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 amnestic 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 often 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±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 amnestic 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.

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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-

lines are therefore necessarily broad and largely at the discretion of the prescriber.

In a recent study of dosing in a heterogeneous psychiatric outpatient population (2), we observed that 32% of patients were treated with antipsychotics at dosages classified as "excessive," because they exceeded by 1.5 times the designated daily dose (DDD) defined by the World Health Organization. To better understand this potential concern, we compared dosing of patients treated by psychiatrists and those treated by general practitioners, because these professionals may differ in their dosing strategies (3). We therefore expanded our analysis to compare prescription patterns of the two groups, as well as characteristics of the prescribers themselves. The patient population and methods were described previously (2); the protocol was approved by the University of British Columbia Research Ethics Board. A total of 406 patients, who provided written informed consent, were recruited from community mental health teams in Vancouver, British Columbia, between October 2005 and October 2006. Antipsychotic dosing was compared by converting to chlorpromazine equivalent (CE) doses, because we have shown that DDDs are unreliable predictors of extrapyramidal symptoms (4). Data about prescribers were obtained through the British Columbia Medical Association. Statistical analyses included chi square tests and analysis of variance.

A total of 323 patients (164 men and 159 women) were prescribed antipsychotics by a psychiatrist, and 83 were prescribed these agents by a general practitioner. The two patient groups did not differ by sex or psychiatric diagnosis. Mean±SD ages indicated that the group treated by a psychiatrist was older by three years (49.4±12.4 and 46.3±10.4, respectively, $p<.05$). The types of antipsychotic medication prescribed were similar between groups, with the exception of clozapine; psychiatrists were more than eight times as likely as general practitioners to prescribe this drug (9.9% and 1.2%, $p<.01$). Notably, dosing was significantly greater for patients treated by a general practitioner than by a psychiatrist (CE=212±14 mg versus 167±7 mg, $p<.05$). A possible corollary of this was that use of anticholinergic agents (a proxy for extrapyramidal symptoms) was almost twice as high among patients treated by a general practitioner (24% and 13%, $p<.01$).

Characteristics of the prescribers themselves (N=76) were examined. Compared with psychiatrist prescribers, the general practitioner prescribers were more likely to have completed their medical degree locally within the province ($p<.001$) and five years earlier ($p<.005$). None of the general practitioners in the study was a physician with a university affiliation, compared with 49% of the psychiatrists ($p<.001$).

The reasons for the difference in excessive dosing between the prescriber groups are uncertain; however, excessive dosing is associated with less awareness of drug treatment algorithms among prescribers and lower adherence to them (5). Further study is therefore needed to determine whether these or similar factors account for higher antipsychotic drug dosing by general practitioners.

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Stigmatization of Mental Illness in Nigerian Home Videos

To the Editor: Stigmatization of individuals with mental illness has been identified as a major hindrance to better care and improvement of their quality of life (1). Awareness of the need to develop long-term strategies to combat stigma is increasing, and a current area of emphasis is on improved efforts to promote "mental health literacy" (2).

As psychiatrists improve mental health literacy through direct public education, they should also make efforts to reduce misinformation. Media depictions of people with mental illness are a widely viewed source of stigmatization. The Nigerian home video industry is ranked second largest in the world (3), and studies have found stigmatizing themes in Nigerian films. In an analysis of 163 Nigerian films, Aina (4) found that 25 (15%) contained scenes portraying psychiatric illness. Mental illness was depicted largely as originating from supernatural or preternatural forces, and effective treatment was por-