intended leaving their job in the near future ... six months later ... eight staff members (23%) have left their jobs in the day hospital and two hostel staff retired." (p. 805)

Main (1980) has put the social perspective in:

"Every human organisation is a social and interpersonal setting that either extends or cramps the personality of those within it, and is variously therapeutic or anti-therapeutic, creating increased or decreased health".

Their described situation cramp staff and patients, is anti-therapeutic, and creates decreased health. The social atmosphere does not tolerate the eccentrics, their staff, nor their interpersonal relationships.

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Depression of old age

SIR: Baldwin *et al* (*Journal*, July 1993, **163**, 82–90) challenge the notion that cerebral disease is an indicator of poor prognosis in the depression of old age. They report only a trend for those with putative cerebral disease to do worse than those assumed not to have cerebral disease.

Cognitive impairment has long been equated with cerebral disease but the reverse cannot be said to be true. Kobari *et al* (1990) found 21.6% of cognitively normal volunteers to have leuko-araiosis. When cardiovascular risk factors are excluded, this figure falls dramatically (Kozachuck *et al*, 1990).

Steingart *et al* (1987) report that cognitively normal people with leuko-araiosis are significantly more likely to have neurological soft signs than those that have none. Fein *et al* (1990) have reported normal cognitive functioning of elderly subjects with extensive white matter lesions over a period of seven years.

Neuroimaging is clearly the gold standard in this area. If this is impractical then a detailed neurological assessment with an eye to soft signs needs to be undertaken and reported. There is also a suggestion that cardiovascular risk factors should be investigated in a similar way. Without taking these into account it is likely that a considerable number of subjects will be wrongly allocated to a functional rather than an organic group. It may be that this failure explains why the results do not bear out those of previous studies.

The important point to emerge from this study is, however, that the treatment of depression in the elderly, of both a functional and organic aetiology, is a worthwhile exercise and should be pursued vigorously within the patients' tolerance.

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Ageing as a risk factor for lithium neurotoxicity at therapeutic serum levels

SIR: In their recent report of patients with lithium-induced neurotoxicity, Bell *et al* (*Journal*, May 1993, **162**, 689–692) discussed several factors known to increase the risk of toxicity with therapeutic levels of lithium. However, the authors did not mention older age as a possible predisposing factor.

Since ageing alters receptor-site sensitivity, it is hypothesised that the elderly are more sensitive to the side-effects of lithium. Indeed, there are data to support this hypothesis: firstly, the prevalence and severity of hand tremor in lithium-treated patients increases with age (Murray *et al*, 1983); secondly, Roose *et al* (1979) and Smith & Helms (1982) found that, at therapeutic blood levels, people 60 years and over had more lithium toxicity, including neurotoxicity, than younger patients. However, these two studies did not control for confounding variables, such as concomitant psychotropic use. There have also been several reports (for example, Lafferman *et al*, 1988; Austin *et al*, 1990) of cognitive impairment, ataxia, extrapyramidal signs, disabling tremor, peripheral nerve palsy, and aphasia developing in