THE MEDICO-SOCIAL RESEARCH BOARD
An Bord Taighde Pobal-Liachta

ANNUAL REPORT 1972
THE MEDICO-SOCIAL RESEARCH BOARD
An Bord Taighde Pobal-Liachta

IRELAND

ANNUAL REPORT 1972

73 LOWER BAGGOT STREET
DUBLIN 2    IRELAND
THE MEDICO-SOCIAL RESEARCH BOARD

Chairman

Michael J. MacCormac, M.A., M.Comm., F.C.C.A., Dean of the Faculty of Commerce and Professor of Business Administration, University College, Dublin.

Members

Peter G. S. Beckett, M.D., F.R.C. (Psych.), Professor of Psychiatry, Trinity College, Dublin.

Ivor W. Browne, F.R.C.P.I., M.Sc., (Harv.), D.P.M., Professor of Psychiatry, University College, Dublin, and Programme Manager, Eastern Health Board.

Michael P. Flynn, M.D., D.P.H., B.Sc., (Public Health), L.M., Programme Manager, Midland Health Board.

J. Cyril Joyce, M.D., D.P.H., D.C.H., Chief Medical Officer, Department of Health.

M. Donal McCarthy, M.A., Ph.D., D.Sc., President, University College, Cork.

Thomas Murphy, M.D., D.P.H., B.Sc., (Public Health), President, University College, Dublin.

Risteard Mulcahy, M.D., F.R.C.P., F.R.C.P.I., Physician, St. Vincent’s Hospital, Dublin.

John Nash, M.Sc., M.D., M.R.C.P., Physician Superintendent, Regional Hospital, Limerick.


Shaun Trant, B.A., M.I.S., Department of Health, Dublin.

Conor Ward, B.A., B.D., S.T.L., Ph.D., Lecturer in Social Science, University College, Dublin.
# THE MEDICO-SOCIAL RESEARCH BOARD’S ACTIVITIES 1972-73

1. Introduction ................................................................. 7
2. The Registration of Births and Deaths ............................... 12
3. The Hospital In-Patient Enquiry Scheme. Mr. John O’Gorman ........ 14
4. The Study at Crumlin Hospital ........................................ 21
5. The World Health Organisation (WHO) Ischaemic Heart Disease Register, Dublin. Dr. Alicia Radic .............. 22
6. A comparative study on methods of rehabilitation after ischaemic heart attacks ........................................ 27
7. The World Health Organisation Stroke Register, Dublin. Dr. Alicia Radic ...................................................... 30
8. National Psychiatric In-Patient Reporting System and Mental Health Study. Dr. Dermot Walsh .......... 32
9. The Three County Case Register Study. Dr. Dermot Walsh ............. 35
10. A study of schizophrenia and other mental illnesses in the Irish community. Dr. Dermot Walsh ........ 38
11. The Psychiatric Services Study, Dr. John Cullen ...................... 40
12. Other activities of the psychiatric section of the Board. Dr. Dermot Walsh ......................................................... 44
14. Cultural factors associated with drinking ................................ 50
15. The care of the aged in County Homes and in the Community in counties Galway, Roscommon and Carlow. Rev. Professor Dougan .......... 51
16. Adoption in Ireland. Miss Vivienne Darling ......................... 52
17. Multiple sclerosis ............................................................. 54
18. Conclusion ........................................................................ 57
THE STAFF OF THE MEDICO-SOCIAL RESEARCH BOARD

Director
Geoffrey Dean, M.D., F.R.C.P., F.F.C.M.

Research and Administration
Anne Finn, R.G.N.R.M., Interviewer for WHO studies on Ischaemic Heart Disease and Strokes.
Peadar Kirke, M.B., B.Ch., B.A.O., D.Obst., R.C.P.I., Medical Assistant to the Director.
Hilda McLoughlin, Personal Assistant to the Director.
John O’Gorman, A.C.I.S., Secretary to the Board and Organiser of the Hospital In-Patient Enquiry Scheme.
Aileen O’Hare, M.Soc. Sc., Senior Research Officer, Mental Health Studies.
Anne Purcell, Supervisor, Hospital In-Patient Enquiry Scheme.
Alicia Radic, M.B., Ch.B., Supervisor, WHO studies on Ischaemic Heart Disease and Strokes.
Mary M. Sugrue, M.B., B.Ch., B.A.O., Assistant Supervisor, WHO Studies on Ischaemic Heart Disease and Strokes.
Dermot Walsh, M.B., B.Ch., B.A.O., D.P.M., Supervisor of Mental Health Studies.

Secretarial and Clerical
Marion Brennan, Sheelagh Downes, Anne Kingston, Deirdre Mooney, Valerie McManus, Gabrielle O’Mahony, Pauline O’Neill, Marie O’Reilly, Mary Power, Del Rocks, Joan Walshe.

Housekeeping
Maureen Dunne.

Expenditure
The total expenditure by the Medico-Social Research Board for year ending 31st December, 1972, was £70,093.
INTRODUCTION

Following his election as President of University College, Dublin, Professor Thomas Murphy resigned from the Chairmanship of the Medico-Social Research Board. Professor Murphy has been a member of the Board since its inception in April, 1965, and has contributed a great deal to the success of the work of the Board. Although no longer chairman he remains an active member of the Board.

In February, 1973, Mr. Erskine Childers, Tánaiste and Minister for Health, appointed a member of the Board, Professor Michael MacCormac, Professor of Business Administration, University College, Dublin, as the new chairman. His experience of administration and finance will be a great asset to the Board in forward planning of research and budgeting.

We would like to express our appreciation of the fine contribution to the work of the Board which was made by Professor William Jessop, Emeritus Professor of Social Medicine and formerly Dean of the Faculty of Physic, Trinity College, Dublin, and Professor Brian McNicholl, Professor of Paediatrics and Dean of the Medical Faculty, University College, Galway, during their terms of office. Mr. Erskine Childers has appointed Professor Peter Beckett, Professor of Psychiatry, Trinity College, Dublin, and Mr. Shaun Trant of the Department of Health, to be the new members of the Board. Professor Beckett has already made a major contribution to the planning of our studies on mental health in the community. Mr. Shaun Trant was the Board's first acting secretary and was of the greatest assistance in the organisation of the Hospital In-Patient Enquiry Scheme. He also had the happy suggestion that the Turnstone Bird, which turns over stones on our beaches, might very well symbolise the research of the Board.

The year 1972 will perhaps be remembered as the one in which there was a radical re-thinking in Ireland about research and development and preparation of long-term plans for research. It was a year of abbreviation; of R. and D. (Research and Development), of the OECD examiners (Organisation for Economic Co-operation and Development), of S.T.I. meetings (Scientific and Technical Information), of the NSC
There have been many meetings to discuss the planning of research in Ireland and the relationship of research institutes with the State and with the National Science Council. How can we best preserve a degree of autonomy and foster original research and yet keep research within the national plan, aspirations and budget. Compared with other countries Ireland spends a relatively small proportion of her income on research and the present planning and our joining the Common Market does presage a real awakening to the need for research, not least into medico-social problems.

There is in Ireland a great dearth of suitably trained epidemiologists to undertake medico-social research and the Board considers that it is one of its functions to train young doctors and sociologists in medico-social research. As part of this policy the Board has appointed Dr. Peadar Kirke as Assistant to the Director and during 1972-73 he is spending two or three months with each of the research projects of the Board. He has also undertaken the writing up of a study on drug-taking among post-primary schoolchildren outside of Dublin. In September, 1973, Dr. Kirke will start the two year course in social medicine leading to the M.Sc. degree at the London School of Hygiene and Tropical Medicine in Gower Street, London, and will then return to work with the Board.

Professor Wing of the Institute of Psychiatry has been appointed consultant to the Board's psychiatric studies on schizophrenia in the community and members of his team visited Dublin and the various areas where we are undertaking psychiatric studies in order to discuss and reach agreement about diagnostic criteria among the psychiatrists concerned. In this study, they have used video-taped interviews with psychiatric patients which were then assessed by the psychiatrists concerned using standardised questionnaires.

Since its inception the Board has been concerned about the unsatisfactory information that is available as to the causes of death in Ireland. As has been repeatedly reported a proportion of deaths in the West of Ireland are registered without the cause of death being medically certified and a further proportion, as the Board has shown, are neither registered nor certified. In 1972 the Births, Deaths and Marriages Registration Act was passed by the Oireachtas and this Act enables the Minister to make certain regulations about the registration of births, deaths and marriages. The Minister has power under the Act
to make regulations requiring undertakers to notify the Registrar of those whom they bury. It is hoped that with the introduction of a fee for items of service method of paying general practitioners more patients will be seen by a doctor before they die and, therefore, medically certified. This change in itself will not be sufficient, in the opinion of the Board, to prevent a number of deaths remaining uncertified and unregistered. We feel that we should consider introducing the same type of regulation about burial that exists in Northern Ireland and in Great Britain where no one may be buried without permission from the local Registrar of Deaths. He, in turn, would only give permission for burial if he had received a doctor's certificate as to the cause of death or he had received permission from the coroner for the burial to take place. This would almost certainly require an increased number of pathologists to undertake an autopsy when there was grave doubt as to the cause of death. It has been well stated that the standard of medicine in a country can be best judged by the proportion of autopsies that are undertaken on those who die. Autopsies help greatly in maintaining a high standard of medical practice.

The Medico-Social Research Board ensures that the information it receives about patients admitted to the general and psychiatric hospitals is totally and completely confidential. The Board provides a statistical service to hospitals and for this purpose the Board should be regarded as an extension of the medical records departments of hospitals: In addition, it provides area and national statistical information for research. Some of this research will be described in the section of this report on the Hospital In-patient Enquiry Scheme.

Our mental health studies are proceeding on three separate but inter-related and complementary levels.

First the hospital level: Here coverage is national and information on selected items of medical, social and demographic interest is being gathered from all in-patient psychiatric hospitals and units in Ireland. These data are both cross-sectional and, since the introduction of record linkage in 1971, longitudinal and provide the basis of a study of the characteristics of patients entering and leaving hospitals. In addition, they make possible cohort studies of selected groups of patients.

Secondly, our studies are proceeding at the level of treated illness through the Three County Case Register Study. Here we have selected three areas, because hospital figures indicate that
they represent the spectrum of psychiatric morbidity. Coverage at this level involves any person experiencing any form of psychiatric treatment whether in-patient, out-patient or other—such as day-centre care. The data gathered on patients using these facilities will be much more extensive than that gathered at hospital level. Standard diagnostic criteria will be used. In addition, selected problems, such as the effect of migration in relation to mental illness, will be studied.

Thirdly, we propose undertaking a study of the factors influencing the incidence of mental illness in Ireland with particular reference to schizophrenia. In this study we will move from the psychiatric services into the community itself.

A study under the direction of Professor Dougan of University College, Galway, is investigating social factors influencing admissions to County Homes (geriatric and long-stay institutions).

The Board continues its interest in the cultural factors associated with drinking and Mrs. Joyce O'Connor’s study on drinking patterns among young people in Ireland and England is nearing completion. We have also held meetings with the Committee on Drug Education in Ireland under the chairmanship of Mr. Bunny Carr and have completed a study of drug-taking among post-primary schoolchildren outside of Dublin. Further research on drug-taking among the under-privileged young people of Dublin and among those who are addicted to drugs and, for instance, are attending Jervis Street Drug Advisory and Treatment Centre, is urgently required. During the last 10 years in Great Britain an epidemic of self-poisoning by drugs, or parasuicide, has developed and the same pattern is also appearing in Ireland. This is a strange phenomenon because in the United Kingdom there has been a fall in successful suicide from 5,000 per year to 3,800, per year during the last 10 years although during the same period of time there has been a massive increase in the number of patients admitted to hospital who have taken an overdose of drugs, about 75,000 such patients being admitted to hospital in 1971. Many of these patients could hardly be considered to have seriously attempted to take their lives, only 1% of those admitted alive to hospital died. The Board is making a study of the epidemiology of self-poisoning by drugs in Ireland in comparison with the situation in Scotland and England and Wales.

The Board’s Ischaemic Heart Disease Register was closed on December 31st, 1972, but the patients will be followed up for a
further year. The WHO Stroke Register has now started and it is going well. It is being undertaken in the same area of South Dublin in which the WHO Ischaemic Heart Disease Register has had such success.

During the year the Director was elected a Fellow of the Faculty of Community Medicine of the Royal College of Physicians. He continues his research on the prevalence of multiple sclerosis among immigrants to England from high prevalence and low prevalence areas of the world.

A brief account of each of the various projects and interests of the Board will be given.
I

THE REGISTRATION OF BIRTHS AND DEATHS

The Medico-Social Research Board has been concerned with the need for the improvement of medical certification of death and increasing the number of autopsies that are undertaken where the cause of death is in question.

In the last Annual Report of the Medico-Social Research Board we described the study which was undertaken in cooperation with the Registrar of Births and Deaths and his staff to find out what proportion of Irish residents in the West of Ireland who were buried had been medically certified, what proportion had been registered but not medically certified and what proportion had been neither certified nor registered. It was found in the study that 6.2% of deaths had been registered only and not medically certified and a further 7½% were neither certified nor registered. Registration of births was very much more satisfactory and over 98% of the 1,796 births of those who were born and survived between 1965 and 1969 had had their births registered.

The practice in the United Kingdom and Northern Ireland is that nobody can be buried without the prior production to the Registrar of Deaths of a medical certificate or, if no medical certificate can be obtained, the coroner is notified and decides whether or not to order an autopsy. The Registrar only gives permission for burial after he has either a medical certificate or permission from the coroner. This safeguard has not been present in Ireland but a big step forward was taken in 1972 with the passing of the Births, Deaths and Marriages Registration Act by the Oireachtas. In Section 5 of this Act the Minister for Health may by regulation prescribe the form and manner in which information required to be registered concerning a birth, marriage or death is collected and maintained and the person by whom the information is to be given.

The 1972 Act certainly empowers the Minister to take the necessary steps to ensure that deaths are medically certified or reported to the coroner, either before burial or after burial, if it is mandatory that the undertaker must report to the Registrar
all those he buries. Nevertheless, this situation would still not appear to be satisfactory and it may be necessary to repeat the study that was undertaken 18 months ago in a year or two to find out what proportion, if any, of those who die are still being buried without their deaths being either certified or registered.
THE HOSPITAL IN-PATIENT ENQUIRY SCHEME

The organisation of the Hospital In-Patient Enquiry Scheme continued throughout the year and at 1st January 1973, the following hospitals were participating, a number of them on a partial basis only:

1. Adelaide, Dublin.
4. Bon Secours, Cork.
5. Cherry Orchard, Dublin.
6. City of Dublin Skin and Cancer Hospital.
7. County Hospital, Bantry.
8. County Hospital, Castlebar.
9. County Hospital, Cashel.
10. County Hospital, Letterkenny.
11. County Hospital, Roscommon.
12. County Hospital, Wexford.
15. Jervis Street, Dublin.
16. Limerick Regional.
17. Mater Misericordiae, Dublin.
22. National Children's Hospital, Dublin.
23. Our Lady of Lourdes, Drogheda.
25. Portiuncula, Ballinasloe.
26. Royal City of Dublin, Baggot Street, Dublin.
27. Royal Victoria Eye and Ear, Dublin.
28. St. Columcille's, Loughlinstown, Dublin.
29. St. Finbarr's, Cork.
30. St. James's, Dublin.
31. St. John's, Limerick.
32. St. Joseph's, Temple Street, Dublin.
33. St. Laurence's, Dublin.
34. St. Luke's, Kilkenny.
36. St. Michael's, Dunlaoghaire.
37. St. Nessan's, Croom, Limerick.
38. St. Mary's, Cappagh, Dublin.
39. St. Mary's, Phoenix Park, Dublin.
40. St. Stephen's, Cork.
41. Dr. Steevens's, Dublin.
42. St. Vincent's, Elm Park, Dublin.
43. Sir Patrick Dun's, Dublin.
44. South Infirmary, Cork.
45. Vergemount, Dublin.

A total of 149,265 discharge summaries was received for processing during the year compared with 90,639 in 1971, and at the start of 1973 summaries were being submitted at a rate of 179,000 per annum.

The number of discharge summaries submitted by hospitals during 1972 showed a gratifying increase of over 60% compared with 1971 but the total of 190,000 discharges which had been anticipated was not reached. This was due to a variety of factors. Two hospitals withdrew from the scheme during the year due to staffing difficulties, and four others which were willing to participate were unable to obtain sanction to increased staffing in their records departments. Two hospitals entered the scheme in September instead of April as arranged, and two others which had been participating on a partial basis in 1971 did not succeed in their declared intention of achieving full coverage in 1972. Perhaps the most disturbing feature which emerged during the year, however, was the practice in some hospitals of not replacing staff engaged on the preparation of discharge summaries during sick leave or alternatively using them as sick and annual leave locums in other departments of the hospital. The numbers of discharge summaries submitted were consequently short of the actual number of discharges from these hospitals. The Hospital In-Patient Enquiry Scheme will be an extremely valuable aid to administrators for planning and operation of hospital services but the full potential of the scheme cannot be exploited at national or in particular at local and regional level, until full coverage is achieved and maintained.
The Medico-Social Research Board therefore makes a special appeal to administrators in the hospital services to ensure that regular and complete returns are made by those hospitals which have already agreed to participate in the Scheme. They are also urged to examine the situation in their own particular areas with the object of having all hospitals under their control included in the Enquiry Scheme by the end of 1973.

The general format of the Enquiry Scheme remained unchanged in 1972 except for an elaboration of the system for coding area of residence. From 1st January 1973 however, in response to numerous requests, the quarterly diagnostic index issued to individual consultants is being discontinued. The same information will, however, be available from the master diagnostic index which will be sent to medical records departments each quarter. In place of the quarterly consultant diagnostic index an annual tabulation of case work in a concise format will be provided, and, of course, the Board will continue to facilitate any doctor requiring special statistics for a research project. Other changes which are being considered at the moment or which have been accepted for implementation from 1st January 1974 are as follows:

(a) Substitution of a four digit system of coding operations for the three digit system in use at present.

(b) Provision for recording three operations instead of two.

(c) Increase in the number of bed categories from seven to seventeen.

(d) Inclusion of social class on the diagnostic index.

(e) Increase in sources of admission from eight to nine to allow collection of statistics on accidents occurring at place of work.

(f) Provision for recording the involvement of two consultants in a case. At present only the consultant on discharge may be recorded.

During 1972 detailed diagnostic and surgical indices, and diagnostic summaries were issued to all participating hospitals quarterly. Diagnostic indices were also issued each quarter to
the individual consultants. Throughout the year nine special sets of statistics were compiled by the Board on request for research on the following subjects:

(a) Hodgkins Disease and Leukaemia.

(b) Kidney Stones.

(c) Road Traffic Accidents.

(d) Tonsillectomy and Adenoidectomy.

(e) Estimation of the number of brain operations conducted annually in the Republic of Ireland.

(f) Analysis of diseases of Alcoholism treated in general hospitals.

(g) Geographical analysis of patients treated in a major hospital over a three month period.

(h) Multiple Sclerosis.

(i) Analysis of duration of stay in Dublin hospitals of patients from Dublin City and County compared with patients from the rest of Ireland.

In due course each participating hospital will receive an analysis of its activities during 1972 giving a breakdown of the various diagnoses by age, sex and average duration of stay. National average durations of stay will be included in the analysis for purposes of comparison.

Duration of stay is a useful indicator of hospital performance and with the detailed information available through the Hospital In-Patient Enquiry Scheme very interesting comparisons can be made. Table I, for example, shows a comparison of duration of stay for some common conditions treated in Ireland and in Scotland. The Irish data was collected through the Hospital In-Patient Enquiry Scheme in 1971 and the data for Scotland was obtained from Scottish Hospital In-Patient Statistics 1970 published by the Scottish Home and Health Department. Taking an example from Table I it can be seen that four days is the normal duration of stay for hypertrophy of the tonsils and
TABLE 1
Comparison of duration of stay by age and sex for selected common conditions

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>I.C.D. Codes (8th Rev.)</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malignant neoplasm of intestine except rectum</td>
<td>152, 153</td>
<td>Republic of Ireland Scotland</td>
</tr>
<tr>
<td>Malignant neoplasm of rectum and rectosigmoid junction</td>
<td>154</td>
<td>Republic of Ireland Scotland</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>250</td>
<td>Republic of Ireland Scotland</td>
</tr>
<tr>
<td>Strabismus</td>
<td>373</td>
<td>Republic of Ireland Scotland</td>
</tr>
<tr>
<td>Varicose veins of lower extremities</td>
<td>454</td>
<td>Republic of Ireland Scotland</td>
</tr>
<tr>
<td>Haemorrhoids</td>
<td>455</td>
<td>Republic of Ireland Scotland</td>
</tr>
<tr>
<td>Hypertrophy of tonsils and adenoids</td>
<td>500</td>
<td>Republic of Ireland Scotland</td>
</tr>
<tr>
<td>Appendicitis</td>
<td>540-543</td>
<td>Republic of Ireland Scotland</td>
</tr>
<tr>
<td>Hernia of abdominal cavity</td>
<td>550-553</td>
<td>Republic of Ireland Scotland</td>
</tr>
<tr>
<td>Infection of kidneys</td>
<td>590</td>
<td>Republic of Ireland Scotland</td>
</tr>
<tr>
<td>Calculus of urinary system</td>
<td>592, 594</td>
<td>Republic of Ireland Scotland</td>
</tr>
<tr>
<td>Hyperplasia of prostate</td>
<td>600</td>
<td>Republic of Ireland Scotland</td>
</tr>
<tr>
<td>Redundant prépuce and phimosis</td>
<td>605</td>
<td>Republic of Ireland Scotland</td>
</tr>
<tr>
<td>Utero-vaginal prolapse and malposition of uterus</td>
<td>623, 624</td>
<td>Republic of Ireland Scotland</td>
</tr>
<tr>
<td>Rheumatoid arthritis and allied conditions</td>
<td>712</td>
<td>Republic of Ireland Scotland</td>
</tr>
<tr>
<td>Osteo-arthritis and allied conditions</td>
<td>713</td>
<td>Republic of Ireland Scotland</td>
</tr>
<tr>
<td>Internal derangement of knee joint</td>
<td>724</td>
<td>Republic of Ireland Scotland</td>
</tr>
<tr>
<td>Displacement of intervertebral disc</td>
<td>725</td>
<td>Republic of Ireland Scotland</td>
</tr>
<tr>
<td>Under 1</td>
<td>1-14</td>
<td>15-24</td>
</tr>
<tr>
<td>---------</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td>8</td>
<td>25</td>
<td>15</td>
</tr>
<tr>
<td>18</td>
<td>17</td>
<td>14</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>9</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>9</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>7</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>22</td>
<td>18</td>
<td>21</td>
</tr>
<tr>
<td>14</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>23</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>16</td>
<td>14</td>
<td>9</td>
</tr>
<tr>
<td>7</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>27</td>
<td>25</td>
<td>34</td>
</tr>
<tr>
<td>32</td>
<td>25</td>
<td>33</td>
</tr>
<tr>
<td>15</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>17</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>19</td>
<td>13</td>
<td>20</td>
</tr>
<tr>
<td>16</td>
<td>18</td>
<td>22</td>
</tr>
</tbody>
</table>
adenoids in the age group 1–14. A further analysis of the data however shows that in Ireland duration of stay for this particular condition varies from 3.3 days at the minimum to 6.9 days at the maximum as follows:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Average duration of stay</th>
<th>Number of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>3.3</td>
<td>73</td>
</tr>
<tr>
<td>B</td>
<td>3.6</td>
<td>1,068</td>
</tr>
<tr>
<td>C</td>
<td>3.6</td>
<td>73</td>
</tr>
<tr>
<td>D</td>
<td>4.0</td>
<td>604</td>
</tr>
<tr>
<td>E</td>
<td>4.1</td>
<td>285</td>
</tr>
<tr>
<td>F</td>
<td>4.5</td>
<td>688</td>
</tr>
<tr>
<td>G</td>
<td>5.1</td>
<td>320</td>
</tr>
<tr>
<td>H</td>
<td>5.3</td>
<td>41</td>
</tr>
<tr>
<td>I</td>
<td>4.7</td>
<td>80</td>
</tr>
<tr>
<td>J</td>
<td>5.9</td>
<td>28</td>
</tr>
<tr>
<td>K</td>
<td>6.6</td>
<td>31</td>
</tr>
<tr>
<td>L</td>
<td>6.9</td>
<td>85</td>
</tr>
<tr>
<td></td>
<td>4.2</td>
<td>3,376</td>
</tr>
</tbody>
</table>

In conclusion we would like to thank the Scottish Home and Health Department for technical assistance and advice during the year. A word of thanks is also due to our computer colleagues who are playing a very important part in the development of the Hospital In-Patient Enquiry Scheme.
STUDY AT CRUMLIN HOSPITAL

The number of patients discharged from Our Lady's Hospital for Sick Children, Crumlin, Dublin, increased from 5,948 in 1961 to 9,628 in 1971, and the bed complement remained static during that period. In practical terms a reduction in duration of stay from 16·0 days to 11·5 days occurred over a ten year period. To quantify the factors which contributed to this remarkable achievement, the Council of the Crumlin Research Centre asked the Medico-Social Research Board to conduct a statistical survey covering the activities of the hospital in 1961 and in 1971, and it was decided to collect the basic information required through the normal systems used for the Hospital In-Patient Enquiry Scheme. The data was extracted throughout 1972 by the records staff of Crumlin Hospital and was prepared for computer processing by the staff of the Medico-Social Research Board. The preliminary results have recently become available and are now being analysed. There are changes in the pattern of illnesses which occurred during the ten year period and a number of conditions where significant reductions in duration of stay have been achieved.
THE WORLD HEALTH ORGANISATION (WHO) ISCHAEMIC HEART DISEASE REGISTER, DUBLIN

The WHO Ischaemic Heart Disease Register was closed on the 31st December, 1972 and no new patients were admitted to the Register after this date. The patients admitted to the Register are, however, followed up for a period of 12 months and the follow-up of patients will, therefore, continue until the end of 1973.

During the three year period, 1970–1972 inclusive, 893 patients were admitted to the Register and in our next Annual Report we will be able to give a full analysis of these patients and the rates by the population at risk at the 1971 census in sex and age groups.

Analysis of Admissions to the Register for 1971

The present report will be confined to an analysis of the 248 patients admitted to the Register in 1971 and for whom we have already received an analysis from the WHO computer service in Geneva. Out of the 248 patients 180 were definite or possible myocardial infarction.

The incidence rate per 1,000 population per annum, age 20–64 years was as follows (population census 1966):

All registered patients:

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
<th>Both Sexes</th>
</tr>
</thead>
<tbody>
<tr>
<td>5·6</td>
<td>1·8</td>
<td>3·6</td>
</tr>
</tbody>
</table>

Patients with definite and possible myocardial infarction:

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
<th>Both Sexes</th>
</tr>
</thead>
<tbody>
<tr>
<td>4·2</td>
<td>1·2</td>
<td>2·6</td>
</tr>
</tbody>
</table>

Male/Female ratio: 3:1.
Age distribution of registered patients:

<table>
<thead>
<tr>
<th></th>
<th>All patients</th>
<th></th>
<th>Definite and Possible myocardial infarction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>Under 40</td>
<td>12</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>40-44</td>
<td>13</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>45-49</td>
<td>27</td>
<td>8</td>
<td>19</td>
</tr>
<tr>
<td>50-54</td>
<td>40</td>
<td>17</td>
<td>33</td>
</tr>
<tr>
<td>55-59</td>
<td>44</td>
<td>16</td>
<td>39</td>
</tr>
<tr>
<td>60-64</td>
<td>45</td>
<td>21</td>
<td>27</td>
</tr>
<tr>
<td>Total</td>
<td>181</td>
<td>67</td>
<td>135</td>
</tr>
</tbody>
</table>

Place of onset of attack:

<table>
<thead>
<tr>
<th>Location</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work</td>
<td>10%</td>
</tr>
<tr>
<td>Home</td>
<td>68%</td>
</tr>
<tr>
<td>Hospital</td>
<td>4%</td>
</tr>
<tr>
<td>Other (street, etc.)</td>
<td>13%</td>
</tr>
<tr>
<td>Unknown or indefinite</td>
<td>6%</td>
</tr>
</tbody>
</table>

Unknown: includes patients who were found dead with no available history preceding death (e.g. living alone).

Indefinite onset: includes patients with crescendo angina or progressive breathlessness that forced them to seek medical advice.

The time between onset of a myocardial infarction and calling the doctor, between calling the doctor and medical examination and between medical examination and arrival in hospital:

Onset—Call Doctor

Call Doctor—Medical Examination

Medical Examination—Hospital

<table>
<thead>
<tr>
<th>Onset</th>
<th>100</th>
<th>200</th>
<th>300</th>
<th>400</th>
<th>500</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Median time elapsed since onset:

Day Night

Week Days

Weekend

23
For half of the patients with definite and possible myocardial infarction the doctor was called within 90 minutes of onset. (median time 90 minutes).

The median time between the call to the doctor and the first medical examination was 30 minutes.

Half of the hospitalised patients were admitted to hospital within 4 hours of the onset of the attack.

64% of the patients were transported to hospital by ambulance, 17% went by private car, 2% by taxi, 5% made their own way either on foot or by bus. 13% were not hospitalised. This 13% consists of the patients who were treated at home, and of those who died at home and were not removed to any hospital, or were taken straight to the City Morgue for autopsy.

The frequency distribution of the day of the week of onset of attack (patients on the Register who did not have a myocardial infarction are excluded):

[Graph showing frequency distribution of days of the week]

The frequency distribution of time of onset of attack, 24 hour clock.
Symptoms in 28 days preceding onset

<table>
<thead>
<tr>
<th>Possible and definite myocardial infarction</th>
<th>Not myocardial infarction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angina pectoris fresh occurrence</td>
<td>% 16</td>
</tr>
<tr>
<td>Angina pectoris exacerbation of pre-existing condition</td>
<td>% 11</td>
</tr>
<tr>
<td>Discomfort in chest</td>
<td>% 10</td>
</tr>
<tr>
<td>Heaviness in arm(s)</td>
<td>% 3</td>
</tr>
<tr>
<td>Unusual tiredness</td>
<td>% 11</td>
</tr>
<tr>
<td>Unusual breathlessness</td>
<td>% 9</td>
</tr>
<tr>
<td>Palpitations (for the first time)</td>
<td>% 1</td>
</tr>
<tr>
<td>Any of the above</td>
<td>% 45</td>
</tr>
</tbody>
</table>

Some of these symptoms such as discomfort in chest, unusual tiredness, are not specific and they show up with more frequency in patients who were found to have no myocardial infarction. Unusual breathlessness is also a symptom that is not confined to myocardial infarction. The most striking difference was that of onset of fresh angina. The numbers are too small to establish the significance of this finding; a fuller analysis will be available from the 3-year study.

Previous Medical History

<table>
<thead>
<tr>
<th>Possible and definite myocardial infarction</th>
<th>Not myocardial infarction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myocardial infarction</td>
<td>% 26</td>
</tr>
<tr>
<td>Angina pectoris</td>
<td>% 39</td>
</tr>
<tr>
<td>Cerebrovascular accident</td>
<td>% 4</td>
</tr>
<tr>
<td>Intermittent claudication</td>
<td>% 8</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>% 6</td>
</tr>
<tr>
<td>Hypertension</td>
<td>% 19</td>
</tr>
<tr>
<td>Other cardiovascular diseases</td>
<td>% 3</td>
</tr>
<tr>
<td>Any of the above</td>
<td>% 58</td>
</tr>
</tbody>
</table>

A previous history of angina pectoris and diabetes mellitus were more common in patients with acute myocardial infarction. The history of previous acute myocardial infarction and hypertension did not vary in the two groups. The history of other cardiovascular disease was more common in the group who had not had a myocardial infarction. This last category includes valvular heart disease, pulmonary heart disease, chronic disturbance of cardiac rhythm and chronic congestive heart failure.
Clinical state at first medical examination

<table>
<thead>
<tr>
<th>Clinical State</th>
<th>Possible and definite myocardial infarction</th>
<th>Not myocardial infarction</th>
</tr>
</thead>
<tbody>
<tr>
<td>No circulatory failure</td>
<td>68%</td>
<td>87%</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Shock</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td>Congestive heart failure with shock</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Cardiac arrest</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>Death before medical examination</td>
<td>17%</td>
<td>3%</td>
</tr>
</tbody>
</table>

The first medical examination, was the first recorded medical examination and was usually obtained from casualty, coronary care unit, or hospital ward. The additional information recorded on examination was heart rate, heart rhythm, blood pressure and respiratory rate.

The full report about the WHO Ischaemic Heart Disease Register should be ready for our next Annual Report and by then we also hope to publish an account of ischaemic heart attacks in our Dublin study in the medical journals. This will provide us for the first time with information about the annual incidence of coronary thrombosis among the population at risk in different sex, age and social class groups in South Dublin.
A COMPARATIVE STUDY ON METHODS OF REHABILITATION AFTER ISCHAEMIC HEART ATTACKS

There is today considerable argument about the most effective form of rehabilitation after ischaemic heart attacks. In the past, doctors were inclined to be very slow to get patients out of bed and back to work after a heart attack. For instance, it was a common rule to keep patients in bed, often in hospital, for six weeks after a coronary thrombosis and then there would often be a further period of three months to six months "rest" before return to work was considered. Also, patients were frequently returned to different and lighter jobs. In some European countries many complex rehabilitation schemes, both physical and psychological, have been proposed and have been undertaken in some centres.

The Coronary Heart Disease Research Unit at St. Vincent's Hospital, as one of its research projects, has taken a very positive approach to obtain a rapid return to a normal life after a heart attack. For instance, the patients do exercises, first of all in bed under the supervision of a physiotherapist from the time of admission. They are encouraged to increase their exercise gradually over a few weeks and they are advised about a longterm exercise programme. It is impressed on them that they should make a good recovery and return to a normal life. They leave their beds a few days after the attack and there is no rule about keeping them in bed for a fixed amount of time. Except in complicated cases, the hospital stay is about 10 days and the convalescent period is about three weeks.

Their risk factors are ascertained, for instance cigarette smoking, overweight, hypertension, diabetes, raised blood cholesterol and triglycerides and a sedentary life.

The patients are given positive advice about their future life, i.e. that they can return to normal life quickly, that they can go back to work—nearly always the same work that they were doing before—and that they must not smoke, that they must
keep down their weight and that they should reduce the animal fat in their diet and take exercise every day.

It is possible that patients admitted to some of the other Dublin hospitals may not have such an active approach proposed for them after a heart attack. It is unlikely that any physicians in Dublin would support the prolonged rehabilitation programmes which are undertaken in a number of continental clinics. For instance, it is most unusual for a patient in Ireland to be sent to a rehabilitation unit after a heart attack or to undergo a period of graduated exercises covering many months.

The Medico-Social Research Board proposes to undertake a study comparing the results of rehabilitation of patients treated at St. Vincent's Hospital, particularly those admitted to the Ischaemic Heart Disease Register under the age of 60, compared with those patients admitted to the other hospitals in the Dublin area. Because the Ischaemic Heart Disease Register has been undertaken in South Dublin 40% of the patients in the Register have been treated at St. Vincent's Hospital.

The patients in the two groups will be matched, will all be male under the age of 60 and will be placed in two sub-divisions—complicated myocardial infarction and uncomplicated myocardial infarction. The complicated group would include those who had developed arrhythmias or, for instance, had a prolonged fall in blood pressure or congestive heart failure or cardiac arrest. The subjects would be divided into five social groups by occupation, using the United Kingdom social group scale.

The end-points would be studied after intervals of six, twelve and twenty-four months and the following end-points only would be considered:

1. The date of return to work.
2. The number of readmissions to hospital.
3. The number of days in hospital during subsequent readmissions.
5. Coronary heart disease mortality.
6. Total mortality.

WHO is undertaking studies comparing rehabilitation methods in different countries. In Ireland we consider that the
comparison of the results derived from one formal rehabilitation programme with the results of the rehabilitation approach in the other hospitals taking part in the Ischaemic Heart Disease Register would be a valuable study. We would also propose comparing the results of treatments in the Dublin hospitals with the result of treatment in the other WHO Ischaemic Heart Disease Register areas where in many places a much more complicated rehabilitation programme is undertaken. In this way we hope to find out whether or not a simple programme of rehabilitation combined with active advice about prevention of further attacks gives results different from those of a more complex scheme of rehabilitation.
THE WORLD HEALTH ORGANISATION STROKE REGISTER, DUBLIN.

The World Health Organisation asked the Irish Government to take part in an international co-operative study in order to find out the incidence and prevalence of the various forms of stroke in the community. The Department of Health agreed and asked the Medico-Social Research Board to undertake a Register of Strokes in Dublin. The Register began as a pilot study under the supervision of Dr. Radic in the same population of Dublin south of the canal which took part in the Ischaemic Heart Disease Register. In this way it was possible to run the two Registers together using the same staff.

We requested the participation of the General Practitioners in the same area of the city as in the Ischaemic Heart Disease Register, and the authorities of all the hospitals serving the area were asked to assist with the Registers. Details of patients with stroke were collected at the hospitals during the same visits at which we collected information about patients who had had Ischaemic heart attacks. All strokes are included in the Register whatever the age of the patient and whether the patient is admitted to hospital or not.

The pilot study began slowly and it took some time to obtain the enthusiastic co-operation and assistance of all the doctors serving the area, the consultants in general and special hospitals, the pathologists, coroners, etc. It undoubtedly meant extra work for the doctors concerned and the Medico-Social Research Board would like to express its thanks to all those who are assisting with the Register.

There were 125 patients in the pilot study which lasted for 8 months from the beginning of May to 31st December, 1972. 60 males and 65 females. The Stroke Register itself began on January 1st, 1973 and there were 22 patients on the Register in January and 22 patients on the Register in February. Since the Register began there were, therefore, 169 patients, a total of 82 males and 87 females, and a male to female ratio of 1:1.

Out of that number 26 or 31.7% of males and 32 or 36.8%
of females died within three weeks of the onset of stroke. The total death rate was 34.3%.

The age distribution of the registered patients with stroke was as follows:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 40</td>
<td>8</td>
</tr>
<tr>
<td>40-49</td>
<td>6</td>
</tr>
<tr>
<td>50-59</td>
<td>23</td>
</tr>
<tr>
<td>60-69</td>
<td>44</td>
</tr>
<tr>
<td>70-79</td>
<td>52</td>
</tr>
<tr>
<td>80+</td>
<td>36</td>
</tr>
</tbody>
</table>

The Stroke Register has only just begun and it is not yet possible to make any comments about the incidence of the various forms of stroke in the population at risk in South Dublin. The age, sex and social class of the population at risk, which numbers about 150,000 people will be known from the 1971 census towards the end of 1973.

All that can be said at this stage is that the incidence of strokes in males and females is similar and that the death rate in the acute stage (3 weeks from onset) is over 30 per cent.

The WHO Stroke Register will enable us to study not only the incidence of stroke in the community but also the type of care that is available to the patient and what services are available for the treatment of stroke and how these can best be improved.
NATIONAL PSYCHIATRIC IN-PATIENT REPORTING SYSTEM AND MENTAL HEALTH STUDIES

The record linked psychiatric in-patient reporting system which was established with a census of all patients in Irish psychiatric hospitals on 31st March, 1971, continues to function satisfactorily. The census returns from the psychiatric hospitals were not completed until the end of June, 1972, and this illustrates the extent to which returns from some hospitals lag behind the events which they are reporting. The census was a major undertaking and since then most hospitals have been furnishing admission and discharge returns with commendable alacrity and admission and discharges returns from most hospitals are now received within two months of the event. There are, however, one or two hospitals which are up to six months, and in one case even more, in arrears with returns.

Statistics on admissions and discharges for the five year period 1965–1969 have now been published as a book containing over 100 tables entitled “Activities of Irish Psychiatric Hospitals and Units 1965–1969”. It has been distributed to all psychiatric hospitals and to many other interested persons and bodies. Despite its comprehensiveness there is considerably more information available on the activities of individual psychiatric hospitals than is presented in the book itself. Information too detailed to be included in the book is being sent to individual hospitals informing them of their own activities during the five year period. For the smaller hospitals the number of cross-tabulations is restricted because of the small numbers in each category. For the larger hospitals, however, where numbers are larger, extensive cross-tabulations are being supplied.

Numbers of admissions to Irish psychiatric hospitals and units increased by 27.6% from 15,440 in 1965 to 19,697 in 1969. Numbers of first admissions increased from 6,210 to 7,652, an increase of 23.2%, in the same period. A considerable amount of the increase in hospital admissions was accounted for by admissions of patients suffering from non-psychotic disorders such as psychoneurosis, personality disorder and alcoholism
admitted to Local Authority hospitals, particularly to the new units in general hospitals. The evidence suggests that the increase of admissions and particularly of first admissions to Local Authority hospitals for patients suffering from non-psychotic disorders is due to the provision of improved Local Authority services and to an improvement in public attitudes towards mental hospitals. Increased acceptability of treatment for mental illness rather than any real increase in the incidence of these conditions probably accounts for the increase in non-psychotic conditions.

Analysis of the data from the five year study confirms the findings of earlier studies of hospitalised psychiatric morbidity in Ireland in that admission rates and residence rates in Irish hospitals remain higher than in England and Wales. In addition when comparison of these indices is made between individual hospitals higher morbidity continues to be found in Western Ireland.

The Board has continued to answer general enquiries from persons throughout the country. Some of these enquiries can be answered from data routinely available to the Board. In some cases, however, enquiries necessitate a special computer exercise. As this is both time consuming and expensive discretion must be used as to whether the requested information is supplied. Nevertheless, the small staff of the psychiatric section of the Board, although heavily pressed for time, have done their best and will continue to do so, to answer any questions relevant to the activities of psychiatric hospitals which the system design allows.

The 1970 admission and discharge data are now being analysed and will be published shortly. Work is due to start on the analysis of the 1971 census which marked the commencement of the new reporting system and the results of this analysis will be published before the end of the year. The analysis of the 1971 admission and discharge activities will follow.

The lag between the events and their publication has been reduced to two years. It is our objective to reduce this time lag to a year or less. The limiting factor to this aim is the rapidity with which returns come from hospitals, for if only one hospital lags behind, then, of course, results cannot be processed or analysed.

So that information about admissions to psychiatric hospitals (1965-1969) might be available to a wider public a simplified presentation of the findings was presented in the Journal of the

The need to supplement hospital statistics

With the in-patient reporting system running smoothly our next concern is to gather reliable information about the community activities of mental health services as a base for administrative and epidemiological research. As mental health services develop community services become increasingly important and more of the treatment of psychiatric illness is carried out in out-patient clinics, day centres, day hospitals, hostels and other forms of extra-mural services. It is, therefore, becoming very important to have reliable information about the way in which these facilities are used. To date no satisfactory data exist on out-patient services at a national level. Our information in relation to such activities is lamentably incomplete by comparison with, for instance, England and Wales where an extensive system of monitoring of the extra-mural activities of the psychiatric services has been established for some time. It is, therefore, the intention of the Board to stimulate interest in this area. It would seem impractical to ask hospitals to co-operate in this way unless their clerical staffs are increased. It has been the experience of the Board in operating the psychiatric in-patient reporting system that the majority of psychiatric hospitals because of staffing considerations have great difficulty in completing the in-patient requirements. It seems unrealistic to expect them to gather reliable out-patient data without an increase of clerical staff.

Mental handicap register

In co-operation with the Department of Health and consultants in mental handicap, the Board is presently discussing the setting up of a register of mentally handicapped persons in institutions for the mentally handicapped, in day care, and those on waiting lists. It is hoped that this register will commence with a census similar to the psychiatric hospitals' census and provide information on the medical and nursing care that is required.

Reference

THE THREE COUNTY CASE REGISTER STUDY

The Three County Case Register Study commenced with a census of all patients in care. The study is designed to examine the social, demographic and medical background of patients coming into all phases of psychiatric care in three areas in Ireland, chosen because of the range of hospitalised psychiatric morbidity which they reflect. It will be recalled that hospital incidence rates of psychiatric illness—that is first admission rates to hospital—are higher than those of England and Wales and that in some illnesses, in particular schizophrenia, they are almost twice those of England and Wales. In 1969 hospitalisation or residence rates in Irish psychiatric hospitals were between two and three times those of England and Wales. One of the questions that the research programme of the Board has set itself to answer is whether these figures merely reflect that more patients have been treated in hospital, rather than in extra-mural services, than is the case in England and Wales or whether there is genuinely more psychiatric illness in the Irish community. The Three County Case Register study takes analysis of morbidity beyond the hospital to the extra-mural services. The areas chosen are approximately equal in size, one represents an area of high hospitalisation, one is intermediate and the third area is low.

At the planning and preparation stage a great deal of time has been devoted to the design of the data sheets to be used in the study. These sheets bear no identifying data but patients are identified by a unique number which is allocated to them at local level as they come into care. In addition considerable consultation took place between the Board and the participating teams in the three areas, as the study is being operated as a joint project. As set out in our last Annual Report, the participating psychiatrists are being asked to make diagnoses in accordance with the International Classification of Diseases. In the matter of inter-psychiatrist diagnostic reliability between the three areas of the study the Board has been assisted by the Social Psychiatry Research Unit of the Institute of Psychiatry,
the University of London. Dr. Walsh visited Professor John Wing, Director of the Unit, in London early last year to discuss diagnostic reliability in the study. Members of the Unit visited Ireland in conjunction with a United States/United Kingdom diagnostic project. This project was initiated in 1964 by means of a research grant from the National Institute of Mental Health of the United States and is concerned with the investigation of differences in diagnostic practice between psychiatrists in the United Kingdom and the United States. In connection with the United Kingdom part of the project the team from the Institute of Psychiatry had already visited Ireland in 1969 and shown a number of video-taped psychiatric interviews to senior Dublin psychiatrists. The symptom-rating and diagnostic practice of the Dublin psychiatrists was then compared with that of psychiatrists in British centres and the results have been published in the *British Journal of Psychiatry.* Broadly speaking psychiatrists in Dublin did not differ substantially in their symptom-rating and diagnostic behaviour from those of British centres. The Unit has now repeated the exercise in Dublin and extended the project to psychiatrists in the rest of Ireland. A visit to Ireland was planned by members of the Social Psychiatry Unit towards the end of 1972. It seemed appropriate both to Professor Wing and Dr. Walsh that this opportunity be availed of to get the participating psychiatrists in the Three County Case Register Study to come together for a period of training in the standardisation of symptom-rating and diagnosis which would be carried out by the London team. This was arranged and the eight participating psychiatrists spent a week in Dublin undergoing intensive training in rating symptoms and standardising diagnoses by means of video-tape and discussion sessions. At the conclusion of the exercise a high degree of reliability has been established.

It is nevertheless anticipated that as time elapses during the course of the study the degree of reliability will fall and therefore a further training session is planned for early next year.

The Board is grateful to Professor John Wing and the Institute of Psychiatry for their help. In particular we are indebted to Doctors John Copeland and Michael Kelleher of the United States/United Kingdom Diagnostic Project who supervised the Dublin training session.

A week's training session was organised in Dublin, prior to the commencement of the project, for the three register
controllers and the seven interviewers from the study areas. Dr. Walsh and Mrs. O'Hare gave several lectures on the historical development of attitudes to and services for the mentally ill in Ireland and the need for setting up of a Psychiatric Case Register. Project items of information to be collected on the forms were explained, and the importance of accurate standardised recording of data was acknowledged. Interviewing techniques were discussed and a language laboratory was used to simulate the interview situation. A meeting with the register controller and interviewers of the Dublin Psychiatric Case Register was arranged and a visit to the computer department of the Eastern Health Board took place. This enabled personnel from the study areas to talk to people already involved in the operation of a Case Register and to receive directions from the systems analyst concerning the technical requirements involved in their project.

During the three years of the study Dr. Walsh and Mrs. O'Hare will be in close communication with the field work teams and monitoring and quality control procedures will be in operation.

References

A STUDY OF SCHIZOPHRENIA AND OTHER MENTAL ILLNESSES IN THE IRISH COMMUNITY

This proposed study will endeavour to investigate some of the possible explanations behind the high hospitalisation rates for mental illness, so providing a more accurate account of these rates. The proposal is to study the incidence of mental illness and the community incidence and prevalence of schizophrenia in the three areas where the Case Register is currently operating. The investigation of schizophrenia has been given this special emphasis because of the very high first admission and hospitalisation rates for this illness in Ireland.

The chances of being admitted at least once to a psychiatric hospital with a diagnosis for schizophrenia before the age of 55 in other countries which have been studied are relatively similar at about 1%, whereas in Ireland the chance of being so admitted is 4%. In addition, schizophrenia is, of all mental illnesses, by far the greatest contributor to chronic psychiatric disability. It accounted for 53% of all patients in mental hospitals in Ireland in 1963 and 49% of patients in hospital in England and Wales in the same year.

This study which has been approved by the Board has as consultants Professor P. G. S. Beckett, Dr. J. Kevany and Professor J. K. Wing. The proposed project will:

1. Apply the same diagnostic procedure to all schizophrenic patients already in hospital and to all new patients, both schizophrenic and other, coming into all types of care in the study period to see what differences, if any, exist in rates between the three areas.

2. Seek to establish the number of persons in the community suffering from mental illness who may, or may not, be obtaining treatment but are not receiving psychiatric care.

3. Attempt to identify environmental factors that may specifically predispose to schizophrenia in Ireland.
The Present State Examination or P.S.E. (4) (5) will be used by the survey psychiatrist to ensure that the same diagnostic procedure is applied to all patients. The P.S.E. is a standardisation of the clinical interview and is a useful tool for epidemiological purposes as it eliminates the ambiguity of diagnostic imprecision so often present in studies of mental illness. The rationale of the P.S.E. is the use of a standard checklist, standard definitions, a structured interview and a trained interviewer. The P.S.E. is being currently used in the U.S./U.K. project and the W.H.O. international pilot study of schizophrenia. The survey psychiatrist will receive special training in the use of the P.S.E. from Professor J. K. Wing of the Institute of Psychiatry, University of London, who devised the P.S.E. schedule.

The other objectives of the study will be achieved through the use of questionnaires and scales designed to elicit the required information. An investigation of environmental factors, which may predispose to schizophrenia in an Irish setting, will be included in the study. A social research worker will be responsible for the interviewing. Both she and the study psychiatrist will spend some time in the study areas before commencing field work. Considerable background data on demographic characteristics, migration patterns and employment opportunities will be required for each of the areas. The participating psychiatrists of the Case Register Study will provide extensive data on the psychiatric services they provide in their own areas and in addition will detail other health facilities, social and community services.

A pilot study, inherent in any major research undertaking, will test the study's design and approach. This will ensure that if changes are necessary they can be made before the research proper commences so striving for maximum realisation of the ends of the study.

References

THE PSYCHIATRIC SERVICES STUDY

The Board has continued its study of the factors that enter into the decision-making processes both medical and administrative in the various forms of psychiatric care provided by the Eastern Health Board. The researchers are under the supervision of Dr. John Cullen and his staff at the Department of Psychiatry and Mr. Bernard Moran and his colleagues at the Department of Business Administration, University College, Dublin.

In the introduction to the report on this group of studies last year a brief account was given of the very extensive changes that had taken place in the Dublin Mental Health Services over the preceding ten years. This evolution of the services was set in a context of administrative change in the health services generally which today all come under the authority of the Eastern Health Board. Mr. J. D. Coyle's researches into this general change in organisation of health care over the decade in question, that is from the 1960 Act establishing the health authorities to mid-1971 have now been published.¹

Coyle has been careful to point out that his study does not see the process of change through to anything near its final goal. Indeed the developments initiated by the 1970 Act setting up the Health Boards and by the McKinsey report are still in progress. However, in recent months the Eastern Health Board has appointed its three Programme Managers for General Hospital Care, Special Hospital Care and Community Care. An integrated approach to the planning of services can now be achieved. A further new development has been the launching of the Government Public Service Department which should in time provide much useful data for management to the Health Boards. Nevertheless much research and development will be required to establish what data is essential to rational decision-making and how it may be collected reliably. It is to this research and development area the present studies are directed. These studies cannot undertake full-scale provision of data about the services for management but are intended to

40
explore the ways in which data of this kind may be collected. The studies can also show how these methods can be used for decision-making. This is a sensitive field and there are many advantages in having its development placed under independent academic scrutiny. Coyle said in this study "Decisions relating to carrying out the service must remain outside the domain of the administrators and in that of the doctors and other professional persons. There is thus a clear-cut dichotomy between the performance of the service and administration of that performance. Similarly, and consequently, autocracy is inconceivable as the central authority in the administration cannot pretend to have full knowledge. Certain areas are barred from him and whatever his practical knowledge of these areas this knowledge will never be given sufficient recognition to grant him authority. This is true even if the administrator is of the medical profession as specialisation within the profession has barred certain areas from him".

The following is a brief report on each of the studies making up the project.

1. Dr. Enda Hession, Lecturer in Business Administration, U.C.D., has carried out a preliminary assessment of how the E.H.B. Special Hospital Programme Team sets its objectives and makes its decisions. This assessment suggested that a more extensive study of a selected high-level decision problem should be undertaken. This might provide considerable insight into the complex problems of choosing between urgent clinical and social needs. Such a study has now been initiated and concerns whether patients under treatment are best maintained in a hostel or in private lodging.

2. Dr. Dermot McDonnell has completed an initial gross statistical survey of the clinical activity of St. Gabriel's Day Centre. The scope of this survey has been extended to include family and community information. The proforma will be applied to other service facilities throughout the E.H.B. service area. In the first place a small local in-patient unit, a hostel, a further day-centre and an out-patient clinic will be studied.

3. Mr. Tom Murphy is preparing a report on the sources of information within the Special Hospital Programme of the E.H.B. which is not at present co-ordinated.
4. Dr. Harry Crawley has undertaken a study of general practitioner roles and attitudes. The mental health service policy of the Eastern Health Board has shifted since the inception of this project from one which envisages a purely specialised psychiatric service to one which sees the service development to be intimately interwoven with community and primary health care. The Programme Manager of the service is on record as saying that he envisages the virtual close-down of the Special Hospital Programme as a logical extension of this philosophy. This means that problems will arise in the relationship of the general practitioner to the Mental Health Programmes. For historical reasons the psychiatric services have operated almost independently of the family doctor in the Dublin city area in the past although the situation is now rapidly changing. Crawley has undertaken a Family Doctor Survey among 22 general practitioners in Dublin city. Eighteen of the doctors considered that the family doctor should take part in educating the public about mental health in addition to acting as personal adviser to their patients. All of the doctors in the study were dissatisfied with their undergraduate training in psychiatry. Crawley's full study will be published shortly.

5. Dr. John Cullen and Mr. Bernard Moran have undertaken a study of clinical decision-making by psychiatrists. The study focussed on the point at which the clinician was required by the patient's condition to make an alteration or discontinue treatment. Fifty-five patients were involved and half of these were out-patients. The psychiatrists were anonymous. No patients were discharged. In 11 patients no change was made in treatment and in 44 the change was from a major tranquilliser or anti-depressant to psychotherapy such as group therapy. There seems little doubt that the psychiatrists taking part in the study may have been influenced by the fact that they were participating in a study of this kind in making their decision to change to psychotherapy. A full account of this study will be published shortly.

6. Mr. Ingo Fischer, Director of the Behaviour Research Unit of Dr. Cullen's research department, U.C.D. and his colleagues have undertaken a survey in a sample of 92 out of 406 of the 8-year old child population and their parents in a Dublin housing estate. The study was designed to make an estimate of families at risk who would benefit from preventive
community services. Using the Bristol Social Adjustment Guides (Home Schedule) it was found that 28% of the children showed definite signs of maladjustment and 7 out of the 39 girls and 7 out of the 53 boys showed severe maladjustment. Achievement levels were normal for Irish circumstances. However, girls were underachievers as compared with boys. As found in other studies generally, Irish norms are one year lower than British norms. The report will be published in full in the near future.

7. Miss Aila Rantala has completed her study of the clinical records of a large Dublin child guidance clinic and a study of the outcome of treatment in a selected group of children. This study has been presented for a master's degree in psychology for the University of Stockholm and will later be made available.

These studies in the psychiatric services in Dublin are all directed to improving decision-making both at the administrative and professional level.

Reference

OTHER ACTIVITIES OF THE PSYCHIATRIC SECTION OF THE BOARD

In 1966 Dr. Dermot Walsh in co-operation with a fellow psychiatrist, Dr. P. D. McCarthy, published a report of a ten year survey of suicide in Dublin. They have continued this research and have now analysed coroner’s records covering the years 1964 to 1968 for Dublin City and County. The under-reporting of suicides in England and Scotland has been the subject of a recent study. As well as monitoring changes in suicide patterns Walsh and McCarthy have examined the factors which influence coroners to return suicide verdicts or not. This study has been supported by the Board and will be completed by the end of 1973.

The Board continues to take an interest in research into the problems associated with alcohol and is a member of the Anglo Irish Drinking Practices Study. In addition Walsh and Walsh have carried out a further study analysing the inter-relationships and inter-actions of various measures of judging alcoholism and the results of this have recently been published.

References

DRUGS—A STUDY OF IRISH RURAL POST-PRIMARY SCHOOL CHILDREN 1970/71

The Irish Cancer Society and the College of General Practitioners carried out a survey of the smoking and drinking habits of post-primary school children in Dublin during the first half of 1970. In view of the increasing concern over drug-taking among young children it was decided to include some questions on drugs. The Irish Cancer Society and the College of General Practitioners made this part of their data available to the Medico-Social Research Board. During the period November 1970–May 1971, the Irish Cancer Society and the College of General Practitioners carried out a similar survey of the smoking, drinking and drug-taking habits of post-primary school children in schools outside Dublin.

From the list of 671 recognised post-primary schools outside Dublin issued by the Department of Education (1968–69) a random sample of 27 schools was taken; the probability of selection being proportional to the school attendance.

The questionnaires were distributed to the children in their classrooms by a specially trained interviewer who explained the questionnaire to them, gave help where necessary and particularly emphasised the anonymity of the forms. The teachers were not present during the sessions. The children were very co-operative and the questionnaires were in general well completed with only a rare facetious comment.

Results of the study

The 27 schools in the sample contained 5,851 children as against 5,483 children in the Dublin study. None of the 5,851 questionnaires was discarded. The age range was 11 to 19 years. The age and sex distribution of both samples was very similar and valid comparisons can be made between them. Sixty-nine children or 1.2% of the sample stated that they had taken drugs. An additional 25 children stated that they had taken

*Rural i.e. excluding post-primary school children attending schools in Dublin city and county.
drugs which are not considered to be drugs of abuse in the accepted sense of that term. The data are presented by a sex and age breakdown in Table 2, 1.4% of the boys and 1.2% of the girls said they had taken drugs. These figures are approximately half those of the Dublin study (2.6% and 1.9% respectively).

The children are divided into two age groups, “under 16 years” and “16 years and over”. The higher incidence of drug-taking in the older children (i.e. 2.9% of the children over 16 years took drugs compared to 0.5% of those under 16 years) was also found in the Dublin study.

**TABLE 2**

**Children who stated they had taken drugs**

<table>
<thead>
<tr>
<th></th>
<th>Under 16 years</th>
<th></th>
<th>16 years and over</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percentage</td>
<td>Percentage</td>
<td>Number</td>
</tr>
<tr>
<td>Boys</td>
<td>11</td>
<td>0.5</td>
<td>1.4</td>
<td>29</td>
</tr>
<tr>
<td>Girls</td>
<td>8</td>
<td>0.4</td>
<td>1.2</td>
<td>21</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td>0.5</td>
<td>1.3</td>
<td>50</td>
</tr>
</tbody>
</table>

As in the Dublin study the commonest drug taken was cannabis. Fourteen children said they had taken L.S.D. Pep pills and heroin were the next two drugs in order of frequency. Fifteen respondents did not specify which drugs they had taken. The pattern of drugs taken by the children in this study is similar to that seen in the Dublin study.

*Those offered drugs*

Of those aged 16 years and over 7.9% had been offered drugs and 2.5% of those under 16 years; the corresponding figures for the Dublin study were 13.2% and 5.4% respectively.

**TABLE 3**

<table>
<thead>
<tr>
<th></th>
<th>Under 16 years</th>
<th></th>
<th>16 years and over</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percentage</td>
<td>Percentage</td>
<td>Number</td>
</tr>
<tr>
<td>Boys</td>
<td>65</td>
<td>3.0</td>
<td>6.5</td>
<td>85</td>
</tr>
<tr>
<td>Girls</td>
<td>37</td>
<td>1.9</td>
<td>4.0</td>
<td>50</td>
</tr>
<tr>
<td>Total</td>
<td>102</td>
<td>2.5</td>
<td>5.4</td>
<td>135</td>
</tr>
</tbody>
</table>


**Attendance at parties where drugs were taken**

Under 16 years of age 2.7% of the boys and 1.8% of the girls said that they had attended a party at which drugs were taken. (Table 4). Over the age of 16 years, 8.1% of the boys and 5.9% of the girls attended such a party. Again the percentages in the schools outside Dublin who had attended such a party were approximately half the percentages among the Dublin school children.

**TABLE 4**

<table>
<thead>
<tr>
<th></th>
<th>Under 16 years</th>
<th></th>
<th>16 years and over</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percentage</td>
<td>Dublin percentage</td>
<td>Number</td>
</tr>
<tr>
<td>Boys</td>
<td>59</td>
<td>2.7</td>
<td>4.2</td>
<td>60</td>
</tr>
<tr>
<td>Girls</td>
<td>35</td>
<td>1.8</td>
<td>5.6</td>
<td>57</td>
</tr>
<tr>
<td>Total</td>
<td>94</td>
<td>2.3</td>
<td>4.9</td>
<td>117</td>
</tr>
</tbody>
</table>

**Friends taking drugs**

Of those under 16 years of age 3.4% and 9.0% of those aged 16 years and over said that their friends took drugs.

The children who had taken drugs differed from the total sample in many respects. More of the drug-takers had been offered drugs and had been at a party where drugs were taken and a greater number said that their friends took drugs.

The replies of the children to the questions on the long-term effects of both “soft” and “hard” drugs on people indicated a general lack of knowledge on the subject.

The incidence of smoking and drinking was significantly higher among drug-takers than in the total sample. The differences in the smoking and drinking habits between the drug-taking group and the sample were especially marked in the case of girls. Furthermore, of those who smoked, the drug-takers were the heavier smokers and of those who drank, the drug-takers did so more heavily than the sample who drank.

Of the 69 drug-takers 29 (42%) had more than £1 to spend compared to only 520 (9%) of the total sample; 23% of the drug-takers had between £2–£10 to spend each week compared to 3% of the sample.
Significant differences were noted between the drug-takers and the total sample as regards leisure pursuits. The children were asked to list the three things they liked doing most in their spare time. Going out with the opposite sex was listed by 56 of the 69 drug-takers as one of their three favourite leisure activities based on the overall pattern adjusted for age; the expected number out of the 69 boys and girls in these age groups would be 31. Fewer of the male drug-takers liked to watch television or listen to the radio and more of them liked to visit coffee bars or clubs than the males in the sample. The differences between the drug-takers and the total sample for the above activities were significant.

The drug-takers spent less time at home than the sample. Twenty per cent of the drug-takers said they were “often bored because they had nothing to do in their spare time” compared to 9% of the sample.

The results of this survey suggest that at the most, only 1.2% of the rural post-primary school children have taken drugs and that of these only a quarter were taking them with any degree of regularity. The indication is that drug-taking among these school children is mainly an experimentation and, therefore, not as yet a major problem.

The rural school children had very little knowledge about drugs. The question of an educational policy on drugs is a controversial one. There is great public interest in the problem of drug abuse in Ireland at the present time and the general opinion seems to be that school children should be provided with information on drugs. The Working Party on the Abuse of Drugs in its recent Report to the Churches in Ireland considers the arguments for and against an educational programme on drug abuse in the schools and concludes that there should be such a programme on drug abuse which should be well-planned and professionally executed and should not receive undue publicity or emphasis but should be part of existing educational courses.

The reactions of society against drug abuse are not only against drugs but against the patterns of behaviour and cultural values of the drug-taking subcultures. The Working Party on Drug Abuse in its report to the Minister for Health stated that among the young people who belong to the drug-taking subcultures (in Dublin) there was widespread rejection of what they considered to be the values of the larger society. They expressed discontent and disillusionment with their parents’
approach to living—especially their concern with making money and possessing material goods. Carney et al recently reported on the social and psychological background of 50 young drug-abusers seen in Dublin in 1970. School attendance and school achievement were poor and work records were unsatisfactory. There was a higher than average incidence of serious psychiatric illness among their parents and data obtained from the 50 cases suggested that this was, generally, a personality disorder group.

In its report to the Churches in Ireland, the Working Party on the abuse of drugs comments that “deprivation leads some to the use of drugs; disillusionment leads others, but more appear to turn to them in their despair” and the Working Party recommends that “practical action should not be permitted to overshadow consideration and advocacy of comprehensive and radical social change”. There is an obvious need for detailed research to ascertain the social, cultural, environmental and other factors involved in the existence of the drug-taking subculture in Ireland.

Comparing this study to the Dublin study, exposure to drugs among post-primary school children appeared to be twice as great in Dublin as in rural Ireland. Exposure to drugs increased with age and was more marked in the case of the boys. In both studies marijuana was the drug most commonly used. In this study, noticeable differences were found between those who had taken drugs and the total sample with regard to smoking and drinking habits, amount of pocket money and leisure activities.

References

CULTURAL FACTORS ASSOCIATED WITH DRINKING

A cross-cultural study sponsored jointly with the Medical Council on Alcoholism of Great Britain (Mrs. Joyce O'Connor, Research Fellow, Department of Social Science, University College, Dublin).

Although the total consumption of alcohol in Ireland is not unduly high by international standards and cirrhosis of the liver is not a common cause of death, our first admissions to mental hospitals for alcoholism, alcoholic psychosis and other addictions, increase year by year and are five times higher than in England and Wales. First admissions to psychiatric hospitals for alcoholism in the Republic of Ireland have increased from 10.6% of all first admissions in 1964 to 16.3% in 1970. This may be due in part to an increased acceptance of treatment and it is not necessarily an index of an increase in alcoholism.

The Medico-Social Research Board is co-operating in a joint study with the Medical Council on Alcoholism in Britain and the Irish National Council on Alcoholism in an Anglo/Irish project under the direction of Mrs. Joyce O'Connor. This study is concerned with social and cultural factors in the use of alcohol by 18-to-21 year olds in Dublin with a similar age group among the English-born children of Irish parents and also those of English parents living in the London area. The parents of the 18-to-21 year olds were also interviewed. The study is progressing very satisfactorily, the field work in Dublin and in London is completed and preliminary analysis of the data has begun.
The study of the aged in county homes and in the community, which is being done at the Social Sciences Research Centre, University College, Galway, under the direction of Reverend Professor Edmund F. J. Dougan, O.F.M., by Miss Delma MacDevitt, M.A. and Mr. Tom Brett, B.A. continued.

Research during the past year has been concentrated on the aged in the county homes in Loughrea, Roscommon and Carlow. Detailed questionnaires on the facilities in the homes were completed by the matrons and sisters in the three homes, a census of the residents of the homes was taken, and the distribution of the residents within the counties studied.

Detailed information has also been collected on the physical and mental condition of a random sample of one in four of the residents in the homes. All the residents in the sample who were capable of being interviewed have been interviewed. Information has been collected on the reasons for their admission, their social background and economic status, their degree of isolation and capacity for self-care, and also on the medical care they received and their utilisation of available services prior to admission. An attempt was made to chart, in their histories, such processes as that of institutionalisation, disengagement from social activities, and the breakdown of reciprocal relationships between them and their relatives.

Data on the patients' attitudes towards loneliness, and on their perception both of changes in their status and of their relations with their families, have also been gathered.

The information already gathered from the patients and staffs of the county homes is now being checked and supplemented by interviews with those patients' relatives. When this is completed, it is intended to proceed with a study of the aged in the community who have not been admitted to the county homes.

It is expected that the study will be completed by December 1973, and ready for publication in 1974.
ADOPTION IN IRELAND

A small study on adoption in Ireland was supported by the Medico-Social Research Board. It has been undertaken by Miss Vivienne Darling of the Department of Social Studies, Trinity College, Dublin, and has been based on a sample of 143 adopting families in 1968.

The study confirmed other findings with regard to the socio-economic class of adopters, that persons in certain occupational classes are more likely to adopt than others. For instance, the professional class and senior salaried employees were represented three to four times more often than the expected number in the sample (based on 1966 Census). On the other hand, the number of unskilled workers who were likely to adopt was less than half the expected number. Nevertheless, it appears that Irish unskilled workers were more likely to adopt than unskilled workers in Britain.

The main reason for adopting was given as inability to have children of their own, about 62% of the sample. 38% already had children of their own and 57% had other adopted children. Only in 9% was the adopted child an only child in the adopter's family.

The standard of adoption practice in this country could perhaps be improved in certain respects. It was noted in the study:

1. Nearly always the counselling service available for applicant adopters appeared to be very limited at all stages, that is before the decision to adopt is taken, during the preparation period for adoptive parenthood and in the supervision after placement of the adopted child.

2. In many instances the assessment procedure for the selection process appeared to be superficial.

3. There was often a rather casual approach to the arrangements for handing over the baby to the new parents.
This study has primarily concentrated on the adoption process as it affects the adopters. The adopters, however, are only one of the parties involved. A complete picture of adoption in Ireland cannot be obtained until studies have also been undertaken into the adoption process as it affects the largely hidden group of natural parents and as it affects the children.

Perhaps the time has come for a comprehensive enquiry into the care of unmarried mothers in Ireland and of their babies, whether they are adopted or not. It is known that an increasing number of Irish girls are going to England each year in order to have an abortion, which makes the need for further enquiry into the problem of the unmarried mother a matter of urgency.
Multiple sclerosis, or disseminated sclerosis, as it is often called, has been a particular interest of the Director of the Board since he emigrated to South Africa in 1947 and found that multiple sclerosis, or MS, was common among immigrants from England, Ireland and Europe, but uncommon among the white South African-born. Those who immigrated to South Africa before the age of 15 also had a low risk of getting the disease.

It has now been established that the prevalence of MS, the most important disease of the nervous system to affect men and women in the prime of life, is high in Ireland, the United Kingdom and Europe, particularly Northern Europe, but there is a relatively low prevalence in Africa, Asia and the West Indies. There are about 2,000 men and women suffering from MS in the Republic of Ireland. The present study is a comparison of the hospitalised prevalence of multiple sclerosis between the United Kingdom-born, immigrants to England from high prevalence areas, for instance from Ireland and Europe, and immigrants to England from low prevalence areas, such as Africa, Asia (India, Pakistan) and the West Indies.

The population at risk by birthplace is already known at the time of the 1966 census and the 1971 census will be available later this year. Approximately 70% of the immigrants to England from low prevalence areas of the world settled in the four London Metropolitan Board areas and in the Birmingham Metropolitan Board area. In addition, there are high populations of these immigrants in certain towns, such as Leicester.

Permission has been obtained from the Medical Research Committees of all the London teaching hospital groups that admit patients with multiple sclerosis to go through the hospital records of multiple sclerosis patients from 1960 onwards. It has been found that by going through the patients' folders it is usually possible to detect those that were born outside the United Kingdom from their personal and family
history, although in about one-third of the patients, where it is suspected that they were born outside the United Kingdom, it is necessary to find the birthplace by writing to the patient’s house doctor.

By far the largest number of the multiple sclerosis patients at any hospital were investigated at the National Hospital, Queen Square, and over 3,000 folders of MS patients have now been studied at this hospital. This work has been undertaken by part-time workers, usually senior medical students and by resident doctors. A number of multiple sclerosis patients have been investigated at more than one hospital, and therefore, it has been necessary to record for each patient the name, age, year of admission, place of residence and birthplace. A card is completed for each patient. Approximately half of the total admissions for multiple sclerosis in the London teaching hospitals have now been filed. Over 2,000 folders will also be studied in the Birmingham area.

The HAA scheme, the equivalent of Ireland’s Hospital In-Patient Enquiry Scheme, for the London and Birmingham Metropolitan Board areas are providing print-outs of the patients with multiple sclerosis admitted to the non-teaching hospitals by sex, age, birthplace, etc. Search is also being made by other methods to find immigrants to England from low prevalence areas with multiple sclerosis.

The Medical Adviser to the Registrar of Deaths is providing details about deaths in patients from low prevalence areas of the world where multiple sclerosis is mentioned on the death certificate. In the United Kingdom, but not in Ireland, birthplace is stated on the death certificate. By including in the study immigrants from high prevalence areas such as Ireland the ability to find the birthplace of the patients will be demonstrated.

Another neurological disease, motor neurone disease, in which there is not known to be a difference in prevalence in Africa, Asia and the West Indies in comparison with the United Kingdom-born has been included in the study. For instance, in South Africa the prevalence of motor neurone disease was the same among the white South African-born as it was among the immigrants from England and Europe, a situation very different to that which occurred in multiple sclerosis.

The prevalence of hospitalised multiple sclerosis patients by age, sex and birthplace will establish whether those patients
who were born in a low-prevalence area of the world bring with them their low risk of developing multiple sclerosis or whether their risk increases to the high risk that is present in these islands. It is considered very likely that MS may be caused by a virus infection which, in countries where the level of hygiene is low, is "caught" in early childhood with resultant immunity. This study will show whether immigrants to England from low prevalence areas of the world remain immune to MS on settling in a country with a high prevalence.

Multiple sclerosis research is a fine example of international co-operation in research. The Director of the Medico-Social Research Board is Founder President of the South African Multiple Sclerosis Society. Multiple sclerosis research in South Africa from 1949 to 1969 was largely supported by the National Multiple Sclerosis Society of New York and the South African Society took an important part in these studies. The present study on immigrants is supported by the Multiple Sclerosis Society of Great Britain and Northern Ireland. The Irish Multiple Sclerosis Society is currently supporting a small study which is being undertaken by the Board.
CONCLUSION

When the Board started as a research institute in October, 1968, a longterm policy was not practicable but we have now reached the stage when there is general agreement about the lines of our continuing research and a more longterm plan, perhaps for three years or five years, can be considered.

Research and development appears to be the term most under discussion in Dublin during 1972 and 1973 and the Medico-Social Research Board consider that it is as important to develop suitable action from its research findings as it is to undertake the research itself. For this reason due publicity is given to the results of our researches in the medical journals and other suitable media.

There is no limit to the resources that can be expended on medical care. In spite of the great increase in the cost of the health service there has been no improvement during the last 20 years in the expectation of life of men in Ireland, and in Western Europe, aged 45 and over. This is largely due to the greater propensity of the male for heart and lung disease and accidental death. Coronary heart disease, cancer of the lung and chronic bronchitis are closely related to lifestyle and, in particular, cigarette smoking. Half the accidental deaths are due to traffic accidents and in many of these excessive alcohol intake is the major factor. No early improvement can be expected in the health of middle-aged men without more effective preventive action about cigarette smoking, the excessive consumption of alcohol and a change in our way of life towards a simpler diet and more active exercise. Resources can perhaps be better spent as far as health is concerned by improving the environment in which we live, better education, better housing and living conditions, cleaner air, more opportunities for social activities other than the pub to encourage a greater sense of personal worth and a feeling of belonging, more places for our children to play, more swimming pools. All this should lead to a greater sense of participation in the active life of our community.

There is good evidence that "Parkinson's Law" comes into play as far as many medical services are concerned, for instance
that the patients increase in number to fill the available hospital beds. Many more investigations could be undertaken through out-patients. Or it could be said that research projects tend to increase to fill the time of the available research workers. However, medico-social research workers are in very short supply. The Medico-Social Research Board is very conscious of the fact that its research, working on the very limited staff and funds available in Ireland, must be most carefully directed to the greatest needs of the Irish community. The more esoteric varieties of research, we believe, can best be left to others. This does not mean that the personal research interests of those who work for the Board will be ignored but a good balance must be kept. This, of course, is the advantage of the type of research undertaken by the Board and the advantage of a national science policy.

How does the Board decide what research should be undertaken? Decision is reached by the Board through a democratic process. Ideas are considered from many different sources. Of course, they come from the Director, the members of the Board and the staff. From the Department of Health, which in turn listens to the wishes of the Minister who reflects the views of the Dáil and the community. From the administrators who need to have accurate information about morbidity in order to administer the health services to the best advantage of the public. From doctors and members of the public who come to the Board with ideas about the research which is needed. The Board then decides which research should be undertaken on the advice of the Director with the funds available.

During the year the Director has taken part in a number of discussions with the Directors of other semi-state institutes to consider what research is needed into the problems associated with poverty in Ireland. He has also attended a number of meetings summoned by the EEC to consider research into the effects of environmental factors on the health of children. If this study is undertaken it will include the effects on health of such factors as diet, housing, family size and urban air pollution.

The lines of research which we are undertaking at present follow, we believe, a natural and commonsense order. We have started with mortality, why people die, secondly why people are admitted to hospital, the Hospital In-patient Enquiry, why they are admitted to psychiatric hospitals, why they attend psychiatric out-patients. We have not yet reached the stage,
nor have the hospitals the clerical staff, for an enquiry into
general out-patients, or the situation in the community itself,
those who visit their general practitioners and those who are
sick but are not seen by a doctor. We have also studied certain
major problems. Heart attacks, which account for 30% of all
male deaths. Strokes which cause so much morbidity and are
such a drain on the resources of the family and of the com-

munity. Problems associated with alcohol and its effect on
personal and family life. Cigarette smoking and health. Drug-
taking and the problem of the excessive amount of drugs that
are consumed. The epidemic of self-poisoning which is also
occurring in Ireland although less so than in England. The
problem of young people, what estranges them from our
society and perhaps causes them to join the still relatively
small group of people in Ireland who opt out by taking mari-
juana or perhaps the dangerous drugs of addiction such as
heroin. Finally, the Board is concerned about those who are
born with a handicap and mentally-retarded children and the
care of the aged.

These medico-social problems must be considered in the
socio-economic background. Ireland is moving from an
agricultural economy towards an industrial one and is still in
a very difficult in-between stage. A time of change is a time of
hope. We are now a member of a new society, the European
Economic Community, and we have many friends who will
help us, if we will help ourselves.
ACKNOWLEDGMENTS

We would like to thank Mr. Erskine Childers, T.D., who was the Tánaiste and Minister for Health until March, 1973, for his continued great interest and support in the work of the Medico-Social Research Board. We would like to welcome the new Minister and Tánaiste, Mr. Brendan Corish, and his Parliamentary Secretary, Mr. Richard Barry. We would also like to thank the Secretary and staff of the Department of Health, the Irish Medical Association and the Medical Union for their continued co-operation. Throughout the year we have kept close contact with the Medical Research Council of Ireland and other Boards and Institutes, in particular, the Economic and Social Research Institute. Finally, the Board would like to express gratitude to two members who have now retired, Professor William Jessop and Professor Brian McNicholl, who have been active members of the Board since its inception.
PUBLICATIONS AND REPORTS 1972-1973


9. Walsh, D. and O’Hare, A. Activities of Irish Psychiatric Hospitals and Units, 1972, Medico-Social Research Board.


*Printed by Cahill & Company Limited, Dublin*