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# ACTIVITIES OF THE MEDICO-SOCIAL RESEARCH BOARD 1979

**1. Introduction**  
7

**2. Registration and certification of deaths in the West of Ireland**  
13

**3. Hospital In-Patient Enquiry Scheme**  
18

**4. Studies on Mental Health:**
- (a) National Psychiatric In-patient Reporting System  
21
- (b) Three-County Psychiatric Case Register  
24
- (c) Determinants of Outcome of Severe Mental Disorders  
25
- (d) Three-County Schizophrenia Study  
26
- (e) Mental Health Services in Pilot Study Areas  
27
- (f) Alcohol-related Problems  
28
- (g) Suicide and Attempted Suicide  
29
- (h) Termination of Pregnancy of Irish Residents in England and Wales  
30
- (i) Psychiatric Illness: Profiles of Aftercare  
31
- (j) Unmarried Parents and their Children  
32
- (k) Mental Illness and the Homeless  
33
- (l) Colloquium on Public Health Approaches in the Prevention of Alcohol-related Problems  
36

**5. Studies in Mental Handicap:**
- (a) Census of the Mentally Handicapped  
40
- (b) Survey of Adult Mentally Handicapped Persons living at Home in a Community Care Area  
41
- (c) Register of Females of Childbearing Age with Phenylketonuria  
44

**6. First Admissions to Psychiatric Hospitals among Irish immigrants resident in South-east England**  
46
7. Commission of the European Communities Studies:
   (a) Epidemiology of respiratory diseases in Agriculture
       (i) Mortality among agricultural workers 53
       (ii) Factors related to respiratory symptoms in Irish men 54
       (iii) The Irish Blood Transfusion Service Study 55
       (iv) Farmer's Lung, 1979/80 55
       (v) Respiratory symptoms in young farmers of the farming community 56
       (vi) Conclusion 57
   (b) The Concerted Action Project on Congenital Abnormalities and of Twins 58
   (c) The Public Health Aspects of Alcohol-related Problems 60
   (d) Natural Background Radiation and Cancer Mortality in Ireland 61

8. Sudden Infant Deaths 62

9. The Causes of Death of Blue-Collar Workers at a Dublin Brewery, 1954-73 64

10. Studies in Perinatal and Infant Mortality 67

11. Childhood Accidents in Ireland 69

12. A Study of Blind and Visually Handicapped Persons in the North Western Health Board area 71

13. Prisoners and Alcohol Research 73

14. Aid to Developing Countries: Primary Health Care and Rural Sanitation in the Kingdom of Lesotho 77

15. Conclusion 80

16. Acknowledgments 84

Expenditure

The total expenditure by the Medico-Social Research Board for the year ended 31st December, 1979 was £343,500 (1978—£285,000).
INTRODUCTION

There has been a great increase in prosperity and an improvement in living standards since Ireland joined the European Economic Community in 1972. This has been a mixed blessing as far as health is concerned. With increasing purchasing power the consumption of cigarettes and alcohol has risen sharply which has resulted in a further increase in mortality and morbidity from lung cancer and chronic bronchitis and in alcohol-related problems and in admissions to our psychiatric hospitals for alcoholism and alcoholic psychosis. The number of motor cars has more than doubled which means that we are walking and cycling much less and we are moving towards a highly urbanised society. These changes have been very pleasant for those who enjoyed a rising standard of living and prosperity has reduced emigration so that the population has increased. Nevertheless, there are still many in Ireland suffering from a considerable degree of poverty, for example the itinerants and those living in some inner areas of our cities and also some of the aged. The annual increase in prosperity is probably coming to an end and we are faced with higher prices and lower purchasing power. We will also have to pay much more for our energy sources, oil and coal.

Prosperity in Ireland has brought with it other problems, for example the hazards from the mining of lead and zinc and in factories dealing with potentially highly toxic agents, such as certain chemicals and asbestos, and now, quite possibly, the mining of uranium. As most diseases result from the way we lead our lives and from our occupations, it is of the greatest importance for the Medico-Social Research Board to study these changing factors in Irish life and to monitor the attendant risks to health.

The Medico-Social Research Board looked again in 1979 at the registration and certification of deaths in the West of Ireland. A study on the registration and certification of deaths during the years 1966-1969 which included 1,421 burials of men and women from a random sample of 21 parishes in the West of
Ireland, showed that in 74% the death had been neither registered nor certified and in a further 6.2% the deaths had been registered only. In the 1979 study, which is described in this report, certification of deaths had improved from 86.3% to 92.1%, an improvement of 5.8%. Accurate certification of death is essential not only for legal purposes but also in making possible studies on the causes of death. There is still room for considerable improvement in the certification of deaths, particularly in rural areas of Ireland.

After death, admission to hospital is the next most concrete information we have on health. During 1979 there has been a very considerable improvement in the degree of national coverage achieved by the Hospital In-patient Enquiry Scheme in spite of a long-drawn out postal strike. By the end of 1979, 84% of the discharges from hospitals were included, if small district and private hospitals are excepted. During 1980 we hope to feed back to the hospitals and consultants much interesting information about hospital admissions and many research projects are based on this information system while keeping confidential information about individual patients. One example is a study to find out why some patients discharge themselves from hospital against advice.

The activities of the Irish psychiatric hospitals and units during 1977 was published in 1979. This report showed that admissions to our psychiatric hospitals and units declined for the first time since 1946 with the one exception of admissions for alcoholism and alcoholic psychosis which show a substantial increase. Alcoholism is now the commonest cause of first admissions to our psychiatric hospitals, particularly among the unskilled manual socio-economic group. The Three-County Psychiatric Case Register showed that, by comparison with the United Kingdom, psychiatric patients tend to make contact with the psychiatric services less frequently in the Republic of Ireland but remain in care for much longer periods of time once they do make contact. Other studies on psychiatric care carried out by the Board during the year included studies on schizophrenia, on the functioning of the mental health services, on alcohol-related problems, and on suicide and attempted suicide. Also studies on the termination of pregnancy of Irish residents in England and Wales, of unmarried parents and their children and on mental illness among the homeless were undertaken.

The Board is preparing for a census of the mentally handicapped in 1980 and in 1979 undertook a survey of adult
mentally handicapped persons living at home in a community care area and also studies on women of childbearing age who have inherited phenylketonuria.

During the year Dr. Geoffrey Carroll was the second member of the staff of the Board to be awarded the Master of Science degree in Social Medicine at the London School of Hygiene and Tropical Medicine. His thesis was on the care in Community Residences for Mentally Retarded Adults in Ireland. The study evaluated the quality of care provided by the Community Residences. There were measurable differences in the quality of care between each organisation. The more retarded residents received, on the whole, less resident-oriented care and the higher the intelligence quotient of the residents the greater the degree of independence they were permitted and the better was their physical environment.

We are concerned not only with the problems of the Irish in Ireland but also with those of Irish emigrants. During 1979 a study was continued on the first admissions to psychiatric hospitals in south-east England of Irish immigrants in England. The Irish immigrants from the Republic resident in south-east England had five times the admission rate for alcoholism and alcoholic psychosis as among those born in England and Wales although a lower admission rate than among those Irish who stayed in Ireland. Only two other immigrant groups in England had high admission rates for alcoholism and they were the immigrants from Northern Ireland and, to a lesser extent, those from Scotland. In contrast, immigrants from the new commonwealth countries, particularly from Asia, had a high admission rate for schizophrenia. The high admission rate of the Irish immigrants in England for alcoholism and alcoholic psychosis is strong evidence that the high admission rate for alcoholism in the Republic of Ireland does not represent simply a pattern of easy admissions for alcoholism to our psychiatric hospitals, but that there is a very real problem of psychiatric breakdown from alcoholism among the Irish.

The Director of the Board attended many meetings as representative for Ireland on the Specialised Working Group—Epidemiology of the European Economic Community (EEC) and the Board continues to take part in a number of EEC studies. These include studies on the epidemiology of respiratory disease in agricultural workers, including farmer’s lung, and the EEC concerted action programme on congenital abnormalities in Dublin city and county and—we hope, later—in a rural area
of the Republic of Ireland. The register, without the names, will be part of an EEC register. We are also taking part in EEC studies on the public health aspects of alcohol-related problems and the Board is responsible for an EEC study undertaken by the Department of Community Medicine, Trinity College, on natural background radiation and cancer mortality in Ireland. The Director is also studying the long-term effects of low dose radiation, for example for such conditions as the X-ray treatment of acne.

More than one-third of all infant deaths between the age of one week and one year are cot deaths, or sudden infant deaths. During the year a pilot study was undertaken by the Board in Dublin city and county at the request of the Minister for Health of all deaths of infants who had died between one week and one year. A special committee has been formed to study this problem. The most common cause of death during the pilot study was the sudden infant death syndrome, followed closely by death from congenital malformations. All infants dying suddenly in the area studied are subject to a detailed autopsy and full reports are obtained from the parents about the previous history. After each sudden infant death, clinical conferences are held whenever possible attended by the relevant doctors and public health nurses as well as the pathologist who carried out the autopsy. During the first year of the study, which will finish on 31st March, 1980, there will be between 45 and 50 sudden infant deaths in Dublin city and county. During the year the Specialised Working Group-Epidemiology of the EEC organised a symposium on the sudden infant death problem and proposed that there should be a concerted action programme, including the countries of the European Economic Community, to study this most important and distressing cause of death in babies.

During 1979 a report was published of a study on the causes of death of blue-collar workers at a Dublin brewery 1954-73. The Dublin brewery workers had a better than average expectation of life but did have an increased risk of death from cancer of the rectum and from diabetes. This study is being followed by a prospective study of the past history, leisure-time activities and alcohol and cigarette consumption of patients who have developed cancer of the rectum and colon and of suitably chosen controls.

We are continuing to study the trends in perinatal and infant mortality in Ireland in relation to other selected countries and the regional differences in Ireland for perinatal and infant mortality.
mortality. These studies should be ready for publication in 1980. Last year we reported on a proposal of the British National Perinatal Epidemiology Unit to conduct a National Perinatal Survey in Britain in 1982 as the Board was interested in carrying out a similar survey in Ireland at the same time as the British survey. Due to changing circumstances, the Department of Health and Social Security in England felt unable to proceed with the proposed survey, the implementation of which would have greatly simplified an Irish survey and reduced the cost. An ad hoc committee of the Board met during the year on a number of occasions to examine the desirability and feasibility of carrying out a similar study in Ireland. The committee decided that until it was possible to assess the effectiveness of our own Department of Health's birth notification scheme, and in view of the greatly increased cost, this study should be delayed although there is a strong argument in favour of a perinatal epidemiological survey, which might lead to the prevention of deaths and serious morbidity.

Other studies which are reported this year are on childhood accidents in Ireland, studies on blind and visually handicapped persons and on prisoners and alcohol.

The Director made two visits to the Kingdom of Lesotho on behalf of the Agency for Personal Services Overseas and of the Department of Foreign Affairs and advised the Department of Foreign Affairs on ways in which Ireland could assist Lesotho with primary health care and with rural sanitation. He also continues his special interest in multiple sclerosis and is a member of the Medical Advisory Committee of the International Federation of Multiple Sclerosis Societies. The studies to ascertain the genetic (HLA blood factors) and environmental factors responsible for the high prevalence of multiple sclerosis in Sicily in comparison with the low prevalence in the neighbouring islands of Malta continue.

The Medico-Social Research Board is not a grant-giving body but is a unique type of a research organisation. How research can best be organised is a subject of great interest in other countries besides Ireland and during the year the Director was invited to be guest speaker on this subject at the Annual Meeting of the British Society of Social Medicine which was held in September, 1979, in Bristol. The subject of the lecture was "Serendipity in Research". Serendipity in medicine has been described as an ability to recognise the highest common factor or HCF in a series of puzzling cases that may differ in many
other ways. In order to be able to recognise the HCF one has to beware of over-specialising, have a good grooming in general medicine and epidemiology and be prepared to travel—what has been called ‘notebook and shoe leather’ epidemiology.

The Board has two main functions. The first is to make available basic information on morbidity and mortality in Ireland, and among the Irish, on which medico-social research studies can be developed: secondly to undertake medico-social research on problems which are considered by the Board to be the major medico-social problems of the people of Ireland. This report outlines some of the ways we have been carrying out this commission in 1979.
THE REGISTRATION AND CERTIFICATION OF DEATHS IN THE WEST OF IRELAND.

A follow-up Study

In 1970 a study on the registration and certification of deaths during the years 1966-69 inclusive, was undertaken on a random sample of 21 parishes in the west of Ireland. There was a total of 1,421 burials of persons who had died within the State and the findings showed that 86.3% had been medically certified and registered, 6.2% had been registered but not certified and 7.5% had been neither registered nor certified. In order to ascertain whether any improvement had taken place in the number of unregistered and uncertified deaths during the ensuing eight years, it was decided to carry out a follow-up study on burials during the years 1974-77 inclusive.

A total of 25 parishes was included in the study. Of these, 12 parishes were selected from those which had taken part in the previous study and the remaining 13 parishes comprised a random sample from counties Donegal, Sligo, Mayo, Leitrim, Galway, Roscommon, Clare and Kerry. The purpose of including 12 parishes from the original study was to compare the two periods to see if any change had occurred. The clergy provided lists of names of those they had buried within their parish and a total of 2,114 burials was obtained but, of these, 87 persons had died outside the State and had been brought home for burial. These were omitted as registration and certification would have been made at the place of death. This left 2,027 burials of persons who had died within the State.

The task of tracing the death registrations was undertaken by the staff of the General Register Office, Dublin. This enabled us to find out the number of deaths that had been registered and the number of registered deaths that had been certified. It was assumed that deaths which had not been registered had not been certified.

Results

There were 1,867 deaths, or 92.1%, which were medically
certified and registered. Of these, 114 had been referred to the coroner for investigation and were certified following an inquest or post-mortem examination. There were a further 37 deaths, 1.8%, which were registered but not certified. Therefore, there were 1,904 deaths, or 93.9%, which were registered. The remainder, 123 deaths, or 6.1%, were neither certified nor registered. TABLE 1. Of these 123 deaths, 39 occurred in 1974 and 26, 33 and 25 in the following three years respectively. It is unlikely that many of them would be registered at a later date under the later registration procedures. It can be seen in TABLE 2 that the proportion of unregistered and uncertified deaths was highest in the older age groups, although 7 occurred in the under 20-age group of which 5 were infants and 2 died as a result of an accident. The majority of persons whose deaths were unregistered or uncertified in the older age groups had either lived alone or with an elderly relative. Eight of the 123 unregistered deaths occurred in either a hospital or nursing home.

When we compared the findings of the 12 parishes from the original study with the same parishes in our present study we found an improvement in both registration and certification. In 1966-1969 out of a total of 806 deaths 90.2% were registered and 85% were certified whereas in 1974-1977 out of a total of 885 deaths 95.2% were registered and 92.7% were certified, an improvement of 4.8% and 5.3% respectively. This leaves 4.8% of deaths unregistered and 7.3% uncertified among these 12 parishes.

**Conclusion**

The total number of deaths registered in the 25 parishes studied in the west of Ireland for the years 1974-1977 inclusive, was 93.9% compared with 92.5% found in our previous study 1966-1969 inclusive, an improvement of only 1.4%. This leaves 6.1% of the total number of deaths in our study unregistered. Certification of deaths improved by 5.8%, from 86.3% in 1966-1969 to 92.1%, leaving the number of uncertified deaths at 7.9%.

Accurate certification and registration of deaths is essential not only for legal purposes but also in making possible studies on the causes of death. It should be incumbent on the undertaker to make sure the death has been at least registered and preferably certified and registered before the body is buried. That the accuracy of death certification in Ireland has improved
is shown by the reduction in the number of deaths ascribed to "senility". However, considerable improvement is still required in the manner in which the occupation of the deceased is described. Where a male death occurs over the age of 65 occupation is often given as "pensioner" rather than the occupation prior to retirement. Female occupation is often given as "housewife" without reference to the husband's occupation.

More knowledge of mortality by social class and occupation would shed great light on the social and environmental factors responsible for ill health and premature death and would be particularly valuable in male deaths under the age of 65. No study of mortality by social class has yet been undertaken in Ireland except for a small unpublished study on men under the age of 65 living in Dublin city and county. Until now, it has not been possible to carry out such studies because of the inadequacy of the information on death certificates about the occupation of the deceased. If information about occupation is more fully recorded this would add greatly to the value of the death certificate.

The certification and registration of deaths in the west of Ireland remains unsatisfactory and therefore a matter for concern until procedures are adopted to ensure that all deaths are both registered and medically certified before burial.

Reference

<table>
<thead>
<tr>
<th>Total burials</th>
<th>Burials excluding those who died outside the State</th>
<th>Number certified and registered</th>
<th>Number registered only</th>
<th>Number registered and certified or registered only</th>
<th>Neither registered nor certified</th>
</tr>
</thead>
<tbody>
<tr>
<td>1966-1969 inclusive 1,458</td>
<td>1,421 100%</td>
<td>1,226 86.3%</td>
<td>88 6.2%</td>
<td>1,314 92.5%</td>
<td>107 7.5%</td>
</tr>
<tr>
<td>1974-1977 inclusive 2,114</td>
<td>2,027 100%</td>
<td>1,867 92.1%</td>
<td>37 1.8%</td>
<td>1,904 93.9%</td>
<td>123 6.1%</td>
</tr>
</tbody>
</table>
### TABLE 2
Comparison by age and sex of deaths registered but not certified with those that were certified in the 25 parishes combined.

<table>
<thead>
<tr>
<th></th>
<th>Under 20</th>
<th></th>
<th>20–39</th>
<th></th>
<th>40–59</th>
<th></th>
<th>60–79</th>
<th></th>
<th>80+</th>
<th></th>
<th>All Ages</th>
<th></th>
<th>Age Unknown</th>
<th></th>
<th>Total</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Sex Unknown</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>Registered but not medically certified.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>-</td>
<td>10</td>
<td>17</td>
<td>-</td>
<td>-</td>
<td>37</td>
<td>100%</td>
<td>-</td>
</tr>
<tr>
<td>Certified</td>
<td>16</td>
<td>10</td>
<td>1</td>
<td>29</td>
<td>13</td>
<td>123</td>
<td>69</td>
<td>632</td>
<td>379</td>
<td>-</td>
<td>-</td>
<td>1,106</td>
<td>760</td>
<td>-</td>
<td>1,867</td>
<td>100%</td>
</tr>
<tr>
<td>Neither registered nor certified</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>32</td>
<td>11</td>
<td>19</td>
<td>17</td>
<td>-</td>
<td>64</td>
<td>33</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>61%</td>
<td>-</td>
<td>1 %</td>
<td>-</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>32</td>
<td>11</td>
<td>19</td>
<td>17</td>
<td>-</td>
<td>64</td>
<td>33</td>
<td>-</td>
</tr>
</tbody>
</table>

% of male out of total all ages: 5.4% 18.9% 27.0% 46.0%
MORBIDITY: THE HOSPITAL IN-PATIENT ENQUIRY SCHEME

In our annual report for 1977 we emphasised that to place the Hospital In-Patient Enquiry Scheme on a sound basis and in particular to ensure continuity of reporting it was imperative that trained clerical staff should be made available by the Board to each hospital. Over the past two and a half years this policy has been supported by the Department of Health through the job creation programme and additional clerical staff have been placed in hospitals, mainly in those which had not been participating in the Scheme previously. The result has been a very considerable improvement in the degree of national coverage achieved. The number of hospital discharges reported has risen from 224,000 in 1977 to 295,000 in 1978 and to an estimated 330,000 discharges in 1979. The improvement in 1979 was not as great as anticipated mainly because no additional clerical staff were approved until December 1979 but these additional appointments will have their effect in 1980 when it is hoped to raise the level of reporting to 339,600 discharges. In addition we anticipate 13,400 reports from district and private hospitals giving an overall total of 353,000.

The two following tables analyse the situation by Health Board Area and by category of hospital.

**TABLE 1**

<table>
<thead>
<tr>
<th>Health Board</th>
<th>*Estimated Discharges 1980</th>
<th>Number of Summaries Expected</th>
<th>% Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Western</td>
<td>18,050</td>
<td>17,350</td>
<td>96</td>
</tr>
<tr>
<td>North Eastern</td>
<td>27,600</td>
<td>24,800</td>
<td>90</td>
</tr>
<tr>
<td>Western</td>
<td>39,200</td>
<td>34,700</td>
<td>89</td>
</tr>
<tr>
<td>Eastern</td>
<td>175,050</td>
<td>154,700</td>
<td>88</td>
</tr>
<tr>
<td>Mid Western</td>
<td>39,350</td>
<td>33,800</td>
<td>86</td>
</tr>
<tr>
<td>Southern</td>
<td>62,800</td>
<td>44,200</td>
<td>70</td>
</tr>
<tr>
<td>Midland</td>
<td>11,100</td>
<td>7,550</td>
<td>68</td>
</tr>
<tr>
<td>South Eastern</td>
<td>33,650</td>
<td>22,500</td>
<td>67</td>
</tr>
<tr>
<td>Totals</td>
<td>406,800</td>
<td>339,600</td>
<td>84</td>
</tr>
</tbody>
</table>
TABLE 2
Estimated coverage of H.I.P.E. Scheme by category of hospital

<table>
<thead>
<tr>
<th>Hospital Type</th>
<th>*Estimated Discharges 1980</th>
<th>Number of Summaries Expected</th>
<th>% Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional</td>
<td>78,350</td>
<td>66,580</td>
<td>85</td>
</tr>
<tr>
<td>Voluntary</td>
<td>205,800</td>
<td>175,600</td>
<td>85</td>
</tr>
<tr>
<td>County</td>
<td>105,800</td>
<td>82,740</td>
<td>78</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>10,200</td>
<td>9,190</td>
<td>90</td>
</tr>
<tr>
<td>Fever</td>
<td>6,650</td>
<td>5,490</td>
<td>83</td>
</tr>
<tr>
<td>Total</td>
<td>406,800</td>
<td>339,600</td>
<td>84</td>
</tr>
</tbody>
</table>

*Estimated discharges are based on preliminary figures for 1978 provided by the Department of Health. District and private hospitals are excluded.

At the beginning of 1980 we are entering a period of economic retrenchment and it is unlikely that there will be any significant increase in the number of clerical staff available for the operation of the H.I.P.E. Scheme in the immediate future. On previous occasions when similar economic difficulties presented, the Scheme suffered from the practice in some hospitals of detaching staff from H.I.P.E. work to cover shortages of clerical staff in other areas of the administration. The H.I.P.E. Scheme has reached its present degree of national coverage through a long and sustained promotional effort and it is now at a level where its potential can begin to be exploited more intensively. It would be regrettable if the level of participation in the Scheme diminished again at this stage and we therefore appeal especially to the hospital administrators who are providing clerical staff for the Scheme from their own resources to continue their support whole-heartedly in the coming year.

During 1979 diagnostic and surgical indices and other routine statistics were issued to the participating hospitals, all individual consultants were provided with indices of their own cases and in addition the H.I.P.E. data were used to provide special analyses on request for the following users:

- Hospitals 19
- Individual Doctors 44
- Department of Health 3
- Health Boards 6
- Universities 10
- Miscellaneous 10

92
This represented an important increase on the 1978 total of 57 special analyses and it is heartening evidence of the increasing value of the H.I.P.E. Scheme to doctors and administrators.

The World Health Organisation's International Classification of Diseases is used for coding diagnoses in the H.I.P.E. Scheme and we shall be changing over to the Ninth Revision of this classification with effect from 1st January 1981. The preparatory work for the changeover will be undertaken during 1980 and it will involve retraining of all coding staff and extensive adjustment of our computer programmes. We are receiving very considerable assistance in this matter from the Medical Computing Department, Western Infirmary, Glasgow and also from the Common Services Agency of the Scottish Health Service. We are most grateful to them for their help and co-operation.
NATIONAL PSYCHIATRIC IN-PATIENT REPORTING SYSTEM

The “Activities of Irish Psychiatric Hospitals and Units 1977” was published in 1979. These annual reports supply tabulations on the main medical and socio-demographic features of admissions to, discharges from and deaths in Irish psychiatric hospitals. The information is arranged for the country as a whole by Health Board areas and by individual hospitals. In addition, much more detailed data are sent to individual hospitals concerning their own activity.

Perhaps the most striking single feature of the 1977 report was that admissions to our psychiatric hospitals and units declined for the first time since 1946. This feature is illustrated in the accompanying Figure which shows how static was the situation concerning admissions for the 90 years from 1856-1946 with not much more than a 50% increase in admissions during that near-century compared with an over ten-fold increase from 1946-1976 and then a small decline to 1977. We have commented before on the very marked change of role that the psychiatric hospital plays in the overall scheme of psychiatric services. Whereas formerly the psychiatric hospital population did not show much movement, the numbers of admissions being small and discharges equally so, nowadays they are much more lively centres of activity, being used only in the severe stages of illness and being complemented by a network of psychiatric community services.

The one exception to the general slowing down of admissions in 1977 has been in those coming to hospital for the treatment of alcoholism and alcoholic psychosis. Compared with 1976 admissions for this diagnosis showed a substantial increase, all admissions going up by 11% and first admissions by 14%. Alcoholism is now the commonest cause of first admission to Irish psychiatric hospitals. The unskilled manual socio-economic group has the highest admission rate for alcoholism and alcoholic psychosis. This may exemplify the remarkable improvement in economic circumstances of the lower paid
socio-economic groups which has occurred in this country during the last ten years together with an apparent great willingness on the part of all sections of the population to devote increasing proportions of expenditure to alcohol. In fact, 13% of all expenditure in this country is devoted to alcohol—higher than in any other western European country.

It is now eight years since our last census of patients in Irish psychiatric hospitals was carried out and because of the considerable population change that has taken place, particularly in the Dublin area, the rates computed at that time are now out of date. This has been a problem too with our “activities” (i.e. admission and discharge) data which all have had to be based on the 1971 Census of Population. We, therefore, intend carrying out another census in 1981 to coincide with the census of population which will be taken at that time. Detailed preparations for this work will shortly commence.
IRELAND 1856, 1946 - 77. ALL ADMISSIONS: NUMBERS.

1. Year ending 31st. March 1856 for district asylums and 31st. December 1856 for private asylums.

2. Estimated figure for 1963 - data available for nine months only.
THREE COUNTY PSYCHIATRIC CASE REGISTER

This case register, dating from 1973, has a two-fold objective. The first is to provide data, from a representative 10% sample of the Irish population, of its patterns of usage of Irish psychiatric facilities both hospital and extra-hospital (i.e. outpatient clinics, day centres, hostels etc.) by psychiatric patients. In addition, the project has a more strictly scientific purpose in monitoring the incidence, prevalence and socio-demographic characteristics of various groups of psychiatric illness.

The broad administrative findings from this project indicate that, by comparison with comparable data in the United Kingdom, psychiatric patients tend to make contact with psychiatric services less frequently but remain in care for much longer periods of time once they do make contact. A detailed examination of these findings will shortly be published in "Psychological Medicine" and those aspects of more immediate Irish interest will be appearing in a comparable Irish journal. It can be said, in summary, that patients tend to accumulate in psychiatric services in this country at a greater rate than is apparent elsewhere. It is not yet clear whether this is because recovery is slower and less complete, particularly from severe illnesses such as schizophrenia or whether the psychiatric services exhibit paternalistic attitudes towards their patients who develop a dependence on them. No doubt the depressed socio-economic circumstances and the cultural inheritance of the past played a role but it would seem that active rehabilitation methods were not generally developed and that primary health care sources show a certain reluctance to take on psychiatric patients from the specialised services.
DETERMINANTS OF OUTCOME OF SEVERE MENTAL DISORDERS

This study is taking place under the aegis of the World Health Organisation and is the logical outcome of their earlier study the “International Pilot Study of Schizophrenia”. This study revealed that there was a substantial difference in outcome of schizophrenia between the various countries participating. It was not clear what the specific factors that influenced this differential outcome were and so the present study was set up to investigate this matter further. Because the possibility existed that outcome for schizophrenia might be particularly unfavourable in this country, we joined the later study and are now one of the thirteen participating centres. The study is principally concerned with highlighting and examining those factors, social and otherwise, which appear to influence outcome differently within countries and between countries. The study is also concerned with establishing a treated incidence rate for schizophrenia for each of the centres which vary considerably in their socio-cultural background. The field work for this study was begun on November 1st 1978 and will continue until October 30th, 1980. Following this there will be a further period of follow-up. It is envisaged that the findings of this most important work will add substantially to our knowledge of the appropriate management of schizophrenia in this country.
THREE-COUNTY SCHIZOPHRENIA STUDY

This study is concerned with examining and measuring the incidence of mental illness and the incidence and prevalence of schizophrenia by standardised clinical schedules and techniques which have already been used in a variety of major international studies. Secondly, to assemble and examine social and cultural data concerning the role behaviour of patients and their early life experiences compared with matched controls. The analytical work on this study has been completed and it will be reported in 1980. A further dimension to this study was the follow-up of schizophrenic patients who have now been re-examined in an attempt to assess outcome. The outcome of these patients has now been assembled and is being analysed.
MENTAL HEALTH SERVICES IN PILOT STUDY AREAS

This is a multi-national study within the European region of the World Health Organisation who are co-ordinating it. The Dublin centre is one of twenty in different countries throughout Europe. The study is broadly concerned with the exploration of cost effectiveness in the psychiatric services. In our case it is based on the St. Loman's psychiatric case register in Dublin city and county and utilises data from this register. An initial census of patients has been carried out and detailed information concerning new admissions to the service is being collected. Later these patients will be re-assessed from the point of view of progress and outcome together with the cost of their treatment.
ALCOHOL-RELATED PROBLEMS

We have continued to maintain our interest in problems related to abuse of alcohol. From the public health point of view the situation concerning these problems is increasingly unfavourable. For example, mortality from cirrhosis of the liver continues to rise and there was a 14% increase in the numbers of admissions to psychiatric hospitals for alcoholism between 1976 and 1977 and admissions for alcoholism are now first among causes of first admission.

In conjunction with the Economic and Social Research Institute we have been investigating the possible role of budgetary measures in primary prevention of alcohol-related problems. Some of the preliminary results relating to the feasibility of using budgetary measures, in increasing cost, in primary prevention were presented at the Second European Symposium on Social Psychiatry which took place in Aarhus, Denmark, in September.

We continue our association with the joint research project entitled the “International Study of Alcohol Control Experiences” with the Finnish Foundation of Alcohol Studies, The Addiction Research Foundation of Ontario, Canada, the Social Research School of Public Health, University of California, the Neuro-psychological Institute of Poland, Warsaw, and the World Health Organisation. The next meeting of this group will be in Warsaw in April 1980. The proceedings of this group will result in a major publication on the place of various measures of control, of alcohol pricing, availability etc. in public health policies devoted to the prevention of alcohol-related problems.
SUICIDE AND ATTEMPTED SUICIDE

The monitoring of trends in the suicide field continues. The possible suicide deaths reported to the Coroner's court in the Dublin area are being investigated and will shortly be reported upon. Staff of the Board participated at the invitation and expense of the International Association of Suicide Prevention, at their 10th annual conference in Ottawa in June. A paper detailing the impact of the ascertainment system in Ireland on the compilation of official statistics was read together with some suggestions for the improvement of statistical reporting systems about suicide in this country.

At the request of the Specialised Committee on Epidemiology of the Committee of Medical Research of the EEC the Medico-Social Research Board presented the results of a preliminary study on attempted suicide in the countries of the EEC and a recommendation for further research action.
TERMINATION OF PREGNANCY OF IRISH RESIDENTS IN ENGLAND AND WALES

Annual Reports are published by the Medico-Social Research Board on the numbers and characteristics of Irish residents who have pregnancies terminated in England and Wales during each year. The report for 1978 shows an increase of approximately 12% over figures for 1977. Irish resident women are having recourse in increasing numbers year by year to termination in Britain. The number of terminations, which is very largely on single women, is now greater than the number of illegitimate live births.
PSYCHIATRIC ILLNESS: PROFILES OF AFTERCARE

This study which was carried out by Dr. P. Keane on patients from St. Loman’s hospital in Dublin has now been completed. Findings of the study will shortly appear.
The Medico-Social Research Board continues to give support to the Federation of Services for Unmarried Parents and their Children. During the summer of 1979 the Board employed a student to carry out a pilot study on children in care for the Federation. This came about because, at its Conference entitled “Finding Parents for Children with Special Needs”, the recommendation was made that research should be undertaken into the reasons why some children in residential care were placed neither for adoption nor foster care.

The pilot study was carried out in the Eastern Health Board and the North Western Health Board areas and found that legitimacy of birth denies family life to half of all parentless children in institutional care. In the great majority of cases these children have no contact with their natural parents. In the case of illegitimate parentless children the principal obstacle standing between them and adoption is either physical or mental handicap or a combination of both. The existence of these handicaps appears to be regarded as an absolute impediment to either foster care or adoption. Withholding of maternal consent towards adoption or fostering is another significant reason why children are retained in institutions even though their parents do not visit them.

It would be valuable to extend this research to the country as a whole to ascertain precisely the number of children who are denied family life because (a) they are legitimate (b) they are mentally and physically handicapped or (c) their mothers withhold consent. The results would enable information to be assembled towards influencing legislative change to enable these children, deprived of family life, to enjoy the full benefits which society has an obligation to bestow on them. In addition this further research would explore the reasons why mentally and physically handicapped children are denied family life.
MENTAL ILLNESS AND THE HOMELESS

In 1979 the Simon Community published a paper presented at the National Conference of the Irish Simon Community in 1978 by Aileen O'Hare, senior sociologist in the mental health section of the Board, on 'Mental Illness and the Homeless'. The data on which the paper was based came from the Board's National Psychiatric In-patient Reporting System.

In 1974 there were 489 admissions i.e. first and re-admissions of persons with no fixed abode to Irish psychiatric hospitals; 402 males and 87 females. Seventy five per cent were single, 18% married, 4% widowed and 3% unspecified. This contrasts with the marital status distribution for all Irish admissions in 1974 of 49% single, 42% married, 8% widowed and 1% unspecified. ¹

A high proportion, 65% of the homeless admissions, were aged under 45 years; this compares with 50% of national all admissions.

The table on page 34 shows the diagnosis and sex for homeless and national all admissions.

The percentage of hospitalised schizophrenics in the homeless group was high at 38.2, in comparison to the national percentage of 24.4. The proportion with a diagnosis of alcoholism and alcoholic psychosis is the next highest and it is higher than the national proportion. A surprisingly low per cent of homeless received a diagnosis of manic-depressive psychosis, 9.6, in comparison to 22.8 for all Irish admissions.

The homeless patients were mainly an urban group, with few farmers or agricultural workers. Forty one per cent were in the unskilled manual group, assigned on the basis of a current or former occupation.

There has been a tradition for the mentally ill to wander homeless throughout Ireland. Prior to 1700 there were no psychiatric services and even after their introduction many wandered the countryside "at large". In 1871, out of a total census number of 17,202, almost 7,000 were "at large"—a

<table>
<thead>
<tr>
<th>Homeless</th>
<th>Schizophrenia</th>
<th>Manic-depressive Psychosis</th>
<th>Other Psychoses</th>
<th>Neurosis and Personality Disorder</th>
<th>Alcoholism and Alcoholic Psychosis</th>
<th>Mental Handicap</th>
<th>Unspecified</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>163</td>
<td>33</td>
<td>21</td>
<td>49</td>
<td>121</td>
<td>11</td>
<td>4</td>
<td>402</td>
</tr>
<tr>
<td>Female</td>
<td>24</td>
<td>14</td>
<td>10</td>
<td>24</td>
<td>9</td>
<td>6</td>
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<td>87</td>
</tr>
<tr>
<td>Total</td>
<td>187</td>
<td>47</td>
<td>31</td>
<td>73</td>
<td>130</td>
<td>17</td>
<td>4</td>
<td>489</td>
</tr>
<tr>
<td>%</td>
<td>38.2</td>
<td>9.6</td>
<td>6.3</td>
<td>14.9</td>
<td>26.5</td>
<td>3.4</td>
<td>0.8</td>
<td>100</td>
</tr>
<tr>
<td>National %</td>
<td>24.4</td>
<td>22.8</td>
<td>10.4</td>
<td>16.4</td>
<td>21.4</td>
<td>2.7</td>
<td>1.5</td>
<td>100</td>
</tr>
</tbody>
</table>

N=24,964
figure arrived at through an estimation by sergeants of the Royal Irish Constabulary, each reporting the number of "lunatics, idiots and epileptics" in his area.\(^2\) By 1901 no one was reported "at large", probably due to the opening of additional mental hospitals.

One of the serendipitous findings of the study was the excess of schizophrenic admissions over those with an alcoholic diagnosis. Contrary to what one might expect, schizophrenics who are discharged from hospital to a home with a "high emotional involvement" were more likely to relapse.\(^3\) Sociologists see the mentally ill person as assuming the sick role which exempts him from normal obligations for a limited period of time. However, in addition to the schizophrenic's apparent inability to deal with expressed emotions he may also suffer from lack of affect and drive associated with the illness and may also suffer from the side effects of drug therapy. In such a situation he may retain the role of patient as a permanent adaption to avoid stress and demands made upon him. Relatives may find a permanent sick role difficult to accept and in time the schizophrenic may drift from family ties and former occupations to end in the disorganised lodging area of urban centres.

However, lack of supportive ties may be just as detrimental. What appears to be the optimum social environment for the schizophrenic is one in which the emotional climate is bland and complex decision-making not a requirement. Homelessness in Britain is now regarded as a housing problem rather than an indicator of social inadequacy.\(^4\) In the absence of a positive programme for the homeless mentally ill, community care has less to offer than the old regime of institutional care.

References

COLLOQUIUM ON PUBLIC HEALTH APPROACHES IN THE PREVENTION OF ALCOHOL-RELATED PROBLEMS

Because of the considerable increase in alcohol consumption and the coincident rise of the extent of alcohol-related problems in Ireland in recent years the Board decided to hold a colloquium on the topic “Alcohol—A National Policy?” in February, 1979. The colloquium was attended by the Minister for Health and Social Welfare, Mr. C. J. Haughey, T.D., members of the Department of Health and psychiatrists, physicians and other professional personnel concerned with the treatment and prevention of alcoholism.

The presentation reviewed the growth of alcohol consumption in Ireland in recent years. This may be best summarised by the accompanying figure.

At the same time the increase in alcohol-related problems over the same time period was reviewed, for example, the increase in mortality from cirrhosis of the liver and in numbers of admissions for alcoholism to Irish psychiatric hospitals. This latter index is shown in the accompanying table. Other indices such as prosecutions for drunkenness, for drunk driving and the recent increase in the number of suicides were also examined.

The economic and fiscal aspects of alcohol including an assessment of the cost in economic terms of alcohol-related problems to the state was also outlined.

It seemed clear that the recent increase in real income and to a lesser extent the decrease in real cost of alcohol were the factors underlying the consumption increases of the past decade. In particular it was noted that sections of the community who previously had low purchasing power, such as lower socio-economic groups and young people, were contributing substantially to the increase in consumption.

The colloquium then examined the possibility of preventive measures. The place of control by pricing policies and in particular by not allowing alcohol to continue to decrease in real cost terms was examined. The role of advertising in promoting
alcohol consumption was also examined. Finally, some time was given to examining the possible role of health education in the alcohol field.

The colloquium proposed that it was necessary to develop a national alcohol policy acceptable to and supported by the community as a whole. This had hitherto been lacking and from the health point of view there had been no consistent approach to the undesirability of increasing alcohol consumption. The colloquium felt that such national policy would require the cooperation of many different Government Departments with powers and responsibilities in the alcohol field. It was proposed that there should be an indepth examination of the preventive potential of price-control through price indexing and/or differential tax manipulation between drink types to ensure that more harmful beverages do not continue to enjoy the price advantages they have gained in recent years.

It was strongly recommended that enforcement of drunk-driving legislation was of paramount importance but the colloquium stressed that it will prove a deterrent only to the extent that it is enforced.

It was concluded that social research is urgently needed because of the many areas of ignorance concerning our behaviour in relation to alcohol, including the distribution of drinking patterns among the population at large and the effects of various preventive measures on different sections of the community. Finally, the colloquium stressed the necessity for programmes of evaluation and monitoring of control policies, such as health education and the effect of advertising.
IRELAND 1961 - 1977
CONSUMPTION OF BEER AND SPIRITS PER PERSON
AGED 15 AND OVER. LITRES.

- **BEER**
- **SPIRITS**

<table>
<thead>
<tr>
<th>Year</th>
<th>Beer</th>
<th>Spirits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1961</td>
<td></td>
<td></td>
</tr>
<tr>
<td>63</td>
<td></td>
<td></td>
</tr>
<tr>
<td>65</td>
<td></td>
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<td>67</td>
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<tr>
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<tr>
<td>75</td>
<td></td>
<td></td>
</tr>
<tr>
<td>77</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

54% 138%
Ireland 1967–1977. First and All Admissions for Alcoholism and Alcoholic Psychosis

<table>
<thead>
<tr>
<th>Year</th>
<th>First Admissions</th>
<th>All Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1967</td>
<td>864</td>
<td>2,013</td>
</tr>
<tr>
<td>1968</td>
<td>1,081</td>
<td>2,526</td>
</tr>
<tr>
<td>1969</td>
<td>1,186</td>
<td>2,886</td>
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<tr>
<td>1970</td>
<td>1,252</td>
<td>3,073</td>
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<tr>
<td>1971</td>
<td>1,538</td>
<td>3,720</td>
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<td>1972</td>
<td>1,697</td>
<td>4,143</td>
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<tr>
<td>1973</td>
<td>1,996</td>
<td>4,846</td>
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<tr>
<td>1974</td>
<td>2,071</td>
<td>5,355</td>
</tr>
<tr>
<td>1975</td>
<td>2,198</td>
<td>6,003</td>
</tr>
<tr>
<td>1976</td>
<td>2,206</td>
<td>6,101</td>
</tr>
<tr>
<td>1977</td>
<td>2,518</td>
<td>6,765</td>
</tr>
</tbody>
</table>
Work is continuing on the proposed Census of the Mentally Handicapped. As reported earlier preparations for this Census have involved the setting up of locally based Record Systems under the control of the Directors of Community Care. Up to the present time information in relation to mentally handicapped persons is available through the Directors when required for specific purposes e.g. revision of allowances or applications for residential care. The material available, however, is not standardised and is not comprehensive. Since a change in the method of financing residential care some years ago the Directors of Community Care are no longer directly informed when someone from their area is admitted to or discharged from a residential centre.

The new Record System which is a simple card index type of record seeks to provide a readily available source of information on every handicapped person originating from a specific Community Care area whether this person be at home or in some form of residential care. It has been designed both to facilitate local provision of services and local planning and to facilitate a National Census of the Mentally Handicapped in 1981. During 1979 meetings were held with officers of the Health Boards and the Director of Community Care in all Community Care areas. Meetings were also arranged with professional bodies involved in the care of the mentally handicapped. Numerous helpful suggestions were obtained from some of the latter and these have been incorporated in the design of the System.

The System was established on a pilot basis in three Community Care areas during 1979, Kerry, West Cork and in Dublin Community Care Area 4. We would like to express our appreciation to the Directors of these areas, namely, Dr. Alec O'Driscoll, Dr. Andrew Stynes, Dr. John Walker and their staff, for their co-operation in these pilot trials. The trials did not reveal any serious defect in the Record System and it is proposed to launch this on a national basis in January 1980.
SURVEY OF ADULT MENTALLY HANDICAPPED PERSONS LIVING AT HOME IN A COMMUNITY CARE AREA

In 1979 the Board commenced a study on adult mentally handicapped persons living at home in a Community Care area. A variety of areas of interest influenced the nature and scope of the information collected in this study. The following are among the main areas investigated:

1. The need for service provision
   Information in this regard was requested by the Eastern Health Board and the voluntary bodies working with mentally handicapped in Dublin. They wished to ascertain a point prevalence of adult mentally handicapped persons living at home in a Community Care area. This interest was administrative and concerned with service provision:
   
   (a) To obtain information on the type and the proportion of mentally handicapped adults who are receiving a service.
   
   (b) To assess the need for and the most appropriate types of community based services required.
   
   (c) To rationalise the planning and provision of residential places.

2. The collection of background information for a Record System on Mental Handicap
   The timing of this study coincided with the further development of Community Care areas and the setting up of a Record System on Mental Handicap. The design of the Record System involved channelling all information collected through the Directors of Community Care. It was known that some adult mentally handicapped persons were not presently attending a service and the information required for the Record System would not, in all cases, be readily available. It was, therefore, decided that the items
of information required for the Record System should be included in this study.

3. Measurement of functional levels
   At a practical level interest was centred on assessing the level of functioning of mentally handicapped adults and at indentifying areas of functioning where there may be problems. This, it was felt, would facilitate designing practical training programmes for the mentally handicapped. Three scales measuring separate aspects of functioning were incorporated into the measurement of functional levels.

   (a) Presence of physical handicap: Items investigated included mobility, use of hands, vision, hearing and epilepsy.

   (b) Level of independent self-care: Items looked at in this scale include ability to communicate, to follow instructions, to look after personal needs, to feed oneself competently, to use public transport and to move about freely.

   (c) Level of independence in a living situation: Items under this heading included ability to prepare food, to look after the house, to handle money, to tell time and to read and write.

4. Recreational activities
   The provision of recreational activities for home based adult mentally handicapped and the integration of the mentally handicapped in the normal social life of the community were among other areas it was considered desirable to investigate and include in the study.

5. Basic social and demographic information
   Information was also collected on the basic social and demographic characteristics of the survey population.

   The study was designed as a pilot study based on Community Care Area 5 in the Eastern Health Board.

   An interview schedule, incorporating the above information, was designed. It has been completed for each member of the survey population with their primary caring person. The Director of Community Care has been supplied with the necessary background information on the adult mentally
handicapped in his area for his Record System. The findings have been coded and are being placed on computer file for statistical analyses.

On the basis of experience gained in this pilot study, the interview schedule has been shortened and it is planned to administer the shortened version in another Community Care area. The collection of information in a second Community Care area will run concurrently with the analyses of the more detailed information, outlined above, which has been collected in Community Care Area 5.
A register of females of childbearing age with phenylketonuria (PKU) was set up by the Board during 1978. It followed on a survey of all cases with PKU which has already been reported.¹ This survey highlighted the problem posed by the increasing numbers of phenylketonuric females at risk of having a child with congenital malformation. Subsequently all the cases in this category were traced by Miss Sile O'Connor and procedures investigated for preventing the birth of brain damaged infants in such cases.

Thirty-five females born prior to the introduction of the National Screening Programme in 1966, who are at present living in the community were identified. Nine of this group are either severely or profoundly mentally handicapped, thus, the remaining 26 are taken as the population at risk. At the request of the treating paediatrician six of this group were not contacted. For the 20 girls contacted the procedures adopted were as follows:

1. The relevant Director of Community Care was informed about the project and asked firstly whether the girl concerned was known to him as having PKU and secondly for the name of the family doctor.

2. The permission of the family doctor was sought to contact the patient and her family. Agreement was received in all cases.

3. At the first visit the dietary status was established and the complications associated with pregnancy in the case of females with PKU were explained to the parents.

The action taken, in particular situations, varied depending on the dietary status and intellectual level of the girls. The frequency of contact has necessarily been greater in the case of those who had given up the diet and those who had never been
on diet. In these cases, excluding those who had been identified as moderately mentally handicapped who were living in relatively protected social situations, the feasibility of introduction or resumption of the diet was discussed. Where this has not proved feasible regular contact is maintained with the families and the crucial importance of commencement of the diet prior to pregnancy is stressed. In the event of this not being done it is stressed that immediately a pregnancy is suspected the family doctor and the metabolic unit at Temple Street Hospital should be notified with a view to immediate introduction of low phenylalanine diet for the duration of the pregnancy.

During 1979 the metabolic unit at Temple Street Hospital was expanded and Dr. Doreen Murphy is now concentrating exclusively on metabolic diseases in a special unit. Following discussions with Dr. Murphy and Dr. Seamus Cahalane of Temple Street it was decided that the future service commitment of this project would be best carried out by a social worker attached to Temple Street Hospital itself. Accordingly, it is proposed during 1980 to transfer the workload involved in this ongoing project to a whole-time social worker who will maintain contact with the patients and also work with the children that are diagnosed now and in the future in the metabolic unit. An essential aspect of this work would involve liaison with the relevant Community Care team and family doctor.

Reference

FIRST ADMISSIONS TO PSYCHIATRIC HOSPITALS AMONG IRISH IMMIGRANTS RESIDENT IN SOUTH-EAST ENGLAND

Immigrant groups are at high risk for psychiatric breakdown and, therefore, for admission to psychiatric hospitals. Previous studies have suggested that Irish immigrants to England, the majority of whom are resident in Greater London and the West Midlands, have a high risk of admission to hospital. These studies, however, have been hampered by the fact that birthplace was not recorded in over 30% of first admissions. A collaborative study was, therefore, launched between the Medico-Social Research Board and the Department of Health and Social Security of the United Kingdom.

The main source of data used in the study was first admissions to mental hospitals in south-east England analysed by age, sex and place of birth during 1976. These hospitals and units cover the geographic region of Greater London, Bedfordshire, Essex, Hertfordshire, Kent, Surrey, East and West Sussex. The Departments of Health and Social Security at Blackpool and London co-operated with the Medico-Social Research Board in this study in ensuring that all the hospitals recorded place of birth and other data for each first admission, and in preparing the computer print-outs. During 1976 we were able to obtain the birthplace of more than 91% of all first admissions in south-east England. The Office of Population Censuses and Surveys, London, also assisted in the preparation of the data.

The sources of the data used included:

(a) English Census County Reports 1971

(b) Department of Health and Social Security In-patient statistics for first admissions 1976.
In order to ascertain the incidence of mental illness in these immigrant groups and to make valid comparisons between them, an expected or theoretical number of admissions was calculated for each age group, diagnosis and sex for each immigrant group living in south-east England. This expected number was based on United Kingdom-born admissions living in south-east England in each age group, diagnostic category and sex. Whether the difference between the expected and the actual number was significant was calculated by using the $x^2$ test. The main differences are highlighted in TABLE 1.

Expected admission figures, based on the age and sex specific first admissions to mental hospitals in the Irish Republic (1975, '76) were also calculated and compared with the actual admissions of Republic of Ireland immigrants living in south-east England. TABLE 2.

**Conclusions**

There was a statistically significant *higher* number of first admissions among male and female immigrants from the Republic of Ireland than the expected number of admissions, based on first admission rates among the United Kingdom-born.

Republic of Ireland immigrants in south-east England had a statistically significant *lower* number of first admissions than the expected number when based on first admission rates among the Irish living in the Republic of Ireland. That is, the first admissions among Republic of Ireland male immigrants in south-east England, age-standardised, were nearly twice the expected number based on the first admission rate among United Kingdom-born males resident in South-east England but less than the expected number of first admissions based on males admitted in the Republic of Ireland. The first admissions among Republic of Ireland female immigrants in south-east England were also significantly higher than among United Kingdom-born females in south-east England but lower than among females living in the Republic of Ireland.

Among Republic of Ireland immigrants resident in south-east England, age-standardised, male admissions for alcoholic psychosis and alcoholism were 5 (5.1) times greater than admissions among United Kingdom-born males resident in
Republic of Ireland male immigrants resident in south-east England had statistically a significantly lower number of first admissions for alcoholic psychosis and alcoholism (2.8 times lower) than the expected number of admissions based on males admitted in the Republic of Ireland.

Republic of Ireland males living in Ireland had a crude rate (not age-standardised) of first admissions for alcoholic psychosis and alcoholism 12.5 times higher than the rate among United Kingdom-born males resident in south-east England.

Admission rates for schizophrenia among the Irish immigrants were a little higher, not significantly for men, significantly for women ($P < 0.001$), than the United Kingdom-born but much lower, one-fifth for men and one-third for women, than in the Republic of Ireland.

The difference in first admission rates between south-east England and the Republic of Ireland may be due in part to a greater tendency to admit patients in Ireland than in England. This could not account for the outstandingly high admissions for alcoholism for the Irish in Ireland and the Irish immigrants to south-east England. Other immigrant groups, except for those from Northern Ireland and to a lesser extent Scotland, do not have very high admission rates for alcoholism and alcoholic psychosis. It must therefore be accepted that the very high admission rate for alcoholism and alcoholic psychosis for the Irish in Ireland and among Irish immigrants in south-east England is not an artefact due to high hospitalisation of the Irish but represents a particular problem with alcohol for Irish men and women.

References

1 Malzberg, B, and Lee, E. Migration and Mental Disease. New York Social Science Research Council, 1956.
TABLE 1a

1976 First admissions, Expected (E) and Actual (A) numbers for persons born in the Republic of Ireland living in south-east England. The Expected (E) number is based on the rates for the United Kingdom-born (Simplified Table).

<table>
<thead>
<tr>
<th>Age group</th>
<th>Schizophrenia</th>
<th></th>
<th></th>
<th>Depressive</th>
<th></th>
<th></th>
<th>Psychosis</th>
<th></th>
<th></th>
<th>Alcoholic psychosis</th>
<th></th>
<th></th>
<th>All diagnoses</th>
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<th></th>
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<tr>
<td></td>
<td>Male</td>
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<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
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</tr>
<tr>
<td>0–19</td>
<td>.2</td>
<td>2</td>
<td>.2</td>
<td>1</td>
<td>1.8</td>
<td>5*</td>
<td>2.8</td>
<td>8*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>20–34</td>
<td>8.4</td>
<td>12</td>
<td>7.3</td>
<td>3</td>
<td>50.1</td>
<td>87*</td>
<td>82.1</td>
<td>86</td>
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</tr>
<tr>
<td>35–54</td>
<td>5.5</td>
<td>10</td>
<td>7.1</td>
<td>3</td>
<td>10.9</td>
<td>54*</td>
<td>50.6</td>
<td>116*</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>55+</td>
<td>1.6</td>
<td>36</td>
<td>3.4</td>
<td>10</td>
<td>2.3</td>
<td>8*</td>
<td>50.2</td>
<td>71*</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>15.7</td>
<td>23</td>
<td>18.0</td>
<td>10.5</td>
<td>17.7</td>
<td>90*</td>
<td>132.0</td>
<td>248*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Statistically significant at more than the 0.05% level.
**TABLE 1b**

1976 First admissions, Expected (E) and Actual (A) numbers for persons born in the Republic of Ireland living in south-east England.

The Expected (E) number is based on the rates for the United Kingdom-born. (Simplified Table).

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>E</td>
<td>A</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>15.7</td>
<td>23</td>
</tr>
<tr>
<td>Depressive Psychosis</td>
<td>10.5</td>
<td>10</td>
</tr>
<tr>
<td>Senile and pre-senile psychoses</td>
<td>6.4</td>
<td>3</td>
</tr>
<tr>
<td>Alcoholic psychosis and alcoholism</td>
<td>17.7</td>
<td>90</td>
</tr>
<tr>
<td>Other psychoses</td>
<td>8.1</td>
<td>15</td>
</tr>
<tr>
<td>Psychoneurosis</td>
<td>20.0</td>
<td>21</td>
</tr>
<tr>
<td>Drug dependence</td>
<td>3.4</td>
<td>4</td>
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<tr>
<td>Personality and behaviour disorders</td>
<td>16.0</td>
<td>23</td>
</tr>
<tr>
<td>Mental handicap</td>
<td>0.3</td>
<td>—</td>
</tr>
<tr>
<td>Other psychiatric conditions</td>
<td>5.4</td>
<td>7</td>
</tr>
<tr>
<td>All other conditions</td>
<td>28.3</td>
<td>52</td>
</tr>
<tr>
<td>All diagnoses</td>
<td>132.0</td>
<td>248</td>
</tr>
</tbody>
</table>
TABLE 2a

1976 First admissions, Expected (E) and Actual (A) for persons born in the Republic of Ireland and living in south-east England. The Expected (E) number is based on the rates in the Irish Republic (1975/1976)

| Age Group | Schizophrenia | | Depressive Psychosis | | Alcoholic psychosis and alcoholism | | All diagnoses |
|-----------|--------------|----------------|---------------------|--------------------------|----------------|--------------------------|
|           | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female |
| 0-19      | .7   | .6 | .2 | 1.5 | .5 | 2.7 | 1.9 | .9 | 2.7 | 1.5 | 2.7 | 1.5 |
| 20-34     | 57.1 | 12* | 41.9 | 7* | 23.7 | 3* | 47.6 | 6* | 86.9 | 28* | 17.9 | 9* | 226.5 | 87* | 217.3 | 86* |
| 35-54     | 45.6 | 10* | 37.1 | 18* | 32.1 | 3* | 67.7 | 4* | 146.8 | 54* | 37.4 | 18* | 281.6 | 116* | 233.4 | 111* |
| 55+       | 10.5 | 1* | 14.5 | 9 | 21.7 | 3* | 40.7 | 10* | 21.5 | 8* | 9.9 | 8 | 108.1 | 40* | 142.8 | 71* |
|           | 113.9 | 23* | 94.1 | 36* | 77.8 | 10* | 156.5 | 20* | 255.3 | 90* | 65.7 | 35* | 619 | 248* | 597 | 276* |

*Statistically significant at more than the 0.05% level.
TABLE 2b

1976 First admissions, Expected (E) and Actual (A) for persons born in the Republic of Ireland and living in south-east England.
The Expected (E) number is based on the rates in the Irish Republic (1975/1976)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>E</td>
<td>A</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>113.9</td>
<td>23</td>
</tr>
<tr>
<td>Depressive psychosis</td>
<td>77.8</td>
<td>10</td>
</tr>
<tr>
<td>Senile and pre-senile psychoses</td>
<td>50.1</td>
<td>18</td>
</tr>
<tr>
<td>Alcoholic psychosis and alcoholism</td>
<td>255.3</td>
<td>90</td>
</tr>
<tr>
<td>Other psychoses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug dependence</td>
<td>5.8</td>
<td>4</td>
</tr>
<tr>
<td>Personality and behaviour disorders</td>
<td>89.8</td>
<td>51</td>
</tr>
<tr>
<td>Mental handicap</td>
<td>11.3</td>
<td></td>
</tr>
<tr>
<td>Unspecified (Irish)</td>
<td>14.4</td>
<td>52</td>
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<tr>
<td>(All other conditions UK)</td>
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<td></td>
</tr>
<tr>
<td>All diagnoses</td>
<td>619</td>
<td>248</td>
</tr>
</tbody>
</table>
Epidemiology of Respiratory Diseases in Agriculture

The study is part of an epidemiology programme aimed at defining, collecting and analysing the data which appear necessary for determining the incidence of respiratory diseases in rural areas. The central co-ordinating team consists of Professor Walter Holland, Chairman, and two field teams, one in Ireland under the direction of Dr. Geoffrey Dean, the Director of the Board, and one in France under the direction of Professor René Pariente.

The two field teams, Irish and French, besides taking part in the general co-ordination of the central project, have a flexible working programme so as to be available for surveys as these appear desirable from the progress of the whole programme. Meetings were held during the period of the contract in London and in Luxembourg to discuss the progress of the work.

7 (a) (i) Mortality among agricultural workers

Mortality information was obtained in the Republic of Ireland in an agreed format for five years, 1969 and 1971–74 (1970 is not available) for the following causes of mortality:

- TB of respiratory system
- Malignant neoplasm trachea, bronchus and lung
- Acute myocardial infarction
- Other ischaemic heart disease
- Other forms of heart disease
- Acute respiratory infection
- Influenza
- Viral pneumonia
- Other pneumonia
- Bronchitis and emphysema
- Asthma
- Empyema and lung abscess
- Other diseases of respiratory system
This information was obtained in five-year age groups from 15–64 for both men and women according to marital status and also according to occupation using the international classification of occupations and dividing the groups into agricultural and non-agricultural occupations. Tables will be prepared for each of the groups in the following form:

Table 1: All males: all areas
2: All males: urban areas
3: All males: rural areas
4: All males: agricultural occupations
5: All males: non-agricultural occupations
6: All males: all areas
7: Married women: urban areas
8: Married women: rural areas
9: Single women: urban areas
10: Single women: rural areas

Agricultural occupations have been subdivided into the self-employed who own their farms, and employees.

The populations at risk are known from the 1971 census.

This information is now being analysed and will be reported upon in 1980/81.

7 (a) (ii) Factors related to Respiratory Symptoms in Irish Men

This was a study undertaken to identify factors related to the presence of respiratory symptoms in Irish men and to investigate the relationship between the presence of respiratory symptoms and performance in a simple test of respiratory function, using the peak flow meter. The study was undertaken in conjunction with the Irish Heart Foundation’s MEDISCAN programme in which Irish men are screened for risk factors for ischaemic heart disease. There were 720 men for whom replies to the questionnaire and peak flow rate measurements were available, ranging in age from 18 to 76 years. The study showed that those who report respiratory symptoms have a significant excess mortality when compared with those who do not report such symptoms. Risk factors for respiratory symptoms in Irish men were a current smoking habit and membership of social classes IV and V. Within social classes I and II smoking was less related to the presence of symptoms than in social classes III, IV and V. Peak flow rates were significantly lower in those
who reported respiratory symptoms and in those who were current smokers. Mean peak flow rates showed significant differences between the social classes and peak flow rates declined with increasing age. The symptoms of breathlessness occurred significantly more often in those from rural areas.

It is suggested from this research project that a screening programme for the presence of respiratory symptoms and respiratory dysfunction could be initiated together with an intervention programme to reduce risk factors such as smoking.

7 (a) (iii) The Irish Blood Transfusion Service Study

Blood donors attending the Irish Blood Transfusion Service mobile clinic were asked to donate samples of their blood for testing for increased sensitivity to Micropolyspora faeni, the commonest fungus to cause farmer's lung and also sensitivity to bird fancier's protein, aspergillus and other antigens.

The summer of 1978 was one of high rainfall and, as a result, hay was often stacked damp. There has been a marked increase in the number of sufferers from allergic alveolitis or farmer's lung in the spring of 1979 when the winter hay was being forked for feeding. In the spring of 1978, 1,285 blood specimens were received from farmers by the Irish Blood Transfusion Service and among these there were five positive for farmer's lung. During the three months 1st March to 31st May, 1979, 1,155 serum samples were examined and of these seven gave a doubtful positive farmer's lung precipitin perfusion reaction, and one doubtful aspergillus reaction.

The percentage of positive reactors to Micropolyspora faeni among those who offer their blood voluntarily to the Irish Blood Transfusion Service is considerably lower than the percentage found, for instance, in north-west Ireland in a random sample of cattle farmers. The reason for this is that a high proportion of rural dwellers who contribute blood to the Irish Blood Transfusion Service are not, in fact, handling hay.

7 (a) (iv) Farmer's Lung 1979-1980

During 1979-1980 there has been a three-fold increase in the number of positive tests using the perfusion method for Micropolyspora faeni in laboratories in the Republic of Ireland and in Northern Ireland. For instance, in the microbiological laboratory at Queen's University, Belfast, in 1979 there were 111 positive tests compared with 31 for 1978.

As has been pointed out previously, a significant number of
farmers with typical symptoms of farmer's lung give a negative test when tested by the perfusion method for sensitivity to the fungus, Micropolyspora faeni, and the perfusion technique is now being compared with the Elisa test, using radio-immunoassay. This test has been found to be more reliable than the perfusion test. The great increase in the reported numbers of farmer's lung in 1979 compared with 1978 follows a wet autumn of 1978 with the result that most of the hay was placed into barns whilst damp which greatly assisted the proliferation of the fungus, Micropolyspora faeni, which then affected the lungs of farmers when the hay was forked in the spring. 1980 is also going to be a year with a high frequency of illness from farmer's lung following the wet autumn of 1979. The variation in the numbers of patients suffering from farmer's lung from year to year due to the variation in climatic conditions of the previous autumn makes it difficult to judge how effective are our efforts to reduce the risk of farmer's lung by education of farmers.

7 (a) (v) Respiratory symptoms in young farmers of the farming community

The annual conference of the young farmers' association (Macra na Feirme) was held at Owenahincha, Co. Cork, on 5-7 October, 1979. A preponderance of members of the organisation come from the richer farming areas of Munster.

A survey of conference delegates was undertaken. This was a pilot study, the aim of which was to assess the prevalence of respiratory symptoms among young farm workers and to provide guidelines on the extent to which young farmers in Ireland are occupationally exposed to causes of respiratory disease.

A questionnaire was administered to participants based on the Medical Research Council's Questionnaire on Respiratory Symptoms (1976). Questions were also asked about symptoms during and following exposure to mouldy hay and about symptoms caused by contact with fresh silage. Peak expiratory flow rates were measured using a Wright peak flow meter. Two "practice" expirations were permitted and the next three readings were recorded. Personal identifying data were recorded. Questions were asked about occupational history, farm size, number of cattle, methods of storing cattle feed, number of fowl, and the frequency with which the respondent fed the fowl. Finally, participants were asked about their smoking habits.
Results

A survey was undertaken of 121 young members of the farming community who were attending the conference. They worked on farms which were larger than average (mean size 132.0 acres) and prevalence of smoking was low (21.5% were current smokers). Silage was made on the majority of the farms (78%) yet 62% of those interviewed had been in contact with mouldy hay within the previous two years. Many of the farms (69%) kept poultry, but in small numbers, and frequently reared both indoors and outdoors. Little is known of the risk of developing extrinsic allergic alveolitis in these circumstances.

Prevalence of cough, phlegm, breathlessness and wheeze, and a history of lower respiratory tract infection appeared high. Five per cent of those interviewed had a history of asthma, while 10 more had breathlessness, chest tightness or wheeze while dealing with mouldy hay. More detailed study of the prevalence of asthma and extrinsic allergic alveolitis associated with mites and fungi in mouldy hay and in grain crops would be useful. Silo-filler's disease does not appear to present a risk to Irish farm workers. A full report about this pilot study will be published in 1980/81.

7 (a) (vi) Conclusion

We are continuing studies to identify which aspects of agricultural work are associated with acute changes in respiratory function, such as allergic alveolitis and asthma, and also studies on health education to reduce respiratory disease in agriculture. To achieve these ends we are co-operating with other agencies, such as the Agricultural Institute, Macra na Feirme, the health boards, the Health Education Bureau and the media. We are also collaborating in a study comparing respiratory illness in farmers in highland and coastal areas of Co. Donegal.

As it is of the greatest importance to monitor the effectiveness of health education in agriculture, we are very pleased to cooperate in 1980/81 with the North Western Health Board in a study to find out whether efforts in health education in the avoidance of respiratory illness in agriculture, in particular allergic alveolitis or farmer's lung, are effective.

Reference

THE CONCERTED ACTION PROJECT ON CONGENITAL ABNORMALITIES AND OF TWINS.

A register of congenital malformations and multiple births was established in the Eastern Health Board area as part of the Concerted Action Project of the European Economic Community (EUROCAT). The area covers Dublin city and county, Co. Kildare and Co. Wicklow. Approximately, 25,000 births a year will be monitored. This is slightly more than one-third of all births in the Republic of Ireland.

The Directors of the community care areas have agreed to notify the Medico-Social Research Board of all the malformations and multiple pregnancies that come to their attention. Dr. Allene Scott, Director of the National Drugs Advisory Board, is also supplying the Board with information on congenital malformations in babies born in the large Dublin maternity hospitals.

The register started on 1st September 1979 and so far, 115 anomalies and 16 sets of twins were reported. At the first Registry Leaders’ Conference held in Brussels further projects for 1980 were planned. These included:

A. Co-ordinated research in developed centres into:

1 Differentiation of different types of Down’s Syndrome.

2 Methods of collecting bias free information during pregnancy.

3 An operational study of methods of efficient data collection.

4 Techniques and strategy for the efficient detection of neonatal hypothyroidism.

5 The establishment of techniques for retrospective studies on prior employment and on environmental exposure.
B. Exchange visits of personnel between registries.

C. Co-operation with workshops of the European Economic Community in establishing protocols for studying embryos and early foetal deaths.

The EUROCAT study will continue co-ordination in registering birth malformations and will be an important tool for monitoring the environment which may affect the unborn child in the countries of the European Economic Community.
THE PUBLIC HEALTH ASPECTS OF ALCOHOL-RELATED PROBLEMS

Jointly with the Department of Medical Sociology, University of Aberdeen, the Medico-Social Research Board carried out, at the request and expense of the EEC, a preliminary project relating to patterns of alcohol consumption and the growth of alcohol-related problems in the countries of the Commission of European Communities.

This preliminary project showed that there has been both an increase in alcohol consumption in most west European countries in recent years and a considerable increase in the extent of alcohol-related problems. Arising from this and a number of other further findings the researchers recommended a European programme in the alcohol field. The first step in this recommendation was the setting up of a workshop to consider appropriate action resulting from consideration of the theme “Strategies and Programmes for the Prevention of Alcohol-Related Problems and Disabilities in the countries of the Commission of European Communities”. This programme is now awaiting final ratification by the Committee of Medical Research of the EEC.

The Medico-Social Research Board in 1976 was requested by the EEC to hold a workshop on “The Medico-Social Consequences of Psychiatric Disorders of Major Public Health Importance”. This workshop which was widely attended by eminent research workers from Europe and also from the United States proposed a research project for joint collaborative research. The proposal was submitted to the Committee of Medical Research on behalf of participants by the mental health division of the World Health Organisation at Headquarters in Geneva.
NATURAL BACKGROUND RADIATION AND CANCER MORTALITY IN IRELAND

The Board are in the third and final year of a study funded by the European Atomic Energy Community (EURATOM) and 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 Ecole Nationale de la Santé Publique, Rennes, where similar methods are being used. The primary aim of this study is to determine if variations in the very low levels of naturally occurring background radiation are associated with variations in cancer rates.

The radiation mapping produced in the first year of the study has enabled us to identify three counties of high average natural background radiation (Waterford, Wexford and Wicklow) and five counties of low average background (Meath, Westmeath, Kildare, Carlow and Kilkenny) for more detailed study.

Detailed radiation mapping of these eight counties will be completed by May, 1980. Average radiation values for each District Electoral Division (DED) within these counties will be calculated. (There are between 50 and 120 DED’s per county.)

All the cancer deaths that occurred in these counties between 1971 and 1976 have been assigned to the appropriate DED by computer analysis of the home addresses of the deceased. The cancer mortality rates for each DED are being calculated.

Because of small numbers, DED’s will be aggregated according to their average background radiation levels. The age-sex standardised cancer (total and type-specific) mortality rates of these aggregates will be compared to see if they correlate with the variations in natural background radiation.

In order to assess the effect of building materials and of other factors on indoor radiation and in order to validate our mortality data, we shall be starting in June 1980 a house-to-house survey of about 150 houses. The pilot study for this was completed in 1979.
SUDDEN INFANT DEATHS

A pilot study was undertaken in Dublin city and county of all deaths of infants who die between one week after birth and one year of age, that is during the first year of life, except for the period when they are likely to be in hospital.

During the first six months of the study (April-September 1979) there were 49 deaths of infants over one week and under one year old in Dublin city and county (Table 1).

### TABLE 1

<table>
<thead>
<tr>
<th>Causes of infant deaths</th>
<th>M</th>
<th>F</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cot Deaths</td>
<td>13</td>
<td>5</td>
<td>18</td>
<td>36.7</td>
</tr>
<tr>
<td>Congenital Malformations</td>
<td>8</td>
<td>7</td>
<td>15</td>
<td>30.6</td>
</tr>
<tr>
<td>Infections</td>
<td>4</td>
<td>5</td>
<td>9</td>
<td>18.4</td>
</tr>
<tr>
<td>Complications of Birth and Prematurity</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>8.1</td>
</tr>
<tr>
<td>Accidents</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>6.1</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
<td>21</td>
<td>49</td>
<td>99.9</td>
</tr>
</tbody>
</table>

The most common cause of death is the “sudden infant death syndrome”—the baby is found dead in its cot—closely followed by congenital malformations.

All home deaths were referred to the Coroner and all had an autopsy. Fifteen of twenty four deaths in hospital had an autopsy (Table 2).

### TABLE 2

<table>
<thead>
<tr>
<th>Autopsy and place of death</th>
<th>Home</th>
<th>Hospital</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autopsy</td>
<td>25</td>
<td>15</td>
<td>40</td>
</tr>
<tr>
<td>No Autopsy</td>
<td>0</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>24</td>
<td>49</td>
</tr>
</tbody>
</table>
The study is continuing and is being monitored by a Sudden Infant Death Committee. Clinical conferences are being held whenever possible after a sudden infant death. Full reports are being obtained from the parents. The doctors and public health nurses who attended the baby during its life are asked to those conferences, as well as the pathologist who did the autopsy.

The first year of the study will finish on March 31st 1980 by which time it is estimated that there will have been 45-50 sudden infant deaths in Dublin city and county, approximately one third of all deaths between one week and one year of life.

At the time of writing this report there were 109 infant deaths; 40 (36.7%) were due to sudden infant death syndrome, 39 (35.8%) were due to congenital malformations, 19 (17.4%) were due to infection, 4 (3.7%) were due to complications of birth and prematurity, 5 (4.6%) were due to accidents and in two cases the cause of death is still unknown.
THE CAUSES OF DEATH OF BLUE-COLLAR WORKERS AT A DUBLIN BREWERY 1954-1973

This study was undertaken in collaboration with the International Agency for Research on Cancer, WHO, Lyon, to see if there was an association between a high consumption of beer and cancer of the rectum and colon. By tradition, the brewery blue-collar workers are high consumers of beer, usually in the form of stout and have, in the past, had relatively easy access to beer at the brewery. The high consumption among the brewery workers was confirmed by the study in Boston and Ireland of factors related to heart disease.

The brewery provided lists of all blue-collar workers and pensioners who had died during the 20-year period 1954-1973. There were 883 deaths between 1954-63 and 745 deaths between 1964-73, giving a combined total of 1,628 deaths. For the purpose of this study those who had resigned from the brewery staff were excluded as they were nearly always young and very few in number (two or three per year, excluding apprentices). All of the 745 death certificates in the second 10-year period and 881 death certificates out of 883 deaths in the first 10-year period were traced in the General Register Office in Dublin, including a few at London, Edinburgh and Belfast. This is good evidence that there is excellent death certification of those who die in Dublin.

In the first 10-year period there were 883 deaths among the brewery male blue-collar workers and pensioners and 918.4 were ‘expected’ at the all Dublin rates for men in the same age categories and for the second 10-year period there were 745 deaths among the brewery workers and 757.6 were ‘expected’. In the two 10-year periods, therefore, the brewery workers had a slightly but not significantly lower mortality than the general male population of Dublin. A comparison by 10-year age groups shows that the brewery workers had a lower death rate than males in Dublin between the ages of 25-54, a higher death rate between 55-64, an equal death rate between 65-74 and then again a lower death rate after 75.
For most causes of death the actual number of brewery workers who died was not significantly different from the expected number based on the Dublin County Borough population in each of the two 10-year periods. Diabetes Mellitus (21 brewery deaths and 10.4 expected) was significantly more common among the brewery employees than among the general population of Dublin County Borough ($P < 0.01$). Deaths from ischaemic heart disease and other forms of heart disease, when taken together, show no significant difference between brewery employees and the general Dublin male population. Cirrhosis of the liver (11 brewery deaths, 7.6 expected) is not significantly higher than expected. There were significantly fewer deaths from pneumonia and bronchitis among the brewery workers and pensioners. Deaths from motor vehicle accidents, other accidents and suicides were not significantly different from the general population of Dublin County Borough.

For cancer of the oesophagus during the 20-year period there were 10 deaths and 15.8 were expected at all Dublin rates. For cancer of the large intestine, except rectum, there were 32 deaths and 27.3 were expected. For cancer of the rectum and rectosigmoid junction there were 32 deaths and 18.2 were expected. For cancer of the liver 7 deaths and 5.5 expected. For the gallbladder, 2 deaths and 2.1 expected. For the pancreas, 17 deaths and 14.0 expected. Only for cancer of the rectum is there a significant difference between the actual brewery deaths and the expected number based on males in Dublin County Borough ($P < 0.01$). There were more deaths from cancer of the colon and fewer from cancer of the oesophagus than expected but the differences are not significant. Those who worked in the brewhouse had an increased risk of death from cancer of the rectum ($x^2 = 18.6, P < 0.001$). Those who worked outside the brewhouse did not have this significantly increased risk. ($x^2 = 2.09$).

The brewery workers tend to be overweight and death certified as from diabetes is more common among them than among the general Dublin male population. Nevertheless, their average expectation of life was 70.7 years in 1954-63 and 72.3 years in 1964-73 and their pattern of death is not that expected of a population consuming large amounts of alcohol. This may be because while they consume, on the whole, above average amounts of stout and other beers they do not drink much spirits and they maintain their general nutrition and do not have the gastritis and lack of appetite that occurs with spirit drinkers.
They do not have an increased death rate from cancer of the oesophagus, pharynx or of the liver, from accidents or suicide, or a significantly increased death rate from cirrhosis of the liver.

A higher death rate from cancer of the rectum among workers at a brewery, especially those working in the brewhouse, does not mean that drinking beer causes this cancer. Alcohol, for instance, is absorbed before reaching the rectum. Cancer of the rectum death rates in men are higher in England than in the Republic of Ireland although much more stout has always been drunk in Ireland than in England. Further research into the past drinking behaviour of patients with cancer of the rectum and colon and of controls is required. The possibility of some carcinogenic substance in the stool of those who have a high consumption of different forms of beer should be investigated.

The Dublin brewery male blue-collar workers and pensioners do not have any increase in deaths from the causes usually associated with the excessive use of alcohol such as cirrhosis of the liver, cancer of the oesophagus or mouth, of increased motor car or other accidents or of suicide. In fact, their expectation of life is excellent and is slightly better than the average for males of all social classes living in Dublin.

References


STUDIES IN PERINATAL AND INFANT MORTALITY

We are currently preparing papers on two important topics in the area of perinatal epidemiology, trends in perinatal and infant mortality in Ireland in relation to other selected countries and regional differences within Ireland in perinatal and infant mortality.

A comparison of perinatal mortality in Ireland and thirteen other countries (Northern Ireland, England and Wales, Scotland, the seven other EEC countries, Sweden, Finland and Japan) showed that in 1976 only Northern Ireland and Italy had higher mortality rates than Ireland.¹

As national statistics on late foetal deaths in Ireland were first published in 1966, one can examine trends in perinatal mortality only since that date. Most of the other countries in the study experienced greater percentage falls in perinatal mortality than Ireland both between 1966 and 1976 and, more recently, between 1970 and 1976. Ireland fared slightly better with regard to infant mortality. Four of the fourteen countries in the study had higher infant mortality rates than Ireland in 1976.

It is clear from our study that countries such as Sweden, Finland, Denmark, the Netherlands and Japan have been more successful than Ireland and Britain in reducing perinatal and infant mortality and it is useful to try and identify reasons for their success. The interpretation of international differences in mortality and morbidity is a complex exercise and a further paper² considers some important points which are especially relevant in examining international differences in perinatal and infant mortality and describes significant differences between the countries studied in the main factors influencing perinatal and infant mortality such as socio-economic circumstances and biological attributes of the mothers and birth-weight.

Another paper nearing completion reports the results of a study of regional differences in perinatal and infant mortality in Ireland. We examined perinatal and infant mortality rates for each Health Board area for the ten year period 1966–1975. The data for each Health Board were aggregated for two five year
periods 1966–1970 and 1971–1975, to overcome the problem of random variation in small numbers from year to year. Differences were found between the Health Boards in perinatal and infant mortality rates and these findings will be reported in full in 1980.

Mortality levels are influenced by socio-economic factors and this is particularly so in the case of infant mortality. In England and Wales in 1975–1976 the infant mortality rate for social class V, the poorest section of the population, was more than twice as high as the rate for the best off group, social class I.3

Little is known of the relationship between socio-economic factors and infant mortality in Ireland. With the co-operation of the Central Statistics Office we are examining the association between infant mortality and socio-economic group by studying the death registration forms (retained by the Central Statistics Office) for all infant deaths in Ireland during 1976. Allocation to socio-economic group is based on the occupation of the deceased or, as in the case of infants, the occupation of the parent or guardian. One of the problems which we encountered in this study was the large proportion of infant deaths (20%) in which it was not possible to allocate a socio-economic group due mainly to the fact that parent’s occupation was not recorded on the death registration form. In contrast, socio-economic group was known for all but 5% of births. With the help of the Central Statistics Office and the Registrar General’s Office we hope to be able to trace the birth certificates of the infant deaths where socio-economic group was unknown so that we can establish the occupation of the parent.

We are also collaborating with the Planning Unit of the Department of Health in a study on the evaluation of the Maternal and Infant Welfare Scheme which is provided by general practitioners for pregnant mothers and their newborn babies. This exercise which commenced in 1979 will continue in 1980.

References

CHILDHOOD ACCIDENTS IN IRELAND

As in other developed countries, accidents are the major public health problem in the one to fourteen age-group in Ireland. Our study describes and analyses the trends and causes of accidental death and injury in Irish children in this age-group with particular reference to the period 1965–1974. The three main sources of data for the study were the Annual Reports on Vital Statistics compiled by the Central Statistics Office, the Hospital In-Patient Enquiry Scheme which is conducted by the Medico-Social Research Board and information on road traffic accidents compiled by An Foras Forbartha.

The principle findings were as follows:

1. Accidents and violence, including accidents on the road, in the home and elsewhere, accounted for one third of all deaths in the 1–14 age-group during the period 1965–1974.

2. Boys were at much greater risk than girls of death and injury from accidents and younger children were particularly vulnerable.

3. Although drownings, fires, falls and accidental suffocation contributed significantly to childhood trauma, road traffic accidents were the major cause of accident mortality and morbidity in this age-group.

4. Our findings show that road traffic accidents are becoming increasingly important as a cause of death and injury in Irish children and they are largely responsible for the rapid rise in the childhood accident mortality rate which we have witnessed in recent decades.

5. Accidents are also a major cause of admission to hospital in childhood. We found that accidents were responsible for one-fifth of all hospital admissions of children resident in Dublin city and county in 1977.
The prevention of accidents in childhood is an important aspect of public health and one which has not received the attention it deserves. We believe that an interdisciplinary approach is likely to provide the best basis for a successful preventive programme and we suggest that Ireland should follow the example of Sweden and the United Kingdom and establish a national committee on childhood accident prevention.
A STUDY OF BLIND & VISUALLY HANDICAPPED PERSONS IN THE NORTH WESTERN HEALTH BOARD AREA

In 1978 the Medico-Social Research Board undertook a study of blind and visually handicapped persons aged 15-54 years who were living in the Dublin area. This study was requested by the National Rehabilitation Board to assess the employment requirements and capabilities of 'known' blind and visually handicapped persons within a working age group. This Dublin study found that: there was not a large number of 'known' blind and visually handicapped persons within this age group in Dublin city and county (73 per 100,000 population); a high proportion of the above population was successfully employed and that there was a high prevalence of multiple handicaps among the unemployed group.¹

As a result of the Dublin study the National Rehabilitation Board requested that a similar more comprehensive study be undertaken in the North Western Health Board Area in 1979. The purpose of this second study was to explore the rural dimension as it was considered that the age structure, living environment and employment outlets could vary considerably from those found in Dublin city and county area.²

Information collected on the social and demographic characteristics of the survey population in the North Western Health Board revealed: over half of the survey population were aged 40-54 years; almost three quarters were single; the majority lived on farms or small holdings owned by their family of origin; the vast majority were partially sighted; about half were multiple handicapped and most had received no more than primary education.

The study found approximately: one quarter of this rural population were gainfully employed; one quarter were not gainfully employed but were fully occupied on family farm or homestead; a further quarter were in training, at school or housewives and approximately a quarter were unemployed.

Further analysis was undertaken of employed, unemployed
but occupied and unemployed groups. Various differences emerged between these groups. There was a significant difference in age grouping with more of the employed group being aged under 30 years. When compared with the other 2 groups; more of the employed group continued in school beyond primary certificate level; more of the employed group were married and significantly less of the employed groups had handicaps or illnesses in addition to a visual one. At a practical level the consent of seventeen persons, among the unemployed but occupied group and among the unemployed group, who were considered to be capable of and interested in employment, was obtained and their names were given to the National Rehabilitation Board for vocational assessment and placement. As a result, some of these persons are now employed.

On a general level these studies of blind and visually handicapped revealed the lack of adequate information on the extent of blindness and visual handicap in Ireland. When analysis of rates per 100,000 of ‘known’ blind and visually handicapped persons in various counties was undertaken, little pattern emerged even between neighbouring counties. It is felt that this inter-county variation may be an artefact and may be related more to the development, type and extent of services than to real differences in rates. On this basis the study recommended among other things, that a National File Index Recording System, containing basic social, demographic and medical information on all ‘known’ blind and visually handicapped persons, should be designed and should have an inbuilt system for updating. This is necessary if we are to ensure that basic statistics could be readily available on a continuing basis.

References


The Prisoners and Alcohol Research Project originated from a request by the Minister for Justice to the Irish National Council on Alcoholism, who requested assistance with:

(a) Determining the prevalence of problem drinking among prisoners and

(b) Recommendations as to how such prisoners might be treated.

This Project was undertaken by Ms. Helen Downing and Ms. Jodie Walsh with the joint Directorship of Dr. Richard Stevenson (Eastern Health Board) and Dr. Dermot Walsh (Medico-Social Research Board).

The three volume report on this study is in the Library in Dáil Éireann and an abridged report has been published by the Department of Justice.

The Study

The population universe for the study was composed of all committed male prisoners in prisons in the Republic of Ireland, with the exception of those serving their sentences in Portlaoise. The focus of the study was on problem drinking among prisoners. No attempt was made to assess the possible association between alcoholism and criminality.

It became apparent in the initial stages of the study that a different use was made of alcohol by under-eighteen-year-olds when compared with over-eighteen-year-olds. As a result, a separate study focusing on drinking patterns was designed for the juvenile population. However, the brief report here concerns only the adult prison population.

Background characteristics of the prison population

The request for treatment recommendations required the collection of social and demographic information on the
characteristics of the prison population, information on their early drinking experiences and their current drinking patterns. Analysis of social and demographic characteristics highlighted many areas in which this population could be said to be disadvantaged.

The findings indicate that there is an over-representation of young urban persons who come from lower socio-economic groups; from very large families; who have had little involvement in formal education and who have had a high level of involvement in criminal activities. Familial and peer group involvement with the law was also found.

Problem Drinking among the Prison Population

The definition, measurement and indicators of alcoholism and problem drinking are contentious issues. A review of literature suggests that different studies use different indicators. The World Health Organisation’s (1952) definition was used for the present study. “Alcoholics are those excessive drinkers whose dependence on alcohol has attained such a degree that it shows a noticeable mental disturbance or an interference with their mental and bodily health, their interpersonal relationships and their smooth social and economic functioning or shows prodromal signs of such development . . .” Hence, it comprises three components:

(a) Excessive Drinking.
(b) Dependence on Alcohol.
(c) Problems related to Alcohol.

To measure excessive drinking, two measures were designed:
(i) A type of drinker index based on the average monthly consumption of absolute alcohol.
(ii) A “bout” or “binge” drinker index.

Dependence on alcohol was measured using the following indicators:
(i) An indicator of physical/chemical dependence.
(ii) An indicator of psychological dependence.
(iii) A “self-perceived” problem.
(iv) A problem perceived by others.
Problems related to alcohol were compiled covering legal, financial, social, familial, employment and medical indicators.

**Excessive Drinking**

The findings indicate that many respondents could be considered to be excessive drinkers in that they had a daily average consumption of at least 15 centilitres (cls) of absolute alcohol,* and in that they were similar in their consumption pattern to persons admitted to clinics in other countries.

**Dependence on Alcohol**

A “Guttman scale” of dependence on alcohol was constructed. This ordered symptoms in terms of severity. The most severe and the least frequently experienced symptom was “delirium tremens”/“horrors”. When persons had experienced this they had experienced all other symptoms on this scale. The second most severe symptom was “morning dry-retching”/“gawks”. When people had experienced this symptom they also had experienced insomnia, morning drinking to steady nerves/“cure” and morning hand shaking/“shakes” after drinking. By the time persons suffered from sleep interference they had also experienced the “shakes” and had taken a “cure” on the morning after drinking. The least severe symptom on this scale was found to be hand shakes on the morning after drinking.

**Problems related to Alcohol**

The prevalence of legal, financial, social, familial, employment and medical problems related to alcohol was based on the percentage experiencing these problem areas in their last year outside prison. Analysis of the problems was undertaken for persons who scored positively on the physically/chemically dependent (Guttman) scale and those who did not.

Analysis of background social and demographic characteristics showed few differences between the dependent and non-dependent groups. However, respondents in the dependent group were a little more likely:

(a) To be themselves unemployed before sentence and for as much as a year or more, and to be in the semi-skilled or unskilled groupings.

(b) To be the first or second child in the family.
(c) To have left school at 14 years of age or younger.
(d) To be over 35 years of age.
(e) To be living alone, in a flat or hostel and living rough and to have had a number of changes in accommodation.
(f) To be recidivist, the most common offences being those against the person or against property with violence and drink-related offences.
(g) To be separated (if married).
(h) To be serving a short sentence, two months or less, or one of two years or more.

In conclusion, the findings indicated a high level of alcohol involvement among the prison population. However, there is no information available on comparative control groups outside prison and no attempt was made in this study to validate the responses.

*15 cl of absolute alcohol would be equivalent to approximately 6 pints of beer or 11 1/2 glasses of spirits.

References

AID TO DEVELOPING COUNTRIES

PRIMARY HEALTH CARE AND RURAL SANITATION
IN THE KINGDOM OF LESOTHO

In January, 1979, the Director of the Board visited the Kingdom of Lesotho at the request of the Agency for Personal Services Overseas (APSO) and, with Mr. Martin Greene of the Irish Development Co-operation Office of the Department of Foreign Affairs in Lesotho discussed with numerous officials of the Government, the Department of Health and others, ways in which Ireland could best collaborate with Lesotho to improve their health services.

There was at that time great enthusiasm that Ireland should assist Lesotho in the development either of a medical school or at least a Faculty of Health Sciences. There are only about 60 doctors in Lesotho, 30 of whom are expatriates, for a population of 1.2 million and it appeared to be premature to consider supporting a medical school in Lesotho, particularly because the cost would be great and ongoing and there would be little support from WHO or other health agencies and, most importantly, there was a very great need for simple primary health care in the rural areas.

It was recommended that if Ireland were to support the health services in Lesotho it should place particular emphasis on the development of primary health care in addition to some assistance in training paramedical hospital personnel, such as laboratory technicians and administrators.

During 1979 the World Bank invited Ireland to take part in a pilot scheme to develop and improve rural sanitation in Lesotho. The World Bank suggested that Ireland might provide some of the personnel needed to develop rural sanitation in collaboration with the Lesotho Ministry for Rural Development and might sponsor and implement one or more pilot schemes to improve rural sanitation and so prevent water-borne diseases.

The Lesotho Government has since decided to seek a grant from the European Development Fund instead of the World
Bank loan and this will inevitably delay commencement of the overall programme and therefore of the proposed pilot scheme.

The Ministry of Health has, however, embarked on a major rural health programme with the help of USAID and plans to train a cadre of nurse clinicians and village health workers over the next few years. They hope that this will give people in remote rural areas access to primary health care at a network of clinics being constructed throughout the country and which will ultimately be staffed by the nurse clinicians. The Lesotho Government, under the Bilateral Aid Programme, could construct a clinic and staff it, initially with an Irish nurse, who would also train a village health worker for each village, in conjunction with the USAID rural health programme.

A second site visit was made to Lesotho in December/January (1980) at the request of the Department of Foreign Affairs. The Director was accompanied by Mr. Dan Mulhall of the Department of Foreign Affairs. Many people were consulted and visits were made especially to rural areas where there was already a strong Irish presence, particularly Thabe Tseka in the central mountainous area where there is the Irish Pony Project (cross-breeding the Basutho ponies with the Connemara ponies) and the Hololo Valley Project area centred on Khukhune in north-east Lesotho. The Hololo Project is in a land area of 56,000 acres and concentrates on improving crop production and combating soil erosion. There is very little primary health care in the area and the nearest hospitals are distant and very inaccessible because of bad roads.

There appeared to be no accurate epidemiological information, for instance, about the infantile death rate or the prevalence of the common forms of sickness—diarrhoea, gonorrhoea, etc. There is a great need for simple epidemiological research and perhaps some of the Irish teachers who have been seconded to Lesotho could be persuaded to study, say, how many babies die in the first year of life. Births are reported to the Chiefs.

The Lesotho Department of Health was enthusiastic that the Irish Government should build a clinic in Khukhune and provide a staff for two or three years to provide primary health care. It was recommended that the clinic should be built to the standard of the Lesotho Health Department design. The Ministry for Rural Development was also enthusiastic that we should provide expatriate advisers to assist in the development of clean water supplies and improve sanitation.
In spite of great financial stringency in the Foreign Affairs budget for 1980, it is planned that a start will be made in providing some facilities for primary health care at Khukhune in the Hololo Valley in 1980 using existing buildings in the first place until a special health care clinic can be built. It is also hoped that a start will be made in plans to improve rural sanitation, at least in the areas where there is already an Irish project.
CONCLUSION

It is the policy of the Medico-Social Research Board not only to undertake research but also to see as far as possible that the results of this research are widely known. There is unfortunately a large gap between knowledge obtained from research and effective action and this perhaps is inevitable in a democratic society. For example, it is now well established that cigarette smoking is a major factor responsible for the shortening of life in older age groups and that alcoholism is the biggest factor accounting for our high admissions to psychiatric hospitals and a major contributory factor to accidents on the roads which result in death for so many of our young people. Action to stop cigarette smoking and to moderate the use of alcohol requires in the first place a demand from the public that such action should be taken. It requires political action rather than medical action. Political action, for example, might include greatly increasing the price of cigarettes and alcohol, making advertising illegal except at the point of sale and insisting on the rights of the non-smoker to have a smoke-free atmosphere in public places. It is significant that recent research has shown that the health of the non-smoker can be affected by inhaling the smoke from cigarette smokers. We are moving in the right direction but far too slowly. For instance, there is a fall in cigarette consumption in the upper socio-economic groups.

Alcohol-related problems present an even greater difficulty than cigarette smoking because so much of social life in Ireland revolves around drinking. Again, as in cigarette smoking, action will only result from an increased public awareness of the dangers resulting from the misuse of alcohol. The Medico-Social Research Board works in the closest collaboration with the Health Education Bureau in studying these problems and welcomes the efforts of the Bureau to awaken the public to the dangers of cigarette smoking and the abuse of alcohol. During the year, the Board held a colloquium on the subject of alcohol-related problems and how we could best deal with them. This colloquium was attended by Mr. Charles Haughey, T.D., Minister for Health and Social Welfare, and by members of the Department of Health and representatives of other groups
interested in alcohol-related problems. The high admission rate of the Irish in south-east England for alcoholism and alcoholic psychosis compared with other groups of immigrants, reported in brief in this annual report, is strong confirmation that the high admission rate of the Irish in Ireland to psychiatric hospitals for alcoholism represents a very real problem.

After such personal factors as cigarette smoking, the excessive use of alcohol, the need to keep to a sensible diet and to take exercise, the next most important influence on health is the environment at work. This is a subject that requires more emphasis in Ireland, although the Board has taken part in studies on the health dangers associated with lead pollution and in agricultural work. Many industries are developing in Ireland which will require careful monitoring, including particularly those which involve radiation and such potentially dangerous substances as asbestos and certain chemicals.

The environment in the home is also of great importance, particularly for child health, and during the year the Board has studied the problem of sudden infant deaths and accidents in childhood in the home and on the roads.

In spite of the good expectation of life in Ireland there are still major differences in health by socio-economic group. Studies on mortality and morbidity by socio-economic group have proved difficult in the past because so often “employment” is not accurately described either on death certificates or on hospital admissions forms and, in housewives, the occupation of the husband is often not given. This makes it difficult to ascertain accurately the socio-economic group of the person concerned. A start has been made in studying health by socio-economic group in our studies on the health of agricultural workers, both owners of farms and farm employees, in comparison with other groups in our society.

1980 is likely to be a year of economic stringency which makes it all the more important that we continue to study carefully how money is spent in the health services and whether it could be better used. For example, the cost and effectiveness of treating patients at home rather than in hospital needs to be studied and also the length of time patients stay in hospital, which is often too long. In addition, we need to enquire carefully into the use of drugs, many of which are consumed unnecessarily and in excessive quantities. If we are to stop the excessive consumption of drugs in Ireland it will require considerable education of the general public who should not
necessarily expect to leave their doctor with a prescription because, more often than not, what is required is advice and counsel rather than any drug. It is understandable that social factors are responsible for health costs besides medical factors. It is extremely difficult to close hospitals because of the local pressure to keep the hospital open. If the hospital is closed many jobs and positions of status may be lost. If the hospital beds are available, they tend to be filled. It is interesting that Dr. Mather, encouraged by Professor Archibald Cochrane, has shown in Bristol that, on average, patients with mild heart attacks do better at home than they do in hospital and that in Holland the majority of maternity cases take place either at home or in one-day hospitals and yet their perinatal mortality and morbidity is very low.

The Medico-Social Research Board is fully aware of the need to collaborate closely with other institutes interested in health in the Republic, in Northern Ireland and elsewhere.

For instance, a collaborative study is being considered for 1980 on the leisure-time activities of post-primary schoolchildren. The findings would be compared with a similar study undertaken in 1970. This study would involve collaboration between the Board, the Health Education Bureau, the Irish Cancer Society, the College of General Practitioners and research workers in Northern Ireland.

The Director represents the Board on the Joint Committee for Smoking and Health. This is a committee, chaired by Professor Risteard Mulcahy, representing the various groups in Ireland concerned with smoking-related health problems. The committee meets frequently to study the best way of drawing the attention of the public, the legislature and other influential groups in Church and State to ways of reducing cigarette smoking in Ireland. Public meetings organised by the committee on smoking-related problems will take place in 1980.

Perhaps the future emphasis should be on the effectiveness and efficiency of the health services provided in Ireland and on the need to look at how we can best obtain the most effective prevention and treatment of illness at the cheapest cost. In order to do this, we will require to monitor efforts at health education and develop randomised controlled trials of the various forms of treatment in hospital and in the community. Monitoring of effort and randomised controlled trials are not easy to undertake in a free enterprise society but they are very necessary if we are to have the best and cheapest medical service possible. Studies on
the effectiveness and efficiency of care will require for their success the closest collaboration with the Department of Health and the goodwill of the caring professions and the general public.
ACKNOWLEDGMENTS

We would like to thank Mr. Charles Haughey, T.D., Minister for Health and Social Welfare during 1979, for the great interest he showed in our work and for the time he spent with the Chairman, the members of the Board and the Director discussing the medico-social problems of Ireland. We congratulate him on his appointment as Taoiseach and welcome his successor as Minister for Health and Social Welfare, Dr. Michael Woods, T.D. We would also like to express our thanks to Dr. Brendan Hensey, Secretary of the Department of Health, and to members of the departmental staff.

We have continued our work in the closest collaboration with the Irish Medical Association and the Medical Union. We would also like to acknowledge the close liaison we have had with the World Health Organisation, with the Committee for Medical Research 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.

Our work would not have been possible without the help we have received from our many friends, medical and non-medical, who have assisted us in our various research projects.