of Missouri, the director of psychiatric services for the state department of mental health is paid less than 21 of the 25 directors of private mental health centers, some of whom are paid two to four times as much. Politicians are not blind to such public-to-private largesse, and the ideologists among them, who know nothing of treatment issues, have apparently decided to starve us out.

My experience has been with a highly centralized state authority, and local boards are therefore appealing. Dr. Kuehn, on the other hand, advocates for the opposite—funneling all available funding into a central mental health authority. Perils are inherent in either model, and currently each state is free to decide how to configure its system.

This discussion would be moot if Harry Truman had succeeded in 1946 with his national health plan that promised that Americans would receive health care "just as they do now" (2). His bill was denounced as "socialistic," as was the Clinton plan in 1994. Recent Medicare legislation is yet another reminder that as health care becomes more privatized, marketized, and uncoordinated, persons with serious mental illness will be shortchanged.

Had I been in Dr. Hogan's shoes, given a mandate for a "budget neutral" New Freedom Commission report, my resignation would have been submitted the next day. If we have no hope of a single-payer system, or even of consolidating all of the federal funding directed to mental health services, state governments will have to create their own unitary funding streams and do a radically better job of expending dollars on direct care—and also find additional funds somehow.

The share of state budgets devoted to mental health has declined precipitously in the last three decades, and although some savings were realized by closing large institutions, atypical antipsychotics, independent housing, and assertive community programs are costly as well. Sadly, bureaucrats and politicians have learned that patients are more readily underfunded when they are in the gutter than when they are in a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations.

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Referral to Aftercare and Rehospitalization

To the Editor: The quality of aftercare received by people with severe mental disorders is often poor. Indeed, 40 to 60 percent of psychiatric patients who are discharged from an inpatient facility do not receive aftercare (1). The article in the September issue of *Psychiatric Services* by Thompson and colleagues (2) shows a positive relationship between referral to aftercare and rehospitalization. On the other hand, the article points out that referral to aftercare services should not be equated with receiving those services and claims an equal access to aftercare.

In 2001 we studied 126 consecutive readmissions to an inpatient unit in Barcelona that occurred within 90 days of the index discharge (3). According to government policy, all patients who are discharged are referred to outpatient aftercare programs. These programs are run by the three mental health centers that serve the community area. A nurse from the mental health centers visits the inpatient unit each week and is given the names of patients whose release from the hospital is pending. Before discharge, the telephone number of the mental health center is given to patients and their families.

Our study showed that the quality of aftercare provided by the three mental health centers was poor. Indeed, among the 126 readmitted patients, 31 (25 percent) did not receive any outpatient care and 46 (37 percent) did not receive psychiatric care during the 21 days before their readmission. Moreover, we found significant variability in the aftercare provided by each of the mental health centers (χ^2=15.57, df=4, p=.004). Of the 38 patients referred to the first mental health center, 16 (42 percent) did not receive any outpatient care. Eight of the 44 patients referred to the second center (18 percent) and seven of the 44 cases referred to the third mental health center (16 percent) received no aftercare. Five of the patients referred to the first mental health center (13 percent) did not receive psychiatric care during the 21 days before their readmission. Corresponding figures for the second and third centers were 21 patients (48 percent) and 20 patients (46 percent), respectively. In our view, these findings warrant further investigation, especially in regard to aspects of the mental health system that are barriers to and facilitators of care.

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"Borderpath" for Cluster B Personality Disorder?

To the Editor: Over the years there has been much debate over the nosological status and nomenclature of personality disorders (1). Factor and cluster analytic approaches have indicated three or four major groups (2), and *DSM-IV* uses a three-cluster system. The fourth group, which is char-

acterized by abnormally rigidity and fastidiousness, has been grouped with cluster C.

In clinical practice, we often see patients with combined borderline and antisocial traits for whom *DSM-IV* and *ICD-10* do not provide clear-cut categories. The term "psychopath," even though it has clinical descriptive value, is not an easy term to explain to a patient and is a misleading description of the complex mixture of personality traits that are evident in this patient group. The term "cluster B personality disorder" is rather unwieldy, and our nonpsychiatrist colleagues may not know what the term means without having to look it up. We suggest the term "borderpath," a fusion of borderline and psychopath, which describes a clinical entity and is relatively self-descriptive.

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Bridging Psychiatric Services Between Asia and America

To the Editor: In the October issue of *Psychiatric Services,* Dr. Chen and his colleagues described the Bridge Program in New York to improve access to psychiatric services among Asian consumers (1). The authors explained that a primary reason for developing the Bridge Program is the profound stigma associated with mental illness in Asian-American communities, which is a major cause for the low use of mental health facilities. I am in full agreement with Dr. Chen's team on this issue. A recent study in Hong Kong, in which 11 interviews were conducted with patients' relatives to explore the relationship between stigma, accessibility of mental health facilities, and family burden, yielded the same conclusion (2). Data analyses showed that much of the burden was related to stigma and to a lack of mental health and rehabilitation services. Consequences included the families' social isolation, patients' difficulties obtaining competitive employment, and financial difficulties for both patients and families.

One of the salient features of the Bridge Program is its goal of enhancing the skills of primary care providers to improve identification and treatment of mental disorders. I am delighted that the program is a success. I would like to propose another component for the Bridge Program, if the authors are interested. The program should encourage exchange of information about research and services between Asia and America. The importance of addressing cross-cultural differences in the development of instruments for psychiatric research has been widely recognized. I believe it is equally applicable in the development of treatment protocols. As a psychiatric researcher in Asia, I have found that advances in psychiatric rehabilitation in America have helped me to better direct my research efforts. By the same token, I believe that the outcomes of research conducted by my group and by other researchers in Asia will be of help to researchers and practitioners in America who work with the Asian population.

My primary concern is to ensure the effectiveness of the programs that my group has developed for use in the Asian context. However, I would be most delighted to learn that the culturally relevant assessment instruments and treatment programs we have developed in Asia can be successfully applied among Asian Americans. Assessments developed and validated in Hong Kong, such as the Workshop Behavior Checklist (3) and the Vocational Social Skills Scale (4), may be useful with Chinese Americans. Similarly, the integrated supported employment program (5) and the Chinese version of the basic conversations skills module on which we are currently working might also be helpful to American practitioners who work with Chinese Americans.

In summary, facilitation of exchange of information about research and services will further enhance the Bridge Program.

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In Reply: We are pleased that our Frontline Report on the Bridge Program has been well received by colleagues in both America and Asia. The concept of "bridge," developed by Dr. Henry Chung, a New York psychiatrist and a researcher and community leader in minority health care delivery, was an attempt to improve the connection between community needs and psychiatric services and to effect better communication and referral patterns between primary care providers and mental health professionals. We welcome Dr. Tsang's proposal to extend the bridge concept toward building more productive con-