Eyes Regulations.[1,2] The British Standards Institution has also issued specifications for eye protectors.[3] Despite these, ocular foreign bodies continue to be a problem. The true number of patients who get foreign bodies in their eye while at work is certainly higher than the number presenting to this department as most firms have first aiders who will try to remove such foreign bodies.

Compliance with wearing eye protectors is not as high as expected, with people deciding for themselves whether protection is needed in various circumstances.[4] Many of the patients interviewed also showed little awareness of the potential dangers of ocular foreign bodies. There seems to be scope for improved education of workers dealing with metals and possibly for the provision of individually measured eye protectors. A range of devices for different activities seems to be desirable.

1 *The protection of eyes regulations.* Statutory Instruments 1974 Part III Section I, 6075-83. London:HMSO, 1976.
2 *The protection of eyes (amendment) regulations.* Statutory Instruments 1975 Part I Section I, 813-4. London: HMSO, 1976.
3 British Standards Institution. *Specification for industrial eye protectors (BS 2092).* London: BSI, 1967.
4 Davey JB. Industrial eye protection. *Ann Occup Hyg* 1987;**31**:67-70.

(Accepted 18 June 1990)

Differences in disability between people with mental handicaps who were resettled in the community and those who remained in hospital

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Br Med J 1990;**301**:646

The white paper *Caring for People* recommends that people requiring continuous health care should not be placed in large institutions unnecessarily.[1] We have examined the position for mentally handicapped people in two London boroughs and assessed the differences between those remaining in hospital and those resettled in the community.

Patients, methods, and results

We studied all patients who had been registered as mentally handicapped in Kensington and Chelsea and Westminster and who were in hospital at the time of their registration. The average period between their registration and the time their record was last updated was five years.

Data were extracted in February, 1989 from the Kensington and Chelsea and Westminster planning registers for people with mental handicaps.[2,3] Information included an assessment of patients' skills, abilities, and behaviours based on the Wessex rating scale.[4] The scale includes questions about continence; mobility; ability to wash, dress, and feed; sight and hearing; communication; and social behaviour. Patients are reassessed each year.

Number (percentage) of people who were recorded as having one or more severe physical or behavioural problems at registration and at last update in Kensington and Chelsea and Westminster boroughs

	At registration (Total group; n=400)	At last update			
		Total group* (n=400)	Hospital group (n=231)	Community group (n=92)	% In hospital: % in community
Wetting at nights	71 (18)	61 (15)	53 (23)	8 (9)	2·6
Soiling at nights	43 (11)	41 (10)	37 (16)	4 (4)	4
Wetting by day	57 (14)	49 (12)	42 (18)	7 (8)	2·3
Soiling by day	40 (10)	36 (9)	32 (14)	4 (4)	3·5
Unable to walk	52 (13)	41 (10)	34 (15)	5 (5)	3
Unable to feed	23 (6)	15 (4)	14 (6)	1 (1)	6
Unable to wash	94 (24)	75 (19)	72 (31)	3 (3)	10
Unable to dress	76 (19)	54 (14)	50 (22)	4 (4)	5·5
Little or no vision	28 (7)	24 (6)	21 (9)	3 (3)	3
Little or no hearing	16 (4)	17 (4)	11 (5)	5 (5)	1
No speech	109 (28)	104 (26)	91 (39)	13 (14)	2·7
Hit people	26 (7)	27 (7)	26 (11)	0	
Damages property	26 (7)	18 (5)	18 (8)	0	
Overactive	24 (6)	21 (5)	20 (9)	1 (1)	9
Attention seeking	32 (8)	29 (7)	25 (11)	4 (4)	2·8

*This includes last update before death.

Four hundred people had been in hospital when they were first registered, of whom 92 were then resettled in the community (community group), 231 remained in hospital (hospital group), and 77 died (seven of whom had been resettled in the community). The overall frequency and severity of problems among all patients at registration was similar to that at their last update (table). Those patients in the hospital group had had significantly more severe problems at registration than those in the community group ($\chi^2=17{\cdot}72$, df=1; $p<0{\cdot}001$). The hospital group also had a greater proportion of people with severe problems at last update than the community group for every variable analysed (table), the largest difference being in ability to wash. There were also large differences in the two groups' ability to feed and dress themselves.

Comment

Our study suggests that in Kensington and Chelsea and Westminster the people who had been resettled had had fewer and less severe problems at registration than those who remained in hospital, rather than that they had less severe problems as a result of living in the community. The resettlement teams have been finding that the available provision in the community is, with few exceptions, not appropriate for the people left in hospital. So far the needs of most multiply handicapped people do not seem to have been met. Although our findings do not necessarily reflect the position throughout Britain, in the absence of detailed data from other parts of the country their implications should not be ignored.

We thank Dr Gyles Glover and Jacqui Bobby for help with computing.

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(Accepted 3 August 1990)

Correction

Aetiological importance of ovulation in epithelial ovarian cancer: a population based study

A printer's error occurred in this paper by Dr Derek J Cruickshank (15 September, p 524). The first sentence of the second paragraph of the comment should read "The incidence of and mortality from ovarian cancer, unlike those associated with other gynaecological malignancies, are rising."