Learning Disabilities (CIPOLD)[3] demonstrated an underlying culture in which people with intellectual disabilities were disadvantaged in accessing equitable healthcare and at risk of premature death because equality for disabled people was assumed to mean treating them the same as others. It does not. Alternative methods of making services available have to be found in order to achieve equality of outcomes. Mizen *et al*, for example, demonstrated that clinical guidelines can actually increase health inequalities for people with intellectual disabilities if reasonable adjustments are not made.[4] If the lack of reasonable adjustments threatens to compromise safety as, in very many cases, it does for people with intellectual disabilities, this needs to be reported and reviewed as a patient safety issue.

Effectiveness – evidence put forward by Tuffrey-Wijne *et al* suggests that ward culture, staff attitudes and staff knowledge are crucial in ensuring that hospital services are accessible to vulnerable patients.[5] Effective care is that which is tailored to the needs of the patient, and this must involve an understanding of the adjustments they need in order to be able to receive appropriate medical and nursing care. In our view, we should go further than Tuffrey-Wijne & Hollins' requirement for Care Quality Commission inspections in England and Wales to oversee patient-specific recording of reasonable adjustments. We also need to be confident that such adjustments are being delivered, and for evidence to be provided of adequate arrangements being in place.

Patient experience – Turner & Robinson note that it is difficult for people with intellectual disabilities and their families to influence policy and practice in healthcare systems if they are not visible within them and if involvement mechanisms such as surveys and focus groups are not accessible to them.[6] Both the Death by Indifference[7] and CIPOLD reports highlighted the lack of attention paid to the views of patients and their families, preventing them from becoming active partners in their care; the CIPOLD report additionally noted the devastating impact on future care that a poor experience of healthcare can have for some people with intellectual disabilities. The provision of reasonable adjustments needs to extend to the ways in which we garner the views of people with intellectual disabilities, communicate with them, and place them at the centre of their care.

The CIPOLD report made 18 recommendations, which included (a) clear identification of people with intellectual disabilities on the NHS central registration system and in all health care records, and (b) reasonable adjustments required by, and provided to, individuals, to be audited annually and examples of best practice shared across agencies and organisations.[3]

It is now 4 years since the Equalities Act 2010 came into force. Our adherence to the Act must be sharpened in the light of the health inequalities faced by people with protected characteristics, including those with intellectual disabilities, so clearly demonstrated in successive reports. We all have a responsibility, and we all have a role to play, in ensuring equal outcomes for vulnerable people through the provision of reasonable adjustments, but strong leadership is central to making it happen.

1 Tuffrey-Wijne I, Hollins, S. Preventing 'deaths by indifference': identification of reasonable adjustments is key. *Br J Psychiatry* 2014; **205**: 86–7.

2 Department of Health. *High Quality Care for All: NHS Next Stage Review Final Report*. Department of Health, 2008.

3 Heslop P, Blair P, Fleming P, Hoghton M, Marriott A, Russ L. The confidential inquiry into premature deaths of people with intellectual disabilities in the UK: a population-based study. *Lancet* 2014; **383**: 889–95.

4 Mizen L, Macfie M, Findlay L, Cooper S, Melviille C. Clinical guidelines contribute to the health inequities experienced by individuals with intellectual disabilities. *Implement Sci* 2012; **7**: 42.

5 Tuffrey-Wijne I, Goulding L, Giatras N, Abraham E, Gillard S, White S, et al. The barriers to and enablers of providing reasonably adjusted health services to people with intellectual disabilities in acute hospitals: evidence from a mixed-methods study. *BMJ Open* 2014; **4**: e004606.

6 Turner S, Robinson C. *Reasonable Adjustments for People with Learning Disabilities – Implications and Actions for Commissioners and Providers of Healthcare*. Improving Health and Lives: Learning Disabilities Observatory, 2011.

7 Mencap. *Death by Indifference*. Mencap, 2007.

Pauline Heslop, Reader in Intellectual Disabilities Research, **Matthew Hoghton**, **Anna Marriott**, University of Bristol. Email: pauline.heslop@bristol.ac.uk

doi: 10.1192/bjp.205.5.411b

Authors' reply: We welcome the detailed response from Heslop *et al* giving more evidence in support of our recommendation for the effective use of reasonable adjustments during in-patient care. They also draw attention to the need for these to be properly audited by staff who understand the Equality Act 2010, which in our view would require an extensive educational programme, as there is no evidence that current audits are much more than a box-ticking exercise.

They repeat an earlier and often made recommendation that people with intellectual disabilities should be identified on a national NHS database. NHS England has already decided to set up a national learning-disability mortality review function, which will require a national database. Regrettably, this cannot commence until data linkages have been enabled by the NHS and the Health and Social Care Information Centre and it seems unlikely that this will be achieved until next summer.[1] Strong advocacy is needed to ensure there are no further delays in giving priority to this work.

1 Hansard. HL Deb 30 July 2014 vol 755 col 1583.

Sheila Hollins, St George's University of London, **Irene Tuffrey-Wijne**, PhD, Kingston University and Faculty of Health, Social Care and Education, St George's University of London. Email: hollinss@parliament.uk

doi: 10.1192/bjp.205.5.412

Corrections

Aripiprazole once-monthly for treatment of schizophrenia: double-blind, randomised, non-inferiority study. *BJPsych*, **205**, 135–144. Figure 3(a), p. 141: x-axis label should be 'Days from randomisation'. The online version of this paper has been corrected post-publication, in deviation from print and in accordance with this correction.

Cost-effectiveness of injectable opioid treatment *v.* oral methadone for chronic heroin addiction. *BJPsych*, **203**, 341–349. In the abstract, the second sentence of the Results should read: 'Costs overall were highest for oral methadone (mean £15 805 *v.* £13 410 injectable heroin and £10 945 injectable methadone; P = n.s.) due to higher costs of criminal activity'. These data were reported correctly in the body of the paper (Table 2, p. 344). The online version of this paper has been corrected post-publication, in deviation from print and in accordance with this correction.

doi: 10.1192/bjp.205.5.412a