated, “It is difficult for anyone outside California to understand why a fifth hospital should be located to so unbalance the Mennonite Mental Health program in relation to Mennonite constituency.” The fifth hospital being in California was a result of local Central Valley needs and recognition of the good work done in KVH in Reedley. Mennonites established mental health hospitals in the rest of the country according to Mennonite demographics; in California, however, the Mennonite presence, while important, was not the sole determinant of location.

Considering Mennonite demographics, California was the least populated American region and the only region at the time planning a branch hospital. The board of the Greater Bakersfield Memorial Hospital also did not consider the Mennonite initiative and presence to be that of “outsiders”; they saw the Mennonites and general hospital to be two groups “thinking together and working together on a common problem.” The Kings View Homes Board of Directors, in compiling their report on the feasibility of the Bakersfield project, made considerable effort to demonstrate that Mennonites were not considered “foreign elements,” that Bakersfield understood their emphasis on “Christian love” in health care. This proposal, unlike the proposal for Kings View, rarely used the word Mennonite. Instead, Kern View relied on the more generic terms of “Christian,” “Christian love,” and “Christian service.”

Perhaps it was ironic that Jost and KVH helped draw California Mennonites into the mainstream of California life by acting on principles born out of CPS. As the religious and denominational impulses that initially governed the creation of KVH were replaced by more “secular,” or generically Christian-appearing, ideals, the process of mediating between California and Mennonite culture gave way to religious and cultural assimilation. Aspects of American Mennonitism secularized in central California in part through its socially active care for the mentally ill.

Government and Mennonite Care

Part of the legacy of Arthur Jost and KVH was their growing reliance on government funding: “Of all the MMHS [Mennonite Mental Health Services] centers and hospitals, Kings View has been the most heavily involved in public funding in terms of dollars received.” When KVH closed
briefly, in 1957–1958, due to financial difficulties, Jost found that MCC “curiously” placed the needs of Mennonites over the needs of others, suggesting that Jost understood his constituency to be much larger than the Mennonites.56 The reopening of Kings View in 1958, under greater local Mennonite control, was part of a larger MCC strategy to relinquish control of the mental health centers to local Mennonite constituencies. In KVH’s case, this coincided with other difficulties.57 In evaluating this relationship with local, state, and federal governments, Jost concluded, “One of the obvious results of public funding was the rapid growth of Kings View over a relatively short period of time.” Rapid growth came with problems, and Jost listed the primary difficulties as staff recruitment and a strain on the “spirit of unity” at KVH.

Jost believed that taking government funding and contracts exacerbated tension with Mennonite churches that had initially raised funds and built the hospital. By the late 1950s, the Mennonite perception was that KVH had been “‘taken over’ by government.” Finally, in his analysis of government funding and Mennonite hospitals, Jost observed: “We have noted that leaning on government for funds coincided with a diminishing sense of responsibility on the part of the churches, that in some centers there seemed to be a tendency to downplay the Christian/Mennonite identity, that there was some drifting of the constituency from the centers (or vice versa) over a period of time.” However, as he argued, coincidence is not causation: “But it would be difficult to demonstrate a direct tie between these developments and receiving government funding.”58 Certainly, the receipt of government funding was a reality shared by all Mennonite hospitals, but Kings View depended the most, by dollar amount, on government grants. The hospital and constituency were nonetheless drifting apart.

In his report to the advisory committee in December 1952, Jost described the religious and therapeutic mix at Kings View in decidedly individualistic terms. Without reference to any particular Christian or Mennonite teaching, he wrote: “In spite of the fact that we have conducted morning devotionals each week day and Sunday school each Sunday morning plus devotional services every other Thursday, I feel that we need to expand in terms of individualized spiritual service.”59 Jost thought that an expansion of religious service would be helpful if it included local ministers. Jackson Dillon, their psychiatrist, suggested that KVH “should continue to do this work within the institution.”60 This was cer-
tainly a Christian-influenced hospital, but the Mennonite connection was seemingly weakening as Jost worked hard to keep the hospitals in front of mental health developments.

In 1953 he reported to MCC that “the term and concept of mental health is with us to stay and that we are bound to relate many of the problems which are common to us to the mental health concept.”61 One of the more peculiar developments at Kings View was the avoidance of hiring a chaplain or holding religious services. There were early attempts at morning devotional services and allowing patients to listen to church services on the radio. Yet, attempts to organize a devotional program were confined to the creation of a committee, “perhaps,” to coordinate it.62 The result was a virtual absence of Mennonite religious expression in the hospital.

Despite problems that eventually emerged with their psychiatrist, Dr. Jackson Dillon, he was consistently supportive of the Mennonite religion and the most surprised at the lack of religious services at KVH. He was encouraged by the ability of Kings View to help and place patients of different religions in the hospital. Dillon appreciated not only the “Christian influence” of the staff as an important addition to the psychiatric community, but also the ideas of holding devotional services in the morning and assisting patients to attend church services at the staff’s own expense. Of particular significance was that as medical director, Dillon stressed the importance of Mennonite Christianity.63

The relationship between administration, medical staff, and their “Christian Witness” was examined in a Kings View Homes Study Committee report in 1955. It concluded that professional training was not enough to define the work at KVH; it needed Christianity to use science for its own ends. The report recommended that KVH build a chapel “as a symbol of the spiritual objectives of the Church in her hospital program” to demonstrate “that there is perfect harmony between true science and the laws of God.” The report stated that it was congruent with Christian principles to have non-Christian psychiatrists treating patients in a Christian hospital because God created the laws of medical science for everyone. What was needed, however, was a governing structure cognizant of the “responsibility of the church to maintain that [Christian] witness.”64 Within five years, Jost referred to the position of chaplain “as a parallel role to the psychiatrist.” Jost believed that the final say in a psychiatric hospital was not necessarily that of the psychiatrist, but of this parallel chaplain, though one was never hired.65
With the planned closing and reorganization of KVH in late 1957, Jost continued to speak of the desirability of having a chaplain for the needs of patients. However, he placed priority on the prestige of the hospital in the psychiatric community. Research conducted at Kings View gave it “considerable prominence” along with changes to California law through the Short-Doyle Program, which opened up government contracts to private hospitals to provide community mental health services for indigent patients. Jost was excited by the prospect of a closer working relationship with the state government in such a program.66

In what appears to be a swift reversal of priorities, on May 3, 1957, Jost reported, “A chaplain should be considered for our staff.” Two weeks later, on May 18, 1957, Jost presented a “partial condensation of brochure material” that included text describing the role of the chaplain and how patients may attend local Protestant or Catholic services.67 By December 1958, the Chaplaincy Program was given “careful consideration,” though it lacked funding.68

The question of having a Chaplaincy Program continued. In spring 1959, after the hospital reopened, Jost reported: “From time to time, the patients have asked and wondered why the hospital doesn’t make use of its Christian symbol. Very often the question comes why did a church engage in a mental hospital program. Without the presence of a chaplain, these questions are sometimes difficult to answer and at best are answered superficially.”69 Jost was certainly a Mennonite Christian, but the trend at KVH was increasingly ambiguous, at the administrative level, concerning religious identity. Other Mennonite mental health centers throughout the United States did not create a chaplaincy until the 1950s, but even then, this trend did not spread to all.70

The religious question was more complex for Jost than simply professional reputation. He questioned the direction of KVH, “Are we consciously and conscientiously rendering a service in the name of Christ?” He found the process of “developing our churchwide goals” to be “discouragingly slow,” and he felt responsibility for that slow pace: “I often feel guilty and selfish when patients and their families commend the Mennonite church for offering such an important and appreciated service to this area to realize how little the church, outside of staff, Board and M.M.H.S. is involved.” The hospital, according to Jost, exhibited a “lack of . . . religious counsel.” As standards of professional society led psychiatry, he hoped the chaplain, as “the church’s counterpart to medical science’s
agent, the psychiatrist, will take his place around the discussion table in
our hospital.” These rueful ruminations about the spiritual and Men-
onite character of KVH, while significant, were not common. The KVH
leadership soon returned to pressing issues of hospital administration, and
religious questions had to wait.

In the early 1960s, KVH began pursuing accreditation by the Ameri-
can Psychiatry Association in order to access insurance monies as well as
“prestige and status.” At the same time, a committee was also struck to
study the issue of a Chaplaincy Program and to recommend one if the bud-
get allowed. It remained difficult to establish a chaplaincy position. In
the 1960 report, Dr. Charles A. Davis, medical director, simply stated on
the chaplaincy issue: “This remains to be developed. We recognize that
there are several factors which have caused this aspect of our program to
go so slowly . . . This is such an important position that much study should
be given it—to feel out the duties of a chaplain, see how his world will in-
tegrate with the existing program, and to find the special individual who
could fill the role.” They clearly took seriously the idea of a chaplaincy;
finding a qualified Mennonite or the will to create the position was more
complicated.

The First Psychiatrist

The relationship between Dr. Jackson Dillon, the first psychiatrist and
medical director of KVH, with the Mennonite administration of KVH is
revealing, on issues of health care and religion. Dillon was a strong sup-
porter of KVH’s continued expansion. In particular, he highlighted the
“personalized, interested care” provided by KVH and was sympathetic to
the Mennonite emphasis on involving the family in a patient’s recovery, a
new concept at the time. Orie Miller, of the advisory committee, asked
him what he thought of non-Christian psychiatrists: “Dr. Dillon pointed
out that the main consideration as far as he was concerned was that the
psychiatrist on the staff be properly qualified. He felt that Christian or
non-Christian psychiatrists could be integrated into our staff if they were
well trained doctors.” Dillon, an influential non-Mennonite psychiatrist
at KVH, held to the professional goals of training first and integration sec-
don. He believed that where differences of religious opinion occurred,
they would simply smooth themselves out.

In early 1957, Dr. Dillon wrote a letter to Orie Miller, describing his
desire, and that of his colleague Dr. Ludwig, to elevate the psychiatric care to the highest standards while working with the church. Dillon, despite his support, faulted Mennonites for not taking psychiatric care seriously enough as a religious or theological issue: "It is imperative to eliminate as many conflicting feelings [regarding psychiatry and religion] in ideology and in other matters as it is humanly possible."78

Though the religious element was muted at KVH, Dillon persistently questioned its absence in a church hospital. In a June 8, 1957, memo to Delmar Stahly, Jost described Dillon’s confusion regarding Mennonites:

It is significant and has been a mystery to Dr. Dillon from the beginning, why a church psychiatric hospital is interested in competent psychiatry and is blind about competent theological staff. He has consistently urged a competent chaplain or at least pastoral assistance so that the patients’ needs are met more adequately in various ways, i.e. devotional program, staff counseling, and working with patient’s minister. He has been further baffled by the distance of Mennonite pastors of the area. This lack of interest is understandable generally, but hardly on the part of pastors who have gotten their churches to build a mental hospital.79

Dillon encouraged the administrators to recruit young Mennonites into psychiatry. However, administrative reports include little, if any, comment on the devotional or religious implications of their work, including the contribution and experience of Voluntary Service (VS) workers. Non-Mennonite medical staff also encouraged administrators to recruit Mennonites.80

Nevertheless, the administration had problems with Dillon and his apparently strained relationships with some area psychiatrists. Some alleged that Dillon often refused to work with psychiatrists who disagreed with his therapeutic opinion, and they in turn would not refer patients to KVH. Jost reported that any attempt to broach the topic with Dillon resulted in threats to resign, causing KVH administrators to back away from any discussion. Though Dillon apparently repaired at least one relationship with a prominent Fresno psychiatrist in 1957, tensions persisted.81

Regardless, by December 1957, KVH closed in order to reorganize. Since Jost had defended Dillon and his ideas the longest, he was in an awkward position when required to choose between sponsors and doctors. Jost supported the doctors. When KVH closed, one board member
observed, “How the patron Saint Dillon has led him [Jost] down a blind alley—the same alley that H. R. [Martens, a KVH sponsor] warned him about and Art [Jost] is forced to close the institution.” Finally, on the eve of KVH’s temporary closing, Jost made one last defense of Drs. Dillon and Ludwig: “We were led in a direction which is quite standard in contemporary psychiatry. [Milieu therapy, where there is no lock-down of patients, emphasizing warm staff and patient relationships and pleasant surroundings] . . . The direction was right and proper, and in my opinion, irreversible.” Jost continued to argue that in reorganization, KVH should build on the existing foundation: “We have little choice to do otherwise if we want to have a progressive program and one which will accomplish the purpose of the church in this area.” Jost, however, was willing to let go of the builders of that foundation.

Jost wrote that Dillon had caused several problems in his relationships with Fresno psychiatrists and that local professional perceptions of KVH had dimmed. As KVH sat at the crossroads, Dillon departed and observed that these Mennonites needed to clarify for themselves what they thought about psychiatric care, because even though they wanted a Mennonite psychiatrist, none seemed to exist.

Despite questions about the appropriate mix of religion and science in California Mennonite health care, issues of government funding, dependency on non-Mennonite specialists, and a lack of religious symbols, the larger Mennonite community read in their denominational history that KVH was an example of “exemplary cooperation of all Mennonite groups.” As early as March 17, 1950, however, Jost reported that closer ties between KVH and the Mental Health Services section of MCC was possible if one of their directors, or assistant directors, actually made a visit to the West Coast.

Civic Mennonitism

Health care service was a conduit for Mennonite accommodation with society, and it went beyond KVH. It even included providing ambulance service for a number of years at mid-century. By the early 1950s, Cairns Funeral Home had provided ambulance service in Reedley for many years. Over time the costs of running the service grew too far out of proportion to the revenues it generated, and Cairns Funeral Home pulled out. A single small business simply could not sustain the operation. Simultaneously, in
1953, due to the high accident rate on highways in Fresno County, the California Highway Patrol was pressuring the Reedley Chamber of Commerce to create a safety council, as other valley towns had done. Reedley followed the trend, and the first order of business for their new safety council was to organize ambulance service. It organized a fund-raising drive known as the “Green Cross,” where people who donated a dollar or more received a green cross sticker for their car. The safety council raised enough money, together with a fee schedule of seven dollars a call plus fifty cents per mile, to restart ambulance service in Reedley and the surrounding area.88

To keep costs down, the safety council decided that the ambulance be operated by trained reliable volunteers. At the suggestion of Marden Habegger, local physician and member of the First Mennonite Church, the volunteer aspect of the service was handed over to the MCC under the leadership of Arthur Jost, who was working with Mennonite volunteers at KVH, fulfilling their I-W service requirements to the government. Jost was on board and saw the opportunity as a way to show Reedley that local Mennonites were willing to serve their community twenty-four hours a day. Trained in driving by the California Highway Patrol and first aid by the high school nurse, twelve single young MCC men took to the task of operating the local ambulance, for service and excitement.89

The service began on August 8, 1953, and in a 1947 six-cylinder Chevrolet, young Mennonite men worked the valley and hills as far as there was paved road in their district. Within two years, they replaced the Chevrolet with a newer, more reliable vehicle, and more men from local car dealerships and the lumberyard began donating their time to run the service. A point of pride for Reedley was the low cost of the service to the taxpayer, as local police and fire departments tended to provide ambulance services in the valley. In Reedley the police had a significant role in training and keeping records and schedules of drivers, but the costs of administration were kept low on account of the volunteer nature, community support, and reasonable rates charged to users. In fact, the Reedley ambulance service did not add anything to the tax bill.90

Mennonite civic engagement through health care also involved the Home for the Aged in Reedley. Significantly, Jost was the administrator at Home for the Aged before moving to KVH. By the late 1950s, KVH was moving increasingly toward a medical and professional model of service described in generic Christian terms without any particularly Mennonite
content. The Home for the Aged, in contrast, dealt with moral discipline issues as problems of “evil,” as was the case when a misunderstanding between a married man and another women found in the basement alone had an “appearance of evil.” While understanding discipline problems morally, the Home for the Aged also refused to join a rest home association: “Since ours was a church home and we were getting along well, we would not want to join any organization of this kind.”

The same principle of not joining with the “world” applied to asking oil companies for funds. A second Home for the Aged was opened in 1960 in the Shafter area, where there were wealthy oil and land companies that could have been solicited. The General Board made a decision on funding for the Home for the Aged that stood in contrast to the increasing closeness between KVH and the state and federal governments. Their 1960 decision stated, “With regard to soliciting money for the Shafter Home from the big oil companies and the Kern County Land Company, it was felt that we did not feel like soliciting the world.” The question was not who was right or wrong; rather, there were two distinct trajectories in two institutions, intimately connected, that both cared for people. One kept to a model of Mennonite suspicion of the world and dealt with discipline issues in moral terms like “evil.” The other, under the leadership of Jost, moved to a more mainstream model of professional accreditation, association, and government funding. It moved from being an institution created in the Mennonite idealism of CPS to one where explicitly traditional Mennonite identifying markers were virtually absent.

The trajectory of KVH, as demonstrated by its relationship with the professional medical staff and its ambiguity regarding a chaplaincy and religious services, came from an administration that in its early years articulated a clear case of working in the will of God to engage a peculiarly Mennonite form of ministry, providing care to the mentally ill. As Jost wrote in 1950: “We feel that the Lord has directed in a very special way to make possible the steps which have been taken and we seek further guidance and direction in order to be of service to those who are unfortunate in becoming ill in mind and spirit.” Furthermore, “We feel a deep conviction that the Lord has also placed the sufferers in our midst for a purpose and yet we must humbly admit that they have received the least consideration and appreciation among all in the school of suffering.” KVH was an important facet of Californian Mennonite institutional self-identification. Through the delivery of mental health care, ambulance service, and a
Home for the Aged, Mennonites were increasingly a part of mainstream California life, engaging the culture as quietly religious and socially active members.

Kings View Homes was a successful mental health facility in California’s San Joaquin Valley, which at the time had no such facility. The Mennonites involved with KVH entered into a strategy of influencing their surroundings through the sincere expression of religious conviction through caring for the mentally ill. That expression, while distinguishing them in California society, ironically helped bring them into the mainstream, as compassionate, though increasingly secularized, religious people.

When KVH reopened in March 1958, the administration boasted ten new patients, with only two coming from the Mennonite constituency. The remaining eight were referred by, among others, local physicians, psychiatrists, and district attorneys. KVH’s administration considered this proof that the aggressive promotional efforts during the shutdown period were effective and that KVH was further integrated into California society. Early in his career, when writing or speaking for Mennonite groups, Jost had included religious elements in his presentations. Already by the mid-1950s, however, he was rarely drawing attention to any religious or spiritual aspect of work at KVH. Though he refuted such extreme religious claims that mental illness was “demon possession,” he did not completely ignore spirituality in mental health, acknowledging, “prayer can contribute . . . as it helps to straighten out the crooked paths of unhealthy human relationships.”

Jost and KVH played an important role in the overall expansion of Mennonite identity in mid-twentieth century California. Created out of the success of the CPS, KVH, as administrated by Jost, represents a stream of Mennonitism in California characterized by social, cultural, and ideological integration. For example, under Jost’s leadership, KVH received more government funding than any other American Mennonite hospital.

The religious program of KVH involved some devotional time and assistance for patients to attend local churches; however, despite the advocacy of non-Mennonite staff, no substantial Mennonite religious presence developed. Jost certainly was not anti-religious, or even a-religious. As a health care administrator, he took his lead from the larger psychiatric community and government grant programs. Looking at the KVH records, we can see that religion played a very minor role, and in government testimony, virtually none. KVH embodied Mennonite ideals of social relief,
yet in this case, barely connected with those ideals religiously. Though Jost was not representative of all Mennonites, he was a go-between Mennonites and California society. He represented a socially active Mennonitism increasingly comfortable with Sacramento. Service to the community born of a religious imperative was also a strategy of accommodation along the lines of service, here healthcare. We saw this in the sanitariums in the early 1900s, and in the postwar years in large projects such as KVH and local ones such as the Reedley ambulance. Professionalization and modernization reached most aspects of Mennonite experience, including service ministries of food and clothing distribution, to which we turn in the next chapter.