label. "Expiry date" will be at the top of the label. Below the blood group (ABO and Rh) and the regional blood transfusion centre will be recorded both sets of information in written and bar code form. The "Date bled" will be immediately below this information.

Also from 1 April the Rh type on most red cell packs will refer to the Rh D group only. Thus, red cells will be labelled Rh D positive or Rh D negative, which will meet most requirements. Additional Rh typing to provide further information concerning the Rh group will be performed at regional transfusion centres, and these specially typed units of red cells will be available when required.

During the next few weeks this important change in labelling will receive wide publicity. Posters will be available in hospitals together with a leaflet illustrating the change to black and white labels. Both of these measures will supplement discussions between staff in transfusion centres and hospitals on the implications for hospital practices of the changes in labelling.

Countries that have changed from coloured to black and white labels have done so successfully. Even if an international colour coding agreement was achieved in the future, reverting to coloured labels may not be popular as black and white labels can be readily printed in house. The discipline of reading the blood group on the label instead of looking at the colour may not be so readily accepted as an advantage. It must be conceded, however, that this principle is one that accords with good clinical practice. It is no different from the well recognised practice of reading the name of a drug on the container before giving it.

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What mentally ill offenders need

All their carers marching to the same tune

Nearly 20 years after the Glancy and Butler reports recommended new psychiatric facilities for treating mentally abnormal offenders[1,2] scandal and mishap keep the subject on the political agenda. Reports of mentally ill offenders in prison,[3] of unacceptable delays in transferring patients from special hospitals,[4] and of inadequate follow up after patients' discharge from hospital are common and sometimes tragic.[5] More than 10 years have elapsed since the Royal College of Psychiatrists emphasised the need for treatment to be available in settings that provide a range of security according to clinical need.[6] Recently the government seems to have rediscovered mentally abnormal offenders. We are instructed that mentally ill offenders should be diverted from prosecution and not imprisoned,[7] services for those who are in prison should be improved,[8] and agencies dealing with mentally abnormal offenders should coordinate their work.[9]

Few would disagree with these statements of principle. So why, now, another government document?[10] Last week marked the end of an 11 week consultation period for a review by the Department of Health and the Home Office of services for mentally disordered offenders and others with similar requirements.[11] A cast of 41, including only seven hands on psychiatrists, assembled in three advisory groups and a steering committee under the chairmanship of Dr John Reed, senior principal medical officer. The review deals solely with services in England.

There are reports concerning hospital, community, and prison services and an overview. Their principal objective is that mentally disordered offenders needing care and treatment should receive it from health and social services rather than in custodial care; at present, we are reminded, "practice all too often falls a long way short of what is desirable." The review makes 87 recommendations with five criteria in mind. Care should be provided on the basis of individual need, as far as possible in the community, near to the patient's home, only at the level of security justified by the patient's dangerousness, and with the aim of maximising rehabilitation and the prospect of independent living. Psychiatrists would vote for all that as they would for the abolition of sin.

Missionary zeal is maintained in the specific recommendations. Prosecution of mentally abnormal offenders should be avoided. Local policies should be agreed by police, health, social, and probation services for the use of section 136 of the Mental Health Act 1983 (removal of a mentally disordered person to a place of safety), and appropriate facilities should be identified as places of safety. There should be a single and consistent point of access, available 24 hours a day, to health and social services. There should be more specialised bail facilities in the community, and defendants should not be remanded in custody solely for medical reports to be obtained.

Deficiencies in prison and hospital services are identified. Psychiatric services in prisons should be contracted out to the NHS in line with the recent proposals for general medical services.[12] Closure of mental hospitals is unacceptable in the absence of provision in the community of a range of services for former inpatients, each of whom should have an agreed care plan. Local psychiatric services should include access to wards providing intensive psychiatric care and to locked wards.

Provision should be made for patients who require long term care in a secure environment but would be inappropriately placed in a regional secure unit or special hospital. The national provision of beds in regional secure units should increase from the current 635 to 1500. Special hospital resources should not be changed at present.

How are these uncontentious, unoriginal, but highly desirable recommendations to be implemented? They involve a range of diverse organisations learning to march to the same tune. Reed proposes an action plan: local assessments of need, the setting up of a "permanent national focus," and dissemination of examples of good practice (for example, some of the court liaison schemes described in the review). General psychiatrists and their managers in district services, for whom the review has major implications, will wait with interest for the second phase of the review, which is considering finance, staffing, and training. Putting Reed's report into effect will not be easy. The fractious years that followed the Butler report provide lessons: regions and districts failed to understand the problems[13]; mentally abnormal offenders lacked influential advocates; ring fenced money was plundered; there were insufficient skilled staff; and regions fortunate

enough to possess, or appoint, a product champion benefited.[14]

Reed's report is about patients with serious psychiatric disorders who, for various reasons, happen to present to police, courts, and prisons. Their offences are usually minor. Their needs are not constant over time but are primarily medical and social. As public sensitivity mounts the government has produced a comprehensive review with sensible, if familiar, recommendations. Substantial new money will be essential. But so too will be competent organisation and real commitment if we are to see an improvement in services that the professions, and now the government, recognise as embarrassingly inadequate.

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Airs, waters, places, and doctors

Time for action

> Man has been endowed with reason, with the power to create, so that he can add to what he's been given. But up to now he hasn't been a creator, only a destroyer. Forests keep disappearing, rivers dry up, wild life's become extinct, the climate's ruined and the land grows poorer and uglier every day.[1]

So laments the doctor in *Uncle Vanya*, written by Dr Anton Chekhov a century ago. Lucky for them that neither is around to see what further despoliation the world, and particularly their Russia, has suffered since then, or what we are promised the next century will bring.

Even if only half the predictions listed in our series on health and the environment are true there is serious trouble ahead. Here's a selection: almost a doubling of the world's population by 2050[2]; energy consumption up 75% by 2020 (so more greenhouse gases)[3]; an increase of 2-5°C in the world's temperature over the next 50-100 years (equal to the increase since the last ice age); a rise of 1 m in the sea level; one third of the world's land for growing crops under water and much of the rest reduced by climatic change to desert; and 50 million "environmental refugees," most of them hungry.[4]

Blame the apocalyptic foreboding that gathers on the eve of a new millennium: history suggests that some of these pessimistic predictions will be wide of the mark. Hasn't the intergovernmental panel on climatic change already backpedalled on its predictions for global warming, deferring a 1°C increase in global mean temperature from 2025 to 2030?[5] To focus on this minor adjustment, however, is to miss the point. Even allowing for wide margins of error, whichever prediction you examine the earth looks like being in big trouble within our children's lifetimes.

The thoughtless destruction of the natural world reduced Dr Chekhov and his medically qualified characters to mainly impotent despair. Could or should today's doctors be doing any more about the environmental impact on health? If their patients are suffering then the answer must be an unequivocal yes. Our series on the environment has provided hard evidence for this: air pollution initiates and exacerbates respiratory illness,[6] swimming in polluted waters results in ear and gut infections,[7] noise at work deafens,[8] road accidents kill and maim,[9] ozone depletion increases the risk of skin cancer.[10]

Patients are already consulting doctors about these risks to their health. As an awareness of the pathological potential of environmental damage filters down to the general public from activist groups like Friends of the Earth and Greenpeace fewer people will let themselves be fobbed off by doctors who apparently know less about the subject than they do.

Certainly, for many environmental pollutants the evidence for an adverse effect on health remains soft—low level radiation and many pesticides fall into this category.[11,12] But further research, which will require doctors' participation, should harden it up. As the series' authors pointed out in their introduction, doctors are best placed to monitor the effects of environmental pollution on human health.[3]

It is only a short step from agnosticism about threats to the environment to paralysis when the enormity of these threats is appreciated. But it is not necessarily downhill all the way. In Britain smog no longer kills citydwellers in the thousands, as it did in 1952.[6] Lead emissions from vehicles with petrol engines have more than halved since financial incentives were introduced to encourage the use of lead free petrol.[13] Fish are now being caught from rivers that were "dead" for years.

What these examples have in common is that they resulted directly from changes in government policy, which suggests the route to further progress. At present the United Kingdom is meant to be incorporating into its laws the environmental standards agreed by the European Community, most of which are stricter than its own. Recently Britain has fallen foul of standards for drinking water,[14] bathing water,[7] and, according to Friends of the Earth, emissions of nitrogen dioxide,[15] adding a few more chapters to its long history of foot dragging and derogation.

As well as drawing attention to the effects of environmental damage to their patients' health doctors should exert what pressure they can on those in authority. It has worked in the past: doctors have been at least partially responsible for some of the great advances in public health. They could start by adding their voices to the chorus of complaint at Britain's tardiness in bringing its environmental standards up to scratch. The stakes are high, and time may be running out.

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