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

ANNUAL REPORT 1978
THE MEDICO-SOCIAL RESEARCH BOARD

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Expenditure

The total expenditure by the Medico-Social Research Board for the year ended 31st December, 1978 was £285,000. (1977—£202,000).
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INTRODUCTION

1978 was, in many ways, a watershed with regard to Ireland's many social problems. During this year when the emphasis was placed by the Minister for Health on positive health and health education we saw for the first time a fall in some of the adverse health trends in Ireland, such as the extent of cigarette smoking in men and of deaths from heart attacks.

The annual report of the Board begins by custom with mortality, the surest of all health statistics. Eight years ago the Board obtained a list of 2,000 names and the dates of death of men and women from the burial records of a random sample of parishes in the west of Ireland. These names were then checked by the Registrar of Births and Deaths to see whether their deaths had been registered and certified. There were 6½% which had neither been certified nor registered and a further 7½% had been registered only. The study is now being repeated and a further sample of 2,000 deaths has been obtained, half from the parishes in the previous study and half from new parishes. During 1979 the study will be completed and will enable us to see if certification and registration of deaths in the west of Ireland has improved in the last eight years and to what extent.

There is a major improvement in the returns from the Hospital In-patient Enquiry scheme with a 32% increase over the previous year and it is expected that the discharge summaries will increase to approximately 348,000 in 1979 or 83% coverage excluding district and private hospitals. The best coverage is in the North-Eastern Health Board area (99%) but there are still areas where there are problems. During the year a study was undertaken on the accuracy of the information on the forms and it was found that while there is some inaccuracy Ireland compares favourably in this respect with the returns in Scotland. The data were used during the year for 57 studies.

The mental health section of the Board’s work continues to be a very major part of our work under the able guidance of our senior psychiatrist, Dr. Dermot Walsh. Studies continued
in the National Psychiatric In-patient Reporting System, the Three-County Psychiatric Case Register and the Schizophrenia Study. There were major studies on alcoholism and on suicide in collaboration with both the World Health Organisation (WHO) and the European Economic Community (EEC). Other studies were on the care of children in hospital and on the increasing number of Irish women who go to England to have abortions. A study is also being completed comparing the admission rates for Irish and other immigrant groups to psychiatric hospitals in south-east England with that of the United Kingdom-born. This is a collaborative study with the Department of Health and Social Security of the United Kingdom and will be ready for publication in 1979.

Mental handicap, both in children and in adults, is unusually common in Ireland and much mental handicap is potentially preventable. Dr. Michael Mulcahy and his co-workers are continuing their research on mental handicap and an account of their studies will be given in this report.

The Director and Dr. John Kevany, Department of Community Health, Trinity College, are the Irish representatives on the Specialised Working Group-Epidemiology (SWG.—Epid.) of the EEC and the Director attended three meetings of this group. Many of the Community’s medical research projects have been initiated by the Board. For instance, the Director and Professor Michel Lechat of the University of Louvain undertook the preparatory work on the first concerted action project of the EEC “The registration of congenital abnormalities and twins”. Following a symposium in Dublin a second concerted action programme on “Attempted suicide as a public health problem” has been initiated. The research on this programme was undertaken by Dr. Dermot Walsh. He also undertook a study with Mr. P. Davies of the MRC Medical Sociology Unit, Aberdeen, for the Community on “Medico-social aspects of alcohol-related problems in the countries of the EEC”. The first EEC study undertaken by the Board was that undertaken under the supervision of Dr. Denis Keating on “Air pollution in Ireland, living standards and respiratory diseases in children”.

The study of respiratory diseases among the farming community has been neglected in the past but is of great importance in Ireland because of the frequency with which “farmer’s lung” occurs. This is a disease caused by inhaling the spores
of a fungus in the dust from mouldy hay and occurs mainly in the early spring, particularly after a summer of high rainfall. These studies are being undertaken in collaboration with Professor René Pariente’s studies on respiratory disease in farmers in Normandy, France, under the Directorate-General for Employment and Social Affairs of the EEC, Luxembourg.

There is an increasing awareness that there is a relationship between radiation and cancer and Dr. John Kevany and colleagues in the Department of Community Health, Trinity College, Dublin, are undertaking for the Medico-Social Research Board an EEC study in Ireland on “Natural background radiation and cancer frequency in human population groups”. The Director is also studying the long-term effects on those who received superficial radiation for such facial skin conditions as acne and syphilis many years ago. There is evidence that even small amounts of radiation increase the risk of certain cancers, such as cancer of the thyroid.

In addition to attending meetings in Brussels of the Specialised Working Group-Epidemiology, meetings with EURATOM in Paris and with the Directorate-General for Employment and Social Affairs in Luxembourg, the Director has chaired a meeting of the sub-committee of the Panel of Epidemiology of the EEC (an advisory panel to the SWG-Epid.) on the subject of confidentiality, a matter of great importance to all who undertake medico-social research in Ireland.

The Board is continuing studies in collaboration with the World Health Organisation. Dr. Alicia Radic has reported on the return to work after a myocardial infarction and on the five year survival after myocardial infarction. Dr. Dermot Walsh is taking part in a WHO study of the determinants of outcome of severe mental disorders.

Dr. Peadar Kirke continues his research on child health care and Mrs. Aileen O’Hare, the Board’s senior sociologist, completed a study of provisions made in Irish hospitals for the special needs of children.

Dr. Geoffrey Carroll for his M.Sc. degree in Social Medicine undertook a study of the homes for the mentally retarded in Ireland and Miss Jodie Walsh carried out a study, at the request of the National Rehabilitation Board and in collaboration with the National Council for the Blind, of blind and visually handicapped persons living in Dublin city and county.
During the year the staff of the Board published five research papers and a report on several other studies will be published in 1979. The Board continues to collaborate with the Economic and Social Research Institute (ESRI) and proposes to hold a colloquium in 1979 on the need for a national policy towards alcohol in which Dr. Dermot Walsh and his brother, Professor Brendan Walsh, ESRI, will play a major part.

At the request of the Minister and Department of Health a sub-committee of the Board met on a number of occasions to consider the problem of deaths in the first year of life and, in particular, sudden infant deaths or “cot deaths”. A pilot study into this problem will be undertaken in Dublin city and county in 1979.

The Director continues his research into the aetiology of multiple sclerosis and completed a study for the EEC on the prevalence of multiple sclerosis in the islands of Malta in collaboration with Maltese neurologists and physicians and in Enna city, central Sicily, in collaboration with Sicilian neurologists. The prevalence of MS in Malta is extremely low, 4 per 100,000, but in Enna city, where it was thought to be low, it was found to be high, 53 per 100,000. He has also undertaken, in collaboration with Dr. Allan Downie, Aberdeen, and Dr. John Goodall, Stornoway, a study on the prevalence of multiple sclerosis in the islands of the Outer Hebrides. In the predominantly Celtic islands of the Outer Hebrides the prevalence of MS was found to be only one-third as high as in the islands of the Orkneys and Shetlands and only two-thirds of that in north-east Scotland. The MS prevalence in the Outer Hebrides was similar to that in Northern Ireland and in the Republic of Ireland. Further studies are being undertaken to see if the difference between eastern and western Scotland and the major difference between the islands of Malta and the nearby island of Sicily are due to genetic factors, such as HLA blood groups, or to environmental factors.
MORBIDITY: THE HOSPITAL IN-PATIENT ENQUIRY SCHEME

The Hospital In-Patient Enquiry Scheme is a reporting system which is organised by the Medico-Social Research Board to collect medical, social and administrative information regarding admissions to all general hospitals in Ireland. The objectives of the Scheme are:

(1) To establish national in-patient morbidity statistics.

(2) To provide administrative data for the management and planning of hospital services.

(3) To facilitate epidemiological research.

(4) To provide an information and research service to doctors.

Participation in the Scheme involves the preparation of a short summary for each patient discharged from hospital. The Medico-Social Research Board arranges for the processing of this information by computer, provides a feedback to doctors and administrators in the form of diagnostic and surgical indices and various statistical tabulations and co-ordinates the general administration of the Scheme. After processing, the basic data is retained on computer tapes where it constitutes a reference for administration and for doctors conducting research.

During 1978 the overall development of the Scheme continued and a very satisfactory increase in coverage of 32% over the previous year was achieved. A total of 295,000 discharge summaries was received compared with 224,196 in 1977 and the increase was achieved mainly through the availability of additional clerical staff sanctioned under the government job creation programme. A variety of considerations still make the
involvement of some of the hospitals not yet participating in the Scheme extremely difficult to achieve. However, it is expected that the number of discharge summaries submitted to the Board will increase to approximately 348,000 in 1979. The two tables below analyse these discharges by Health Board Area and by category of hospital.

**TABLE 1**

<table>
<thead>
<tr>
<th>Health Board</th>
<th>*Estimated Discharges 1979</th>
<th>Number of Summaries Expected</th>
<th>% Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Eastern</td>
<td>28,021</td>
<td>27,739</td>
<td>99.0</td>
</tr>
<tr>
<td>Western</td>
<td>43,780</td>
<td>37,364</td>
<td>85.3</td>
</tr>
<tr>
<td>Mid Western</td>
<td>45,074</td>
<td>37,165</td>
<td>82.5</td>
</tr>
<tr>
<td>Eastern</td>
<td>191,940</td>
<td>153,272</td>
<td>79.8</td>
</tr>
<tr>
<td>North Western</td>
<td>20,209</td>
<td>14,970</td>
<td>74.1</td>
</tr>
<tr>
<td>Southern</td>
<td>78,10</td>
<td>54,380</td>
<td>69.5</td>
</tr>
<tr>
<td>Midland</td>
<td>18,561</td>
<td>12,254</td>
<td>66.0</td>
</tr>
<tr>
<td>South Eastern</td>
<td>36,777</td>
<td>10,681</td>
<td>29.0</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>462,572</strong></td>
<td><strong>347,825</strong></td>
<td><strong>75.2</strong></td>
</tr>
</tbody>
</table>

**TABLE 2**

<table>
<thead>
<tr>
<th>Hospital Type</th>
<th>*Estimated Discharges 1979</th>
<th>Number of Summaries Expected</th>
<th>% Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional</td>
<td>70,062</td>
<td>61,252</td>
<td>87.4</td>
</tr>
<tr>
<td>Voluntary</td>
<td>210,877</td>
<td>179,362</td>
<td>85.0</td>
</tr>
<tr>
<td>County</td>
<td>105,335</td>
<td>80,614</td>
<td>76.5</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>9,466</td>
<td>8,258</td>
<td>87.2</td>
</tr>
<tr>
<td>Fever</td>
<td>7,682</td>
<td>6,349</td>
<td>82.6</td>
</tr>
<tr>
<td><strong>Sub Totals</strong></td>
<td><strong>403,422</strong></td>
<td><strong>335,835</strong></td>
<td><strong>83.2</strong></td>
</tr>
<tr>
<td>District</td>
<td>23,247</td>
<td>3,809</td>
<td>16.4</td>
</tr>
<tr>
<td>Private</td>
<td>35,903</td>
<td>8,181</td>
<td>22.8</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>462,572</strong></td>
<td><strong>347,825</strong></td>
<td><strong>75.2</strong></td>
</tr>
</tbody>
</table>

*Based on preliminary figures for 1977 supplied by Planning Unit, Department of Health.
During 1978, in addition to the production of routine statistics, H.I.P.E. data was used to provide special analyses for the following:

- Hospitals: 20
- Individual Doctors: 22
- Department of Health: 4
- Health Boards: 4
- Universities: 3
- Miscellaneous: 4

Total: 57

The use of the H.I.P.E. data in this way over the past few years has been most encouraging and it should be noted that special analyses of this type are provided free of charge by the Board on request.

In last year's report we mentioned briefly that a study had been initiated in conjunction with the Department of Community Medicine and Epidemiology, University College, Dublin, to assess the validity of the data being submitted under the H.I.P.E. Scheme. The study was based on H.I.P.E. data submitted in 1976 and a random sample of 17 participating hospitals was chosen. In each of these hospitals 23 charts were randomly selected giving a sample of 391 charts.

The study consisted of comparing the information entered on the H.I.P.E. summary sheet on discharge of the patient, with the information contained in the charts. This comparison was done by the same doctor in every one of these hospitals. Fourteen charts (3.6%) chosen in the sample were not available for checking. Nearest chart numbers were examined instead.

The following is the list of items entered on the forms and the number and % of wrong entries. The results of a similar study conducted in Scotland in 1969 are also shown for purposes of comparison.

It was clear from the survey that the accuracy of information was proportional to the ease with which the information could be retrieved. Hospitals should be encouraged to include a summary sheet as part of the chart.

In undertaking research the greatest confidentiality is kept, so that research does not interfere with the confidential relationship that should exist between the doctor and the patient. It is
<table>
<thead>
<tr>
<th>Item</th>
<th>Number of Errors Ireland</th>
<th>% Errors</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of admission</td>
<td>0</td>
<td>0</td>
<td>1.6</td>
</tr>
<tr>
<td>Date of discharge</td>
<td>5</td>
<td>1.3</td>
<td>3.6</td>
</tr>
<tr>
<td>Discharge code</td>
<td>10</td>
<td>2.6</td>
<td>0.6</td>
</tr>
<tr>
<td>Year of birth</td>
<td>14</td>
<td>3.6</td>
<td>2.7</td>
</tr>
<tr>
<td>Sex</td>
<td>4</td>
<td>1.0</td>
<td>0.6</td>
</tr>
<tr>
<td>Marital state</td>
<td>8</td>
<td>2.0</td>
<td>1.8</td>
</tr>
<tr>
<td>Source of admission</td>
<td>11</td>
<td>2.8</td>
<td>3.0</td>
</tr>
<tr>
<td>Area code</td>
<td>12</td>
<td>3.1</td>
<td>5.2</td>
</tr>
<tr>
<td>Consultant</td>
<td>15</td>
<td>3.8</td>
<td>6.4</td>
</tr>
<tr>
<td>Principal diagnosis</td>
<td>23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal diagnosis not entered</td>
<td>2</td>
<td>9.2</td>
<td>6.2</td>
</tr>
<tr>
<td>Principal diagnosis code</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal operation</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Principal operation code</td>
<td>15</td>
<td>5.9</td>
<td>10.3</td>
</tr>
<tr>
<td>Operations not entered</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of operation</td>
<td>8</td>
<td>2.0</td>
<td>7.5</td>
</tr>
<tr>
<td>Wrong chart numbers</td>
<td>17</td>
<td>4.3</td>
<td>0.2</td>
</tr>
<tr>
<td>Forms that had one or more of the above entries wrong</td>
<td>162</td>
<td>41.4</td>
<td>42.0</td>
</tr>
</tbody>
</table>

Range between hospitals of forms that had at least one item wrong was 0—78%.

On this account that the Hospital In-patient Enquiry scheme does not include the name or address in the computer print-out. The patient’s name and reference number is kept completely separate from the reference number and data about the patient. By this rather complicated method confidentiality is maintained and yet it is still possible to undertake epidemiological research based on the number of people sick with a particular condition, as opposed to the number of admissions, out of a population of known sex and age distribution.

In this very important matter of confidentiality a compromise has been reached between strict doctor/patient confidentiality on the one hand and the need for epidemiological research for the benefit of society on the other. In developing this compromise strict safeguards have been developed and observed in collaboration with the Irish Medical Association to make it impossible for any unauthorised person to obtain access to the health data of any particular individual.
MENTAL HEALTH

3 (a)

THE NATIONAL PSYCHIATRIC IN-PATIENT REPORTING SYSTEM

At the end of 1978 our latest report in this series appeared entitled "Activities of Irish Psychiatric Hospitals and Units 1975/1976". With this report the series has been brought up-to-date in that the events reported are now reasonably near the time of their occurrence, thereby obliterating a backlog inherited from the previous reporting system initiated in 1963. From now on it is intended to publish reports covering one year only and it is hoped that this will further reduce the lag between the reports and the events they record. A report for 1977 should appear during 1979.

The main features of the latest report confirm trends that have been emerging in recent years. Thus, there has been a slowing down in the numbers of first admissions generally with an increase in the number of re-admissions. These facts indicate a changing pattern of mental hospital usage whereby shorter but more frequent stays in hospital are replacing periods of continued hospitalisation as was the tendency in the past. There is also a greater flexibility in the component facilities of psychiatric services so that patients tend to move more rapidly from hospital to hostel to day-centre and back to out-patient care reflecting a more sensitive awareness and grading of patients' clinical states and needs at any point in time.

Attention is drawn in the report to the continuing increase in the numbers of people admitted for the treatment of "alcoholism". This condition is now the commonest cause of first admission to psychiatric hospitals and the indications are that it will continue to increase. Not all of this increase can be considered to be due to an increase in the numbers of those
dependent on alcohol and suffering the consequences of that dependency. There are some reasons to believe that people are now coming to hospital earlier in the course of their addiction to alcohol and that psychiatric hospital facilities are viewed with greater favour by the community for the treatment of alcoholism and are, therefore, availed of more readily than in the past. The pattern of hospital usage by alcoholics would indicate that for the majority of them admission and “treatment” is seen simply as the immediate response to some pressing problem such as early symptoms of delirium tremens or because there is some domestic pressure to enter hospital or other immediate problem such as trouble with the police. The event of hospitalisation is probably conceived of by many excessive drinkers as serving an immediate relief function in relation to some crisis in their lives, at a particular point in time, rather than any convinced desire to give up or reduce their alcohol consumption.

From the point of view of cost effectiveness, use of expensive hospital facilities in this way must be questioned particularly as there are a number of studies indicating that out-patient treatment of “alcoholism” is, in uncomplicated cases at least, as effective as in-patient care.

In relation to neurotic and psychopathic conditions it appears that the peak for hospitalisation for these disorders has passed perhaps because of the development of more acceptable non-hospital alternatives such as out-patient care. Persons with the more serious psychotic illnesses such as schizophrenia and organic psychosis continue to enter hospital and leave hospital in about the same numbers and it would appear that a stable situation has been reached as far as their use of hospital beds is concerned.

Socio-economic status is shown to be an important determinant of admission to hospital. In 1976 the unskilled manual group had the highest admission rate to psychiatric hospitals, followed by the lower and then the higher professional groups. The ranking of these socio-economic groups was similar to that of 1973, with the intervening years showing only a slight interchange of position between the higher and lower professional groups. The unskilled manual group also had the highest admission rate—double that of the mean—in 1976, having maintained that position since 1972.

There were also interesting sex differences in the first ad-
mission rates for the socio-economic groups with higher male rates in all groups with the exception of the farmers, lower professional and other non-manual groups. Since 1972 both the farmers and other non-manual groups have consistently had higher female first admission rates.
THE THREE-COUNTY PSYCHIATRIC CASE REGISTER STUDY

This project which began in 1973 in Carlow and South Kildare, Roscommon and Westmeath continues. The census data, 1973, yielding a one-day prevalence of treated mental illness in the three areas under study suggest that, by comparison with data from similar case registers, for example the Camberwell and Salford registers, the prevalence of psychiatric illness and particularly of major conditions, such as schizophrenia, is high. Raised prevalence of this kind may be due to a poor outcome with prolongation of symptoms to an extent not observed in other cultures or it may be due to a raised incidence of the condition under study. Unfortunately, there is not sufficiently accurate data concerning the incidence of psychiatric illness in Ireland in the past. The Board is, however, examining the incidence rates in three counties through the case register study and will, therefore, be able to determine what the contribution of present-day incidence to the high prevalence may be.

Because the observed raised prevalence may be related to a relatively poor outcome of, for example, schizophrenia patients in Ireland, it is necessary to look at the possible influence of certain social and environmental factors on this unfavourable outcome. In this context our participation in the WHO "Determinants of Outcome of Severe Mental Disorders" study and in particular in the Disability Sub-Study, is of great importance. (See page 44).
THE THREE-COUNTY SCHIZOPHRENIA STUDY

This study was carried out in the same three areas in which the registers operate.

The focus of the study was twofold:

1. to measure the incidence of mental illness and the incidence and prevalence of schizophrenia, using standardised psychiatric schedules already employed in international studies of major mental illness;

2. to collect appropriate socio-cultural data on early life experiences and role behaviour of patients and on a sample of matched controls. Information was gathered on all patients in psychiatric care at the commencement of the study, both in-patients and out-patients and on all new cases of psychiatric illness entering care during the study year in each area. The study employed two field workers, a psychiatrist, Dr. Máirín Ní Nualláin and a social research worker, Miss Bernie McHugh, who spent a year in each of the three areas.

The data from this study have been processed and are now being analysed and it is hoped that the major psychiatric and sociological findings will soon be available.

In addition, schizophrenics from two of the three study areas have been followed-up and re-interviewed with the broad objective of ascertaining their present level of functioning and adjustment. The patients in the third area will shortly be eligible for follow-up.
3 (d)

STUDIES ON ALCOHOL-RELATED PROBLEMS

From its inception the Board has been concerned about the growing problems arising from an increasing national consumption of alcohol. Since 1966 consumption of alcohol in Ireland has increased by about 250% with spirit consumption growing more rapidly than beer consumption. At the same time, all the evidence indicates a corresponding increase in the extent of alcohol-related problems. Perhaps the best indication of this is the increase of admissions to psychiatric hospitals and units for alcoholism. For 1965 these numbered 699 but by 1976 they had reached 5,100. Of these, 2,100 were first admissions making the alcohol dependence syndrome the commonest cause for first admission to hospital. Other indices of alcohol-related problems such as cirrhosis of the liver show the same upward trends. It, therefore, seems to the Board that an exploration of any preventive measures likely to be effective is important. For this reason the Board has been particularly pleased to have been asked to join in the International Study of Alcohol Control Experiences. This study is being carried out by a group of experts from such well known international centres of public health research in the alcohol field as the Finnish Foundation for Alcohol Studies, the Addiction Research Foundation of Ontario, Canada, the Social Research Group, School of Public Health, University of California and the World Health Organisation. We have already participated in the initial meeting at Helsinki last year and an examination of the preventive value of control measures and, in particular, of price control has been prepared for the next meeting in California in 1979.

A study on Alcohol-Related Problems among the Prison Population, supported by the Board in conjunction with the Irish National Council on Alcoholism, has recently been completed and the findings have been presented to the Minister for Justice.
OTHER STUDIES BY MENTAL HEALTH SECTION

Season and place of birth of schizophrenics

This study which has been completed and is awaiting publication confirms earlier findings of a distinct seasonality in schizophrenic births. The general tendency is for these births to occur in the earlier months of the year in the northern hemisphere. This occurs to a greater extent in Ireland than in the other countries in which similar studies have been made.

After-care in psychiatric illness

A study of the intensity of after-care by personnel in the psychiatric services delivered to various types of patient discharged from St. Loman's Hospital, Dublin, has been recently completed and partially analysed by Dr. Petrina Keane. Initial findings from this study which, it is hoped, will shortly be published and which have already been presented at a number of scientific meetings in Dublin and in London, indicated that, in general, intensity of care is related to chronicity of illness. A great deal of information has been collected by the study group which will be analysed further.

Suicide

Our work on suicide is ongoing and at present arrangements are being made to collaborate with the Dublin city coroner and investigate in some depth the trend and characteristics of suicide in the city in recent years.

Termination of pregnancy

Our annual reports on the numbers and characteristics of Irish residents whose pregnancies are terminated in mainland Britain continue and the report for 1977 should be appearing shortly. There is still no sign of a levelling off in the increasing number of pregnancies being terminated.
The following projects in mental handicap were undertaken by the Board in 1978:

1. Preliminary work relating to a further Census of the Mentally Handicapped.

2. A follow-up study of adult mentally handicapped persons in the Midland Health Board region.

3. Establishment of a register of females of childbearing age with phenylketonuria.

Census of the Mentally Handicapped

Since debate continues concerning the prevalence of severe and moderate mental handicap it is clearly important to monitor trends in prevalence. One way of doing this is by repeated censuses. Accordingly it was decided in 1978 to repeat the census of 1974. The procedure chosen for the next census will be different from the previous one in that it is now proposed to channel all information collected through the Directors of Community Care both in relation to the handicapped living at home and to those in residential care. During 1979, it is proposed to establish a register of the mentally handicapped in each Community Care area. Once these have been set up the census in effect will be obtained from these local registers. Preliminary work on the design of the register commenced during 1978 and during this period the use of a basic record card was piloted in eight Community Care areas.

Study of the adult mentally handicapped in the Midland Health Board Region

A feature of the findings in the Census of the Mentally Handicapped in 1974 was the apparent relatively high prevalence of the adult moderately mentally handicapped, both male
and female. It was postulated that this high prevalence, which in fact exceeded the prevalence of the condition in children, could have resulted from variations in incidence over time or from demographic factors e.g. selective migration. An overestimation of the numbers due to lack of information, particularly psychological assessment, was felt to be the most likely cause.

In order to inquire further into this, a survey of moderately mentally handicapped adults within the Midland Health Board region was carried out by Miss Sile O’Connor, M.Soc.Sc. and by Mr. Brendan Broderick, M.A.

Within this region, 138 people between the ages of 20 and 40 were reported as moderately mentally handicapped in 1974. Seventy-three of this group were living in the community and 65 were in residential care. Only 3 (4%) of those living in the community and 16 (25%) of those in residential care had been psychologically assessed; 119 of those returned as moderately mentally handicapped had not been psychologically assessed. It emerged that 24 (20%) of this group had Down’s syndrome and 19 of these were living in the community. With a view to establishing whether or not there had been an over-estimate and whether certain persons functioning above the moderate mental handicap level had been included, it was decided to assess psychologically those estimated to be moderately mentally handicapped. It was assumed that those who had Down’s syndrome were moderately mentally handicapped, and these persons were not assessed. Since four people returned in 1974 had died, two in residential care and two in the community, the number to be assessed was 91; 42 of these were in residential care and 49 were in the community.

The details of the actual survey and the case finding techniques involved in the follow-up will be published. The basic findings were as follows.

Of the 42 persons returned as moderately mentally handicapped from residential centres of all kinds but not confirmed by psychological assessment, 31 were confirmed on assessment as falling within the functional range of moderate mental handicap. Eleven were found to be functioning within the mild mental handicap range. Similarly, of the 49 cases in the community 36 were confirmed as having been accurately assessed and 13 on formal assessment were found to be mildly mentally handicapped. Accordingly a total of 23 out of 91 cases assessed
or 17% of the 138 cases returned as moderately mentally handicapped in 1974 were under-estimated in the census as to their actual intellectual capacity defined by the sub-categories of mental handicap.

This under-estimate of intellectual functioning was age related in that the older the individual the more likely he or she was to be under-estimated with regard to the level of mental capacity. Whilst the Midland Health Board area cannot be considered as a representative sample of the country as a whole similar factors are probably operating in other Health Board areas. Table I assumes this and gives revised prevalence rates for the adult moderately mentally handicapped in Ireland.

<table>
<thead>
<tr>
<th>Age group</th>
<th>1974 rate per 1,000 population</th>
<th>Revised rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-24</td>
<td>2.6</td>
<td>2.4</td>
</tr>
<tr>
<td>25-29</td>
<td>2.8</td>
<td>2.7</td>
</tr>
<tr>
<td>30-34</td>
<td>3.0</td>
<td>2.6</td>
</tr>
<tr>
<td>35-39</td>
<td>2.8</td>
<td>1.9</td>
</tr>
</tbody>
</table>

Two other findings of the study have particular relevance: First, the inadequacy of the services available during the childhood of the population in question was highlighted. Second, the intensified case finding of the survey revealed that five cases of moderate mental handicap had in fact not been ascertained during the census.

Register of females of childbearing age with phenylketonuria

The introduction of the phenylalanine free diet for phenylketonuria has produced an entirely new population of individuals, namely persons treated since infancy who have developed normally. While, fortunately, they are free of mental handicap the most recently available evidence suggests that there is considerable risk of multiple congenital anomalies occurring in the children of phenylketonuric mothers. Phenylketonuric babies of normal mothers are only exposed to high levels of
phenylalanine after birth, while babies of phenylketonuric mothers are at risk from conception to birth.

During 1978 the task of contacting personally all women of childbearing age known to have phenylketonuria was undertaken. Twenty-three women in this category were found and the number can be expected to increase by approximately five each year. The purpose of this register, which is being maintained in co-operation with the staff of the National Screening Project for Phenylketonuria in children at Temple Street Hospital, is twofold: first, to prevent, where possible, the birth of a congenitally abnormal and brain damaged child and second, to carry out a prospective study of the outcome of pregnancies in this group of women. The work undertaken initially involved explaining what we know about maternal phenylketonuria to the women concerned and to their parents. Intervention by reintroduction of diet accompanied by close monitoring methods during pregnancy will now be attempted with a view to establishing the outcome of these pregnancies.

Two medical students were employed by the Board during the summer, Miss Honora Molloy and Mr. Fintan Harte, to work with Dr. S. Cahalane of Temple Street Hospital in a biochemical screening survey of routine blood samples from women attending the antenatal department of Dublin hospitals. This work illustrates a complementary approach towards the problem of maternal phenylketonuria, namely, that of screening all first pregnancies to detect either cases of previously diagnosed phenylketonuria, which are not reported at the time of pregnancy, or the rare but important missed cases of phenylketonuria and hyperphenylalinaemia.
COMMISSION OF THE EUROPEAN COMMUNITIES
STUDIES
5 (a)
RESPIRATORY DISEASES IN FARM WORKERS

Since 1976 studies have been carried out on respiratory disease among agricultural workers. A major part of this research has been a study in north-west Ireland of a disease known as farmer’s lung. This was part of a collaborative study supported by the E.E.C. on farmer’s lung and respiratory disease among farmers in France, the United Kingdom and Ireland.

Farmer’s lung is caused by exposure to mouldy hay. If hay is stored in a damp state, the growth of fungi is encouraged. These fungi produce spores, which are released in vast numbers when the mouldy hay is raked or turned over. Some individuals develop an allergic reaction to these spores which results in the illness known as farmer’s lung. The farm worker develops a fever, with a persistent unproductive cough and becomes short of breath. The symptoms may last from 12 hours to a week or more. Some individuals have a more insidious form of the illness with gradually increasing breathlessness.

Once farmer’s lung has been diagnosed the farm worker should never again handle mouldy hay and in many cases he or she is advised to retire from agriculture, if possible, and seek alternative employment. Other farmers who develop the illness suffer permanent lung damage and are no longer able to work on the farm due to weakness and breathlessness. Rarely a farmer may die during an acute episode of farmer’s lung.

Mouldy hay can also cause illness in cattle. It is found particularly in adult cattle who are fed indoors. Symptoms in cattle include weight loss, rapid breathing, cough and low milk yield.

Study in north-west Ireland

To study the extent of the problem of farmer’s lung in Ireland, a study was undertaken during 1976–1978 in the North-Western Health Board area. For the purposes of the study, the Director of the Board was assisted by Dr. Dermot
Collins, Consultant Physician at the General Hospital, Sligo. The field work in counties Sligo and Leitrim was carried out by Dr. Farook Dinah and a team from the General Hospital, Sligo. Dr. John McHardy, Donegal, visited the farms in County Donegal.

A random sample of farms was visited in counties Sligo, Leitrim and Donegal. The adults who worked on the farms were asked to participate. A questionnaire on respiratory symptoms was completed. Further questions were asked about the method of saving and storing hay and the presence of symptoms during or after exposure to mouldy hay. A sample of blood was taken for examination for sensitivity to various fungi. These tests were carried out by Mr. James Evans of the Department of Microbiology and Immunobiology, The Queen's University of Belfast.

A total of 276 men and 67 women were interviewed. In counties Sligo and Leitrim the farms ranged in size from four to 159 acres with a mean average of 41.4 acres. They had an average of 22 cows per farm ranging from two to 160 cows. On most of the farms which were visited in counties Sligo and Leitrim the fodder was stacked either as hay in a shed (nearly 60%) or hay outdoors (11%). Hay was baled on 19% of the farms, while 7% used silage. The other 3% of farms used a combination of methods to store the fodder. Most of the farms using baled hay or silage also stored small amounts of loose hay.

Many of the farm workers had risk factors for respiratory disease. Forty-seven per cent were current smokers, and the majority of these smoked cigarettes. Only 34% of those interviewed had never smoked. Eighteen per cent of the men who were interviewed had previously worked in a dusty occupation.

Farmer's lung among those interviewed

The farm workers who gave a history suggestive of farmer's lung, (malaise, shivering attacks and lower respiratory tract symptoms occurring some hours after contact with mouldy hay) were classified as having definite, probable or possible farmer's lung. This was done by taking into consideration the results of blood tests, chest X-ray and the past and current history of other respiratory disease.

Among the 343 farm workers of both sexes there were three
men with definite farmer's lung. These three men had typical histories and X-ray findings and they had permanent disability. Six farm workers (five men and one woman) were classified as having probable farmer's lung on the basis of their history of episodes of illness following exposure to mouldy hay. Ten other farm workers gave a history of lower respiratory tract symptoms 4–12 hours after exposure to mouldy hay. However, due to a past history of respiratory disease, or because they were heavy smokers, it was not possible to assess the extent to which mouldy hay contributed to their symptoms. These ten men were classified as having possible farmer's lung.

A total of 279 blood samples were tested for sensitivity to various fungi. Six of the blood samples showed definite sensitivity to fungi, while samples from seven other farm workers were weakly sensitive. Two of those with positive blood tests were classified as definite farmer's lung. None of the other farm workers who had positive or weakly positive blood tests had symptoms following exposure to mouldy hay.

The results of this study highlight the fact that those who have symptoms of the disease may have negative blood tests if tested at a time of the year when they have not been in contact with mouldy hay. Conversely, some farm workers may have positive blood tests though they may have no symptoms after exposure to mouldy hay. The latter group are at risk of developing farmer's lung on future exposure to mouldy hay.

In this study of farmer's lung in north-west Ireland there were three definite cases of farmer's lung and six probable cases among 343 farm workers. This gives a prevalence of 2.6% among those interviewed. The results of blood tests on eleven other farm workers (or 3.2% of those interviewed) showed that they were at risk of developing farmer's lung.

Screening for fungus sensitivity using blood from the Irish Blood Transfusion Service.

The Irish Blood Transfusion Service Board collaborated in carrying out a survey to assess the extent of sensitivity to the fungi of mouldy hay throughout the country. In March to June, 1978 rural donors attending the Irish Blood Transfusion Service mobile clinics were asked for consent to the use of a sample of their donation for a research study on
farmer's lung. The request was confined to those who lived or worked on a farm, the majority of whom handled hay. Only those who are in good health may be blood donors. It is unlikely that those with symptomatic farmer's lung would attend the mobile clinics.

A total of 1,285 blood samples were collected. Five of these showed sensitivity for the fungi which cause farmer's lung while three other samples showed weak sensitivity. So 0.6% of those tested were at risk of developing farmer's lung. This suggests that the number at risk of developing farmer's lung on a national basis may be lower than the number at risk in north-west Ireland. This may be due to higher summer rainfall and a smaller percentage of farms using silage in the north-west. This study will be repeated in 1979 because the summer of 1977 was drier than usual and, therefore, hay would be less likely to become mouldy on storage.

Respiratory symptoms in urban and rural dwellers

A further survey was carried out in conjunction with the MEDISCAN programme of the Irish Heart Foundation. In addition to their routine examination for risk factors for coronary heart disease, the Irish Heart Foundation agreed to administer a short respiratory questionnaire and a test of respiratory function. The survey included 720 men. It is hoped that by taking into consideration such factors as cigarette smoking and being overweight, it will be possible to assess if there are differences in respiratory symptoms and function between those who live in rural and in urban areas.

Prevention of farmer's lung

The survey of farmer's lung in the north-west of Ireland stimulated renewed interest in the disease. Medical personnel and agricultural advisers in the North-Western Health Board area have met to discuss the disease and the steps which can be taken to prevent it. Farmers are being advised to dry hay as thoroughly as possible and to store it in well-ventilated sheds. These measures have the added advantage of producing a fodder of good nutritional value. Farmers are also being advised to handle mouldy hay with care, to avoid carrying it at shoulder level and to stand with their backs to the wind when opening a bale of hay. They are also advised to wear a light-weight face mask while handling mouldy hay. Advisers
of committees of agriculture and similar bodies are offering further advice to farmers as to what action would be most suitable on any particular farm. A change to silage would eliminate the hazard.

By improved awareness of the disease it is hoped that farmers, agricultural advisers and the medical profession will co-operate in an effort to reduce the risk to farmers of developing farmer’s lung in Ireland.

Reference

THE CONCERTED ACTION PROJECT ON REGISTRATION OF CONGENITAL ABNORMALITIES AND OF TWINS (EUROCAT)

The European Economic Community has approved as its first concerted action project a programme to co-ordinate registers of congenital abnormalities and of twins. Dr. Josephine Weatherall of the Office of Population Censuses and Surveys, London, has been appointed the project director and she visited Ireland in 1978 to study the registers that were already in existence here and to see how these registers could be co-ordinated with each other.

There are two registers of congenital abnormalities in the Republic of Ireland at present, one supervised by Dr. Allene Scott, Director of the National Drugs Advisory Board, and the other by Dr. Victoria Coffey of Trinity College. Neither are national, probably overlap and may not be complete.

Dr. Scott's register was established to look for any association between drug usage and congenital malformation. Specially trained nurse-interviewers are employed to watch for babies born with congenital malformations in four hospitals in Dublin and the maternity hospitals in Galway and in Limerick. It is estimated that babies at risk covered by the Dublin register amount to 8% of the births in the Eastern Health Board area. The searchers inspect the delivery room records and those of the perinatal wards and the paediatric units. The nurses search the earlier records of pregnancy kept by the general practitioner and the mother is also sent a questionnaire. For each abnormal baby reported a control baby is selected, the data is analysed by the staff of the National Drugs Advisory Board and the drug usage of mothers of malformed children is compared with the drug usage for control babies.

In the parallel study of Dr. Victoria Coffey primary data is in the form of voluntary notification at birth from the maternity units gathered from a special entry made on the
compulsory notification of birth returns made to the health authority which is used to alert the health visiting services. Periodically, local health officers pass on the information to Dr. Coffey of each case of congenital abnormality that occurs. Information is then collected about the birthplace of the child from the hospital records and additional information is collected with the help of a questionnaire from the mother. In addition, members of Dr. Coffey’s team telephone the maternity units periodically to ask about malformed children who are born and a series of control babies is selected. The system covers stillbirths and neonatal deaths in Dublin hospitals, 97% of which are autopsied by pathologists with training in paediatric morbidity. Infections occurring in the first three months of pregnancy are ascertained by questionnaire and blood samples, where necessary, are sent to virologists. A special study in progress is one on Down’s syndrome which involves searching lists of hospital records and children’s death records during the first year of life.

In discussions to improve the registration of congenital abnormalities and twins the possibility of choosing in the first place a defined geographic area was raised. It was felt that the Dublin city area with about 20,000 births per year would be a good initial area to start a central register and means will need to be found to see to what extent the two existing registers ascertain all malformed children in the area and record details of their malformations. Much goodwill will be necessary to build a unitary register from the two registers already in existence.

The possibility of registering twins and of recording their zygosity has also been considered. It is suggested that a conference should be held within one of the major maternity units in Dublin under the aegis of the concerted action project to consider the compilation of a teaching guide to determine zygosity from examination of the placenta. In the past Ireland had a high twinning rate due particularly to child-bearing persisting into the 40’s when twinning is more likely. The increased risk of twins with age is an increase in dizygotic or two eggs twins and not in monozygotic or one egg twins which occur at all ages at a rate of 3.5 per 100,000 births. At present the dyzygosity of twins has not been reliably determined. Genetic studies will be included in the programme and Galway would be a major centre for genetic studies, particularly into the
epidemiology of coeliac disease and in studying chromosomal abnormalities among the children with multiple malformations.

The concerted action project on congenital abnormalities will be assisted in Ireland by the introduction shortly of a new perinatal record form by the Department of Health.

Reference

ATTEMPTED SUICIDE AS A PUBLIC HEALTH PROBLEM

At the request of the Commission of European Communities the Medico-Social Research Board convened a Workshop on “Attempted Suicide as a Public Health Problem” in Dublin in March, 1977. This meeting was attended by experts on attempted suicide from Europe and also by officers of the European Regional Office of the World Health Organisation.

Attempted suicide and, in particular, deliberate self-poisoning by drugs was considered to be of major importance by the Commission of European Communities because of the epidemic growth in deliberate self-poisoning or parasuicide among young people in the countries of the Commission. For instance, in France and in England and Wales the annual number of admissions to hospitals after deliberate self-poisoning is now more than 100,000 per year.

Although this phenomenon is called attempted suicide it is doubtful whether there is a true intent to commit suicide in the majority of cases. It is usually a call for help and is a phenomenon which is twice as common in women as in men and in the United Kingdom and Ireland the peak incidence is between the ages of 15 and 24 years. Successful suicide, on the other hand, is more common among men than women and more common in older age-groups.

Because of the enormous demands that deliberate self-poisoning by drugs make on the medical services of the European countries any preventive measure that would reduce its incidence is clearly important.

The Workshop proposed that a concerted action programme or a combined research project should be undertaken to study the causes of the phenomenon and the best ways of preventing it. The research project was drawn up and presented to the Commission by the Medico-Social Research Board.

It was proposed that within each country field investigation centres should be set up to study the phenomenon of attempted
suicide, its incidence, the characteristics of those who attempt suicide and the likely precipitating social and cultural factors. Persons presenting at medico-social facilities following suicide attempts would be the basis of study in the project. Sub-samples among them would be studied in much greater depth and a follow-up study, over three years, of their subsequent history in terms of completed and further suicide attempts would be carried out. In this way it is hoped to investigate the significance of various predictive factors in the field of attempted suicide. These would attempt to identify, among persons who attempt suicide, those particularly at risk for suicide itself or for further suicide attempts. At the same time the project will examine critically the usefulness and efficacy of various methods of treatment and after-care.

Following further meetings of experts at Brussels this research project has now been ratified by the Specialised Committee of Epidemiology and by the Committee of Medical Research of the EEC and it is awaiting ratification by the Council of Ministers.
PROJECT ON PUBLIC HEALTH ASPECTS OF ALCOHOL-RELATED PROBLEMS IN THE EUROPEAN COMMUNITY

The increasing consumption of alcohol and the rapid growth of alcohol-related problems in Ireland and in the countries of the European Community have prompted the Medico-Social Research Board to indicate to the Commission that the growing toll of alcohol-related health and social problems justified a major investigation. In Ireland alcohol consumption has doubled in ten years and all admissions to psychiatric hospitals for alcoholism increased by 240% between 1966 and 1975.

The Medico-Social Research Board, together with the Department of Medical Sociology, University of Aberdeen, were requested by the Commission to carry out a preliminary investigation of trends in alcohol consumption and in alcohol-related problems in the countries of the Commission of European Communities and in other countries which had experience in this field and which were thought to have information of value to the investigation.

In the course of this study 16 countries including all the countries of the Commission of European Communities were visited by Dr. Dermot Walsh and by Mr. Phil Davies of the Department of Medical Sociology, University of Aberdeen, and a report submitted to the Commission.

The main conclusions of the investigation were as follows:

1. There is a consensus view that there is a relationship between national per capita consumption of alcohol and the extent of alcohol-associated medical and social problems.

2. There has been a considerable increase in alcohol consumption in most European countries between 1950-1976.

3. Since 1970 there has been either a decrease or a levelling off of increases in alcohol consumption in some European countries. In the majority, however, consumption increases are continuing.
4. The extent of the increase in alcohol consumption in European countries shows great variation.

5. Most countries report a broadening of the demographic base of alcohol consumption with an increase in the numbers of young people and women drinking.

6. The factors influencing changes in alcohol consumption in different countries are poorly understood and need further research.

7. Concomitant with the increase in alcohol consumption there has been an increase in each country in associated medical and social problems such as deaths from cirrhosis of the liver, admissions to psychiatric hospitals for alcoholism, etc.

8. The degree of application of preventive programmes and the extent of their development varies considerably between countries.

9. The effectiveness of preventive programmes currently utilised is poorly understood and needs to be researched.

Recommendation

Because of the general growth in alcohol consumption and of the extent of an increase in alcohol-related problems, in the countries of the Commission of European Communities, the many data deficiencies existing, the unstandardised nature of data collection and presentation in the field of alcohol-related problems and the lack of knowledge about the appropriateness and effectiveness of preventive and control policies in relation to alcohol problems in Europe, it is recommended that a Workshop be held as a preliminary step to establishing a Programme for a European project entitled "Strategies and Programmes for the Prevention of Alcohol-Related Problems and Disabilities in the Countries of the Commission of European Communities". The workshop would bring together approximately 15 to 20 persons from the Commission of European Communities and, if necessary, outside of it, selected on the basis of their knowledge and contributions to the field of alcohol-related problems and of their influential status within their own countries. The workshop would also consider inviting experts from international bodies prominent in the field, such as the World Health Organisation.
THE MEDICO-SOCIAL CONSEQUENCES OF MAJOR PSYCHIATRIC DISORDERS

In September, 1976, the Medico-Social Research Board, at the request of the Commission of European Communities held a workshop on “Medico-Social Consequences of Psychiatric Disorders of Major Public Health Importance” in Dublin. The Workshop was attended by experts from the field of psychiatry in Europe and in the United States and a research proposal for joint collaborative research was recommended by the Workshop. This proposal was submitted by the representatives of the Mental Health Division of the World Health Organisation in Geneva who attended the meeting. They later submitted the proposal to the Commission and it is presently awaiting sanction. It is anticipated that Ireland will be one of the participants in this study.
A three year study has been funded by the EEC European Atomic Energy Community (EURATOM) through the Medico-Social Research Board and is being carried out by the Department of Community Health and the Department of Physics, Trinity College, Dublin. A similar study is being carried out at the same time in Brittany by the École Nationale de la Santé Publique in Rennes where similar methods are being used.

The health effects of high doses of radiation are well known but much less is known about the effects of very low doses. The primary aim of this study is to determine if variations in the very low levels of naturally occurring background radiation are associated with variation in cancer rates. If such an association is found, this will contribute to evidence suggesting that there is a linear dose response relationship between radiation, even at very low levels, and the risk of cancer.

Other aims of the study are to map the country for background radiation. This will provide information which was not known before and develop techniques for breaking down cancer and other mortality statistics and other demographic data into very small geographic units (less than 10 km²). These small areas may then be aggregated into any desired pattern. For example, the small units might be aggregated to match areas of high or low rainfall, etc.

We are presently into the second year of the study. During the first year, the country was mapped for background radiation and a computer programme was developed which could "read" an address and assign it to the appropriate six inch map reference. We have found that Ireland has some of the lowest values for background radiation in Europe.

Based on the radiation map, areas where the highest and lowest levels of natural background radiation occur have been selected for further study. These are being mapped for radiation
in detail (approximately 10 radiation readings per 10 km²). Records of all cancer deaths occurring between 1971 and 1976 and records of all persons resident in these areas at the 1971 census are being analysed, in order to produce age-adjusted cancer mortality rates, for the “high” and “low” background radiation areas. Statistical tests will be applied to determine if the rates are different in these areas.
WHO STUDY ON ISCHAEMIC HEART DISEASE

RETURN TO WORK AFTER MYOCARDIAL INFARCTION

The return to work after myocardial infarction (M.I.) has been analysed for men only as very few women who suffered a heart attack at the time of the study were employed outside the home.

Of the 306 men who survived 28 days after the heart attack 52 were unemployed or retired before the onset of the attack. These men did not go to work within the year after the attack. Fifty-two or 20.5% of the remaining 254 men who were in employment before the onset of the attack did not return to work within the year. TABLE 1. The percentage of those who returned to work varied little in different age groups, being slightly lower in men under 50 years of age. Of the 202 men who returned to work, 149 or 73.8% did so within 100 days from onset of the attack.

<table>
<thead>
<tr>
<th>Age</th>
<th>Returned to work</th>
<th>Did not return to work</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>Under 40</td>
<td>12</td>
<td>75.0</td>
<td>4</td>
</tr>
<tr>
<td>40-44</td>
<td>7</td>
<td>70.0</td>
<td>3</td>
</tr>
<tr>
<td>45-49</td>
<td>34</td>
<td>72.3</td>
<td>13</td>
</tr>
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<td>50-54</td>
<td>47</td>
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<tr>
<td>55-59</td>
<td>55</td>
<td>83.3</td>
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</tr>
<tr>
<td>60-64</td>
<td>47</td>
<td>81.0</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>202</td>
<td>79.5</td>
<td>52</td>
</tr>
</tbody>
</table>

Death among men who did not go back to work within the year was 34.6% and for those who did, it was 4.9%.
FIVE YEARS' SURVIVAL AFTER MYOCARDIAL INFARCTION

A register of patients who suffered an ischaemic heart attack in a defined area of Dublin was undertaken during the period 1970–1972 inclusive in collaboration with WHO. Those who were included in the register and who survived 28 days after the heart attack were followed up for five years.

Originally there were 450 men and 167 women under 65 years of age on the register. Out of that number 306 men (68%) and 123 women (74%) survived 28 days after onset of the heart attack.

During the five-year follow-up period 14 men and 8 women were lost to follow up. Some of these are known to have emigrated.

Tables 1 and 2 show the five-year survival rate for men and women which was 60.1% and 56.9% respectively. The five-year death rate for both men and women is very similar, being 35.3% for men and 36.6% for women. The age-specific survival for five years after onset is shown in Table 3. Although the women had lower total survival during the five-year follow-up, this was mainly due to greater mortality.

### TABLE 1

<table>
<thead>
<tr>
<th></th>
<th>Alive</th>
<th>Dead</th>
<th>Lost to follow-up</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>At 28 days</td>
<td>306</td>
<td>100.0</td>
<td>0</td>
</tr>
<tr>
<td>At 1 year</td>
<td>263</td>
<td>85.9</td>
<td>43</td>
</tr>
<tr>
<td>At 2 years</td>
<td>240</td>
<td>78.4</td>
<td>58</td>
</tr>
<tr>
<td>At 3 years</td>
<td>218</td>
<td>71.2</td>
<td>78</td>
</tr>
<tr>
<td>At 4 years</td>
<td>196</td>
<td>64.1</td>
<td>98</td>
</tr>
<tr>
<td>At 5 years</td>
<td>184</td>
<td>60.1</td>
<td>108</td>
</tr>
</tbody>
</table>

42
in the 60-64 year age group which was at least twice that of any other age group. In men, the survival rate ranged from 50% to 80% and was more evenly distributed through the age groups.

The cause of death in 76.5% of cases was another heart attack. The next commonest cause of death was cancer which accounted for 7.2% of deaths, closely followed by cerebrovascular accidents responsible for 5.9% of deaths. The remaining 10.4% of deaths were due to a variety of diseases including diabetes, rheumatic heart disease, cor pulmonale and renal failure.

Reference:
THE DETERMINANTS OF OUTCOME OF SEVERE MENTAL DISORDERS

On the first of November 1978 field work began in Ireland on a WHO study "The Determinants of Outcome of Severe Mental Disorders". This study follows the WHO International Pilot Study of Schizophrenia which was a preliminary investigation to determine whether research methods could be designed and utilised in various cultures, in the field investigation of mental disorder, and to establish, through the use of these methods, whether major psychiatric illnesses of various types are identifiable in different cultures.

The present study on determinants of outcome is taking place already in eleven centres throughout the world, Nottingham (England), Prague (Czechoslovakia), Aarhus (Denmark), Moscow (USSR), Hawaii and Rochester (USA), Nagasaki (Japan), Ibadan (Nigeria), Agra and Chandigarh (India) and Cali (Columbia), with Ireland an associated centre.

The questions that the present outcome study will attempt to answer include the following:

1. Are there real differences in the extent, nature and mode of occurrence of schizophrenic illnesses in different parts of the world?

2. Is it possible to assess in a standardised and cross-culturally comparable way selected elements of the social environment, social functioning and other characteristics of the schizophrenic patient as possible determinants of course and outcome?

3. Is it possible to identify social, clinical and biological variables which predict and might be causally related to course and outcome?

The first objective is called the "Core" study in which all centres including Ireland are participating. Several "sub-
studies" with both a medical and sociological content have been designed to investigate objectives (2) and (3).

Studies already carried out by this Board indicate that the outcome of schizophrenia in Ireland may be less favourable than elsewhere. If this is so, then impairments and disabilities would develop more rapidly and more extensively in Irish schizophrenic patients than in those of other centres.

Because of this possibility Ireland is participating in what is known as the "Disability" sub-study which will investigate the prognosis of disabling impairments of schizophrenic patients over a number of years. The study area in Ireland, the same area where the Three-County Schizophrenia Study is being undertaken, has a population of a quarter of a million. It is anticipated that the study will be of three years' duration. The field work is being carried out by a psychiatrist, Dr. Kieran Power, and a social research worker, Miss Bernie McHugh.

In 1973 the Mental Health Unit of the European Office of the World Health Organisation inaugurated a project to investigate Mental Health Services in Pilot Study Areas. The broad general purpose of this study is to encourage psychiatrists, other mental health professionals and public health administrators to look critically at the functioning of their own psychiatric services. Twenty two of the European member states are already participating. The study will examine the hypothesis that new and innovative patterns of psychiatric care are more effective and efficient than the older traditional approaches and to examine the economic aspects of both types of services. Direct and indirect costs of different types of patient care will be examined and, in particular, the different pathways which patients take within the complex network of mental health care and related services. It is at the local level that the majority of direct costs are generated and it is here that least is known about the cost effectiveness of the health care currently in operation. The cost of health care is continuing to increase at a rate which does not appear commensurate with the health benefits obtained.

Dr. Dermot Walsh was invited to attend the sixth meeting of the working group on Mental Health Services in Pilot Study Areas in Madrid in October, 1978, to examine the feasibility and implications of Ireland's participation in this study and he recommended to the Department of Health that Ireland's participation would both be feasible and desirable.
Our collaboration with both the Mental Health Division of the World Health Organisation's Headquarters in Geneva and of the European Regional Office in Copenhagen continues. In August, 1978, Dr. Walsh acted as rapporteur to a WHO European Office Conference on "The Public Health Aspects of Alcohol and Drug Dependence" in Dubrovnik, Yugoslavia. The report which he has written will shortly be published by the Regional Office of WHO.
Dr. Peadar Kirke is especially concerned with a programme of research in child health. Papers will be published in the near future on perinatal mortality and infant mortality in Ireland and also on accidents to Irish children. In the first paper perinatal and infant mortality rates, will be examined in the light of trends in Europe. Some of the reasons for the differences that exist will be discussed. Trends in perinatal and infant mortality for the eight Irish health board areas (since 1966 in the case of perinatal mortality and since 1940 for infant mortality) form the basis of the second paper. These trends will be considered in the light of the limited information which is available on the factors associated with perinatal and infant mortality in Ireland. The basic epidemiology of childhood accidents in Ireland will be described in a third paper. Accidents are the commonest form of death in the 1-14 age group in Ireland as in most developed countries.

An important development in research in child health in Ireland is the possibility of conducting an Irish perinatal mortality survey at the same time as the proposed British perinatal mortality study which is scheduled for 1982. Routinely collected statistics on births and perinatal deaths in Ireland provide limited information. This should be improved when the Department of Health’s birth notification system achieves full coverage but there will still remain large gaps in our knowledge, for instance, the relationship between various social, biological and environmental factors and perinatal mortality and morbidity. The association between mortality and morbidity and the obstetric and neonatal medical services also requires further study. Such information is essential to help understand the factors that influence perinatal mortality and morbidity in the Irish situation. This further information can be best obtained by means of a specific research project. Cognisant of this, the Board has been following developments of the proposed British study with great interest.
The National Perinatal Epidemiology Unit (Britain), which is located in Oxford, was established by the Department of Health and Social Security (DHSS), the Royal College of Obstetricians and Gynaecologists and the British Paediatric Association and is funded by the DHSS. One of the main reasons for setting up this Unit was to assess the need for and the feasibility of a further national perinatal mortality survey in Britain. While the specific objectives of the British survey have not been clarified at this early stage, there are three broad areas which the study would seek to examine:

1. The social and biological factors in the mother and father which put the foetus at risk, e.g., maternal age and parity, occupation, illegitimacy, smoking, chronic disease, infections during pregnancy, time of first visit to general practitioner to report pregnancy and first visit to antenatal clinic;

2. Environmental factors which put the foetus at risk, e.g., housing, area of residence, distance from general practitioner and hospital;

3. An assessment of the relationship between the various components of obstetric and neonatal care and the state of health of the newborn baby.

Discussions have been held between the Medico-Social Research Board and the British National Perinatal Epidemiology Unit on the possibility of conducting an Irish perinatal mortality survey at the same time as the proposed British survey in 1982. The National Perinatal Epidemiology Unit would welcome this and would be prepared to give considerable assistance. The main advantages in conducting an Irish survey at the same time as the British study are the opportunity to collect essential information for Ireland for the first time and the access which would be available to the considerable expertise and experience of the staff of the National Perinatal Epidemiology Unit in this type of research. There would also be access to their data processing facilities (specially developed for the purposes of the British survey) and comparable data would be available.
For the Irish study it is envisaged that the questionnaire used in the British study be employed and adapted, where necessary, for the local situation. A form would be completed for every birth occurring in the country during a specified period. In the Irish context, this would possibly mean 5,000/20,000 births (one to four months' duration of data collection); the actual number of births to be included depends on the particular questions being asked. Follow-up examinations will be carried out on the British children at about age two, by which time gross morbidity related to events of pregnancy, delivery and neonatal period should have become apparent. A similar follow-up study could be conducted for the Irish births and would be highly desirable given our very limited epidemiological information on the health of Irish children. The availability of a national cohort of births opens up numerous opportunities for epidemiological research.

In summary, there is now the possibility of conducting a comprehensive and well-designed epidemiological study of perinatal mortality and morbidity in Ireland. Because of the considerable support and assistance that is available from Britain this could be carried out for a significantly smaller financial outlay than if the Board mounted such an exercise on its own.

Many Irish obstetricians, paediatricians and pathologists already know about the proposed British survey and are anxious to see full advantage being taken of the opportunity of conducting a similar study in Ireland at the same time.

Under the auspices of the Board, a small committee (Dr. Seamus Cahalane, Dr. Gerald Cussen, Professor Kieran O'Driscoll and Dr. Peadar Kirke) is following developments in the proposed British survey and is examining the possibility of carrying out a similar study in Ireland. The committee will report on its deliberations to the Board as soon as it has had an opportunity to study the National Perinatal Epidemiology Unit's research proposal.
A STUDY OF PROVISIONS MADE IN IRISH HOSPITALS FOR THE SPECIAL NEEDS OF CHILDREN

A study of the provisions made in Irish hospitals for the special needs of children was carried out by Mrs. Aileen O Hare, sociologist, with Miss Anne Cleary, a social science student doing the field work, on behalf of the Association for the Welfare of Children in Hospital (Ireland). All except one of the 112 hospitals admitting children collaborated in the main section of the study. In the subsidiary section which concerned the matrons in Dublin city and county hospitals, the response rate was 93%, with 27 of the 29 hospitals involved co-operating.

The principal findings were as follows:

(1) the lack of uniformity in the hospitals' age definition of "child", 36 of the 111 hospitals opting for an under 16 year-old definition, with the majority of hospitals having other and differing definitions,

(2) there were 82,919 admissions of children—defined in the study as aged under 16 years—to Irish hospitals in 1976, the majority being in the under five age-group,

(3) despite the fact that there were 2,799 designated children's beds and cots in Irish hospitals and 2,000 children in hospital on the study census night, 12.8% of them were accommodated in adult beds,

(4) 61% of hospitals had "unrestricted" visiting and 42% provided some type of overnight accommodation to parents—a room, bedside chair or folding bed,

(5) 16% of hospitals employed one or more teachers and 38% had some play area available, commonly in the wards, with 8% employing a play leader,
(6) 45% of hospitals with a nurse-training school included a child psychology course on their programme, but the amount of time specifically concerned with child psychology would be “minimal at best”, according to a Bord Altranais spokesman.

(7) The majority of Dublin city and county matrons were in favour of “unrestricted” visiting and found the presence of parents on the wards had not posed problems.

After reviewing current knowledge on children’s needs in the context of hospitalisation and separation from home in conjunction with the study findings, the report concluded that:

Children for health purposes should be defined as aged under 15, in line with the ICD recommendation and for comparability with Irish census data available by age under 15. This would enable hospital information to be rated, so providing inter-and intra-national comparisons of variables such as sex, diagnosis and length of stay.

Children, when hospitalised, require a paediatric environment, that is, separate accommodation from adults, where facilities appropriate to their age-group are provided.

Unrestricted visiting and overnight accommodation for parents are desirable facilities for all children, but essential for those aged under five and for children who may be vulnerable to hospitalisation. To ensure that unrestricted visiting is available and not disruptive of hospital organisation it is considered advisable that nurses would be trained to accept parents on the wards and be orientated towards the “parent and child unit. Nurses would also train the parents in their new role of parent on the ward.

Play for children of all ages appeared to be a neglected facility in Irish hospitals. This runs contrary to the current importance placed on play for the child in hospital, as promoting normal development and in helping to meet the particular stresses and problems arising from hospital admission. As children do not automatically play on their own, the employment of trained play leaders is necessary.
Children of school-going age need education facilities in hospital, as even a short break from school can be harmful and short-stay patients could benefit from schooling which would also make their hospital stay more interesting.
EVALUATION OF CARE IN THE COMMUNITY FOR THE ADULT MENTALLY RETARDED

Dr. Geoffrey Carroll, as part of the requirement for the M.Sc. Social Medicine course at the Department of Community Health, London School of Hygiene and Tropical Medicine, has been carrying out a research project to evaluate the care provided in small residential units designated as group homes or hostels for the adult mentally retarded in Ireland.

These units are physically separate from the traditional large institutional facilities for the mentally retarded. Their establishment represents a further stage in the development of services for the mentally retarded by the independent organisations, some religious, some lay, which provide a variety of services—institutional, work-training centres, schools and functional assessment of both children and adults.

Two considerations have influenced the nature and design of the study:

1. The evaluation of care: The measurement and description of the means used to achieve defined goals in our health services is of fundamental importance to health service planning. The Hospital In-Patient Enquiry Scheme, for example, has been analysed to derive indicators of resource use and performance but, as yet, has not been used to any great extent to supplement information for management on efficiency, effectiveness and quality of care. Ireland is currently participating in the European Hospital Collaborative Study on Cost Containment and Quality of Care with seven other countries.

2. The development of community care in Ireland: Are services for the mentally retarded based on clear policy and careful planning?

This project is, therefore, a feasibility study with the following aims:
(i) to develop methods to describe and evaluate the care provided,

(ii) to establish the factors which are associated with differences in the quality of care in this type of service,

(iii) to provide a series of options for planners on the basis of the evaluation of care and the factors affecting care.

A questionnaire was designed and the medical and administrative directors of eight organisations providing community homes for the adult mentally retarded was interviewed. At least one member of the direct-care staff in each of the 17 homes maintained by these organisations was interviewed using the same questionnaire. This allows the examination of differences within and between the organisations.

Staff perception of goals

This perception was examined in the interview by completion of a questionnaire. Goals fall into three groups:

(i) Organisation: For example, the staff believe the unit should provide activities such as occur in a normal family or provide individual care programmes.

(ii) Method: The staff believe the unit should develop social functioning skills, training in the use of leisure or to provide rehabilitation for vocational placement.

(iii) Expressive: Where the staff try to foster socially acceptable behaviour, personal adjustment to the group or to the community and the development of independent functioning skills.

Autonomy and decision-making

The questionnaire is designed to clarify the relationship between senior organisers and direct-care staff. For instance:

(i) Staff perception of decision-making (authority, responsibility, organisation).

(ii) Selection and assessment of residents and of staff.
(iii) Administration.

(iv) Planning programmes for residents.

(v) Contact and relationship between direct-care staff and agency professionals, for example psychologists, social workers and medical staff.

(vi) The perception of the services provided by staff members at different levels.

**Quality of care**

Six scales have been used in order to measure differences in the quality of care in each of the 17 homes. These scales examine:

(i) the degree of emphasis on individual care,

(ii) the staff’s participation in decision-making,

(iii) the quality of the physical environment, for instance, facilities, crowding,

(iv) the assumption of household responsibilities,

(v) the independence of residents,

(vi) community contact by the residents, for instance, shopping and recreation.

**Characteristics of the residents**

These are related to admission criteria and influence the care provided. Information on the demographic, intellectual, medical, behavioural and occupational characteristics of the residents was obtained partly by questionnaire and partly by direct participant observation.

When goal perception is translated into action by each organisation this has direct effects on decision-making which, in turn, influences the quality of care.
STUDY ON BLIND AND VISUALLY HANDICAPPED PERSONS

In May, 1978, the Medico-Social Research Board commenced a study of blind and visually handicapped persons at the request of the National Rehabilitation Board. The study was undertaken by Miss Jodie Walsh, a social research worker. The National Rehabilitation Board requested this study because of their concern about allegedly high numbers of unemployed blind persons who were both capable of and interested in working. Up to this time, little or no scientific information had been available, in the Irish context, about blind and visually handicapped persons and, in particular, in relation to employment or the lack of it among this group. It was considered that an essential first step was to find out how many visually handicapped persons were able and willing to work. The study, therefore, undertook to collect relevant information on the blind and visually handicapped between the ages of 15 and 54 in Dublin city and county, to find out their potential for training and employment and to see to what extent there are barriers to employment in terms of handicaps or illnesses other than blindness.

The National Council for the Blind co-operated with this study. They keep a register of persons who are certified as being “technically” blind. This register is considered to be the most comprehensive available. All persons on this register, living in Dublin city and county and aged between 15-54 years were included in the study. The age range 15-54 was chosen as it was considered that it was the most important age group as far as employment was concerned. The files compiled by the National Council’s social workers contain a great deal of factual data and form a reservoir of useful material which was used in the study. Documentary analyses were supplemented by the use of an interview schedule. More recent information was added where necessary and the data was coded. An inter-
view schedule was used to interview the social workers about each unemployed client on their case files.

**Main findings**

The study found that there is not a large number of blind and visually handicapped persons within the 15–54 years age group in Dublin city and county (320 persons or 73 per 100,000 population). Ninety-four or 29% persons were totally blind and 226 or 71% of the survey population were partially-sighted.

It was further found, Table 1, that a high proportion of the survey population were successfully employed and that there is not a large unemployment problem among visually handicapped in Dublin city and county.

<table>
<thead>
<tr>
<th>Employment or “known” blind and partially-sighted persons in Dublin city and county aged 15–54</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open paid employment/self-employed</td>
<td>127</td>
<td>39.7</td>
</tr>
<tr>
<td>Sheltered workshop (salary)*</td>
<td>35</td>
<td>10.9</td>
</tr>
<tr>
<td>Sheltered workshop (no salary)</td>
<td>9</td>
<td>2.8</td>
</tr>
<tr>
<td>In training/school</td>
<td>26</td>
<td>8.1</td>
</tr>
<tr>
<td>Housewife</td>
<td>37</td>
<td>11.7</td>
</tr>
<tr>
<td>Not employed</td>
<td>86</td>
<td>26.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>320</strong></td>
<td><strong>100.0</strong>*</td>
</tr>
</tbody>
</table>

*Sheltered production workshop employing blind and visually handicapped persons and paying a negotiated trade union wage.

In relation to the unemployed group, Table 2 shows that the social workers considered that only 16 unemployed persons were both capable of and interested in working. As a consequence of the study, the consent of these 16 persons was obtained and their names were put forward to the National Rehabilitation Board for vocational assessment and a number of these persons are now employed.

The main reason put forward for those not considered to be capable of working was that they had other handicaps or illnesses as well as blindness.
### TABLE 2

<table>
<thead>
<tr>
<th>The unemployed group</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capable of and interested</td>
<td>16</td>
<td>18.6</td>
</tr>
<tr>
<td>Capable of but not interested</td>
<td>15</td>
<td>17.4</td>
</tr>
<tr>
<td>Not capable of but interested</td>
<td>9</td>
<td>10.5</td>
</tr>
<tr>
<td>Neither capable of nor interested</td>
<td>43</td>
<td>50.0</td>
</tr>
<tr>
<td>Don't know</td>
<td>3</td>
<td>3.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>86</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

On completion of this study the National Rehabilitation Board requested the Medico-Social Research Board to undertake a similar study in the North-Western Health Board area. The purpose of this second study is to examine the situation outside of Dublin as it is likely that the age structure, living conditions and employment outlets will vary considerably from those found in Dublin city and county. This second study commenced in October 1978 and will be completed by the end of March, 1979.

**Reference**

THE PROBLEM OF SUDDEN INFANT DEATHS OR "COT DEATHS"

The Minister for Health requested the Medico-Social Research Board to consider what research should be undertaken on sudden infant deaths, or cot deaths, in Ireland. The Board appointed a sub-committee, under the chairmanship of the Director of the Board, to consider the problem and prepare a report. Members of the sub-committee are Professor James McCormick, Professor Geoffrey Bourke, Professor Conor Ward, Dr. Seamus Cahalane, Dr. Brendan O'Donnell, Dr. Patrick Bofin, Dr. Bartley Sheehan and Mr. Shaun Trant.

Dr. John Emery of the Department of Community Medicine, Sheffield, took part in the discussions and visits were made to the Department of Community Medicine in Sheffield to study the research that is being undertaken in a population of seven million people in six centres. All births in the study areas are analysed for discriminants to identify the high risk group. Points are given for various risk factors and where the points add up to more than 500 (that is in 12% of births) the birth is classified as being in a high risk group. In Sheffield 70% of the cot deaths which take place in the first year of life occur in the 12% considered at high risk. The risk factors found in Sheffield are not, however, the same as those found in other centres taking part in the study, for instance in Birmingham, and the risk factors in Dublin may be different.

The general concept of a cot death is that it is a condition in which babies are found dead who were apparently previously healthy. From our studies of the literature it is clear that this is a convenient myth and that, in fact, cot deaths can be divided into three groups; one-third in which there is something very definitely wrong with the child which is responsible for the death and has been overlooked, one-third in which there is some disease process which could have contributed to the death and only one-third in which the deaths are unexplained after investigation using the present methods of
study. Nevertheless, post-neonatal deaths are nearly twice as great in England and in Ireland as in the Scandinavian countries, yet the rates for various congenital abnormalities are much the same. This is evidence that a high proportion of cot deaths are potentially preventable.

Much could be done by educating the midwives and general nurses about the special needs of the children at high risk and in improving the services for medical care, particularly for the poorer section of the community.

It is proposed that there should be a pilot study of infant deaths occurring after the first week of life or after the child leaves the maternity hospital through the first year of life. Only limited study should be applied to those deaths where there was an obvious cause, for instance congenital heart disease or spina bifida. The proposed pilot study will be undertaken in Dublin County Borough and Dublin City. It should be possible to determine what are the discriminants which best describe those babies who are at high risk of death in the first year of life.

For each sudden infant death there will be a case conference which would include the pathologist, the social workers, the district nurse, the paediatrician, the coroner, when possible, and if he wished to attend, the general practitioner.

Increased emphasis on health education, particularly among midwives and nurses, regarding the care of infants who are at high risk of death in the first year of life is of great importance. Such education could be based on what is already known about the high risk group; factors such as the age and parity of the mother, the length of time in labour and the attitude to breast-feeding.

Some of the most important risk factors are those caused by poverty. The education of mothers should begin at the prenatal stage, be continued while they are in maternity hospitals and extend to the post-natal period. It should be part of good health education in general and not specifically education in the prevention of sudden infant deaths. It is important to take the emotional emphasis out of the particular designation of “cot deaths”.

Voluntary groups, such as the Irish Sudden Infant Death Association (ISIDA), should be included in programmes dealing with the possible causes of “sudden infant deaths”.

The Epidemiological Advisory Committee of the EEC
considers that sudden infant deaths are a major problem and has recommended that there should be a collaborative EEC programme of study of the problem in the countries of the Community. This proposal has been approved by the Committee for Medical Research (CRM) of the European Community.

An effort to reduce the infant mortality, while depending in the first place on the education of mothers and good social services, will require the close collaboration of many groups involved in health, for instance not only the general practitioners and health visitors but also the obstetricians, the paediatricians, the social workers and groups specially interested in the problem, such as the ISIDA.
CONCLUSIONS

The work of the Medico-Social Research Board described in this report naturally evolves with the changes in the social pattern in Ireland. In the past, our major health problems were associated with poverty, for instance serious malnutrition and infectious diseases, particularly tuberculosis and gastro-enteritis in children. To-day, the major problems are associated with the sudden acquisition of wealth and the increasingly materialistic approach to life that has accompanied it, for example the greatly increased consumption of alcohol, cigarette smoking, lack of exercise and over-eating, particularly of animal fats, sugar and over-refined low fibre foods.

Until recently most advances in medicine have resulted from studying disease in a particular individual. However, this type of research has not enabled us to understand the causes of most of the diseases of modern society and during the last 30 years most major advances in medicine have come from studying the incidence and prevalence of diseases in a known population and also from studies of the changes in incidence and prevalence that occur in a defined population living in a certain environment compared with those living in other environments. It is for these reasons that the Board, for example, studies not only the prevalence of diseases among various groups in Ireland but also among the Irish who emigrated to England and compares the pattern of disease in Ireland with that in the United Kingdom and in other countries of the European Economic Community. A good example of this is a study on the admission to psychiatric hospitals of Irish immigrants resident in the four Thames regional health authority areas of London and south-east England which we are at present undertaking.

What are our major medico-social problems? In the first place, they are the problems that have previously been discussed in our annual reports—cigarette smoking remains the greatest cause of morbidity and mortality but active measures to deal with that problem have been taken during the year.
Fortunately, among men, particularly in the cities, cigarette smoking is becoming less common, especially among the upper socio-economic group, but in rural areas and in women, especially in young women, cigarette smoking is increasing. Drinking is another major problem. On average in Ireland, 13% of our spending is on alcohol; as many do not drink others must be spending a quarter, or more, of their income on drink. This results in much personal and family misery. Admissions to psychiatric hospitals for alcoholism have doubled in the past seven years and to-day alcoholism and alcoholic psychoses are the commonest reason for admission to our psychiatric hospitals. In addition, other patients in hospital as the result of abuse of alcohol may be coded on discharge with some other diagnosis. Our motor car accident rate remains high and is frequently the result of the abuse of alcohol, as is much absenteeism from work. It is very difficult to judge what is the true hidden costs of our excessive social dependence on drinking but it is undoubtedly great.

With our increasing prosperity and the increased industrialisation there is a need in Ireland for much greater attention to the dangers to health at work places. In this report we describe studies which are being undertaken on respiratory disease among farm workers but there are many problems relating to health among industrial workers which require constant monitoring. This is becoming increasingly important in Ireland with the development of new mines for zinc and lead—fortunately, up to now, blood lead levels in Ireland are low—and industrial processes which handle potentially dangerous substances such as asbestos and chemicals. There is perhaps need for study of medical inspection, legislation and the regulations on health in industry in Ireland.

The Board takes a special interest in the care of young people and we continue research into child health. In 1979 reports will be published on perinatal and infant mortality in Ireland and on accidents among Irish children. The Board has held numerous meetings to discuss the problem of deaths within the first year of life and, in particular, sudden infant deaths or “cot-deaths”. A pilot study to investigate these deaths will be undertaken in Dublin city and county in 1979. The care of children in hospital is another of the Board’s interests.

Studies in the United Kingdom have shown great differences in death rates by social class. Unfortunately, similar studies
have not yet been possible in the Republic of Ireland, except for the Board's work on psychiatric illness, although no doubt similar major differences also exist. A pilot study among men in Dublin city, undertaken in collaboration with the Central Statistics Office, has shown that the expectation of life among the professional class is better than among the skilled and unskilled workers and that, for instance, mortality from chronic bronchitis was twice as high among semi-skilled and unskilled workers as it was among the business and professional socio-economic group. Similar differences were also found for other conditions, for instance for stomach cancer. It is hoped that in 1979 it will be possible to develop other studies on mortality and morbidity related to social class differences. It is already known that in Ireland a lower percentage smoke cigarettes among the upper socio-economic groups I and II compared with the other groups and that more alcohol is consumed by skilled and semi-skilled workers compared with professional men and managers. Studies on social class inequalities would need to take into account smoking and drinking patterns, risks at work and other medico-social factors if they are to be understood.

During the year, at the request of the Agency for Personal Services Overseas (APSO), the Director, while on a visit to South Africa, visited the Kingdom of Lesotho to study in what ways Ireland could best contribute to the health needs of that country and he continues to collaborate with APSO, the Department of Foreign Affairs and the Agency for Overseas Development in our efforts to assist in the medical needs of Lesotho.

The Board has continued its close collaboration with the medical, dental and paramedical professions and has advised on a number of other research projects which have not been described in this report, for instance an EEC-supported survey of dental care in Ireland and another on osteoporosis, or the decalcification of bone.

The Medico-Social Research Board continues to collaborate with the Economic and Social Research Institute and the Health Education Bureau. Members of the staff attended many meetings and conferences and consider it is part of their work not only to undertake research but to make the results of the research widely known. They publicise the work of the Board and further health education by lectures, by radio and television
interviews and by close collaboration with sociologists and health administrators.

Perhaps the keynote of the year is one of optimism. There is increasing awareness that our health is largely under our personal control and that it is possible to prevent, to a great extent, our major causes of illness and death, such as heart attacks, stroke and lung cancer. Many medico-social problems to-day result from greed and a very materialistic approach to living. Death is, of course, a part of life but knowledge and understanding of our problems enables us to make informed decisions so that we can avoid, if we wish, unnecessary illness and premature death.
ACKNOWLEDGMENTS

We would like to thank Mr. Charles J. Haughey, T.D., Minister for Health and Social Welfare, for the great interest he has shown in our work and for meeting with the Chairman and Members of the Board and the Director to discuss the medico-social problems of Ireland and the work of the Board. We would also like to express our thanks to Dr. Brendan Hensey, Secretary of the Department of Health, and members of the Departmental staff.

We have continued our work in the closest collaboration with the Irish Medical Association and the Medical Union and we would also like to acknowledge the close liaison we have had with the World Health Organisation, the various committees of the European Economic Community, the Medical Research Council of Ireland, the Economic and Social Research Institute, the Irish Heart Foundation, the Irish Cancer Society, the Multiple Sclerosis Society, the Irish Blood Transfusion Service, and many other Boards, Societies and Institutes.

Lastly, we would like to express our gratitude for all the help we have received from our many friends, medical and non-medical, who have assisted us in our various research projects.