

Letters from readers are welcome. They will be published at the editor's discretion as space permits and will be subject to editing. They should not exceed 500 words with no more than three authors and five references and should include the writer's e-mail address. Letters commenting on material published in *Psychiatric Services*, which will be sent to the authors for possible reply, should be sent to Howard H. Goldman, M.D., Ph.D., Editor, at psjournal@psych.org. Letters reporting the results of research should be submitted online for peer review (mc.manuscriptcentral.com/appi-ps).

Cognitive Impairment in Mental Illness: An SSA Blind Spot?

To the Editor: The field now recognizes that our patients, particularly those with a diagnosis of schizophrenia, have significant co-occurring cognitive impairment (1). Unfortunately, in our experience at Thresholds, the disability determination process used by the Social Security Administration (SSA) often does not recognize cognitive impairment of individuals with schizophrenia and similar conditions otherwise considered stable (the exception is for the category of patients with dementia, delirium, or amnesic disorders, for whom cognitive impairment is taken into account). SSA does not recognize the importance of cognitive impairment in most mental disorders as a vocational impairment in determining disability.

The current SSA guidelines for determining disability focus heavily on the overt signs and symptoms of mental impairments but do not focus on cognitive impairment. Proposed new rules would deemphasize the signs and symptoms, but there is no evidence of concern about cognitive impairment in schizophrenia and other psychiatric disorders in the proposed rules. The actual vocational disability that results from these disorders is of-

ten unrelated to delusions, hallucinations, sadness, or anxiety. Our patients, even when their symptoms have remitted, are left with cognitive impairments that interfere with concentration, attention, visuospatial function, language, memory, and executive function. These are the enduring and disabling features of serious mental illness. There is no good way to demonstrate these impairments unless you test for them.

The Montreal Cognitive Assessment (MoCA) was designed as a rapid test for "mild cognitive impairment" among elderly persons (2). Like the Folstein Mini-Mental State Exam, scores on the MoCA range from 0 to 30. The MoCA takes about 12 minutes to administer. For persons with no cognitive impairment, MoCA scores averaged 27.4 ± 2.2 . Persons with known dementia of the Alzheimer type had MoCA scores that averaged 16.2 ± 4.8 . Persons with "mild cognitive impairment" had MoCA scores that averaged 22.1 ± 3.1 .

In a 2010 study at Thresholds, we administered the MoCA and the Folstein Mini-Mental State Exam to 112 stable individuals with schizophrenia (Wilkniss S, Teachout A, Robin L, et al., unpublished manuscript, 2010). The mean \pm SD MoCA score of persons with schizophrenia was 22.7 ± 4.3 . This score falls squarely into the "mild cognitive impairment" range observed with an elderly sample. On the Folstein Mini-Mental State Exam, the same individuals had a score of 27.1 ± 2.5 , which is in the normal range.

As part of preparing a report for SSA, we also administered the MoCA to 224 individuals seen for consecutive psychiatric evaluations. The group had a wide range of diagnoses. We cannot validate the representativeness of the sample with respect to all individuals who apply to SSA for disability benefits; however, we did nothing to specially select the sample. We were surprised by the high rates of cognitive impairment across all diagnostic categories. [A table with mean MoCA scores for patients in the main diagnostic categories is available

in an online supplement to this letter at ps.psychiatryonline.org.]

On the basis of our experience, we propose that SSA recognize cognitive impairment as a common work-related impairment in a wide range of mental disorders not confined to dementia, delirium, or amnesic disorders. Failure to do so risks inappropriate denials of disability benefits. Physicians reporting to SSA need to perform more sophisticated cognitive testing. The SSA guidelines should accommodate the concept of co-occurring cognitive impairment in all diagnostic categories. Adjudicators and administrative law judges need to be educated about this phenomenon. At the same time, strategies to facilitate recovery and exit from the disability roll must target cognitive impairment and remediation of cognitive deficits.

Mark A. Amdur, M.D.

Dr. Amdur is senior psychiatric consultant at Thresholds, Chicago.

Acknowledgments and disclosures

The author reports no competing interests.

References

1. Keefe RSE, Fenton WS: How should DSM-V criteria for schizophrenia include cognitive impairment? *Schizophrenia Bulletin* 33:912-920, 2007
2. Nasreddine ZS, Phillips NA, Bédirian V, et al: The Montreal Cognitive Assessment (MoCA): a brief screening tool for mild cognitive impairment. *Journal of the American Geriatrics Society* 53:695-699, 2005

Excessive Antipsychotic Dosing in a Canadian Outpatient Population

To the Editor: Although the efficacy of antipsychotic drugs for the treatment of psychotic disorders is well established, there is still considerable debate about how these drugs should be dosed. Numerous considerations must be made in decisions about dosage, including the patient's mental status, medical history, age, concurrent medications, smoking status, and tolerance for side effects (1). Guide-