The concept of comprehensive planning for community mental health services was not born with the report of the Joint Commission on Mental Illness and Health in 1961. The need for coordination and an overview in planning has been recognized by many professionals whose minority voices have been unpopular and largely ignored.

Over a quarter of a century ago, Kingsley Davis (1938) said:

... community mental health activities represent more than what the mental health professions do within and for a community in the name of individual adjustment. Such activities involve the redefinition and redirection of mental health services to include the application of theories, methods and knowledge from sociology, political science and public health. The binding spirit for the creation and evaluation of such activities is a concern about styles of living within the organization of communities; the motivating force is the desire to attain some ideal future state.

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The Joint Commission's report did result in a federal appropriation which made 4.2 million dollars available to the states and territories for comprehensive mental health planning. More recently, an additional 2.2 million dollars has been appropriated for similar planning for mental retardation services. These significant funds are intended to help the states organize planning groups to cut across the traditional, and often rigid, service and professional orientations.

The federal guidelines for this effort mandated the involvement of all segments of the professional and lay community, the search for new ideas, the importance of community-based services, and the organized understanding of the state's efforts in mental health. This immediately raised the question of locating the professional people who could move comfortably and efficiently in this unusual frame of reference. This planning framework is indeed unique and requires a sensitive response to the problem of all the aspects of human services.

One definition of this strange new professional animal is offered by Levy (1964):

In terms of function, the planning division itself plans, facilitates planning activity in other groups, implements plans, and evaluates plans. In terms of people, it employs persons with a broad understanding of the field of mental health who can think creatively—innovate and plan for the future of the state community mental health program. . . . the talents of community organization people and their associated skills are well represented in the planning division. Evaluation requires persons with knowledge of research methodology, technical sophistication in the use of high speed electronic data processing equipment, persons who know how to conduct a continuous “quality control” operation throughout the organization, all combined with a general substantive knowledge of the special problems associated with the field of mental health.

It is obvious to thoughtful observers that the average state government does not contain these paragons of scientific objectivity within their departments in any encouraging number. Indeed, the departments of government have a proliferation of planning activities in much the same manner that checks and balances were built into our Constitution. This often results in a fiercely protective planning program for each precise offering of service.

We are learning about the talents which are necessary for a comprehensive planner, and can begin defining the prerequisites: a broad experience in social and behavioral sciences, a knowledge of research methodology as a result of having done research, clinical awareness, administrative and political competence sufficient for survival in large systems of government, and a commitment to coordination as a process.

The question of which professional discipline the comprehensive planner should represent is a trap. His unique contribution is in interprofessional functioning and in rejecting the shibboleths of the various mental health disciplines. Those definitions which establish a clear staking out of an area for a particular discipline are usually offered from the standpoint of historical vested prerogative. In discussing the difficulty of identifying this profession, Caplan (1964) has noted:

. . . at times I have evaded the problem of staffing the programs [in community psychiatry], and assigning the various functions by using the term psychiatrist to denote any of the mental health specialists. My reason for doing so is that I do not believe we yet know enough about the expectable problems and the possible contributions of the various professionals and non-professionals to enable us to lay down role definitions and job classifications [pp. 272-273].

The social worker who feels that community organization is pre-empted by some course work and a title, the psychologist who feels that no research is important except that which is controlled and correlated, and the psychiatrist who feels that mental health problems may only be approached or solved by those who offer medical credentials—these all present a vision which produces a hopeless social myopia.

Fortunately, they are few in number, they are decreasing, and their importance is becoming minimal. The ground swell of professional and lay response to the broadening of the concept of service is developing new professional leadership.