excluded by other units. The differing admission criteria must certainly account for some of the variation in admission rates and length of patient stay.

We decided that for our catchment population of approximately 190,000, a specialised unit would not be appropriate and we were not impressed by the solution of placing the occasional mother and baby on an acute general adult psychiatric ward. It seemed to us that it should be possible to avoid many admissions by providing intensive support at home, and we feel that this could most efficiently be provided by a further development of our community nursing service. We will, however, also need to explore, with neighbouring districts, the possibility of providing a joint mother and baby unit for those women who still require admission.

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The Problems of Tracing

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The importance of tracing technique and persistence was stressed by Sims.[1] Long-term follow-up studies help to complete the clinical picture, a phrase used by Morris.[2] They also help to clarify such issues as the effectiveness of treatment methods and changes in the socio-demographic status of patients. Unless a high percentage of the follow-up group is effectively traced, then the results of a long-term follow-up study must be suspect.

In this paper we hope to outline the tracing strategy we used in a recent follow-up study of male alcoholics who were admitted to our hospital 20 years ago.[3] We feel this information may have some value for others engaged in this type of research. Also, we have included some of the unusual situations we encountered. Lastly, we hope to comment on some of the ethical issues involved in this type of study.

The study

St John of God Hospital is a 200-bed private psychiatric hospital in the south side of Dublin. The patients were exclusively male until 1968. The hospital deals with all types of psychiatric disorder and is regarded as having a special interest in the treatment of alcoholism.

The study group comprised first admissions to the hospital, in 1964, with a diagnosis of alcoholism. There was no specified catchment area. The cohort numbered 133. The age range was from 25 to 72 and the majority came from socio-economic groups 1,2 and 3.

Changes of address, as far as possible, were noted using hospital charts and telephone directories. A letter was sent to each subject introducing ourselves and the project. We enclosed a stamped-addressed envelope to facilitate the return of the acceptance form. This form had a space for changes of address where applicable.

We attempted to protect confidentiality by firstly keeping the research team to a minimum, that is two. Secondly, all forms with confidential information had a reference number only. The key to these numbers was available to the research team only. In the following tracing methods we attempted to restrict information divulged to the various contacts to a minimum.

The following sequence was employed for non-responders:

1. Telephone calls were made using any of the telephone numbers available to us from the original charts or from new telephone directories. This sometimes meant that our initial contact was with a relation or a friend who accompanied the patient at the time of admission.
2. If contact was still not effected we then contacted the Gardai (police) of the area for which we had an address for the subject. They were asked if they knew if the subject still lived at the last address we had, and to check the register of electors for the area if they did not know.
3. We called at the last address we had for the subjects still not traced from the Dublin area. (It would have been impractical for us to follow this course for the whole country.) We interviewed the current occupants about the subject and his whereabouts. If this did not help then we asked the current occupants for several houses on either side of the original house for similar information.
4. The consular section of the Department of Foreign Affairs was contacted about subjects who were from abroad or had emigrated during the follow-up period.
5. The death certification offices and coroners offices in relevant areas were contacted. This was to obtain death certificates for those we knew to be dead, but also to try to determine if subjects still untraced were in fact dead.

TABLE I
The results of tracing strategies (cohort numbered 133)

Method	Results
Initial letter	46(34.6%)
Phone calls	31(23.3%)
Gardai (police)	5(3.8%)
House calls	3(2.3%)
Other sources	9(6.7%)
Total	94(70.7%)

Of the original group of 133, we successfully traced 94 (70.7 per cent). Of these, 53 were dead at the time of follow-up; the remaining 41 completed our questionnaire. We discuss the mortality data and the other outcome information elsewhere.[3] Forty-five (33.8 per

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cent) responded to our initial enquiry with 20 expressing willingness to take part in the study and 25 of the responses giving information about subjects' deaths. Ten were returned by the Post Office informing us that the addressee no longer lived at the given address.

Telephone calls to all available telephone numbers helped us trace a further 31 (23.3 per cent) of the subjects. Information from the Gardai (police) helped us trace five subjects. One helpful Garda from a rural area told us that the man we were tracing had moved to a different part of the country 20 years ago and that his son was working in a large firm in Dublin. We contacted this firm and his son actually answered the telephone. He was amused by the coincidence and gave us the information we required to trace his father.

Calling at the last available address helped us trace three further subjects. The sister of one subject was still living in the house and was able to give us a full history about her brother, now in America.

Fourteen of our subjects were from the UK, and two had emigrated to America. The relevant embassies were contacted, but were unable to help because of diplomatic protocol. All our enquiries had to be made through the Irish Department of Foreign Affairs. This department was very co-operative. They arranged that all addresses we had for subjects who had gone abroad were visited by their official in the relevant areas. Unfortunately, no one was actually traced by this route.

The death certification and coroners offices were able to help us trace only an extra two subjects. One of our subjects came from a remote country village and by coincidence one of the consultants at our hospital came from the same area. He was able to give us details about the subject's death although there was no death certificate traceable from the appropriate agencies.

Discussion

It is interesting to note that telephone calls boosted the tracing success by 23.3 per cent. However, this method of contact had some unfortunate consequences. The wife of one subject we contacted wrote to us to complain. She said her husband had recently started developing a neurological disorder and was quite upset after the telephone call. Another subject answered our initial letter affirmatively. Several weeks later it was noted that he made no further contact as had been arranged. When telephoned to ask if he was still interested in taking part, we were told by his brother that he had died two days previously. Another respondent claimed that he had never been admitted to our hospital, but he had in fact been admitted twice before on temporary certificates.

Probably the most important aspect of ethics in relation to research studies is to do with causing harm to patients. Wing[4] discusses this, but mainly in relation to control studies in which drugs are used. Our study did not involve drugs or the risk of serious damage, but there may have been a risk of minor damage with upset to patients. This cannot be disregarded. Is it justifiable to contact someone about an admission to a psychiatric hospital they had 20 years ago? There is a risk that feelings best forgotten may be opened up, and there is also the chance that a son or daughter will open the letter addressed to their dead father and discover for the first time that he was once a patient in a psychiatric hospital. One patient who was starting to suffer from a neurological disorder was upset by the contact. Another family could have been upset by a research oriented phone call about their brother who had just died.

Another important ethical consideration is confidentiality. As Wing[4] asserts, the main problem in small-scale research projects is likely to be carelessness. We agree with him that keeping the research team as small as possible and having reference numbers only on confidential documents are useful safeguards.

Balancing the benefit with the possible harm, as Wing suggests, we feel that this type of study is justified. Although out of our study group of 133 only one person was upset by the contact, it is important to be aware constantly of the sensitivities of the subjects and their families. Long-term follow-up studies help understand the natural history of disease and the effectiveness of treatment. In this study the chance of benefit seemed to outweigh the slight chance of harm.

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Merck Research Prize in Child and Adolescent Psychiatry

The Merck Prize for Research is awarded for particularly outstanding work in the field of child and adolescent psychiatry. The Prize is open to any scientist who is not yet 40 and who is resident in Europe. (Employees of industrial businesses are excluded from the competition.) Apart from basic research, papers which deal with diagnostic as well as with therapeutic questions in this special field will be considered. Papers should not be more than 40 typed pages of 30 lines, and tables and illustrations should not be more than a quarter of the whole. Manuscripts should be written in English, German and French, following the instructions of a scientific journal.

The award of the Prize usually takes place in the course of the Congress of the European Society of Child and Adolescent Psychiatry. The next award will take place at the symposium to be held in Lausanne in Autumn 1986. All submissions must be received by 30 June 1986, and should be sent to: Dr Max H. Friedrich, Kinderneuropsychiatrie, Wahringer Gurtel 18–20, A–1090 Vienna, Austria.