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IMPROVED METHODS OF CONTACT TRACING*†

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At a meeting at County Hall, London, in April, 1964, it was decided to carry out a pilot study on contact tracing at The London Hospital and St. Thomas' Hospital. It was agreed that there should be one full-time V.D. Social Worker at each clinic and a third working between the two clinics. Many were of the opinion that this type of contact tracing would not be successful, but the figures for the first 9 months of the two years 1964 and 1965 show an increase in the number of contacts attending since the scheme was started.

Attendances in 1964 and 1965 (Table)

Gonorrhoea (Jan. to Sept.)

1964 978 persons were given as gonorrhoea contacts and 666 contact slips were issued. As a result, 287 (29·3 per cent.) contacts attended, of whom 175 were found to have gonorrhoea; thirteen of these attended other clinics, five with gonorrhoea and eight with other diagnoses.

A further 89 persons were given as secondary contacts; 75 contact slips were issued, and 29 contacts attended, of whom fifteen had gonorrhoea and nine other diagnoses. Five of them attended other clinics.

1965 1,005 persons were given as gonorrhoea contacts and 799 contact slips were issued. As a result of contact tracing, 453 (45·1 per cent.) contacts attended, of whom 312 had gonorrhoea; 67 of these attended other clinics, 44 with gonorrhoea and 23 with other diagnoses.

A further 112 persons were given as secondary contacts; 107 contact slips were issued, and 35 contacts attended, of whom fifteen had gonorrhoea and thirteen other diagnoses. Seven of them attended other clinics.

Early Syphilis (Jan. to Sept.)

1964 72 people were given as syphilis contacts, 39 contact slips were issued, and thirteen contacts attended, four of whom had syphilis.

Four other persons were given as secondary contacts, four contact slips were issued, and one contact attended but was found not to have syphilis.

1965 66 people were given as syphilis contacts, 38 contact slips were issued, and nineteen contacts attended, six of whom had syphilis.

Fifteen other persons were given as secondary contacts, fifteen contact slips were issued, and four contacts attended but none of them had syphilis.

Sex, Age, and Race

In the first 9 months of 1965, there were 796 male patients who attended with gonorrhoea. Of these 295 were coloured, and 115 of their contacts who attended were white girls, 73 under 25 years of age. Only two white men had coloured girl friends, who were both under 25 years of age. There were 32 Maltese and Cypriots, and eighteen of their contacts who attended were white girls, fifteen under the age of 25 years.

Of the 796 new male cases, fifty were teenagers and 62 were homosexuals. There were 79 teenage girl patients.

Dealing with the Patient

The problem of bringing in contacts who are known to the patient (*i.e.* wife, fiancée, friend, or acquaintance) has always been the easier one. The casual pick-ups and prostitutes present the greatest difficulty. The basic initial interview is the same for all, but how one continues the interview depends on the attitude of the patient. It is important to establish a good relationship and

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TABLE

RESULTS OF CONTACT TRACING IN THE FIRST 9 MONTHS OF 1964 AND 1965

Disease			Gonorrhoea		Early Syphilis	
Year			1964	1965	1964	1965
Contacts	No. Given		978	1,005	72	66
	Slips Issued		666	799	39	38
	Attended	Total	287	453	13	19
		Percentage	29·3	45·1		
		With Disease	175	312	4	6
	*Attended Other Clinics	Total	13	67	3	5
		With Disease	5	44	—	—
		With Other Diagnosis	8	23	3	5
Secondary Contacts	No. Given		89	112	4	15
	Slips Issued		75	107	4	15
	Attended	Total	29	35	1	4
		With Disease	15	15	—	—
		With Other Diagnosis	9	13	1	4
	*Attended Other Clinics	Total	5	7	—	—

* These form part of the total who attended in each section.

make it clear that attendance at the clinic is absolutely confidential. It is at times helpful to offer to take the contact to another clinic and even to say that we come from a different clinic; this is sometimes the only way when two homosexuals live together and are afraid of breaking a long-standing friendship. Whenever possible it is better to interview a patient at the first visit to the clinic. When a patient has just been informed that he has an infection he has received a shock and because of this is apt to be more co-operative. It is impossible to cover all the hours that the clinic is open, but it is possible to check up each day, write a request in the notes, and see the patient on a subsequent visit.

It is important to interview the patient alone in a quiet room. If the patient appears to have had enough, or is tired, it may pay to cut short the interview and to see him again at his next visit to the clinic. Our experience in interviewing and visiting patients has shown us how ignorant most people still are about venereal disease. A supply of leaflets not only for patients but also for contacts helps to spread this knowledge and often makes a difference in the patient's attitude towards his contact, and a chart which illustrates the spread of venereal disease may have more impact than the spoken word.

As a patient is often unable to give all the necessary information at the first attendance, it is helpful to give him a stamped addressed envelope with his number printed inside, or one's phone number and extension; this encourages him to make inquiries which may be vital in finding the contact: also it helps to bring home to the patient the urgency of finding his contact. I received one such letter from a British West Indian; he did not know his contact's name, but he found out her address and that she was living at the top of the house with "a tall British West Indian", who was a ponce and brought in the clients. The girl was making £100 per week which the ponce spent mainly on gambling.

Finding the Contact

It may appear immaterial whether the patient brings in the contact as a result of the interview, or whether we find the contact ourselves, but two important factors must be borne in mind:

(1) If the V.D. Social Worker has obtained sufficient information to enable her to visit, but the contact is not available or the information is incomplete and further research is necessary, she then visits again. On the other hand, if the patient himself does not succeed in finding the contact at the first

attempt he does not usually try again.

(2) If the V.D. Social Worker with the advantage of her many years of experience, approaches the contact, she is much better fitted than the patient to answer the contact's questions, and she has the authority of the clinic behind her. The very fact that she comes from the clinic and offers to bring the patient in may make all the difference, as the contact sees that she would not make a visit without good reason.

Identification

The first version of the contact-tracing form did not give a complete picture of the type of person one was trying to find, as men very rarely remember the colour of a girl's eyes, or the state of her teeth; but they do remember how she is made-up, whether she is well-dressed or unkempt, a heavy smoker or non-smoker, a drinker or non-drinker. The detailed form at present in use is shown on p. 209.

In building up a picture of the contact with the patient's help one sometimes learns further details which may make all the difference to finding the contact or not. For example, one man said he was almost sure that the girl, whom he had picked up in a Brixton Cinema, had told him that she worked in an Express Dairy. It seemed reasonable to suppose that the shop would be in Brixton, and the good description of the girl made it possible to trace her. She had gonorrhoea and she was also pregnant.

Even if one has a name and address, this further information may be very important as it enables one to visit on a more friendly basis. Another problem is that in the type of house in which so many of these girls live there is a constant change of population; many find it wiser not to be known by their real names. It is also important to obtain as many details as possible regarding the house itself. One homosexual syphilis contact had been picked up late in the evening and taken to his (the contact's) flat. The patient did not know the name of the road or the number of the house; but he knew the exact date of his encounter; that the road was up and completely blocked to traffic; that the house was the last but one; and that it was a top flat; he also described the view from the house. The person he had picked up was a British West Indian bus conductor in his twenties who had spent some time in the United States. This information enabled us to trace the contact.

It may be better to fill in the contact-tracing form from notes taken at the time, but after the departure of the patient, as this makes the interview less official.

Methods of Approach

There are four methods of reaching the contact:

(*1*) *Through the Patient.* At times the best method of approach is to give the patient the phone number or a note to pass on to the contact.

(*2*) *By Writing.* If visits would cause embarrassment (at the place of employment) or if the contact is rarely at home or living at a distance, a letter may be the only practicable method of communication.

(*3*) *By Telephone.* This is a very useful and speedy method. It is very satisfactory when a casual pick-up who has been given as a contact by several patients, and whom one has been trying to contact for weeks, suddenly phones.

(*4*) *Visiting.* On the whole this is the best method. It is very important to establish a good relationship at the first visit.

A small fund enabling one to offer the contact cigarettes or to take her into a nearby restaurant for a cup of tea is of considerable help to both the visitor and the interviewer. It would be helpful if the fund could be enlarged to enable us to bring a difficult person to the clinic by taxi. One has to make it clear that attendance at the clinic is confidential; that the reasons they have been approached are (*a*) concern for their health, (*b*) the fact that they may re-infect their contact or infect others if they do not attend. As a rule the only way to bring in contacts is to conduct them straight back to the clinic by public transport.

Patients use the term "friend" very loosely; one often finds that the man hardly knows the girl, or that she has been living with him only for a few days. British West Indians often pick up a girl in a public house or in the street and, because they feel sorry for her, take her home: she stays a night or longer, until they have a row or she has picked up another man. This type of girl is extremely difficult to trace. The majority have a poor home background or are not very intelligent. Girls are sometimes grateful for our help because the boy friend's attendance at the clinic has caused a rift.

Dealing with the Contact

For a girl to come to a Venereal Disease clinic for the first time is always an ordeal. There are times when a male patient is bringing his contact and she suddenly refuses to go any further. A phone call from the patient may enable one to overcome this difficulty by going out to meet them. Some male patients discuss attendance with their contact but leave it to the V.D. Social Worker to do the rest. For contact-tracing to be successful one needs

to interview the female as well as the male patients. If a girl has already been given as a contact, one can add extra details to the form already filled in. If she has not been given as a contact, it is helpful to make out a form so that, if she is subsequently given as a contact, one immediately recognizes her. One of the interesting factors which has emerged is how frequently a female patient has been given first as a contact of one patient and later of others. In the 9 months of this work we had forty new cases of syphilis, of whom seventeen were homosexuals and one of these alone had fifteen contacts.

It is often more difficult to bring in a syphilis contact because of the time factor. Two male patients I interviewed, both middle class, had contracted syphilis from their 18-year-old steady girl friend. One of these men had been abroad for some months; the girl had been to a party and had had sexual intercourse with a casual male. In both cases the young men told me that the girls' parents were aware of the fact and had advised them to attend a clinic, but both fathers had categorically refused to allow the daughter to say where she herself had attended.

As a rule the patient who has repeated infections seems less inclined to help as regards his contact than the patient who has been infected only once or twice. Sometimes a patient will say to me, "Did you manage to find and bring in my last contact"? When I say "Yes", he says, "Very well I'll bring in this one".

Sex is often used as a form of payment for a lift by a long-distance lorry driver, an expensive taxi fare, or an evenings entertainment. The present fashion in parties makes contact-tracing at times extremely difficult. Sometimes in a public house, word will go round, or a card will be circulated stating that there will be a party at a particular address; people either take drink with them or buy it there. Sexual intercourse in the early hours of the morning is not unusual and as the contacts are complete strangers tracing is difficult.

Spread of Infection This problem is illustrated by a prostitute who was found and brought in through the contact-tracing scheme; all her clients were coloured; her usual place for picking them up were public houses, though for a time she had a beat which she generally walked from 12 p.m. to 3 a.m. Her usual price was £1, but if the men deviated at all she charged them double. If on reaching the flat they refused to have sexual intercourse with her because the place was very dirty, she charged them 15/- for the inconvenience. Between March and September she had gonorrhoea six times. Though we had ample evidence that she was a prostitute, she always strongly denied it. She was then found to have early syphilis. It emerged that she had had sexual intercourse with 385 men during this period, with some more than once.

V.D. Social Workers' Problems

One of the problems of visiting is that one often has to spend hours on research going from one address to another. Some visits have to be done very early in the morning, some during the day, others in the evening, and after hours of such work one may draw a blank. A knowledge of the local and West End cafés and clubs where girls congregate is useful. The Medical Officer of Health for Lambeth has made accommodation and a telephone available to us at the Health Department. This is of considerable help to us as it is important to have a direct liaison by telephone between interviewer and field worker so that contacts may be more accurately recognized and responsibility shared for making approaches when the identity of contacts is in doubt. In visiting it is sometimes wiser to say that one is employed by the Borough and if we need to write we usually place the letter in two envelopes, the inner one addressed to us at the Borough, in case the contact should no longer be living at the address given. It is most important that a member of the Borough staff should be available by day and night to confirm the identity of the V.D. Social Workers, should the need arise. If on visiting we felt that a girl's name had been given out of spite, we would leave it to her whether she attended the clinic. My colleague finds it useful to say that she has not interviewed the patient, but they can contact me. Only once during the 9 months did a man come to the clinic and leave without being seen, as we were both doubtful and left it to him whether he was seen or not. A good relationship between the interviewer and the visitor is essential, and the work of both is equally important. This does not mean that if required the interviewer should never visit or the visitor never take over the interviewing. We also keep a close liaison with V.D. Social Workers in other clinics. If a patient resides outside the London area, we fill in one of the contact-tracing forms and send it to the authority concerned.

The clinic staff form a team, and the rest of the team can help a great deal to make contact-tracing a success.

Future Developments

What of the future? It would be very helpful if our initial interviews and leaflets could be translated into different languages. Up to now, on the whole, we have had time to concentrate only on cases in which there is a chance of success. For contact-tracing to be really effective a larger number of V.D. Social Workers is needed. One of the difficulties in the past has been that it was impossible to bring up all casual contacts between 10 a.m. and 7 p.m., and it has now been arranged with the Casualty Department that either the V.D. Social Worker or the patient can bring in a contact after 7 p.m. Another weakness of the present system is that there is no central organization. The experience gained in the past year indicates the need for a central bureau, preferably under the ægis of the Ministry of Health, where all cases in the Greater London area could be listed; later this could be extended to cover a wider area. Quite often patients are willing to give a name but no address, and they say, "I am sure he (or she) has attended a clinic". One tries the nearest clinics, and draws a blank: perhaps 6 months later one sees the same patient and he says, "Oh, he went to such and such clinic the other side of London". Sometimes one spends hours visiting only to find that the person in question is already attending a clinic. As far as contact-tracing is concerned, if we could send duplicates of our forms, provided we had a fair amount of information, to a central office where the descriptions could be correlated, one contact might be identified by patients in several separate clinics, and once the contact had been found by one V.D. Social Worker, the other officers could be informed. Recently we received a Memorandum from the Ministry of Health, which stated, "As part of the endeavour to improve contact-tracing, the Ministry is now in touch with a number of public health authorities in other countries and is in a position to forward, under confidential cover, details of contacts of patients treated in this country who have acquired their disease abroad. It will be most helpful if you will forward any information of this kind obtained from infected patients who have no objection to it being passed on to the Ministry of Health."

Conclusions

Contact-tracing has not been just a job of work for us, but a way of life. We have communicated with each other to pass on urgent information from early morning until late evening. Looking back over the 9 months in each year, we have noted that whenever one of us was away for any length of time, the number of contacts attending fell considerably. No such project can ever be 100 per cent. successful, the very nature of the circumstance making this impossible, but with time and experience it can be made more and more effective.

In the first 9 months of 1965, we were not only able to increase the number of gonorrhoea contacts attending to 45·1 per cent., as against 29·3 per cent. in the first 9 months of 1964, but were also able to help and advise many patients and their contacts. We have always made it a practice not to moralize or talk down to our patients, and as a result have always been made welcome when we have had to re-interview or revisit.

We should like to express our gratitude to all those members of the staff who have helped us, not only those in Lydia Department, St. Thomas' Hospital, but also those at other clinics who have often taken considerable trouble to assist us.

VENEREAL DISEASE CONTACT REPORT

To the Medical Officer of Health, ...

A male/female patient of this Clinic, Ref. No. ....., under treatment for ....., of approximately ..... days'/weeks'/months' duration, has disclosed in strict confidence the following information: .....

Alleged Contact: Name and Nickname .....

Address .....

Age (yrs) ..... *Nationality* ..... *Occupation* .....

Single Married Separated Widowed Children

Description:

Colour:	White	Coloured	Half-caste			
Hair:	Fair	Red	Brunette	Black	Style short medium long	
Height:	Tall	Short	Medium	ft.	in.	
Build:	Thin	Slim	Medium	Plump	Stout	
Eyes:	Blue	Green	Grey	Brown	Other	Glasses
Teeth:	Even	Uneven	Good	Bad	Missing	False
Speech:	Dialect		English		Poor	
Make-up:	Heavily made-up		Nicely made-up		No make-up	
Face:	Round		Long			
Marks:	Scars	Tattoos	Birthmarks	Moles	Warts	
Physical Defects:						
Characteristics:		Nonsmoker	Smoker	Heavy smoker	Heavy drinker	
Dress:	Well-dressed		Ordinary		Unkempt	Headscarf
	Coat	Suit	Costume	Skirt	Jumper	Slacks
	Blouse	Frock	Jacket	Cardigan	Jeans	Handbag
Footwear:	High heels	Low heels	Stockings			
Jewellery:	Rings	Earrings	Bracelet	Necklace		

Type of Contact: Cohabiting Friend Pick-up Prostitute Other

Place of Encounter: Public House Home Bus or Rly Station Dance Hall
Cinema Park Taxi Coffee Bar Club
Party Street

Name and Address .....

Solicitation: Yes/No Fee Paid Evening's entertainment

Place of Exposure: Hotel His Home Her Home Friend's Home
Car Park Street Taxi Brothel

Name and Address: .....

Date of Exposure: .....

Any Other Information: .....

Date of Report: ..... Signed .....
V.D. Social Worker

☐ May Visit
☐ Contact's Address/Description
☐ May use Patient's Name

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