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Running head: ADULTS WITH LEARNING DISABILITIES AND OFFENDING

A Multi-Centre Study of Adults with Learning Disabilities
Referred to Services for Antisocial or Offending Behaviour:
Demographic, Individual, Offending and Service Characteristics

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Abstract

The current study was carried out as part of a larger study commissioned by the UK Department of Health to investigate the service pathways for offenders with learning disabilities (LD). The study covered three health regions in the UK and included 477 people with LD referred to services because of antisocial or offending behaviour during a 12-month period. Data were collected concerning demographic, individual, offending behaviour and service characteristics. The study findings are broadly consistent with contemporary research concerning this population, particularly in relation to the nature and frequency of offending, history of offending, psychopathology, age and gender distribution. However, very few of those referred had any form of structured care plan, despite having significant offending histories, and this may have compromised early identification of their needs and communication between the health, social and other services involved.

Key Words: Offending behaviour; learning disability; referrals; demography; health; developmental history

A Multi-Centre Study of Adults with Learning Disabilities
 Referred to Services for Antisocial or Offending Behaviour:
 Demographic, Individual, Offending and Service Characteristics

Services for people with learning disabilities (LD) who engage in offending and offending-type behaviour are a matter of concern. Entry into secure services often involves people being sent to out-of-district facilities, with a resultant drain on the resources of local services (Crossland et al., 2005). This in turn can lead to a lack of development of alternative pathways, local staff failing to develop knowledge and skills in managing these clients, and geographical variability in the type and quality of provision available (Sturmey et al., 2004). It has been suggested also that the resources currently invested in such services would be better directed towards developing local community-based support services (National Development Team, 2007).

However, these observations have not, to date, been informed by good quality studies of individuals with LD who display offending and offending-type behaviour. In considering this issue, Holland et al. (2002) and Sturmey et al. (2004) argued that careful examination of the individual, social and service pathway determinants of offending and anti-social behaviour by people with LD is a priority.

Despite the long association between crime and low intelligence, it is not clear whether people with LD commit more or less crime than those without (Holland, 2004). Research in the UK on the prevalence of offending by people with LD has yielded rates of between 0% and 8.6% depending on the location of the study sample (Holland et al., 2002). Other sources of variation in offending rates reported across prevalence studies include the inclusion criteria used (particularly if people with borderline intellectual functioning are included or not), the method used to detect ID (e.g. IQ test vs. clinical interview), and different social and criminal justice policies that are applied in the study setting (Taylor & Lindsay, in press).

Similarly, there is no good evidence to show that the frequency and nature of offending by people with ID differs from that committed by offenders in the general population (Lindsay & Taylor, 2005). For example, Walker and McCabe (1973) in a study of 331 offenders with LD detained under hospital orders in England and Wales, found high rates of fire-raising (15%) and sexual offences (28%) when compared with other groups in their secure hospital sample. However, in a recent study Hogue et al. (2006) reviewed a number of characteristics of 212 offenders with LD across community, medium/low secure and high secure settings. They found that the rates of arson in the index offence depended on the setting with low rates in the community setting (2%) and higher rates in the medium/low secure setting (15%). These findings indicate that the setting in which data is collected is likely to influence the results and subsequent conclusions drawn about the study population.

Studies which have investigated the demographic characteristics of people with LD who engage in offending-type behaviour have concluded that they share certain features with offenders in the general population – being mainly young men, with a history of socio-economic disadvantage, being related to, or habitually associating with, convicted offenders (e.g. Winter et al., 1997; Farrington et al., 2006). In their review of one local authority area, McBrien et al. (2003) reported that 30% of women with LD known to services had histories of offending and offending-type behaviours. In contrast, Barron et al. (2004) found that 13% of a sample of offenders with LD in community settings were women.

Barron et al. (2004) also reported that the mean age of their study participants was 33.1 years, while Novaco and Taylor (2004) found the mean age of 129 male

offenders with LD in medium/low secure hospital settings was 33.2 years; and in a study by Hogue et al. (2006) a mean age of 37.4 was reported for 212 male offenders with LD across community, low/medium and high secure forensic services. These studies reported the mean IQ of their participant groups to be 65.2, 67.5 and 66.0 respectively.

Several studies (e.g. O'Brien, 2002; Hogue, et al., 2006, Lindsay, Steele et al, 2006) indicate that the rates of psychiatric disorder amongst offenders with LD vary widely according to the study sample and location. Higher rates of mental disorder are found in more secure services, with lower rates in community and other samples. Recently there has been considerable attention given to the role of autism spectrum disorder in offending behaviour (e.g. O'Brien & Pearson, 2004; Scragg & Shah, 1994). However, one in-patient study found that the rate of autism among LD offenders was not elevated, but reflected the prevalence of autism among adults with LD in general (O'Brien & Bell, 2004); and Novaco and Taylor (2004) found just 1.6% of detained male offenders with LD had a diagnosis of Asperger Syndrome.

The research to date concerning offenders with LD has been variable in quality and has produced wide-ranging results concerning prevalence of offending behaviour, psychiatric disorder and socio-demographic characteristics. The current study is a multi-centre systematic investigation of the demographic, individual and offence characteristics of adults with LD referred to a range of service settings in the UK during a 12-month period.

Method

Setting and Participants

The data reported in this paper were collected as part of a retrospective case note study designed to investigate the service pathways for adults with LD in three health regions (North East England, East of England, and East Coast of Scotland) referred to LD services as a result of antisocial or offending behaviour during 2002. The three regions involved have a combined total population of approximately 12 million. The services involved in the study included local generic LD services, specialist community forensic LD services, local LD inpatient services, and low, medium and high secure specialist forensic LD units.

Eligibility Criteria

To be included in the study participants met the following criteria: (i) they were aged 18 years by 31 December 2002; (ii) they had been referred to services for people with LD during 2002; and (iii) the referral concerned antisocial or offending behaviour (including verbal and physical aggression, stalking, cruelty and neglect of children, sexually inappropriate and aggressive behaviour, fire setting, damage to property, stealing, motor vehicle and traffic offences, obtaining goods or money under false pretences, and drug and illegal substance offences) whether suspected or resulted in arrest, charge or conviction.

Exclusion criteria included referrals for self-injurious, stereotypical and inappropriate verbal challenging behaviour, although many study participants did display such behaviour in addition to antisocial and offending behaviour.

Ethical Approval

The project was approved by the Edinburgh Multi-Centre Research Ethics Committee following the issuing of a section 60 exemption under the Health and Social Care Act (2001) by the Department of Health Patient Information Advisory Group. This enabled access to case notes without the usual patient consent requirements and meant that all eligible referrals were included in the study.

Data Collection Procedures

Study data were collected by four research assistants trained in the use of a data collection pro-forma guided by a scoring manual. Information was collected concerning participants up to the point of referral concerning: (i) demographic and individual characteristics (age, gender, level of LD, psychiatric diagnoses, history of abuse, key relationships, living situation, etc.); (ii) antisocial and offending behaviour characteristics (e.g. nature of index behaviour leading to referral, history of antisocial and offending behaviour, age of first offence); and (iii) service and support characteristics (including source of referral, work, education and day care services).

As the study relied on retrospective extraction of data from case notes the research assistants were trained in the use of the study pro-forma and scoring manual using anonymised sets of case notes. Reliability of data extraction and coding was assessed and training and refinement of the data collection tools continued until inter-rater agreement on all items reached at least 85%.

Results

Demographic and Individual Characteristics

Data were collected on 477 people with LD referred for antisocial and offending behaviour across the three study regions during 2002. Data collection was extended to 2003 for the high secure hospital services involved in the study due to the low numbers of referrals ($N = 25$) to these services each year. Of those referred, 74 % ($N = 354$) were men and 26% ($N = 123$) women. On the day of their index antisocial or offending behaviour the mean age of study participants was 33.0 years ($SD = 12.4$; range 18-82 years). The level (or severity) of LD of those referred is summarised in Table 1. It can be seen that the majority of referrals (68%) involve people with mild and 'borderline' levels of LD.

One hundred and forty six (31%) of those referred had some kind of formal or statutory care plan. This included 75 (16%) people who were subject to Mental Health Act sections, 11 (2%) with Probation Orders, 22 (5%) under the Care Programme Approach or some other structured care plan arrangement ($N = 38$; 8%).

On the day of their index antisocial or offending behaviour most participants were living in community settings, with most of the remainder residing in some form of hospital facility ($N = 89$; 19%); and just a few were in prison (see Table 2). A majority of participants were living in the wider community in family, group or their own homes ($N = 299$; 63%), and very few were homeless.

Just 11% ($N = 52$) of those referred were involved in a significant relationship with a partner on the day of their index antisocial or offending behaviour. Relationships were considered to be significant if they had existed for 6 months or more, regardless of whether they were sexual in nature.

Peri-Natal Adversity and Developmental Disorders. There was evidence that 101 (21%) participants had experienced some form of birth problem that may have been associated with their subsequent developmental difficulties. These included 15 people (3%) in whom low birth weight was recorded in their case notes, 10 (2%) in whom peri-natal brain damage was recorded, 6 (1%) whose notes indicated that there had been peri-natal central nervous system infection, and 71 (15%) who had some other significant recorded birth difficulty.

Table 1 shows the frequency and percentages of participants who had recorded psychiatric disorders in childhood. A total of 154 (32%) had diagnosed ICD-10 disorders, mainly ADHD/Hyperkinetic Disorder and Autistic spectrum disorders. The 'other' category includes disorders recorded in fewer than 2% of cases.

Adult Mental Health Problems. The frequency of recorded ICD-10 categories of psychiatric disorder is summarised in Table 1. Just under half ($N = 220$; 46%) of the

referrals had presented with at least one psychiatric disorder in adulthood. A significant proportion had more than one diagnosis. In cases where more than one diagnosis of severe mental illness was documented in the case notes (e.g. schizophrenia, bipolar disorder and other non-organic psychotic disorder) the most recent diagnosis was recorded in the study data collection pro-forma. It can be seen that 24% ($N = 108$) of those referred experienced one of these severe mental illnesses and the same proportion had experienced anxiety and depression conditions. The 'other disorders' category includes a wide range of diagnoses, each with prevalence of 2% or less.

Adult Physical Health Problems. One hundred and ninety nine (42%) of those referred had a current major physical health problem requiring regular medical treatment. These included 90 (19%) who were being treated actively for epilepsy, 35 (7%) that had other neurological problems; and 19 (4%) who were diabetic. A further 100 (21%) participants had some other physical condition requiring regular medical treatment.

Abuse and Neglect Experiences. One hundred and sixty five (35%) participants had documented histories of child abuse or child neglect. Of these, 58 (12%) had suffered some form of non-accidental injury, 51 (11%) had been the victim of childhood sexual abuse, 22 (5%) had suffered neglect, and 116 (24%) had suffered some type of severe deprivation as a child.

Fewer participants ($N = 53$; 11%) were recorded as having suffered abuse and neglect as an adult (i.e. aged 16 years and above). Twenty eight (6%) had at least one episode of non-accidental injury recorded, 12 (2%) had suffered from sexual abuse, and 13 (3%) some other form of severe deprivation.

Antisocial and Offending Behaviour Characteristics

Index Antisocial and Offending Behaviour. The frequencies of index antisocial and offending behaviours are given in Table 3. More than one third of the cases ($N = 177$; 37%) were referred for multiple incidents, defined here as ≥ 5 episodes of the index behaviour. Also, many individuals were referred because of more than one category of antisocial or offending behaviour.

Offences against the person (569) were far more frequent than other offences (172). Aggression (verbal and physical combined) was the most common index behaviour referred, present in 83% of cases. Sex offending was next most frequent at 29% in total – contact and non-contact offences combined – with the latter mostly indecent exposure offences. The incidence of stalking offences was very low. Property damage was the most common form of non-person offence, however there were relatively low rates of theft, traffic-related and substance-abuse offences and also, notably, of fire setting. Police involvement or action was recorded in only a third of cases referred ($N = 161$; 34%).

History of Antisocial and Offending Behaviour. Most study participants had significant histories of antisocial and offending behaviour. Over three quarters ($N = 374$; 78%) had presented with the same index behaviour previously. As for the index offending behaviour, the majority of these previous incidents had not resulted in police involvement or action. That said, 180 participants (38%) had been charged by the police in the past with at least one criminal offence.

The age at which the first antisocial or offending-type behaviour is recorded is an important criminological indicator. The mean age for first recorded incidents in this study sample was 15.1 years ($SD = 10.8$ years). Another important indicator is the number of prior offences. In this sample the mean number of previous offences was 3.2 ($SD = 2.0$), with a range of 0-9.

Service and Support Characteristics

Sources of Referral. Referrals came from a wide variety of sources. These are summarised in Table 4. Overall, the majority of referrals ($N = 266$; 56%) were from health services, mainly from secondary and tertiary services. Of the remainder, most ($N = 145$; 30%) were referred from other community sources (social services, day care staff, families and self-referrals) and a smaller proportion from the courts and offender services. The referring agent 'not known' cases were already well known to local community learning disability services in each case.

Referral Destination. Overall, 70% ($N = 336$) of referrals were directed to local LD services; with fifty percent ($N = 239$) directed to generic community LD services, and a further 20% ($N = 97$) directed to either specialist community forensic LD services or to local non-forensic LD in-patient units. Specialist forensic LD low, medium and high secure services received the remaining 30% ($N = 141$) referrals. These specialist forensic services are typically 'out-of-area' and some distance from the clients' homes and families.

Employment and Organised Daytime Activities. Approximately 60% of referrals ($N = 285$) were either in meaningful employment or had organised daytime activities at time of their index antisocial or offending behaviour. Some participants had more than one type of daytime activity. For example, a number were in both supported employment and were enrolled on college courses. Forty five percent of referrals ($N = 213$) accessed some organised day care, 13% ($N = 60$) were in open or supported employment, 10% ($N = 46$) were enrolled on educational courses, and 2% ($N = 9$) were doing some voluntary work. A substantial minority of 191 referrals (40%) had no organised meaningful daytime employment, day care, education or other day care activity.

Discussion

As a case note study the design of the current study has a number of recognised shortcomings. The raw data are necessarily retrospective and its quality is dependent on the practice of the clinicians involved and the records policies and requirements of the participating services. In an effort to counteract these limitations the method of data extraction employed was rigorous using a pro-forma guided by a detailed manual which produced high levels of inter-rater reliability and an extensive dataset.

Demographic and Individual Characteristics

The rate of female referrals at 26% in the current study is similar to the 30% rate found in the largest previous community study of offenders with LD (McBrien et al., 2003). Thus the number of women with LD who display offending-type behaviour is by no means insubstantial and this group's needs should be taken into account when services are being planned and designed. The mean age in the present study was 33 years. Previous studies of LD and offending behaviour in community settings have reported mean ages of between 22 and 26 years (Lyll et al., 1995a; Mason & Murphy, 2002; Winter et al., 1997), while research involving offenders with LD in secure settings found mean ages of between 33 and 37 years (Hogue et al., 2006; Novaco & Taylor, 2004). However, as the present study is a multi-centre study of all referrals to the full range of services in three health regions it arguably provides a more complete picture of those adults with LD who engage in antisocial and offending behaviour.

The majority of the participants in the present study were in the mild range of LD (IQ 50-69). Few subjects with moderate, severe or profound LD were identified. These findings are consistent with previous research in the field (e.g. Hogue et al.,

2006; Novaco & Taylor, 2004). This reflects both the nature of challenging behaviour displayed by people with higher degrees of LD and how such behaviour is conceptualised by statutory services, and indeed by wider society (Holland, 2004). The 22% of referrals involving people without LD is of note as it indicates the need for an integrated service pathway for offenders with mild and borderline LD as indicated in earlier research and commentary in this field (e.g. Day, 1993).

The method of data extraction employed in the current study meant that only diagnoses that were clearly recorded in the case notes and met operational criteria were included. This is likely to have resulted in the reported rates of psychiatric and other disorders being conservative. However, almost 50% of referrals were found to have had at least one psychiatric diagnosis in adulthood and this is in line with previous research (e.g. Novaco & Taylor, 2004). This suggests that there is an association between psychiatric disorder and antisocial behaviour amongst a significant number of adults with LD and that clinicians in the field need to give proper attention to the recognition and treatment of such mental health conditions as they are likely to affect the expression of offending-type behaviour in some cases.

The rate of personality disorder reported in the current study, at just over 10%, is low compared to recent research that has found rates of more than 30% (e.g. Lindsay, Hogue et al., 2006; Mannynsalo et al., 2008). This may be due to a lack of familiarity with diagnostic criteria for personality disorder among clinicians working in LD services in the current study, or reticence about labelling clients with potentially stigmatising diagnoses. This is an important issue as personality disorder has been shown to be associated with increased risk for violence and recurrent offending behaviour in offenders with LD (e.g. Hogue et al. 2006; Lindsay, Hogue et al. 2006) and indicates a need for staff training in this area.

The 10% rate of autism spectrum disorder found in the current study is similar to the overall rate reported among adults in the IQ range of the present study by O'Brien and Pearson (2004), and is consistent with previous reports of the prevalence of autism among learning disability offender groups (e.g. O'Brien & Bell, 2004). The present study findings therefore suggest that offending behaviour may not be over-represented among individuals on the autism spectrum. Clearly this does not minimise the challenges presented by people with autism who offend and who require special attention (Howlin, 2000).

The reported rates of peri-natal disadvantage and other neurological disadvantage in the present study, and documented history of experience of neglect and abuse are consistent with the findings of previous studies (O'Brien, 2006; O'Brien & Bell, 2004). However, the rate of physical morbidity requiring regular medical treatment is high and its relationship with antisocial and offending behaviour requires further elucidation.

Antisocial and Offending Behaviour

The finding that over one third of the cases were referred for multiple incidents (at least 5 episodes) of the index behaviour is striking and indicates that many of these individuals present substantial and chronic problems. The fact that many referrals were made only after repeated antisocial or offending behaviour may reflect the widely-recognised resistance of service providers to refer LD adults exhibiting this type of behaviour (Lyall et al., 1995a). This is despite more than three quarters of those referred having previously presented with the same index offending-type behaviour, generally from their mid-teens – the mean age of offending onset was 15 years. This, along with the finding that only a minority of offences received police

attention, suggests that more forensically informed services and multi-agency working are required, particularly in community service settings.

Overall, the types and rates of offending are quite similar and consistent with previous research (e.g. Lindsay, Steele et al., 2006; McBrien et al., 2003) with offences against the person more prevalent than non-person offences, aggression the most common antisocial or offending behaviour reported, and similarly low rates of property damage, fire setting and substance misuse offences. However, McBrien et al (2003) reported higher rates of sex offences and theft. It would seem that the profile of antisocial and offending behaviour amongst people with LD is becoming clearer. In particular, earlier suggestions that certain types of offences – most notably fire setting – are particularly associated with this population are not supported by this or other recent good quality studies.

Service, Support and Lifestyle Considerations

It is unsurprising that the majority of referrals were from health services personnel as the index behaviours which are the focus of the current study are commonly observed by clinicians whose work concerns the mental health, behaviour and well-being of people of people with LD.

An important finding in respect of referral destination was that 70% of the referrals were to local service networks. This underlines the need for local LD services need to have the capability and capacity to manage such cases as previously suggested by other commentators (e.g. Lyall et al., 1995b; National Development Team, 2005). However, the finding that 30% of the referrals were made to secure services indicates the continuing need for specialist forensic LD services that are integrated with good quality and well supported local community services.

Very few people referred in the current study were homeless, or in temporary accommodation. Most (74%) were settled, living either in their own home or their family home, or in some setting arranged for them by the local authority. These findings suggest that most people referred were not living in situations of complete social exclusion or marginalisation. However, only just over 10% of those referred were in a stable personal relationship at the time of their index behaviour or offence. These findings are broadly consistent previous research concerning the protective value of personal relationships in preventing offending among all populations (e.g. Farrington et al., 2006).

Another factor thought to be protective against offending and re-offending is employment and meaningful daytime activity. In the present study, 60% of participants had some employment or access to daytime activity. This rate compares favourably with other UK studies of employment rates among adults with LD (O'Brien, 2006). The present findings suggest that while the role of employment and appropriate day care in protecting against criminality is not to be under-estimated, even when such arrangements are in place adults with LD can present with offending-type behaviour.

Concluding Comments

The current study was carried out as part of a larger study commissioned by the UK Department of Health to investigate the service pathways for offenders with LD. The aim of the project was to assist service planning, by investigating the background, nature and the extent of offending behaviour which currently presents to services for people with LD throughout the UK, and to consider the response of the services to these individuals. The findings of this multi-centre study are broadly consistent with contemporary research concerning this population, particularly in relation to the nature and frequency of offending, history of offending,

psychopathology, age and gender distribution. Other findings concerning the relatively high levels of employment and daytime occupation and stable living arrangements of participants are surprising as these have been thought to be protective against delinquent lifestyles. Perhaps important in this context is the finding that just over 30% of those referred had any kind of formal care plan, with only 13% subject to CPA or another form of structured care planning. This is potentially significant given that around 80% of participants had significant histories of antisocial or offending behaviour. This lack of formal care planning is not in line with the recommendations of government and other policy commentators (DoH, 2001; National Development Team, 2007). Obviously, it cannot be stated conclusively that well organised care for these individuals – arranged within a formal framework – would have prevented their antisocial and offending behaviour. However, the provision of such arrangements could potentially go some way to meeting the identified requirements for staff and carer support, early identification of clients' needs, and improved communication between the health, social and criminal justice services and agencies involved.

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Table 1
Frequency and Percentages of Participants' Recorded Learning Disability, Childhood and Adult ICD-10 Psychiatric Disorders (N = 477)

Documented Psychiatric Disorder		Frequency	% Cases
<i>Severity of Learning Disability</i>			
None	IQ >80	25	5
Borderline	IQ 70-79	80	17
Mild	IQ 50-69	242	51
Moderate	IQ 35-49	40	8
Severe/Profound	IQ <35	32	7
Not known or recorded		58	12
<i>Psychiatric Disorders – Onset in Childhood</i>			
ADHD/Hyperkinetic Disorder		73	15
Autism/ASD/Asperger Syndrome		47	10
Other		34	7
<i>Adult Psychiatric Disorders</i>			
Anxiety and Obsessive Compulsive Disorder		60	13
Depression		51	11
Personality Disorder		50	11
Schizophrenia		42	9
Other nonorganic psychotic disorders		42	9
Bipolar Disorder		26	6
Other Disorders (various individual diagnoses)		80	16

Note. A significant proportion of participants had more than one diagnosis.

Table 2
Frequency and Percentages of Participants' Living Situation on Day of Offending or Offending-Type Behaviour (N = 477)

Living Situation	Frequency	% of Cases
<i>Community Settings</i>		
Family home	120	25
Group home	106	22
Own home	73	15
Other ¹	33	7
Sheltered accommodation	16	3
Hostel	11	2
Homeless	5	1
Community Total	364	76
<i>Institutional Settings</i>		
Learning disability unit (locked)	33	7
Learning disability unit (open)	24	5
Medium secure Unit	17	4
General psychiatry unit	11	2
Prison	6	1
Maximum secure unit	4	1
Residential School	4	1
Institutional Total	99	21
<i>Not known/not recorded</i>	14	3

Note. ¹Includes bed-sits, temporary accommodation, and living with friends - mainly short-term accommodation whilst awaiting a more permanent place.

Table 3

Frequency and Percentages of Participants' Index Offending Behaviour (N = 477)

Index Behaviour	Frequency	% of Cases
<i>Offences Against the Person</i>		
Physical aggression	238	50
Verbal aggression	158	33
Inappropriate sexual contact	69	15
Inappropriate sexual non-contact	67	14
Cruelty/neglect of children	28	6
Stalking behaviour	9	2
<i>Non-Person Offences</i>		
Damage to property	91	19
Substance abuse	28	6
Theft	27	6
Fire-starting	20	4
Traffic offences	6	1
<i>Other Problematic Behaviour</i>	139	29

Note. Many of the referrals were in respect of individuals with more than one recent index offending-type behaviour, and so descriptions are not mutually exclusive, hence the sum is greater than 100%.

Table 4
Frequency and Percentages of Sources of Referrals (N = 477)

Referring Agent	Frequency	% of Cases
Secondary health care	120	25
Tertiary health care	118	25
Other community sources	78	16
Social Services	67	14
Courts and offender services	62	13
Primary health care	28	6
Not known	4	1

Notes.

Secondary health care primarily included local community learning disability teams and local community mental health teams

Tertiary health care services included established hospital services unrelated to learning disability services such as psychiatric hospitals and general hospitals. Referrals from high security hospital were also included here.

Referrals from *other community sources* were from a number of non-statutory community sources, including day care staff, other care staff, family and self-referrals (of which there were 3).

Social Services included all social work services such as community teams, community assessment services, residential social work services and day services

Courts and offender services included probation services, the police, Court referrals and prison referrals

Primary health care included all those associated with family physician/General Practitioner and health visiting services