

Uncovering private family law: Adult characteristics and vulnerabilities (Wales)

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This report by the Family Justice Data Partnership—a collaboration between Lancaster University and Swansea University—exposes the heightened socioeconomic and health vulnerabilities of women and men involved in private law proceedings in Wales. The study uses anonymised linked private law and healthcare data to examine the characteristics of those involved in a first application to the family courts between 2014/15 and 2019/20. It is the third in a series that aims to help build the evidence base on private law children cases in England and Wales.

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Recommended citation

Cusworth, L. et al. (2021). *Uncovering private family law: Adult characteristics and vulnerabilities (Wales)*. London: Nuffield Family Justice Observatory.

Acknowledgements

The authors would like to thank other team members involved in the Family Justice Data Partnership—a collaboration between Lancaster University and Swansea University—including Dr Becky Pattinson, Jane Huddleston (Lancaster University), Jon Smart and Simon Thompson (Swansea University).

We would also like to thank the following for their support with this project: Lisa Harker (Director), Jude Eyre (Associate Director-Strategy and Delivery) and Alice Roe (Researcher), Nuffield Family Justice Observatory; Nigel Brown, Matthew Pinnell and Beth Altman, Cafcass Cymru; Dr Annika Newnham (Associate Professor in Family Law, University of Reading and external reviewer); Administrative Data Research Centre Wales; and Welsh Government. Comments from our reviewers have been exceptionally helpful in ensuring this report is accessible to a range of stakeholders.

The authors would like to acknowledge all the data providers who make data available for research. We are also grateful to all those who provided previously validated clinical codes for the measures used within this study, including the Adolescent Mental Health Data Platform.



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Disclaimer

Nuffield Family Justice Observatory (FJO) has funded this project, but the views expressed are those of the authors and not necessarily those of Nuffield FJO or the Nuffield Foundation.

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Foreword

The significant impact of separation on children and families is well known. With unprecedented demand on the family court and the huge backlog in private law cases, there is an urgent need to establish better ways to support couples to resolve their disputes, whether that is in or out of court.

Any changes, however, must be informed by the needs and circumstances of separating families—something we know surprisingly little about. This report is part of a series of studies intending to help address this. It builds on previous Nuffield Family Justice Observatory research into the characteristics of parents in private law proceedings by looking at their use of health services.

The findings underline the vulnerabilities of parents who are involved in private law proceedings. This may come as no surprise to those working in private law cases—but the significantly higher levels of vulnerability of these parents when compared to their peers is particularly striking.

The research raises questions about the impact of an adversarial legal system on **parents' mental and physical well-being** and the corresponding impact that this must have on children.

Finding alternative ways to help parents resolve their disputes is clearly a priority. At the same time, unless the alternatives to our current court model are designed in such a way to take account of the high vulnerabilities of parents in private law disputes, they are unlikely to be successful.

Lisa Harker
Director

Executive summary

This report by the Family Justice Data Partnership—a collaboration between Lancaster University and Swansea University—exposes the heightened socioeconomic and health vulnerabilities of women and men involved in private law proceedings in Wales between 2014/15 and 2019/20.

The research team analysed anonymised linked healthcare (GP and hospital admissions) and private law (Cafcass Cymru) data for 18,653 adults involved in their first private family law application, either as an applicant or a respondent, between 1 April 2014 and 31 March 2020. Findings were compared to a group of 186,470 adults in the general population of Wales with similar demographic characteristics, matched on age, gender, local authority and deprivation quintile.

Within the cohort group:

- 94% were parents, and mostly involved in an application for a child arrangements order
- men were more likely to be applicants (73%), and women more likely to be respondents (68%)
- 84% were involved in an application between two parents—the remainder of the cases involved one or more non-parents
- almost a third of adults lived in the most deprived areas of Wales.

What are 'private law children cases' or 'proceedings'?

Where parents (or other carers) cannot agree arrangements for children, an application can be made to the court under the Children Act 1989. The majority of applications are made by parents for a child arrangement order following separation, but there are a range of other orders available for different circumstances.

Key findings

This study can only present on issues that were both known to healthcare practitioners and coded into patient records within the study period. As such the figures presented are likely to be underestimates for both the cohort and comparison groups.

Healthcare use

Adults involved in private law applications had higher levels of health service use in the year prior to proceedings than their peers in the comparison group at the study's midpoint—differences were greatest for emergency or unplanned care.

- Around a quarter (26%) of both men and women in a private law application had an emergency department attendance, compared with 16% of the comparison group.
- 12% of women and 7% of men in the cohort group had an emergency hospital admission—almost double the rate of the comparison group (6% and 4% respectively).

Mental health

Both men and women involved in private law proceedings had higher levels of mental health problems than their peers.

- More than 4 in 10 women (41.7%) and 3 in 10 men (31.2%) in the cohort group had at least one mental health-related GP contact or hospital admission in the year prior to court—this represents one and a half times the level for men and women in the comparison group at the midpoint of the study.
- Common mental health conditions were between two and a half and three times more likely among adults involved in a private law application. In the year prior to proceedings, 13% of women and 9% of men had a diagnosis of depression, with 12% and 7% respectively having a diagnosis of anxiety.
- Although only small numbers of adults involved in private law proceedings had diagnoses of more serious mental illnesses, the prevalence of bipolar disorder (for men and women) and schizophrenia (for women only) was at least twice as high as in the comparison group.
- Prevalence of attention deficit hyperactivity disorder, conduct disorders, personality disorders and eating disorders was also higher among adults involved in private family law—with levels between one and a half and two and a half times those in the comparison group.

Substance use

Known substance use—indicative of problem, harmful or hazardous use of alcohol and/or drugs—was higher in the group of adults involved in private law proceedings.

- Based on combined GP and hospital admission records, substance use was recorded for 2.6% of cohort women and 2.8% of men in the year prior to proceedings—over three times the rate of women and approaching twice the rate of men in the comparison group at the study midpoint. The relative difference is even more marked for hospital records of substance use. Women in the private law cohort were five and half times more likely to have a hospital record for substance use and men were three and a half times more likely than the comparison group.

Self-harm

Men and women in private law proceedings were more likely to have had an episode of self-harm than their peers.

- In the year leading up to court proceedings, 1.7% of women and 1.5% of men had at least one episode of self-harm recorded in their GP records—rates between four and five times higher than the comparison group at study midpoint.

Domestic violence and abuse

In the year prior to proceedings, 4% of women in the cohort group had exposure to domestic violence and abuse recorded in their GP records—20 times the rate of women in the comparison group at study midpoint (0.2%).¹

- Although proportionally very low, women in the cohort group were also more than 11 times as likely to have a domestic violence and abuse-related hospital admission (0.24%, compared with 0.02%).

Men in both the cohort and comparison groups were less likely than women to have exposure to domestic violence and abuse recorded—but the disparity between the two groups was greater than for women.

- Men in the cohort group were almost 30 times more likely to have exposure to domestic violence and abuse recorded in their GP records in the year prior to proceedings than those in the comparison group at study midpoint (1.3% compared to 0.05%) and almost 17 times more likely to have a domestic violence and abuse-related hospital admission (0.1% compared to 0.007%).

¹ Note that the same clinical codes are used in both a victim's and perpetrator's medical records. This means we cannot tell from the data whether the adult was a victim or the perpetrator.

Implications

This research exposes the heightened needs and vulnerabilities of both women and men involved in private law applications to the family courts in Wales. This has important implications for the family justice system, and for health and other services.

- Mental health issues or substance use may compromise an **individual's** ability to engage with support services, including mediation, outside of the court. With the increasing emphasis on diverting private family law cases away from the court—primarily through encouraging the use of mediation and other forms of alternative dispute resolution—it is critical that policymakers give due attention to the wider needs of families and how to better support them to engage with **other services**. The **Private Law Working Group's proposal to direct** cases without safeguarding concerns to 'assessment, advice and assistance with issues-resolution' rather than into the family court will require involvement from mental health, drug and alcohol services, and other professionals, if it is to successfully resolve disagreements and disputes around arrangements for children.²
- Any family law service response will need to consider how best to identify mental health or substance use issues at an early stage. But identification alone is not enough. There also need to be services that families can be referred to. Integrating family court with wider public health services is therefore crucial.
- Court processes can be intimidating and stressful in any circumstances but for individuals struggling with additional vulnerabilities these experiences may be magnified. Thought needs to be given to the implications of this both for adults and for their children and how a redesigned system might lesson this impact.
- The findings of this study support previous research in identifying domestic abuse as a substantial issue within private law proceedings. The role of GPs and hospital staff in recognising and accurately documenting domestic violence and abuse—and in signposting support services for both victims and perpetrators—is paramount.

Further research could help shed light on the needs of—and design of services for—those involved in private law applications.

- There is a need to investigate the health needs and vulnerabilities throughout and beyond proceedings (including subsequent applications and cross-applications, and case outcomes), as well as the needs of the children involved.
- It is important to bear in mind that adults involved in private law proceedings are a diverse group; the Family Justice Data Partnership is planning to explore the differentiated needs of different court users—parents and non-parents applying for contact or residence post-separation; those applying for non-standard

² The Private Law Working Group was established in 2019. Consultation reports were published in June 2019, March 2020 and December 2020 (Private Law Working Group 2019; 2020a; 2020b).

orders, such as specific issue or prohibited steps; and adults involved in applications that include two or more applicants and/or respondents.

- There continues to be a gap in the data and therefore subsequent analysis around ethnicity—further work is needed to fill this gap both in terms of data collection moving forwards and attempts to link other data sets, which might better record ethnicity to Cafcass and Cafcass Cymru data.

Introduction

Private law children cases relate to disagreements or disputes, usually between parents after relationship breakdown (although they may involve grandparents or **other family members**), about arrangements for a child's upbringing, such as where a child should live and/or who they should see. Currently, the evidence base to inform policy and practice in England and Wales is much less developed for private family law than for public family law (or child protection cases), even though there are more than twice as many private law cases each year. Through the use of population-level data, the *Uncovering Private Family Law* series—researched by the Family Justice Data Partnership, a collaboration between Lancaster University and Swansea University— aims to help address this deficit.

Previous reports in the series started to develop a demographic profile of the families involved in private law proceedings, including levels of deprivation, the patterns of orders applied for, and the proportion of repeat applications, in both Wales (Cusworth et al. 2020) and England (Cusworth et al. 2021). The current report extends this work by providing an in-depth look at the pre-court needs and vulnerabilities of adults in private law proceedings, which aims to help inform policy and practice and enable appropriate system reform, both within and outside the court.

While only a minority of separated families turn to the family courts to make arrangements for their children, the number of private law applications has risen over the last few years (Ministry of Justice 2020a).³ Even prior to the pandemic, there were concerns about how the family courts, the Children and Family Court Advisory and Support Service (Cafcass in England and Cafcass Cymru in Wales), and other services could meet the needs of children and families in the face of increased demand (McFarlane 2019).

To date the policy response to private law cases has focused heavily on attempting to divert cases from reaching the court, primarily through encouraging the use of mediation and other forms of alternative dispute resolution. Most recently, the Private Law Working Group, established by the President of the Family Division to review the operation of the Child Arrangements Programme, emphasised that an effective range of out-of-court family resolution services, rather than court, would better serve a significant proportion of families and their children when parents separate (Private Law Working Group 2019). A further report by the Family Solutions Group (a subgroup of the Private Law Working Group) recommended better provision of information to separating families, and support with issue resolution at an earlier stage, before or alongside a court application, not just as a means of diversion (Family Solutions Group 2020). The second report from the Private Law

³ Previous estimates range from 10% (Blackwell and Dawe 2003; Lader 2008; Peacey and Hunt 2008) to a third (Williams 2018), although putting a precise figure on it is methodologically challenging (see Cusworth et al. 2021, pp. 15–16 for a discussion).

Working Group called for ‘fundamental, long-term and sustained system change in the way “private law” family disputes are resolved’ (2020a, p. 3).

Alongside this call for change came serious concerns raised in the Ministry of Justice’s ‘Risk of Harm report’ about how the family court handles allegations of domestic abuse in private law cases (2020b).⁴ It has prompted a major review of the operation of the family court, to ensure safety is a first principle, rather than presumption of parental contact.

The final report of the Private Law Working Group, set out proposals ‘to deliver a significant and ambitious programme of reform’ both within and outside of the court (2020b, p. 1). Alongside a number of interim measures to manage an ever-increasing backlog of private law cases, caused at least in part by the COVID-19 pandemic, the report outlined plans for pilots to test plans for longer-term reform. At the launch of the Uncovering **Private Family Law: Who’s Coming to Court in England?** report in February 2021 (Cusworth et al. 2021) the President of the Family Division announced that two pilots of new ways of working would be developed and trialled in Dorset and North Wales.

It is important that any system redesign is based on a clear understanding of the characteristics and vulnerabilities of those coming to court. Improving support for domestic abuse survivors is understandably a key focus of the proposed reforms. A recent study by SafeLives for the Domestic Abuse Commissioner found that only 1 in 10 domestic abuse survivors said they received the support they needed in the family courts, and recommended that independent domestic violence advisors be an integral—and funded—part of the family justice system (SafeLives 2021).

The renewed focus on how the family courts deal with domestic abuse is welcome, but it is also important to consider the wider needs and vulnerabilities of separating parents, such as deprivation or mental health difficulties, which might affect their ability to engage with advice and support services, including mediation, outside of the court.

Previous research, based on relatively small casefile samples, identified a number of indicators of vulnerability experienced by litigants in person, including being a victim of violence, depression, alcoholism, drug use, mental illness, learning difficulties, physical ill-health and language difficulties (Moorhead and Sefton 2005; Trinder et al. 2014).⁵

Previous reports in the *Uncovering Private Law* series established a clear link between deprivation and private law cases for the first time, with applications disproportionately being made by those living in more deprived areas. The current study goes further, to investigate a number of other potential health needs and vulnerabilities for the full population of adults involved in private law applications, including levels of healthcare use, mental health problems, substance use, self-harm,

⁴ Practice Direction 12J (PD12J) of the Family Procedure Rules 2010 provides detailed guidelines on the actions a court is required to take following allegations of domestic abuse in a child arrangements case. Evidence submitted to the panel preparing the ‘Risk of Harm report’ raised concerns that the direction is not operating as intended and is being implemented inconsistently.

⁵ Litigants in person represent themselves in court. Although many private law litigants have always had to represent themselves, the introduction of the Legal Aid Sentencing and Punishment of Offenders Act 2012 (LASPO) means that the majority are now litigants in person.

and exposure to domestic violence and abuse. This is the first time that population-level data collected routinely by Cafcass Cymru (a Welsh Government organisation **that represents children's best interests in family justice proceedings in Wales**) has been linked, for all adults, including non-parents involved in private family law proceedings, to health records. The findings will help inform policy and practice and enable appropriate system reform, both within and outside the court.

Methodology

This report is based on analysis of anonymised Cafcass Cymru data and linked, anonymised health data. Administrative data collected and maintained by Cafcass Cymru was acquired by the SAIL Databank (Ford et al. 2009; Jones et al. 2017; Jones et al. 2020). The SAIL Databank contains extensive anonymised health and administrative data about the population of Wales, which is accessible via a secure, privacy-protecting trusted research environment, underpinned by an innovative and proportionate information governance model. For each data source within the SAIL Databank, including records from Cafcass Cymru, personal identifiable data has been removed and replaced with a unique identifier, otherwise known as an anonymised linkage field (ALF) for each person to enable linkage of records from different sources. SAIL anonymisation and linkage methodology is described elsewhere (Lyons et al. 2009; Ford et al. 2009).

We used Cafcass Cymru data (described elsewhere (Johnson et al. 2020)) to create a cohort of 18,653 adults involved in private family law proceedings in Wales, and whose first application (as an applicant or a respondent) was recorded by Cafcass Cymru between 1 April 2014 and 31 March 2020.⁶ The date of this first application **was set as the 'index date'** for the cohort adults, with demographic characteristics described at this point.

To create a comparison group as similar as possible to the cohort, we first established a general population group of adults from the Welsh Demographic Service Dataset (WDSD) at a fixed index date of 1 April 2017 (the midpoint of the cohort study period), consisting of individuals who had not been involved in family court proceedings.⁷

For each adult in the Cafcass Cymru cohort we randomly selected up to 10 adults from the general population who matched on gender (male or female), age (in years at index date), local authority and deprivation (overall deprivation quintiles or fifths, from most deprived to least deprived).⁸ The final matched comparison group consisted of 186,470 adults.

We then aimed to link records for each adult in the cohort and the matched comparison group to the following data sources, available within the SAIL Databank:

- Welsh Index of Multiple Deprivation (WIMD) (2014 version)
- Welsh Longitudinal General Practice (WLGP) data (general practice interactions)
- Patient Episode Database for Wales (PEDW) (hospital admissions)

⁶ We checked all applications in the Cafcass Cymru dataset for individuals from 2011. It is possible that individuals may have been in an application prior to this date and not recorded in the dataset.

⁷ The WDSD provides demographic characteristics of people registered with GPs in Wales.

⁸ 10 adults were included in the comparison group for the vast majority of the Cafcass cohort, with only 16 having less than 10 matches (minimum 3).

- Emergency Department Dataset (EDDS) (accident and emergency attendances)
- Outpatient Dataset for Wales (OPDW) (hospital outpatient appointments).

A number of measures were derived from the Cafcass Cymru data to describe the demographic characteristics of the adults in the cohort and their first private family law application: their age, gender, deprivation, role on the application (applicant or respondent), relationship to (youngest) child, the type application (based on the number of applicants and respondents and their relationship to the (youngest) child), and the type of order(s) being applied for. We also considered whether there were any markers of significant case complexity or safeguarding concerns in the case which the application was part of (based on whether a section 7 or section 37 report was ordered, a section 16A risk assessment carried out, and/or a rule 16.4 appointment made).

Measures to indicate overall use of different health care settings were created. In addition, a number of measures relating to mental health, self-harm, domestic violence and abuse, and substance use were established, based on specific clinical codes recorded within primary care (GP) and secondary care (hospital inpatient) admissions data. We calculated, and compared, the proportion of adults in the cohort and the comparison group with these health-related vulnerabilities recorded at any time prior to the index date, and within the 12-month window prior to this date.⁹ All reported differences between the Cafcass Cymru cohort and the comparison group were statistically significant at the 5% level ($p < 0.05$).

Full methodology details are available in the appendices.

Study strengths and limitations

This is the first population-based study to link administrative private family law data, collected routinely by Cafcass Cymru, to health data. This has enabled us to establish information on the health-related vulnerabilities of adults involved in their first private law proceedings, comparing these to a matched comparison group. The descriptive analyses presented here provide a picture of the characteristics and vulnerabilities of adults as they apply to the family court, for the full population of court users. Better understanding of the circumstances and needs of this group will enable more tailored policy and practice responses, resulting in more carefully targeted interventions and support, both within and outside the court. However, we acknowledge the following limitations.

⁹ Health data was available from 2000, so conditions or vulnerabilities diagnosed prior to this date will not necessarily be identified, unless also recorded at a later date. Adults who have moved into Wales, or between GPs, may not have complete historical health records. As this is the same for the cohort and comparison groups, comparisons of prevalence are still valid, if likely to be an underestimate for both groups.

- Studies based on administrative data are necessarily limited by the scope and quality of available data, collected primarily for non-research purposes. The Cafcass Cymru database records the extent of its involvement in a case, which in private law often ends at the first hearing, unless concerns exist over child welfare and the court has directed further work or has decided to appoint a **children's guardian under 16.4 of the Family Procedure Rules**. In addition, the data source does not record directly who a child is living with at the time an application is made, or whether or not there are safeguarding issues, such as domestic abuse. Specific strengths and limitations of Cafcass Cymru data are reported elsewhere (Johnson et al. 2020).
- Demographic profiling is limited by the availability of data on demographic characteristics. For example, neither the Cafcass Cymru nor the health data used in this study records ethnicity or religion, although planned work by the Family Justice Data Partnership aims to consider the potential of other data sources in filling these gaps.
- The WLGP data contains GP records for patients registered with a GP in approximately 80% of practices that supply data to the SAIL Databank. As such, information for GP-based measures was not available for all adults in the cohort or comparison groups. Measures were calculated using the same method for both groups and therefore the comparisons remain valid, although we recommend any more detailed analyses should investigate this further.
- This study only reports on mental health problems, self-harm, substance use and exposure to domestic violence and abuse that are both known to healthcare practitioners and coded into patient records within the study period; as a result, we cannot estimate or report on undisclosed, unrecorded or pre-existing conditions or vulnerabilities. Our figures are therefore expected to be an underestimate of the true numbers of adults with these disorders or needs.
- By design, analyses are descriptive and include a wide range of measures to start to build a picture of the needs and vulnerabilities of all adults involved in private family law proceedings. Further research is required to understand the individual and co-occurring needs of different types of court users. This would shed more light on what might distinguish the profiles of single, repeat, and multiple users, enabling earlier identification and management of issues that might lead to cases returning to court on multiple occasions.

The study cohort group consisted of 18,653 adults who were involved in a first private family law application between 1 April 2014 and 31 March 2020. The matched comparison group consisted of 186,470 adults who were not subject to family law proceedings, matched on age, gender, local authority and overall deprivation quintile.

Findings

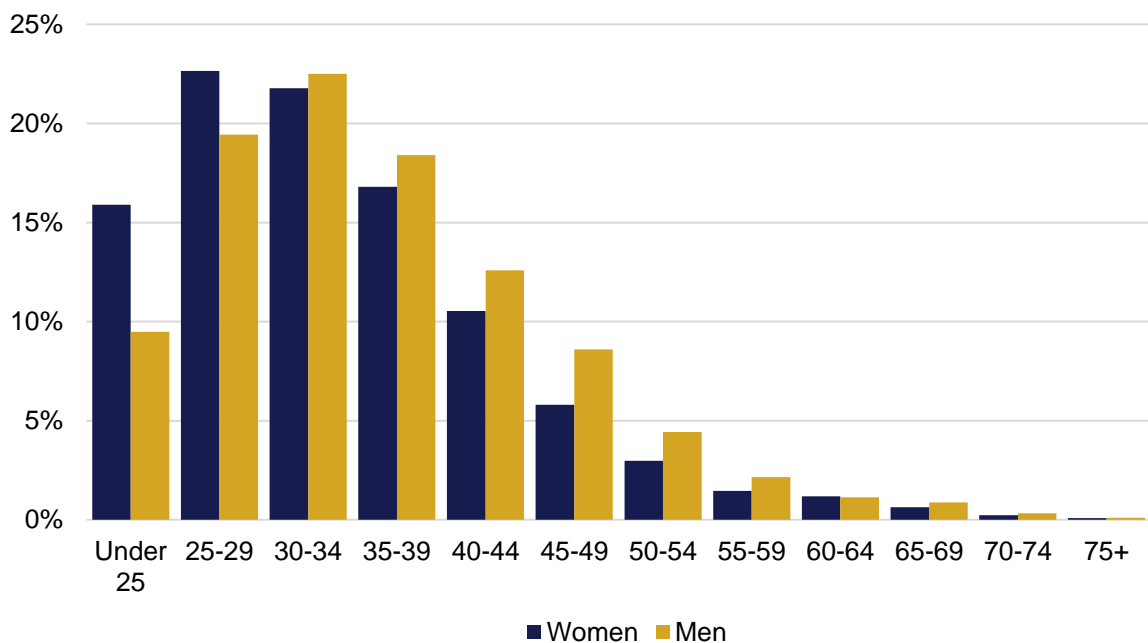
Adult demographic characteristics

Age and gender

There were 8,735 men (46.8%) and 9,918 women (53.2%) in the cohort, with identical proportions in the comparison group.

Men were on average 35.7 years old (in both the cohort and comparison groups); women were on average 33.6 years old. Figure 1 shows the age distribution for the cohort by gender. There were higher proportions of women than men in the younger age-groups—under 25 and 25–29 years. There were small numbers of older adults in the cohort—overall, 9.0% of men and 6.6% of women were aged 50 or over.

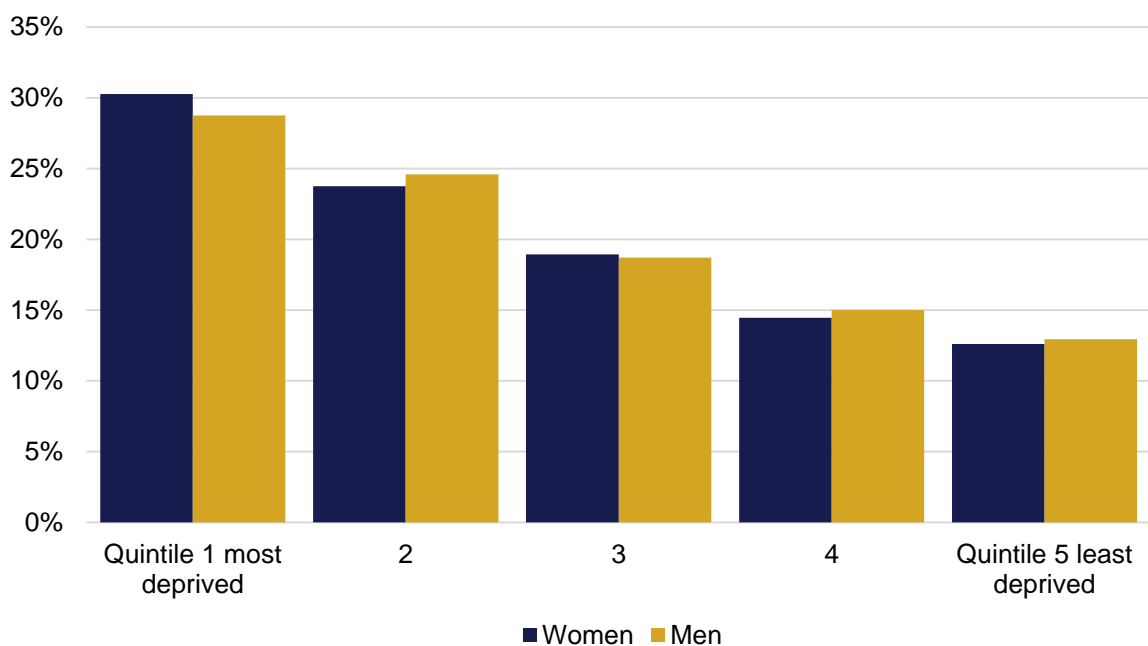
Figure 1: Age category of adults in first private law applications (cohort group) by gender



Deprivation

Building on exploratory work by Johnson et al. 2020, the previous report for Wales in the *Uncovering Private Law series* established a clear link between deprivation and private law cases for the first time, with standard parental applications disproportionately being made by those living in more deprived areas (Cusworth et al. 2020).¹⁰ A similar pattern of deprivation is seen here, with almost a third of all adults (28.8% of men and 30.3% of women) involved in a first private law application living in areas in the most deprived quintile. Over half (53.3% of men and 54.0% of women) lived in the two most deprived quintiles (see Figure 2).¹¹

Figure 2: Area-level deprivation quintile of adults in first private law applications (cohort group) by gender



A description of adults' first private law application

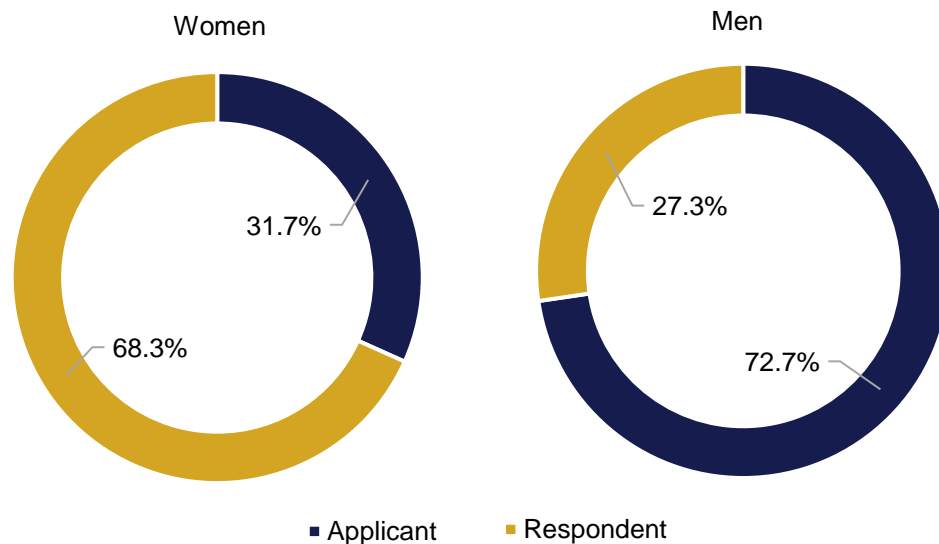
This section describes the **cohort adults' first private law application**, including their role in the application (applicant or respondent), relationship to the (youngest) child, the type of application, and the order(s) applied for. We also describe whether any markers of significant case complexity or safeguarding issues were identified in the data.

¹⁰ This previous report focused on applications involving one male and one female adult party, presumed to be parents of the child subject(s) of the application. Following discussions with the data owner, further data fields have been made available which specify the relationships between each adult and child involved, e.g. parent, grandparent, other relative.

¹¹ We used WIMD 2014 overall deprivation quintiles.

Of the 18,653 adults in the private law cohort, half (50.9%) were applicants and half (49.1%) were respondents on their first private law application. But there was a significant gender difference—men were far more likely to be an applicant than women (72.7% compared with 31.7%) (Figure 3). This is in line with existing evidence (outlined in Cusworth et al. 2021) that the majority of private law applications are made by men, typically non-resident fathers.

Figure 3: Role of cohort adults in application, by gender



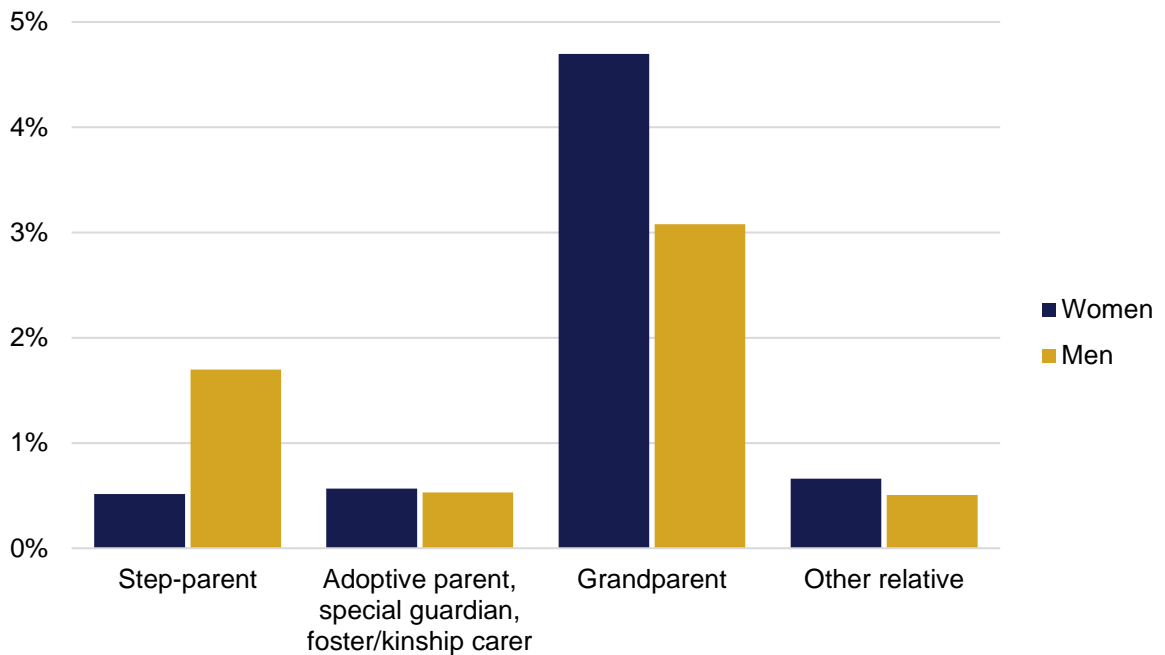
We found that a majority of the adults (84.0%) were involved in an application between two parents ('standard parental cases'), with 2.7% involved in applications including two adults, at least one of whom was not a parent, and the remaining 13.3% involving two or more non-parent applicants and/or respondents.¹² A slightly higher proportion of cohort women were involved in non-standard cases (17.2%) than cohort men (14.7%).

In terms of the relationship of the cohort adults to the (youngest) child in the private law application, the majority were parents (93.9%).¹³ Non-parents made up the remaining 6.1% of adults: grandparents were the largest group (3.9%); other relatives (0.6%); step-parents (1.1%); and adoptive parents, special guardians and foster/kinship carers (0.5%). There were some gender differences, with higher proportions of stepfathers than stepmothers, and higher proportions of grandmothers than grandfathers (Figure 4).

¹² Earlier reports found that around 90% of all private law children applications made between 2011 and 2018 in Wales were between 2 separating parents, with the remaining 10% involving one or more non-parents (Cusworth et al. 2020). The current study has a different unit of analysis (adults rather than applications), and timeframe (2014–2020).

¹³ The adult's relationship to the (youngest) child was missing in the data for 3.8% of the cohort adults.

Figure 4: Relationship of cohort adults (non-parents) to (youngest) child in the application



The vast majority of applications (93.3%) were primarily about child arrangements—where a child should live and who they should see (Table 1). This is much higher than the proportion of all private law (standard parental) applications for child arrangements orders (CAO) (Cusworth et al. 2020), as the current analysis is focused just on first applications, and subsequent or repeat applications are more likely to be for a specific issue order, prohibited steps order or enforcement orders. These make up just 2.7% of first applications for cohort adults. The remaining 4.0% of cohort adults were involved in an application for a special guardianship order, adoption order, or very small numbers of other orders. A slightly higher proportion of men in the cohort (4.4%) were involved in these non-section 8 orders than cohort women (3.5%).

Table 1: Types of application

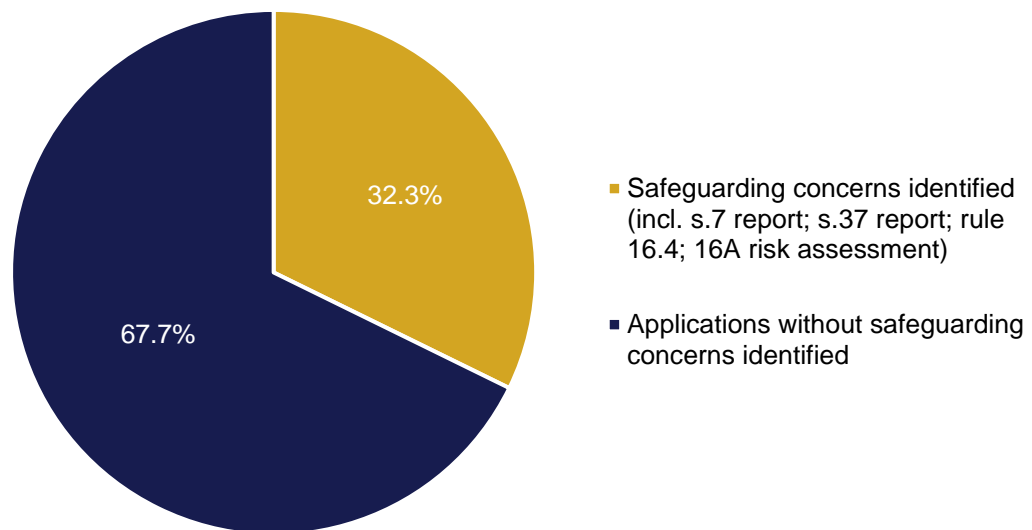
Application type	Women	Men	All
Section 8 and enforcement	96.5%	95.6%	96.0%
CAO/contact/residence	93.6%	93.0%	93.3%
Specific Issue	1.7%	1.5%	1.6%
Prohibited steps	0.6%	0.6%	0.6%
Enforcement	0.6%	0.5%	0.5%
Other orders	3.5%	4.4%	4.0%
Special guardianship	0.9%	0.8%	0.8%
Adoption orders	1.4%	2.3%	1.8%
Other	1.3%	1.3%	1.3%

We also looked at whether there were any markers of significant case complexity or safeguarding concerns identified in the case that the **cohort adults' first private** family law application was part of. This was based on whether one or more of the

following occurred: a section 7 or section 37 report was ordered; a rule 16.4 appointment was made; or a 16A risk assessment conducted.

Overall, almost a third of adults (32.3%) were involved in a case where one or more of these markers was identified (Figure 5). This represents cases where welfare concerns (such as a safeguarding concern or an issue of significant complexity) were identified and professional involvement ordered to assist the court in its decision making. We are not able to say from this data how often welfare concerns went unrecognised or were raised but did not result in orders or direction from the court. This proportion may also be an underestimate, as where a local authority is involved in a case and prepares a welfare report (either a section 7 or section 37), this may not be recorded by Cafcass Cymru and therefore be evident in the dataset.

Figure 5: Case-level markers of significant case complexity or safeguarding concerns identified



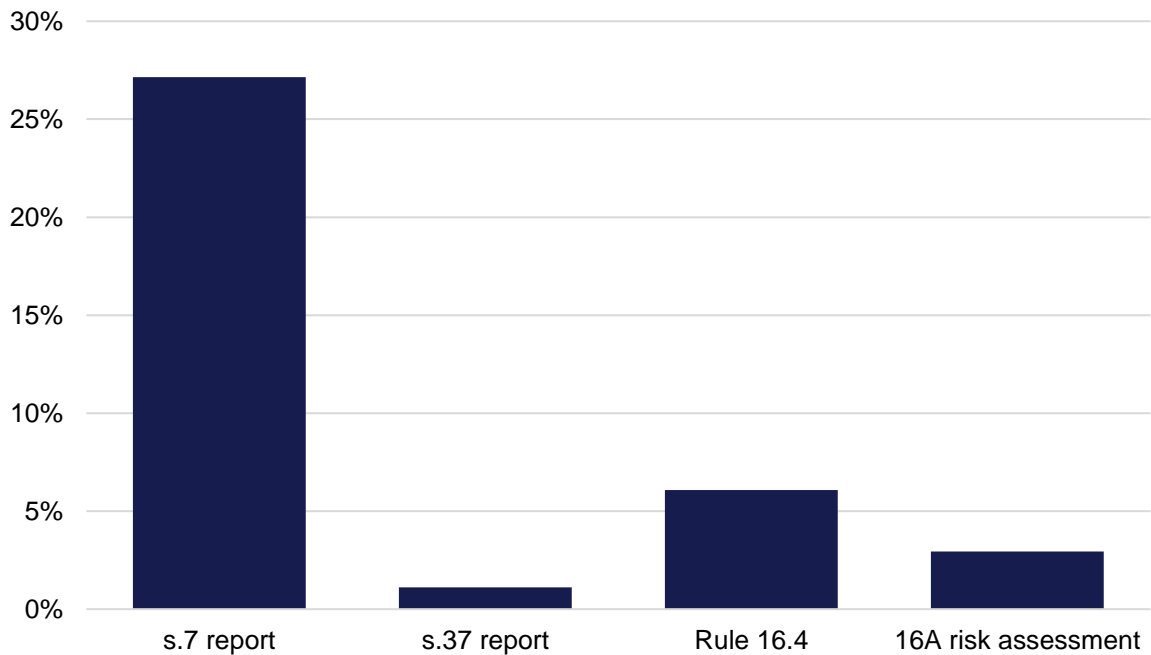
The most common indicator of complexity or safeguarding concerns (in 27.1% of cases) was a section 7 report (Figure 6). The court may order either Cafcass Cymru or the local authority to prepare a **section 7 report on 'such matters relating to the welfare of the child as are required to be dealt with in the report'** (Children Act 1989).

In particularly complex private law cases, under rule 16.4 of the Family Procedure Rules 2010, children may be made a party to the proceedings, with a children's guardian appointed to **independently assess the child's wishes and feelings, and welfare needs**. This occurred in 6.1% of the cases that cohort adults were involved in, and is likely to suggest that there were safeguarding concerns or that disputes had become very difficult to resolve.

If the court becomes concerned about a child's welfare during the course of proceedings and it seems that it might be appropriate for a care or supervision order to be made, then it will direct a local authority to undertake an investigation of the child's circumstances and prepare a welfare report under section 37 of the Children Act 1989. Such a report was prepared in just 1.1% of cases that cohort adults were involved in.

Where a Cafcass or Cafcass Cymru officer has cause to suspect a child is at risk of harm, at any stage of proceedings, they have a duty to conduct a risk assessment under section 16A of the Children Act 1989 to alert the court to their concerns. This was carried out in 2.9% of cases that cohort adults were involved in, and may be a catalyst to more pronounced involvement, through the appointment of a rule 16.4 guardian or directing the local authority to produce a section 37 report.

Figure 6: Indicators of case complexity or safeguarding concerns



Adult vulnerabilities

This section uses the linked health data to describe overall health service use. It also compares the proportions of the cohort and comparison groups with recorded mental health disorders, self-harm, substance use, and domestic violence and abuse, both at any point prior to the index date, and within the 12 months leading up to it.^{14,15} We can only report on the vulnerabilities and experiences that are both reported to healthcare practitioners and coded into patient records—therefore our figures are likely to be an underestimate of the true numbers of adults with these disorders or needs.

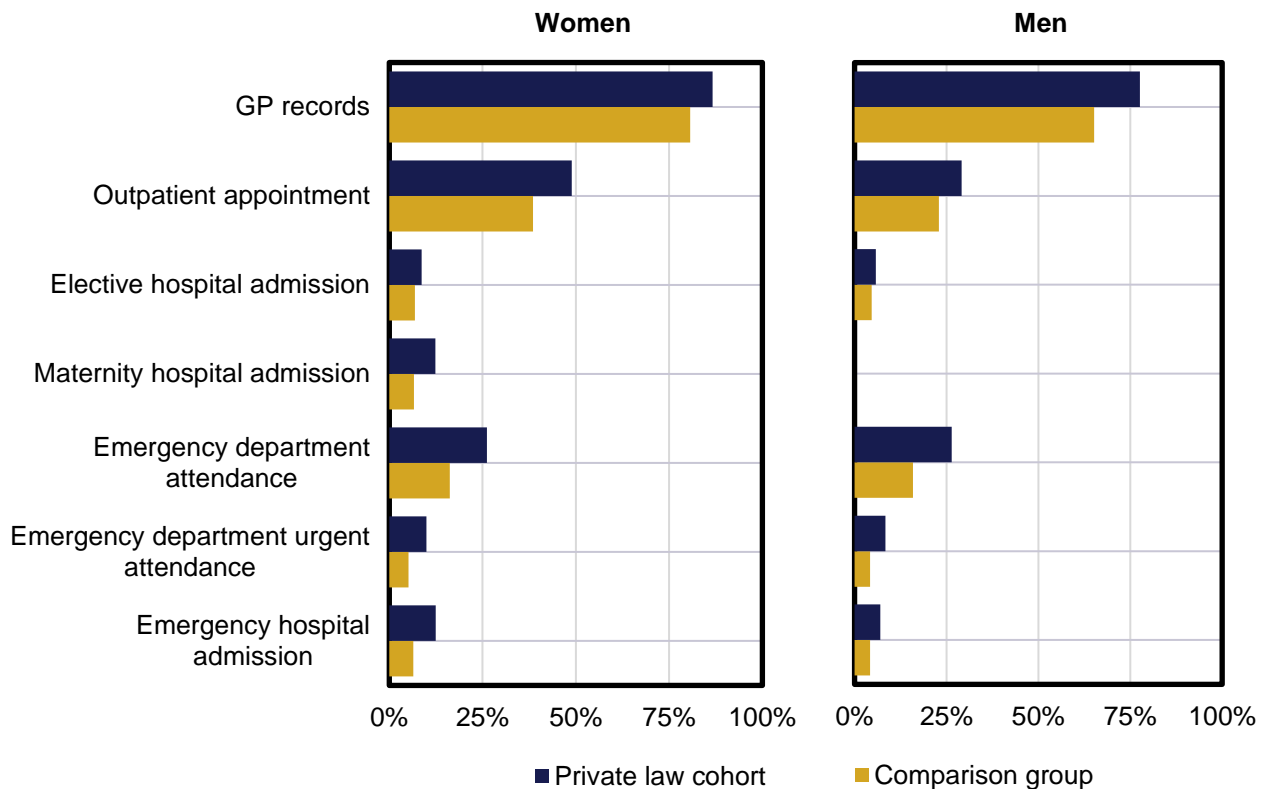
¹⁴ Health data was available from 2000, so conditions or vulnerabilities diagnosed prior to this date will not necessarily be identified, unless also recorded at a later date. Adults who have moved into Wales, or between GPs may also not have complete historical health records. As this is the same for the cohort and comparison groups, comparisons of prevalence are still valid, if likely to be an underestimate for both groups.

¹⁵ Here and throughout, the 'index date' is the court date for the cohort group and the midpoint of the study for the comparison group.

Overall health service use

To explore overall use of healthcare services, we analysed the proportion of adults who had at least one interaction in various healthcare settings in the year prior to the index date. The overall pattern, for men and women, is one of higher use by adults involved in (a first) private law application (Figure 7).

Figure 7: Use of different healthcare settings in previous year



The largest differences between the groups are for emergency department attendances and emergency, or unplanned, hospital admissions: 12.4% of women in the cohort had emergency hospital admissions; 26.2% had emergency department attendances; and 10.0% had urgent emergency department attendances. This is around twice the proportion of women in the comparison group.¹⁶ Similar patterns are observed for men, with the proportion of the cohort with emergency hospital admissions and emergency department attendances 1.7 times that of the comparison group. Twice the proportion of men in the cohort (8.4%), had an urgent emergency department attendance in the previous year.

¹⁶ We classified emergency department attendances with triage category ‘immediate’, ‘very urgent’, or ‘urgent’ as urgent attendances. For further details see appendix.

Mental health

To examine potential vulnerability at the time of application to the family court, we considered whether adults had either recent and/or a history of mental health problems. We established the proportion of adults in the cohort and comparison groups with clinical codes indicating any mental health concerns in either GP or hospital inpatient admission records at any time prior to the private law application being made and in the 12 months leading up to it, together with combined measures (GP or hospital inpatient records) for both time periods.¹⁷

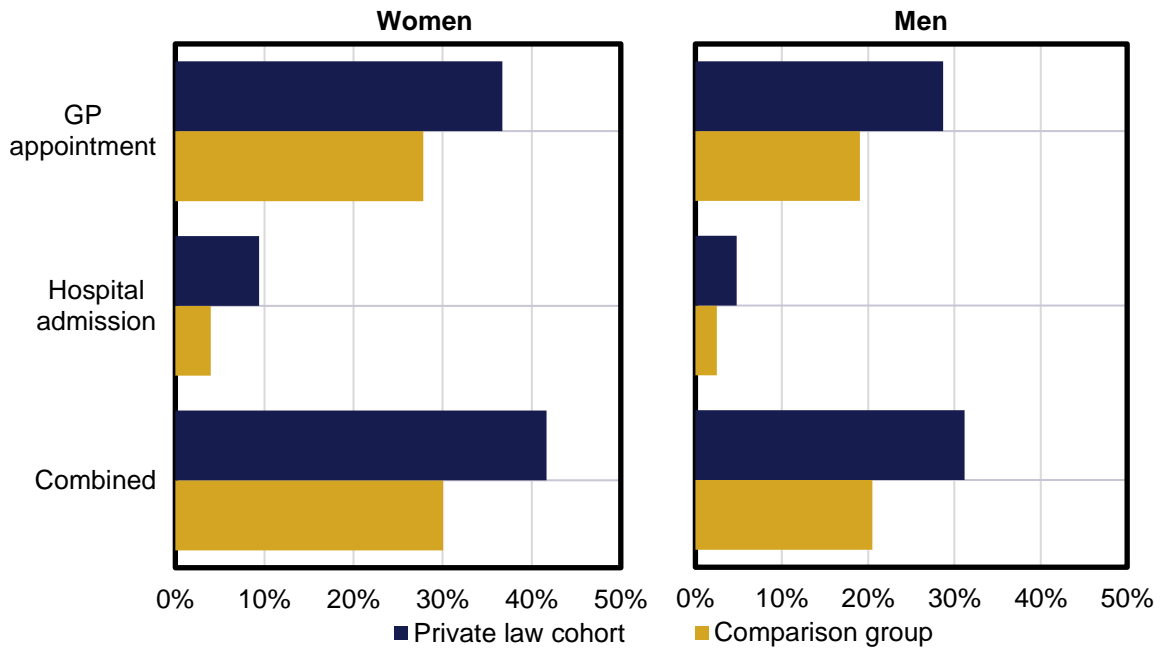
In addition to an ‘any mental illness’ measure, specific mental health conditions were considered, including common mental disorders (depression and anxiety), severe mental illnesses (bipolar and schizophrenia-spectrum disorders), and others (eating disorders, attention deficit hyperactivity disorder (ADHD), autism spectrum disorders, conduct disorders, developmental disorders, intellectual disability, and personality disorders). Some disorders, such as conduct disorders, tend to be diagnosed in childhood and although some difficulties may persist into adulthood, are less likely to be recorded in GP or hospital notes later in life, thus only measures of whether individuals had ever had these mental health conditions recorded are reported. This will not necessarily identify conditions diagnosed prior to 2000 (when health data is available from), but as this is the same for the cohort and comparison groups, comparisons of prevalence are still valid, if likely to be an underestimate for both groups.

Any mental health disorder

Figure 8 illustrates the increased levels of mental health problems for cohort adults in the year prior to an application being made to the family court compared to those in the comparison group—a pattern repeated for both men and women. More than 4 in 10 (41.7%) cohort women and 3 in 10 (31.2%) cohort men had at least one mental health-related GP contact or hospital admission in the year prior to court; this represents one and a half times the level for men and women in the comparison group. For both the cohort and the comparison group, the proportion of men and women with recorded mental health-related hospital inpatient admissions was lower than in the GP data, but the difference in prevalence between the two groups was greater—two and a half times the proportion of cohort women (9.4%) and twice the proportion of cohort men (4.8%) had a hospital admission in the year prior to court than adults in the comparison group (4.0% and 2.5% respectively).

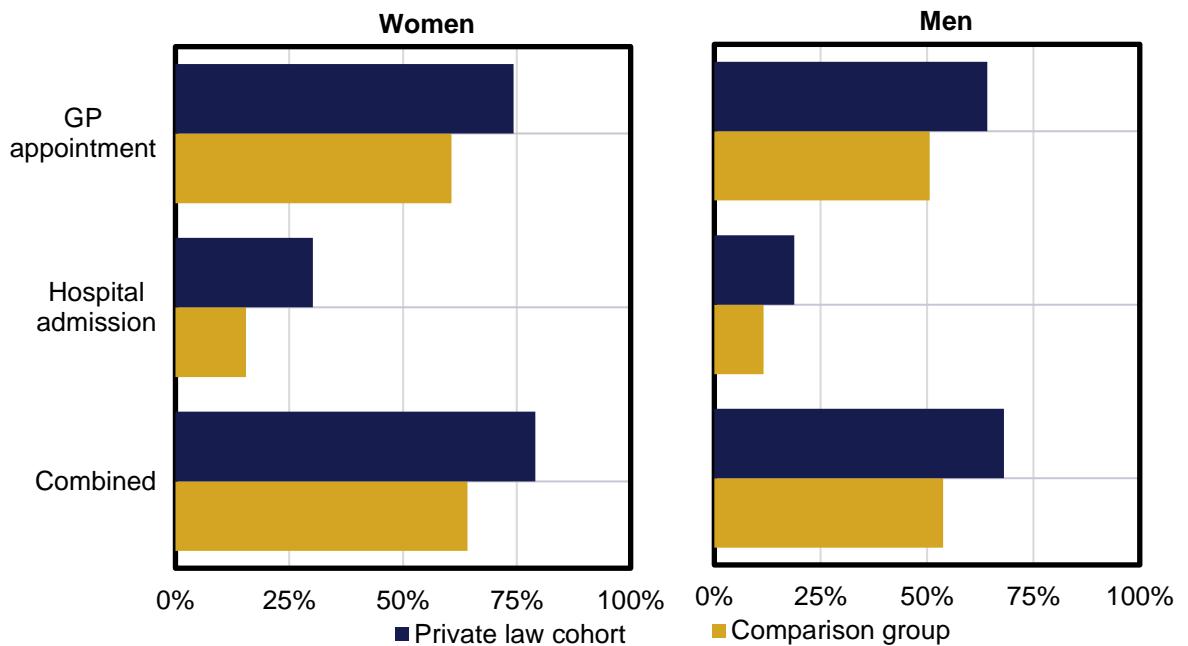
¹⁷ Clinical codes are used to record the primary reasons for a contact or admission and other relevant conditions or comorbidities. Details of the codes used and sources are provided in the appendices.

Figure 8: Percentage of adults with any mental health disorder in year prior to index date



Understandably, greater proportions of both the cohort and comparison groups had a history of mental health problems at any time prior to proceedings, as shown in Figure 9. Almost three quarters of cohort women (74.3%) and almost two thirds of cohort men (64.2%) had a mental health-related GP contact at any time prior to court, compared to 60.7% and 50.6% respectively in the comparison group. One fifth of men (18.8%) and 3 in 10 women (30.2%) and had at least one mental health-related contact or admission recorded in the hospital data—almost twice the proportions of the comparison group.

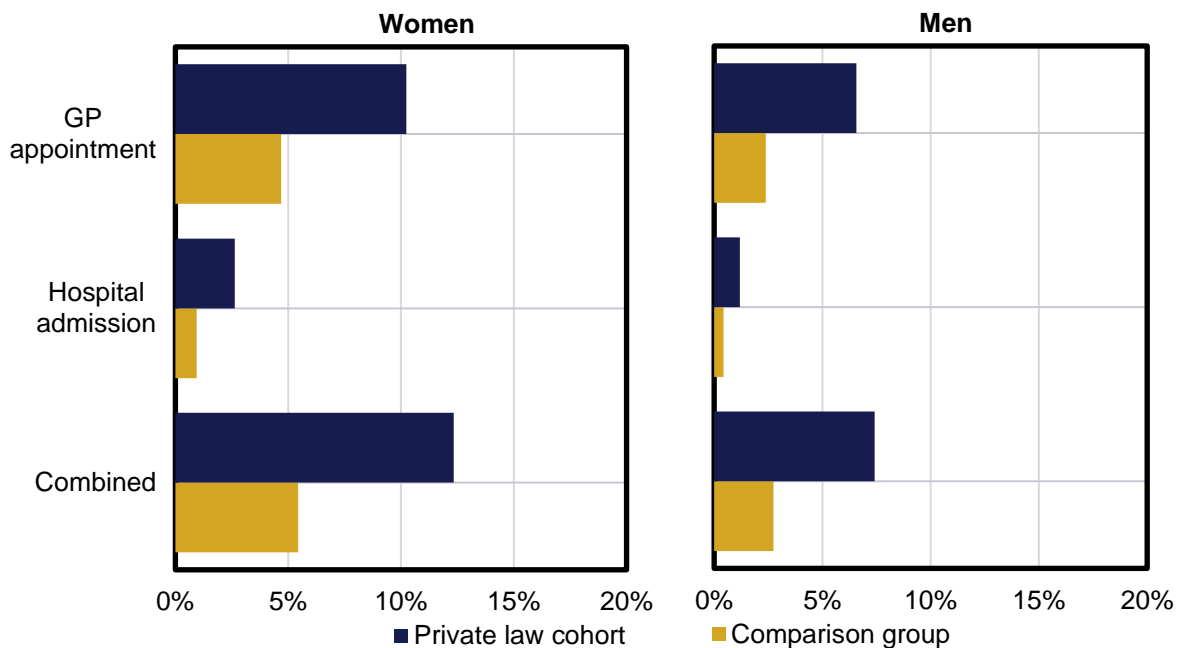
Figure 9: Percentage of adults with any mental health disorder at any time prior to index date



Anxiety

The overall pattern is one of higher levels of anxiety-related problems for adults in private law proceedings compared to the comparison group, with higher prevalence among women in both groups. Figure 10 shows an increased difference in both anxiety-related GP contacts and hospital admissions for both women and men in the year prior to the index date.

Figure 10: Percentage of adults with anxiety-related contact or admission in the year prior to index date

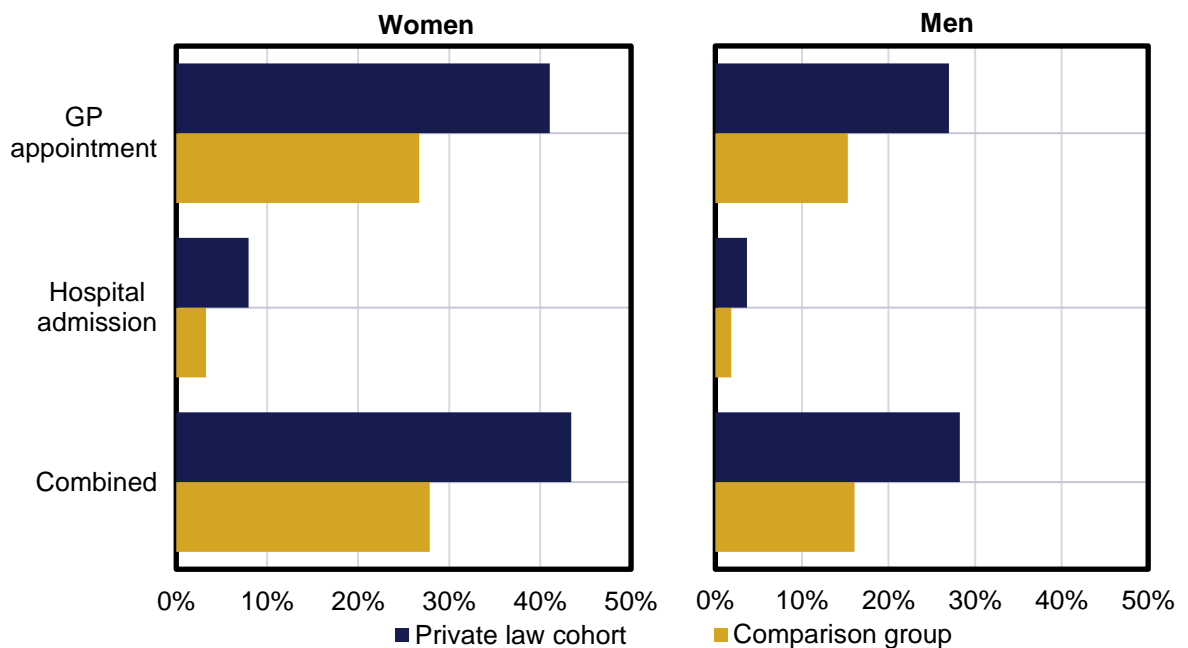


The proportion of women in the cohort with at least one anxiety-related GP contact in the year prior to proceedings was 10.2%—more than twice the proportion of the comparison group (4.7%). For men the prevalence of anxiety in the GP data was almost three times as high as that in the comparison group—6.6% compared with 2.4%. For both the cohort and the comparison group, the proportion of both men and women with recorded anxiety-related hospital admissions was lower than in the GP data. Prevalence was almost three times higher for adults involved in private law proceedings, with 2.6% of women and 1.2% of men having had an anxiety-related hospital admission in the year prior to proceedings, compared with 0.9% and 0.4% of men and women in the comparison group. Overall, for the combined measure, there were twice the proportion of women (12.3%) and two and half times the proportion of men (7.4%) having at least one anxiety-related GP contact or hospital admission in the year prior to private law proceedings, compared with 5.4% of women and 2.7% of men in the comparison group.

We see a similar picture when considering the prevalence of anxiety at any time prior to private law proceedings (Figure 11). In the cohort group, 4 in 10 women (43.4%) and almost 1 in 3 men (28.2%) were classified as having at least one anxiety-related GP contact or hospital admission at any time prior to private law proceedings, more than one and a half times the proportion in the comparison group (27.9% and 16.1%

respectively). Results for GP contacts separately show similar disparity: 41.1% of women and 27.0% of men in the cohort had at least one anxiety-related GP contact, compared to 26.7% and 15.3% in the comparison group. Anxiety-related hospital admissions were also higher in the cohort group than comparison group for both women and men—two and half times and twice the proportion respectively.

Figure 11: Percentage of adults with anxiety-related contact or admission at any time prior to index date

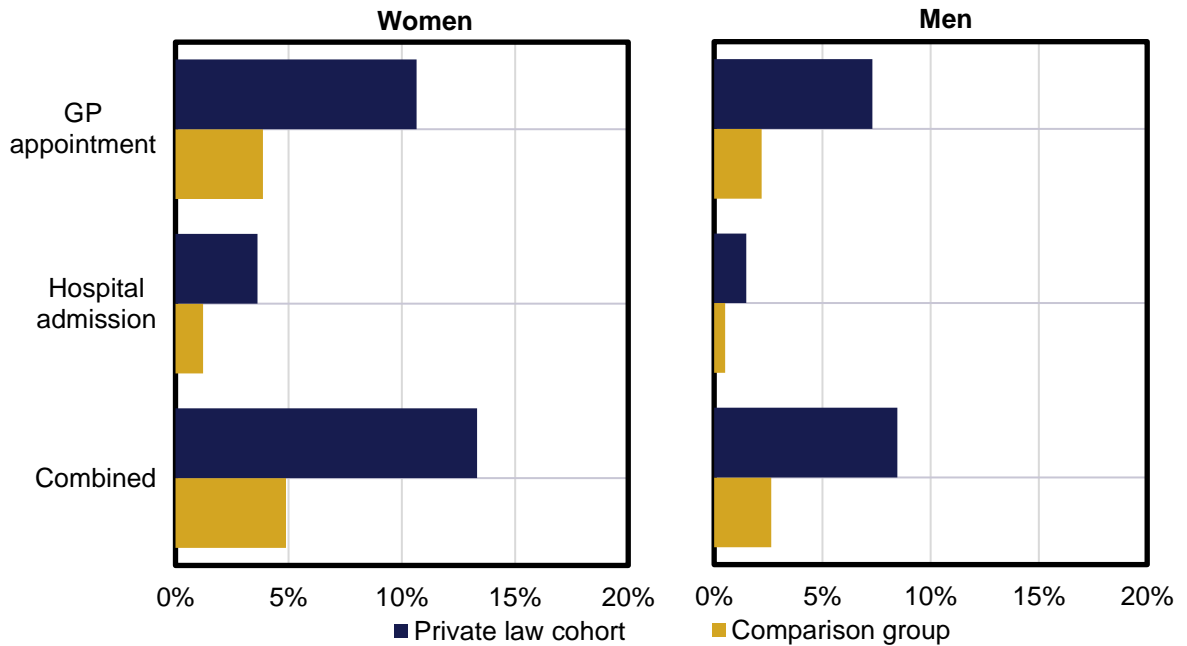


Depression

There were higher proportions of depression-related GP contacts and hospital admissions in the cohort group than the comparison group, both in the year preceding a first private law application and historically—this pattern is consistently seen for both women and men.

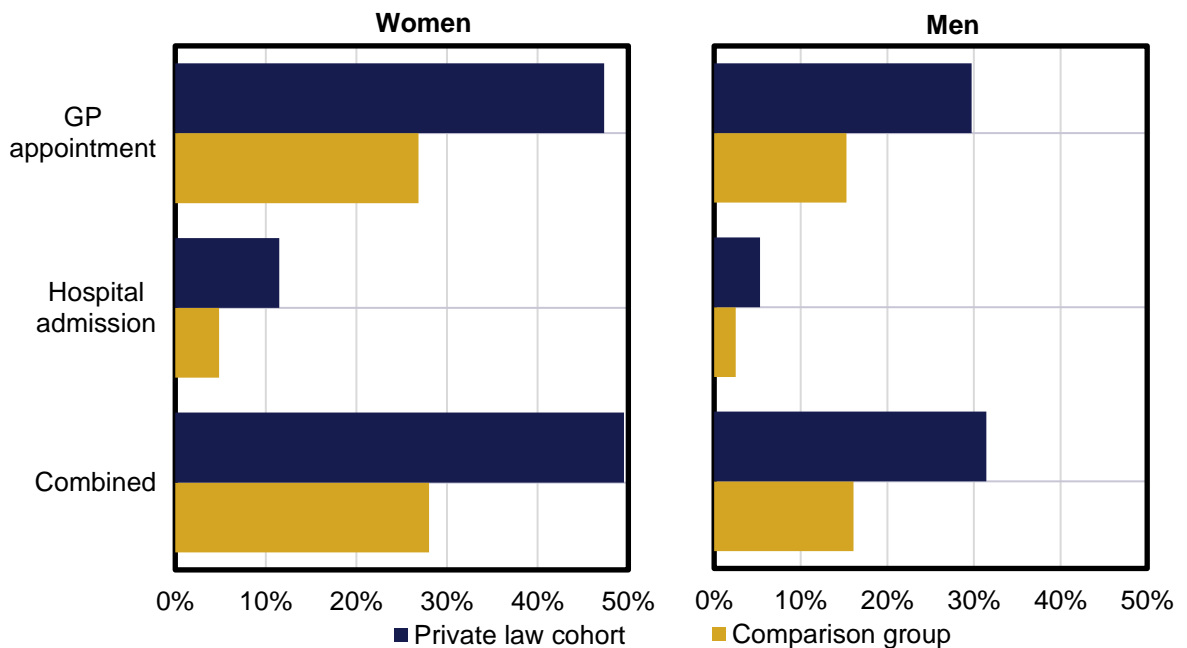
The largest differences between the cohort and comparison group are seen in the prevalence of depression in the year prior to private law proceedings (Figure 12). Both women and men in the cohort group were three times more likely to have depression-related GP contacts and hospital admissions than the comparison group: 10.6% and 3.6% of the cohort women had a depression-related GP and hospital admission respectively, compared with 3.9% and 1.2% of comparison group women; 7.3% and 1.5% of the cohort men had a depression-related GP and hospital admission respectively, compared with 2.2% and 0.5% of the comparison group men.

Figure 12: Percentage of adults with depression-related contact of admission in the year prior to the index date



When we consider whether adults had depression-related GP contacts or hospital admissions at any time prior to the index date, we see a similar pattern. As shown in Figure 13, close to a half (47.3%) of cohort women, and over a quarter of cohort men (29.7%) had experienced at least one depression-related GP contact at some point — this represents almost twice the proportion of women and men in the comparison group (26.8% and 15.3% respectively). When comparing depression-related hospital admissions this disparity increases to two and half times for women and over twice for men. For both women and men, the proportion of depression-related GP contact was higher than that of hospital admissions.

Figure 13: Percentage of adults with depression-related contact or admission at any time prior to index date



Severe mental illness

As seen in the general population (McManus et al. 2016), prevalence of severe mental illness, which includes schizophrenia-spectrum and bipolar disorders, is proportionally low, both in the year prior to the index date and historically. However, comparative differences between adults in the cohort and comparison group are remarkably high, with larger differences seen in the year leading up to the index date. The overall pattern shows adults in the private law group were more likely to have a severe mental illness than adults in the comparison group. Figure 14 shows the proportion of cohort and comparison group adults who had either a GP contact *or* hospital admission (combined measure) relating to bipolar disorder or schizophrenia-spectrum disorders in the year prior to the index date. Figure 15 shows the historical picture.

Figure 14: Percentage of adults with severe mental illness in the year prior to index date

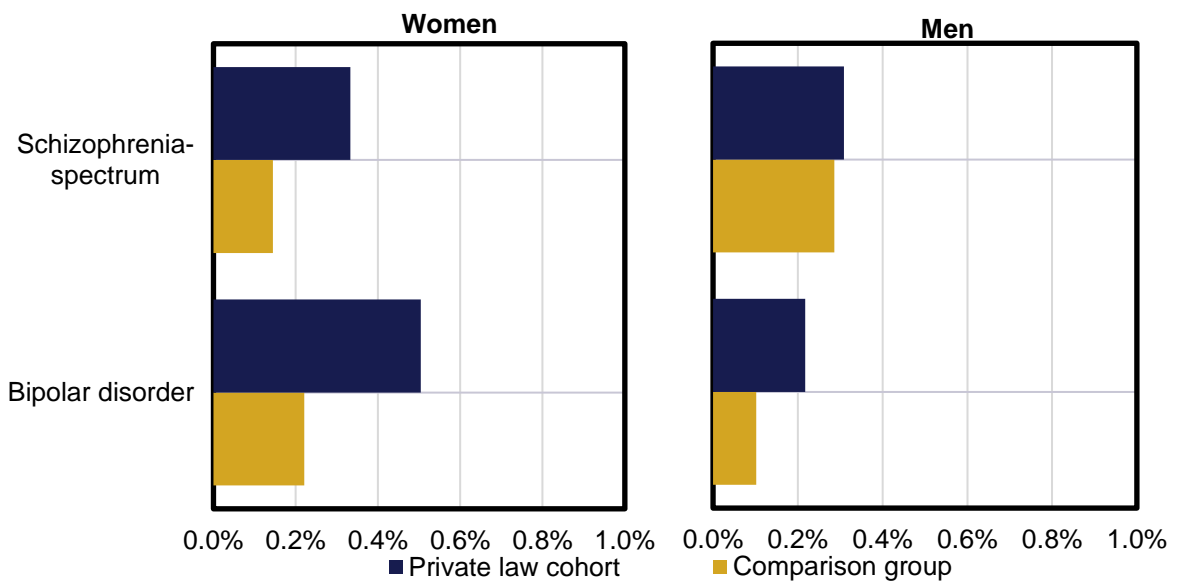
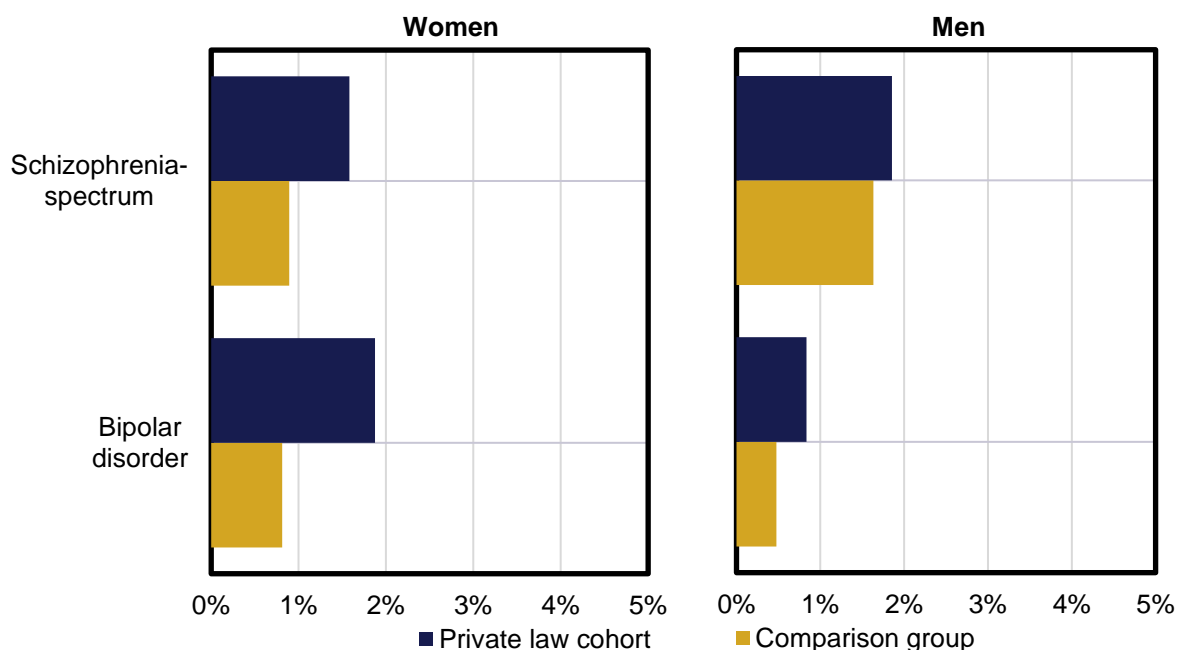


Figure 15: Percentage of adults with severe mental illness at any time prior to index date



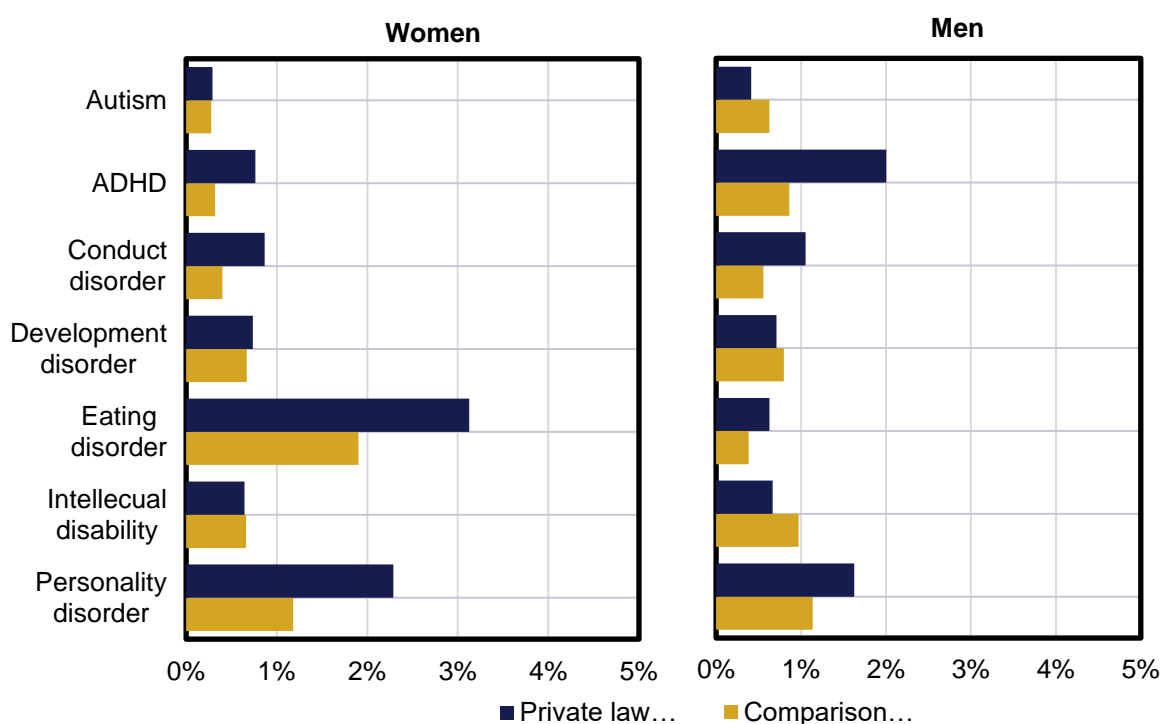
Over twice the proportion of both cohort women (0.5%) and men (0.2%) had a record in either the GP or hospital data to indicate bipolar disorder in the year prior to proceedings compared to adults in the comparison group (0.2% and 0.1% respectively). A similar pattern can be seen historically, with cohort women and men twice as likely to have a bipolar disorder recoded at some point prior to the index date compared with the comparison group.

Similarly, in the year prior to their first family court application, the proportion of women in the cohort group with a schizophrenia-spectrum contact or admission was two and a half times that of the comparison group (0.33% compared to 0.14%). Taking a more historical view, compared to the comparison group, almost twice the proportion of cohort women were recorded as having this type of severe mental illness (1.6% compared to 0.9%). Surprisingly, no substantive differences were seen between males in the cohort group and comparison group in either the year prior to the index date or historically.

Other mental health disorders

In this section we consider the proportion of adults who had other mental health conditions recorded within GP or hospital admission data (combined measure) at any time prior to the index date (Figure 16). Other mental health disorders included here are ADHD, autism spectrum, conduct, development, eating, intellectual disability and personality disorders, all of which have relatively low prevalence, occurring in less than 3% of adults. It is important to note that while the health data is available from 2000, conditions diagnosed prior to this date will not necessarily be identified here. This may more broadly apply to older adults in the cohort and comparison groups, as some disorders, such as ADHD are more commonly associated and diagnosed in childhood.

Figure 16: Percentage of adults with other mental health disorders at any time prior to index date



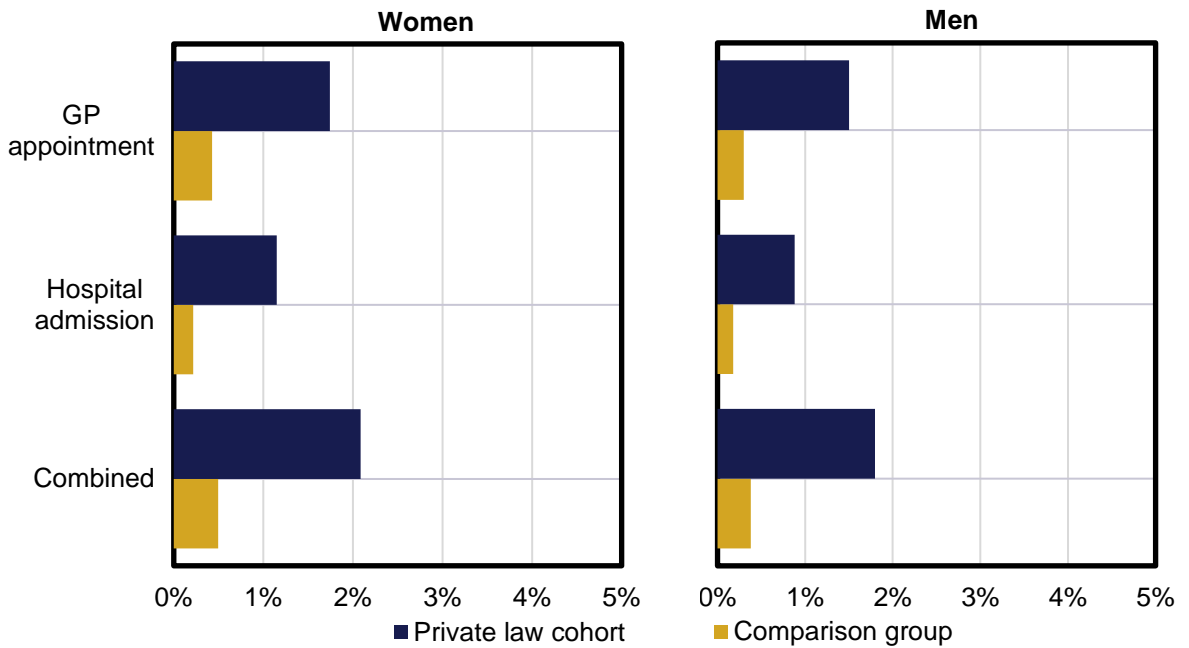
Higher prevalence of some other mental health disorders was seen among adults involved in private family law proceedings than those in the comparison group: ADHD (a difference of almost two and a half times), conduct disorders (two times), personality disorders (two times for women and one and a half times for men), and eating disorders (over one and a half times), with the same disparity seen for both women and men. In contrast, rates of autism spectrum disorders, development disorders and intellectual disability were either similar for the control and comparison groups or higher in the comparison group.

Self-harm

This section describes the prevalence of self-harm among adults involved in private family law proceedings and the comparison group, as identified in GP records and hospital admissions, both in the year prior to the index date and historically. Self-harm was defined, as in the NICE Clinical Guidelines (NICE 2004), as any act of intentional self-poisoning or self-injury, irrespective of suicidal intent or motivation, with clinical codes ranging from forms of non-suicidal behaviour to near-fatal attempted suicide (developed by Carr et al. 2016 and used in Morgan et al. 2018). Commonly associated with mental illness, and a strong risk factor for subsequent suicide (McManus et al. 2016), self-harm is a significant indicator of vulnerability.

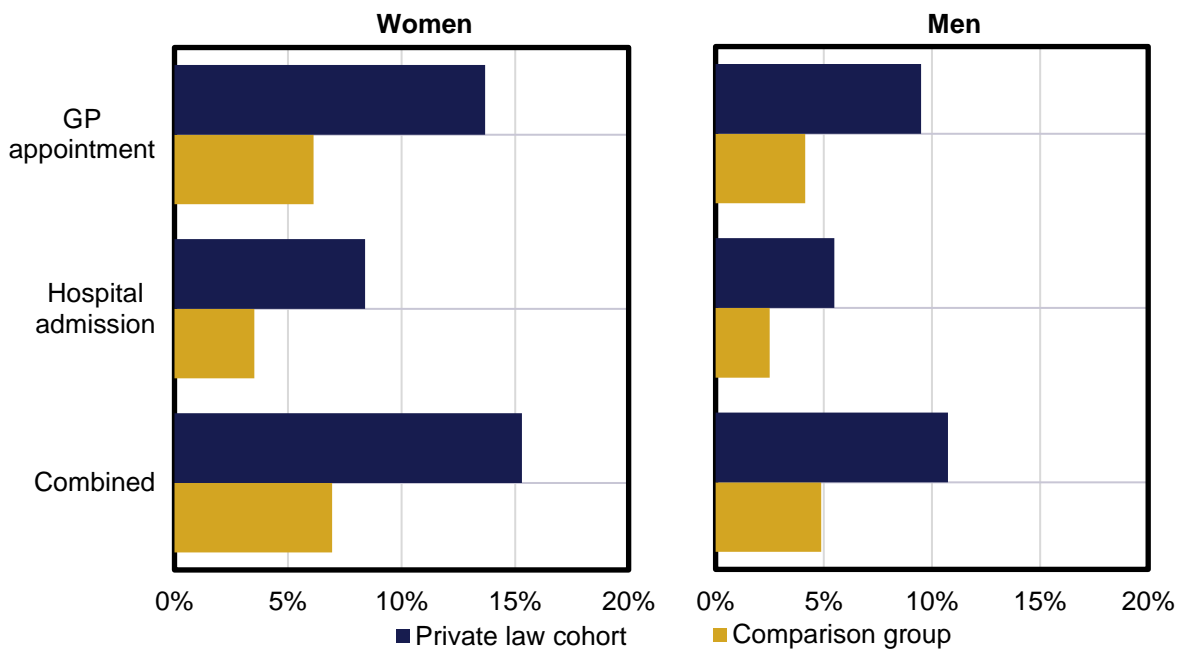
In the year prior to the index date, 1.7% of women and 1.5% of men involved in private law proceedings had at least one episode of self-harm recorded in their GP records—four and five times higher than for women and men in the comparison group respectively (0.4% and 0.3%) (Figure 17). Although proportionally lower overall, there was more than a fivefold difference in the prevalence of hospital contacts or admissions related to self-harm, with 1.1% of women and 0.9% of men in the cohort having at least one self-harm episode recorded in the hospital data in the previous year, compared with 0.2% of women and men in the comparison group. As a combined measure, between four and five times as many women and men involved in private law proceedings had a GP contact or hospital admission related to self-harm in the year prior to the index date.

Figure 17: Percentage of adults with self-harm recorded in the year prior to index date



When we consider whether adults had any history of self-harm recorded in the health data we see a similar pattern, although with smaller relative differences between adults in the cohort and comparison groups (Figure 18). Between two and two and a half times the proportion of both women and men in the cohort had a self-harm episode recorded in the GP records (13.7% and 9.5%) and hospital admissions data (8.4% and 5.5%) than in the comparison group.

Figure 18: Percentage of adults with self-harm recorded at any time prior to the index date



It is notable that while prevalence of self-harm was higher for both men and women involved in private law proceedings than in the comparison group, cohort men were at higher relative risk than women of having an episode of self-harm recorded in the

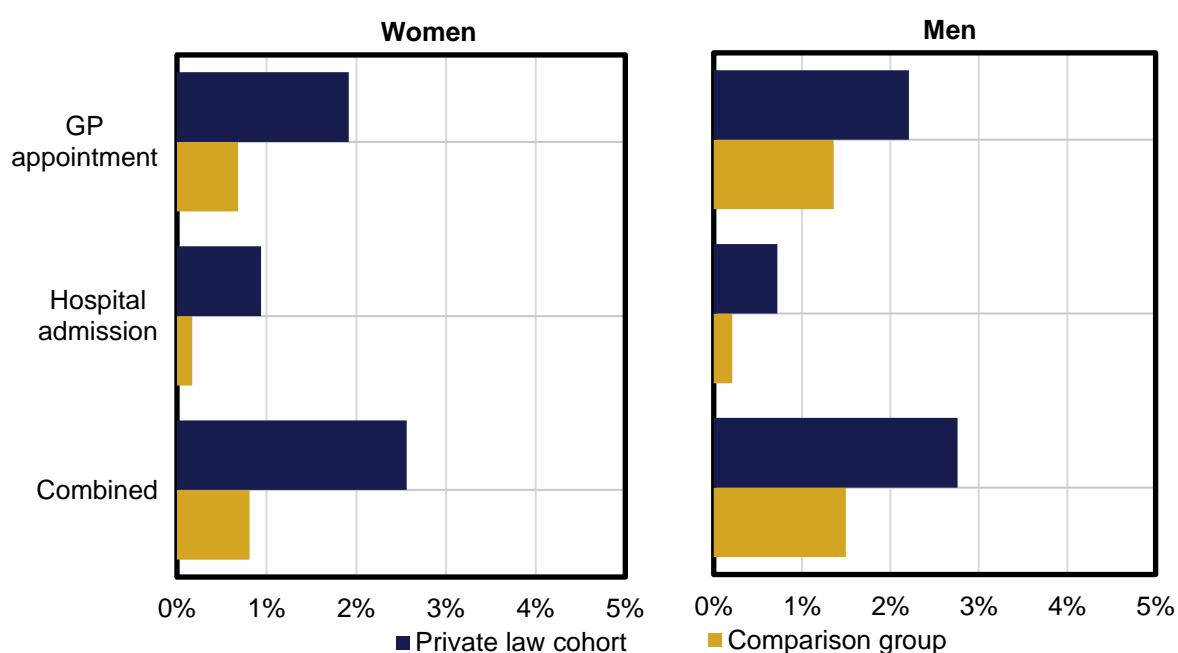
GP data, with cohort women at higher relative risk of having a hospital admission relating to self-harm. This pattern was seen in both the year prior to the index date and over the longer term. Additionally, both men and women involved in private law proceedings were relatively more vulnerable to self-harm in the year prior to proceedings compared to the adults in the comparison group—with rates between four and five times higher—than they were in terms of having a history of self-harm, where prevalence rates were between two and two and a half times higher.

Substance use

In this section we describe the proportion of adults who had substance use recorded within GP or hospital admission data in the year prior to the index date (Figure 19), and the proportion with a history of substance use or diagnosis (Figure 20). Clinical codes indicating substance use indicative of use of alcohol and/or illicit drugs necessitating contact with health services (as detailed in Rees et al. 2020 and provided by the Adolescent Mental Health Data Platform).

In the year prior to the index date, a similar proportion of women and men involved in private law proceedings received a substance use diagnosis, although there were stark differences between the levels of substance use for adults in the cohort group and those in the comparison group. Based on combined GP and hospital admission records, substance use was recorded for 2.6% of cohort women and 2.8% of men—over three times that of women and approaching twice that of men in the comparison group. The relative difference between cohort adults and their comparators was substantively higher in hospital records (five and a half times for women and three and a half times for men) than GP records (three times for women and one and a half times for men).

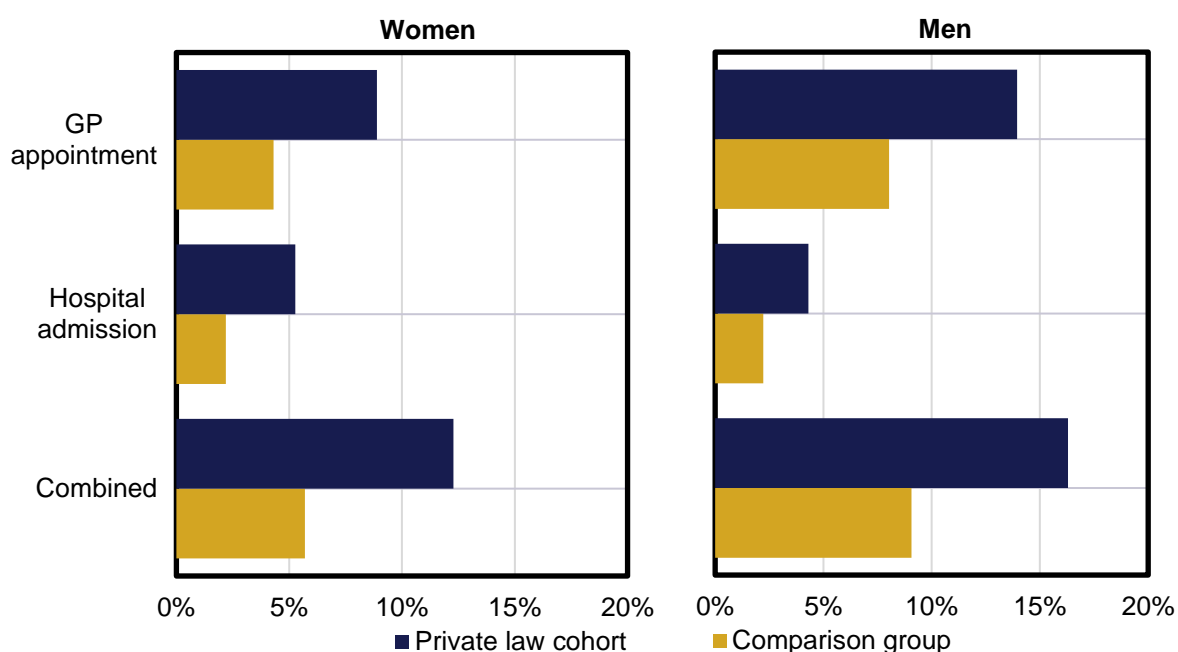
Figure 19: Percentage of adults with substance use recorded in the year prior to the index date



As a combined measure, adults involved in private family law proceedings were twice as likely to have any history of substance use recorded in the GP or hospital

admissions data than those in the comparison group: 12.3% of women and 16.3% of men in the cohort had a record of substance use, compared to 5.7% of women and 9.1% of men in the comparison group. A higher proportion of men than women in both the cohort and comparison group had a substance use record in both the GP and hospital admissions data. While the proportions were smaller for women, the relative difference between the cohort and comparison group was greater for women, suggesting that women involved in private law proceedings were relatively more vulnerable to having a history of substance use, compared to the comparison group, than men.

Figure 20: Percentage of adults with substance use recorded at any time to the index date



Domestic violence and abuse

We know from other studies that between around 50% and 60% of private law child arrangement order cases involve allegations of domestic abuse (Hunt and Macleod 2008; Harding and Newnham 2015; Cafcass/Women's Aid 2017), although fact-finding hearings are held in less than 10% of such cases (Barnett 2020). Serious concerns were raised by the MoJ's 'Risk of Harm report' about how the family court handles allegations of domestic abuse in private law cases (Ministry of Justice 2020b).¹⁸

Here, we were interested in the proportion of both men and women involved in a private law children application who had a record of exposure to domestic violence and abuse recorded in their medical (GP and hospital admission) records, and how

¹⁸ Practice Direction 12J (PD12J) of the Family Procedure Rules 2010 provides detailed guidelines on the actions a court is required to take following allegations of domestic abuse in a child arrangements case. Evidence submitted to the panel preparing the 'Risk of Harm report' raised concerns that PD12J is not operating as intended and is being implemented inconsistently.

this compared to the proportions in the matched comparison group. There are several limitations to note.

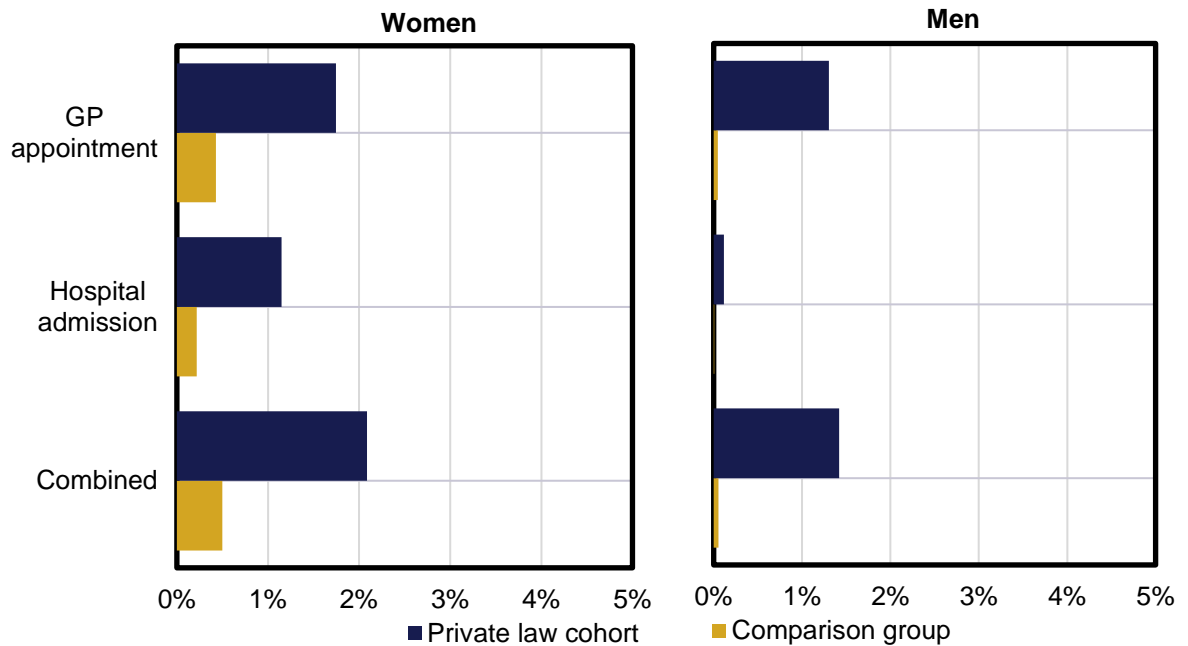
Based on self-reported measures, the 2019 Crime Survey for England and Wales estimated that 5.7% of people aged between 16 and 74 years old had experienced some form of domestic abuse in the previous year (Office for National Statistics (ONS) 2019). It is well known that only a small proportion of victims seek help from health professionals, even when they experience physical injuries (ONS 2018). One UK study in primary care found an 83% under-recording of exposure to domestic violence and abuse when comparing rates in electronic medical records with **patients' self-reported rates** (Richardson et al. 2002). Thus prevalence rates established for the adults in our cohort and comparison groups are likely to be a significant underestimate. However, as the same measure is used for both groups, comparisons between the groups are still valid and meaningful. We have replicated the Read codes (GP data) used to indicate exposure to domestic violence and abuse in a study by (Jackson et al. 2019), together with the equivalent ICD-10 codes (hospital admission data) (used in Olive 2018).

As Jackson et al. acknowledge, although multiple clinical codes exist for domestic violence and abuse, recording practices vary considerably across UK general practice. In one study **clinicians' recording of domestic violence and abuse in medical records** was influenced by the need to provide continuity of care for the **victim, to protect children, and as an opportunity to address the perpetrator's behaviour** (Drinkwater et al. 2017). While guidance (outlined in Dheensa 2020) suggests the recording of domestic violence and abuse in a **perpetrator's records**, only a quarter of the clinicians in the Drinkwater study said they would routinely do so. An additional issue is that the same clinical codes are to be used in both a **victim's** and a **perpetrator's records (with detail recorded in free text)**—so where domestic violence and abuse is identified from medical records in the current study it cannot be determined whether the adult was a victim or a perpetrator.

Notwithstanding the limitations, the overall pattern observed was that adults involved in private family law proceedings were significantly more likely to have exposure to domestic violence and abuse recorded in both GP and hospital admission records than those in the comparison group, both in the year prior to proceedings and historically.

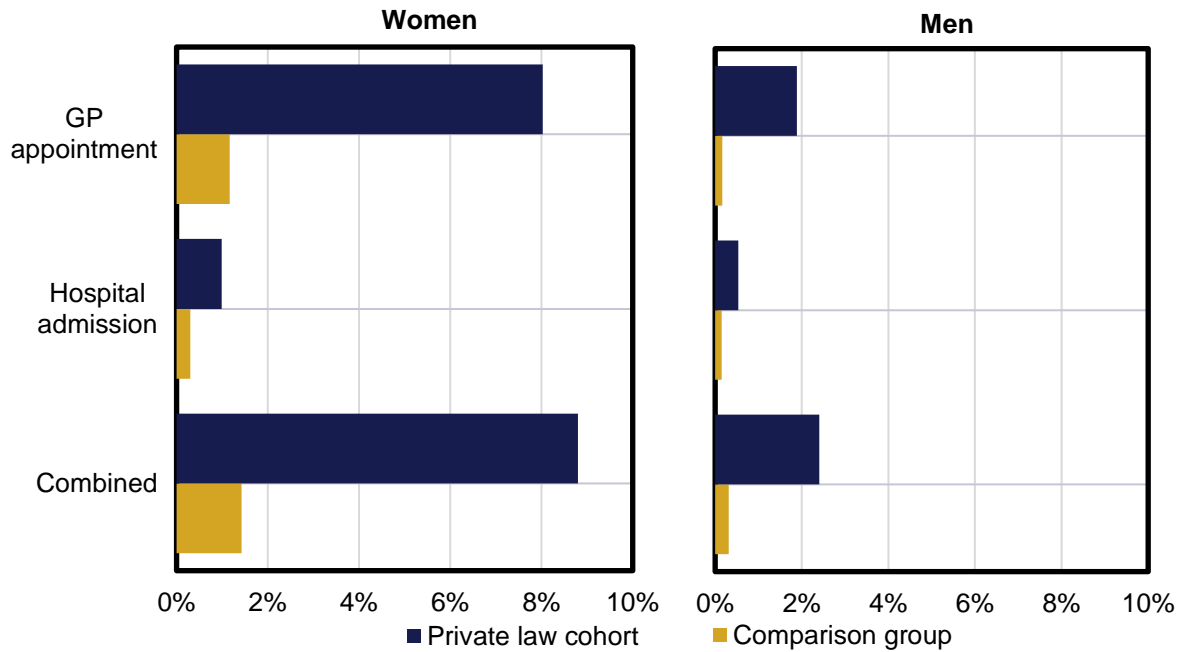
In the year prior to proceedings, 4.0% of women in the cohort had exposure to domestic violence and abuse recorded in their GP records—20 times higher than the proportion of women in the comparison group (0.2%) (Figure 21). Although proportionally very low, they were also more than 11 times as likely to have a domestic violence and abuse-related hospital admission (0.24%, compared with 0.02%). Men in both the cohort and comparison groups were less likely than women to have exposure to domestic violence and abuse recorded—but the disparity between the two groups was greater than for women. Cohort men were almost 30 times more likely to have exposure to domestic violence and abuse recorded in their GP records in the year prior to proceedings than those in the comparison group (1.3% compared to 0.05%). They were almost 17 times more likely to have a domestic violence and abuse-related hospital admission (0.1% compared to 0.007%).

Figure 21: Percentage of adults with domestic violence and abuse recorded in the year prior to the index date



If we consider whether cohort adults had exposure to domestic violence and abuse recorded in their GP or hospital data at any time prior to proceedings, we find the same general picture of greater vulnerability, albeit with smaller relative differences between the cohort and comparison groups (Figure 22). Women in the cohort were seven times more likely to have ever had exposure to domestic violence and abuse recorded in their GP data (8.0% compared with 1.2%) and more than three times as likely to have ever had a DVA-related hospital admission (1.0% compared with 0.3%). Men in the cohort were at increased relative risk compared to the comparison group than women, with rates more than eleven times and three and a half times higher respectively: 1.9% of cohort men had exposure to domestic violence and abuse ever recorded in their GP data (compared with 0.2%) and 0.5% had ever had a domestic violence-related hospital admission (compared with 0.1%).

Figure 22: Percentage of adults with domestic violence and abuse recorded at any time prior to the index date



Discussion

This study has uncovered valuable information about adults involved in private family law proceedings in Wales, providing a number of new insights. Analysis of the Cafcass Cymru administrative data has highlighted the diversity of private law adults and their court experiences. While the majority of adults were parents involved in an application regarding arrangements for children between two parents (who we presume to be the separated parents of the child(ren), not all were. More than 1 in 20 (6.1%) of the cohort adults were non-parents, primarily grandparents, and in total, 16% were involved in an application involving 1 or more non-parents. Around a third of adults were involved in an application with case-level markers of complexity or safeguarding concerns.

In addition to confirming the finding from earlier work by the Family Justice Data Partnership that higher proportions of adults involved in private law proceedings come from the most socioeconomically deprived areas of Wales (Cusworth et al. 2020; Johnson et al. 2020), this research also identified other vulnerabilities, using linked administrative health data. Adults involved in private law proceedings experienced higher prevalence of mental health problems, substance use and self-harm, both in the year leading up to proceedings and prior to that, than adults in the comparison group. These findings are similar to those observed for parents involved in care proceedings (Johnson et al. 2021).

In terms of common mental health conditions, both men and women in private law proceedings were between two and three times as likely to have anxiety and depression than their peers in the comparison group. In the year prior to proceedings, around 1 in 10 adults in private law proceedings had a GP contact or hospital admission for depression, with similar proportions having a record relating to anxiety (there may be some overlap, as both conditions can be experienced at the same time). As the majority of private law adults are separated parents, this would seem to reflect findings from previous research, that common mental health conditions are more frequent among those experiencing relationship distress (Whisman and Uebelacker 2003; Holt-Lunstad et al. 2008; Santini et al. 2015). Links with less common mental health conditions such as personality disorder have also previously been established—although this association may be bidirectional, with mental health disorders both a cause and a consequence of relationship distress (Truant 1994; Whisman and Schonbrun 2009). Although only small proportions of private law adults had diagnoses of personality disorder, schizophrenia and bipolar disorder (less than 2.5% for each disorder type), the levels were at least double those for comparison adults.

Almost 1 in 6 (15.3%) cohort women and more than 1 in 10 cohort men (10.7%) had a history of self-harm, again indicating a level of vulnerability more than double that observed in the comparison group. This disparity was notably higher in the year prior to proceedings, with more than four times as many cohort women and almost five

times as many cohort men having a record of self-harm than adults in the comparison group. Previous research has shown that the majority of those who self-harm do not seek professional help afterwards, so the prevalence rates reported here may be an underestimate, both for private law adults and those in the comparison group (McManus et al. 2016).

Previous research has found some links to substance use and conflict post-separation (Saini and Birnbaum 2007), and accusations of substance use are often used by one or both parents as a reason to oppose contact or residence (Peacey and Hunt 2008; Hunt and Macleod 2008; Harding and Newnham 2015), although it is **not known if these allegations are substantiated or evidence of parents' hostility and conflict**. The current study considered prevalence of substance use in adults involved in private law proceedings, as indicated by GP and hospital records. These show rates of substance use at least twice as high among adults in private law proceedings. Although levels of substance use were generally higher for cohort men, women appeared to be at higher relative risk than those in the comparison group, particularly in relation to substance use-related hospital admissions.

Relative to adults in the comparison group, women in the private law cohort were six times more likely and cohort men were almost eight times more likely to have a history of domestic violence and abuse recorded in their medical records (—although the data does not allow us to identify whether they were a victim or perpetrator). In the year prior to proceedings, this relative vulnerability was even more pronounced, with women 20 times and men 27 times more likely to have exposure to domestic violence and abuse recorded. As outlined above, there are limitations in the use of health data on exposure to domestic violence and abuse, due to both under-reporting and under-recording. Previous research has suggested that at least half of private law child arrangements cases involved allegations of domestic abuse (Hunt and Macleod 2008; Harding and Newnham 2015; Cafcass/Women's Aid 2017). However, we found a history of domestic violence and abuse in the medical records (GP and hospital admissions) for just 8.8% of women and 2.4% of men involved in private family law proceedings. Many victims of domestic violence and abuse do not seek help from medical professionals. Even when they do, there may be concerns about documenting their experiences in medical records due to the risk of abuse escalation if a perpetrator discovers disclosure (Woodman et al. 2015).

The research also revealed greater overall use of healthcare services by adults in private law proceedings, using the routine health data to compare levels of interaction with those of the comparison group. The largest differences were seen in the need for emergency health care. Adults in the cohort group, both women and men, were almost twice as likely to have had an urgent hospital admission or emergency department attendance in the previous year as adults in the comparison group.

The findings presented here provide a picture of the heightened vulnerability of adults in private law proceedings in Wales relative to adults in a matched comparison group, in relation to mental health, self-harm, substance use and exposure to domestic violence and abuse, as well as overall use of healthcare services. Only needs and experiences reported to medical professionals and recorded in the health data can be considered here, which may under-represent the true extent. However, the novel use of linked family court and health data has contributed entirely new—and much needed—evidence.

Conclusion

This research has exposed the heightened needs and vulnerabilities of both women and men making a private law application to the family courts in Wales. The figures presented here are also likely to be an underestimate of the real level of need within the private law cohort, as we can only identify those vulnerabilities and experiences that are both reported to healthcare practitioners and coded into patient records. These findings have important implications for the family justice system, and for health and other services.

Presence of mental health problems or substance use **may compromise an adult's** ability to engage with support services, including mediation, outside of the court. With increasing emphasis in policy on diversion of private family law cases away from the court, it is critical that policymakers give due attention to the wider needs of families and how to better support them to engage with other services. The **Private Law Working Group's proposal to direct cases without safeguarding** concerns to **'assessment, advice and assistance with issues-resolution'** rather than into the family court will require involvement from mental health, drug and alcohol services, and other professionals, if it is to successfully resolve disputes around arrangements for children.

Adults involved in private law proceedings were found to be at higher relative risk of mental health problems, self-harm and substance use in the year prior to proceedings, perhaps associated with increased parental or family conflict leading towards an application being made to the courts.

Levels of domestic violence and abuse were between 20 and 30 times higher for adults involved in private law applications than for the comparison group of adults. Despite the data limitations stated earlier, this supports the evidence from numerous previous studies that domestic abuse is a substantial issue within private law proceedings. As well as a potential reluctance to disclose experience of domestic violence and abuse to medical professionals due to fear of disclosure, it has been acknowledged above that there are significant variations and inconsistencies in recording practices, including the use of clinical codes in both a **victim's** and a **perpetrator's** records. The role of GPs and hospital staff in recognising and accurately documenting domestic violence and abuse, and in signposting support services for both victims and perpetrators, is paramount. The recent Pathfinder Toolkit developed by major domestic abuse charities to improve the response of health bodies included recommendations around recording and monitoring disclosures of abuse (Webb et al. 2020). Further guidance on the consistent use of clinical codes—to allow distinction between victims and perpetrators—would be welcome.

While this research found elevated health needs and vulnerabilities of adults involved in private law proceedings, it is important to bear in mind that adults involved in private law proceedings are a diverse group. The Family Justice Data

Partnership is planning to explore the differentiated needs of different court users—parents and non-parents applying for contact or residence post-separation; those applying for non-standard orders, such as specific issue or prohibited steps; and adults involved in applications that include two or more applicants and/or respondents. There is also a need to investigate the health needs and vulnerabilities throughout and beyond proceedings, as well as the needs of the children involved.

This study used linked population-level data for Wales, and while it is not currently possible to replicate this analysis for England due to availability of the necessary linked data, the findings have implications for both jurisdictions. It is vital that the current programme of reform within the family justice system, including development of the private law pilots, considers the circumstances and vulnerabilities of the families using the private law courts, in order to effectively tailor policy and practice response, whether focusing on the court process or diversion from court.

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Appendix A: Data sources

For each data source within the SAIL Databank, including records from Cafcass Cymru, personal identifiable data has been removed and replaced with a unique identifier, otherwise known as an anonymised linkage field (ALF) or residential anonymised linkage field (RALF) (Rodgers et al. 2009; Johnson, Griffiths, et al. 2021) for each person to enable linkage of records from different sources. SAIL anonymisation and linkage methodology is described elsewhere (Lyons et al. 2009). All data within the SAIL Databank is treated in accordance with the Data Protection Act 2018 and is compliant with the General Data Protection Regulation.

Cafcass Cymru (CAFW)

The primary source of family justice data was electronic case management data routinely produced by Cafcass Cymru, which was securely transferred to and anonymised within the SAIL Databank. Further details about Cafcass Cymru and Cafcass England data, and the Family Justice Data Partnership are available elsewhere (Johnson et al. 2020; Bedston et al. 2020).

Adults involved in a (first) private law application initiated between 1 April 2014 and 31 March 2020 were included in this study. Information relevant for this study included details relating to:

- application: date of issue, order(s) applied for, number of applicants, respondents, and subjects involved, presence of welfare concerns (based on whether a section 7 or section 37 report was ordered, a section 16A risk assessment carried out, or a rule 16.4 appointment made)
- adults (applicants and respondents): week of birth, gender, role on the application, relationship to the (youngest) child in the application
- children – week of birth, gender.

For the purpose of this study, the Cafcass Cymru data was linked to other data sources within the SAIL Databank using ALFs.

Welsh Demographic Service Dataset (WDSD)

The Welsh Demographic Service Dataset (WDSD) provides demographic characteristics of people registered with general practices in Wales—providing **residents' demographic and address details (RALFs) including lower layer super**

output area (LSOA 2011 version), which can be linked to obtain measures of deprivation.

Welsh Index of Multiple Deprivation (WIMD) (2014 version)

The Welsh Index of Multiple Deprivation (WIMD) is the Welsh government's official deprivation measure for small areas in Wales. Each LSOA, which in 2011 in Wales and England contained an average population of 1,614 (Office for National Statistics 2012) is ranked from 1 (most deprived) to 1,909 (least deprived), then divided into five equal parts to obtain deprivation quintiles. We used the overall deprivation domain.

Welsh Longitudinal General Practice data (WLGP)

The Welsh Longitudinal General Practice (WLGP) data contains GP records for patients registered with a Welsh GP, for the approximately 80% of practices that supply data to the SAIL Databank.¹⁹ Each record within the data source contains key information such as the event date and 'Read codes' which are used by GPs to record patient's primary reasons for an appointment or contact and other relevant conditions or comorbidities.²⁰ For this study, WLGP event date coverage was restricted to between 2000 to 2020 inclusive. Further dataset information and data dictionaries are available elsewhere.²¹

Patient Episode Database for Wales (PEDW)

The Patient Episode Database for Wales (PEDW) contains data for all episodes of hospital inpatient and day-case activity in NHS Wales hospitals, including elective and emergency admissions, minor and major operations, and hospital stays for childbirth.²² Key data variables used in this study include admission dates and ICD-10 diagnosis codes for each episode of care, relating to the reason for admission and co-morbidities for each patient.²³ For this study, WLGP event date coverage was restricted to between 2000 to 2020 inclusive.

¹⁹ 94.1% of cohort adults, and 91.9% of comparison adults had records within the WLGP data; we did not adjust the denominator for GP measures—this may result in underreporting in both groups and any further, more detailed work should investigate this further.

²⁰ https://www.datadictionary.nhs.uk/web_site_content/supporting_information/clinical_coding/read_coded_clinical_terms.asp?shownav=1

²¹ <https://data.ukserp.ac.uk/Asset/View/17>

²² <https://data.ukserp.ac.uk/Asset/View/15>

²³ International Statistical Classification of Diseases and Related Health Problems 10th Revision <http://apps.who.int/classifications/icd10/browse/2016/en>

Emergency Department Dataset for Wales (EDDS)

The Emergency Department Data Set (EDDS) attempts to capture all activity at Emergency Departments (EDs) and Minor Injury Units in NHS Wales hospitals. For this study, EDDS event date coverage was restricted to between 2000 to 2020 inclusive.

Outpatient Dataset for Wales (OPDW)

The Outpatient Data Set captures data for all consultant or nurse led clinic activity and includes face to face appointments, virtual clinic appointments (patient contact) phone, and virtual clinical reviews (non-patient contact). For this study, OPDW event date coverage was restricted to between 2000 to 2020 inclusive.

Appendix B: Cohort and comparison group selection process

Cohort creation

Family Justice Data Partnership has created a series of family court data research-ready data assets (RRDA), which aim to make the research process more efficient by reducing the amount of time required for initial data preparation. We used the 'Case-Adult' RRDA as the basis to select adults involved in private law proceedings in Wales, which gave a total of 58,679 adults, of whom 47,453 had a valid ALF (an initial match rate of 80.9%).²⁴ Adults were included in the study cohort where the following criteria were met:

- gender was recorded as male or female
- they were aged 16 years or over
- they were an applicant or respondent on an application that had at least one applicant, one respondent and one subject recorded
- the application had at least one private law order being applied for
- the first private law application they were involved in was issued between 1 April 2014 and 31 March 2020.

This resulted in a final cohort of 18,653 adults.

Matched comparison group

Initially we created a general population comparison group of adults selected from the WSD that consisted of all individuals who had *not* been subject to private law proceedings (i.e. within Cafcass Cymru data). Using an index date of 1 April 2017 (the study midpoint), each adult in the Cafcass cohort was then matched on age (in years), gender, local authority and overall deprivation quintile to up to 10 randomly selected adults from the general population comparison group. The final matched comparison group consisted of 186,470 adults.

²⁴ ALF match rate = total number individuals with an ALF / total number of records * 100.

Appendix C: Measures

The table below provides details on each measure used within the analyses, including definitions and data sources. The index date refers to the earliest date an individual was involved in a private law application (for the Cafcass cohort) or the study midpoint (for the comparison group).

Table C.1: Measures

Data item	Data source	Data item detail
Demographic characteristics		
Age	CAFW, WDS	Calculated in years at the index date, and categorised into 12 categories: 16–24; 25–29; 30–34; 35–39; 40–44; 45–49; 50–54; 55–59; 60–64; 65–69; 70–74; 75+.
Area-level deprivation	WDS, WIMD	Measured by linking an individual's ALF to an address (RALF) and thus LSOA at, or within two years of index date, and then linking WIMD 2014 overall deprivation domain quintile (1 – most deprived, to 5 – least deprived).
Gender	CAFW, WDS	Adult gender: male, female.
Private law case characteristics		
Role	CAFW	Adult's role on the application: applicant or respondent.
Adult relationship to youngest child in the application	CAFW	The relationship of the adult to the (youngest) child (subject) included in the application, as defined in the Cafcass Cymru data, as either: parent; stepparent; adoptive parent/special guardian/foster carer/kinship carer; grandparent; or other relative (including aunt/uncle and sibling).
Type of private law application	CAFW	Type of application, based on number of applicants and respondents, and their relationship to the (youngest) child involved: parent/parent applications; other applications with one applicant and one respondent; applications with two or more applicants and/or respondents.
Order(s) applied for	CAFW	Application type, based on order applied for: child arrangements; prohibited steps; specific issue; enforcement order; special guardianship order; adoption order; and other order.
Welfare concerns in the case	CAFW	Separate measures to indicate whether a section 7 or section 37 report was ordered, a rule 16.4 appointment was made, or a 16A risk assessment conducted within the case that the adult's first application was a part. An 'any welfare concerns' measure was derived to indicate if any one (or more) of these occurred during the course of private law proceedings.

Health service use		
Hospital admissions	PEDW	Hospital admissions in the year prior to the index date, categorised into three separate measures of emergency, elective, or maternity based on admission method classification as detailed: http://www.datadictionary.wales.nhs.uk/#!WordDocuments/admissionmethod.htm
Emergency department attendance	EDDS	Any new attendance (excluding follow up attendances) in the year prior to the index date, with separate measures for 'any attendance' and 'urgent attendance' (those with triage category 'immediate', 'very urgent', or 'urgent'). Further details available at: http://www.datadictionary.wales.nhs.uk/#!WordDocuments/triagecategory.htm
Outpatient appointments	OPDW	Any 'new attendance' appointment within the core outpatient dataset, in the year prior to the index date.
GP records	WLGP	Any record in the GP data in the year prior to the index date.
Mental health		
We identified mental health-related primary care (GP) contacts and hospital admissions from READ and ICD-10 codes recorded in adults' health records (WLGP and PEDW data). For each category of mental health disorders, and an overall 'any mental health' measure, dichotomous variables were created to indicate if adults, in the Cafcass cohort and the matched comparison cohort, had a mental health contact or admission in the 12 months prior to the index date, and at any point prior to the index date. Separate indicators were created for GP contacts, hospital admissions, and a combined GP/hospital measure. Each measure and the code lists applied are described in more detail below. The measures are not mutually exclusive.		
Any mental health	WLGP, PEDW	The presence of any diagnostic inpatient codes from Chapter V: Mental and behavioural disorders of the ICD-10 (PEDW) and/or the equivalent diagnosis codes (with 'E' as the first character) within the Read classification system (WLGP).
Depression	WLGP, PEDW	Defined by the presence of codes for mild, moderate, severe, single episode and recurrent depression, based on those used in Morgan et al. 2018, and published on https://clinicalcodes.rss.mhs.man.ac.uk/ (Springate et al. 2014).
Anxiety disorders	WLGP, PEDW	Defined by the presence of codes for neurotic, stress-related and somatoform disorders, including anxiety, panic attacks, and phobias, based on those used in Morgan et al. 2018, and published on https://clinicalcodes.rss.mhs.man.ac.uk/ (Springate et al. 2014).
Bipolar disorder	WLGP, PEDW	Defined by the presence of codes for bipolar affective disorder, single and recurrent manic episodes, with manic or depression symptoms, based on those used in Morgan et al. 2018, and published on https://clinicalcodes.rss.mhs.man.ac.uk/ (Springate et al. 2014).
Schizophrenia-spectrum disorders	WLGP, PEDW	Defined by the presence of codes for schizophrenia, schizotypal and delusional disorders, based on those used in Morgan et al. 2018, and published on https://clinicalcodes.rss.mhs.man.ac.uk/ (Springate et al. 2014).
Personality disorders	WLGP, PEDW	Defined by the presence of codes for specific, mixed and other personality disorders, based on those used in Morgan et al. 2018, and published on https://clinicalcodes.rss.mhs.man.ac.uk/ (Springate et al. 2014).
Conduct disorders	WLGP, PEDW	Defined by the presence of codes for conduct disorders, including hyperkinetic conduct disorder, characterised by a repetitive and persistent pattern of dissocial, aggressive, or defiant conduct. Codes were used in Rees et al. 2020 and sourced from the Adolescent Mental Health Data Platform (ADP) (https://adolescentmentalhealth.uk).

Developmental disorders	WLGP, PEDW	Defined by the presence of codes for specific development disorders of speech and language, reading, spelling and mathematical skills, or motor function. Usually the delay or impairment is diagnosed in infancy or childhood, although may persist in adult life. Codes were used in Rees et al. 2020 and sourced from ADP (https://adolescentmentalhealth.uk).
Intellectual disability	WLGP, PEDW	Defined by the presence of codes for mild, moderate and profound mental retardation and learning difficulties, as used in Reilly et al. 2015 and published on https://clinicalcodes.rss.mhs.man.ac.uk/ (Springate et al. 2014).
Autism spectrum disorders	WLGP, PEDW	Defined by the presence of codes for autistic disorders including Asperger's syndrome and atypical autism. Codes were used in Rees et al. 2020 and sourced from ADP (https://adolescentmentalhealth.uk).
Attention deficit hyperactivity disorder	WLGP, PEDW	Defined by the presence of codes for hyperkinetic disorders and attention deficit disorder. Codes were used in Rees et al. 2020 and sourced from ADP (https://adolescentmentalhealth.uk).
Eating disorders	WLGP, PEDW	Defined by the presence of codes for eating disorders, including anorexia nervosa and bulimia nervosa. Codes were used in Rees et al. 2020 and sourced from ADP (https://adolescentmentalhealth.uk).
Self-harm		
Self-harm	WLGP, PEDW	Measures of recent (within 12 months of the index date) and historical self-harm were identified by Read and ICD-10 codes corresponding to any act of intentional self-poisoning or self-injury, irrespective of suicidal intent or motivation. The codes used are taken from Marchant et al. 2020 (as based on lists of codes previously validated by Carr et al. 2016, and used in Morgan et al. 2018) and were sourced from ADP (https://adolescentmentalhealth.uk).
Substance use		
Substance use	WLGP, PEDW	Health records were analysed for clinical codes indicating substance use indicative of problem, harmful or hazardous use of alcohol and/ or illicit drugs, in the year prior to the index date and at any time. Codes were used in Rees et al. 2020 and sourced from ADP (https://adolescentmentalhealth.uk).
Domestic violence and abuse		
We derived measures relating to adult's recorded exposure to domestic violence and abuse (DVA), through the presence of relevant Read and ICD-10 codes in the GP (WLGP) and hospital admissions (PEDW) data. Dichotomous variables were created to indicate if adults, in the Cafcass cohort and the matched comparison cohort, had records indicating current/recent exposure to DVA (in the 12 months prior to the index date) and at any point prior to the index date.		
DVA (GP)	WLGP	Identified through the presence of Read codes in adult's GP records which indicate experience of domestic violence and abuse (DVA), including being a victim of domestic abuse, at risk of violence in the home, referral to a Multi-Agency Risk Assessment Conference (MARAC), or receipt of a police domestic incident report. Codes were used by (Jackson et al. 2019) and provided by the author.
DVA (hospital)	PEDW	Identified through the presence of the ICD-10 classifications that most closely align with World Health Organization's definition of intimate partner violence (World Health Organization 2012): T74.1 maltreatment (physical abuse) by spouse, Y07.0 other maltreatment by spouse or partner, and Z63.0 problems in relationship with spouse or partner. These ICD-10 codes were previously used by Olive (2018), and correspond to the Read codes used in the DVA (GP) measure.
DVA (GP/hospital)	WLGP, PEDW	A combined measure of exposure to DVA, as recorded in the GP or hospital admissions data.

Appendix D: Analytical process

The analysis was designed to be descriptive. We calculated demographic characteristics and characteristics of the private law application at the index date, and measures of health service use, mental health, self-harm, substance use and exposure to domestic violence and abuse over the year preceding the index date and recorded at any time prior to this date. For each measure if a person had at least one of the event types (e.g. a hospital admission), they were counted (maximum once per measure) and included in the numerator, then divided by the total number of individuals in that group to create the percentage value. For the analyses each measure was not mutually exclusive, for example, in the mental health analysis an individual appearing within the depression measure could also appear within the anxiety and other conditions. We compared the proportions of the private law cohort and the comparison group on each measure by calculating risk ratios. For example, 41.7% of women in the cohort and 30.1% of women in the comparison group had 'any mental health disorder'; this gives a relative risk of 1.4 (41.7%/30.1%), interpreted as cohort women having 1.4 times the risk of having any mental health disorder compared to women in the comparison group. All reported differences between the Cafcass Cymru cohort and the comparison group were statistically significant at the 5% level ($p < 0.05$). Data processing and analysis was carried out using SQL, Excel and SPSS.

Appendix E: Information governance approval and statistical disclosure control

The project proposal was reviewed by the SAIL Information Governance Review Panel (IGRP) at Swansea University. This panel ensures that work complies with information governance principles and represents an appropriate use of data in the public interest. The IGRP includes representatives of professional and regulatory bodies, data providers and the general public. Approval for the project was granted by the IGRP under SAIL project 0990. Cafcass Cymru (the data owner of the family courts data) also approved use of the data for this project. The agency considered the public interest value of the study, benefits to the agency itself, as well as general standards for safe use of administrative data.

SAIL has strict statistical disclosure processes and policies to prevent potential disclosure of any individual. This includes suppressing of information in tables where the number in any individual cell is less than five, or where geographical identifiers might disclose the identity of the individual concerned either alone or in combination with other data. Percentages were calculated on available counts only, and are reported to one decimal place.

Nuffield Family Justice Observatory

Nuffield Family Justice Observatory (Nuffield FJO) aims to support the best possible decisions for children by improving the use of data and research evidence in the family justice system in England and Wales. Covering both public and private law, Nuffield FJO provides accessible analysis and research for professionals working in the family courts.

Nuffield FJO was established by the Nuffield Foundation, an independent charitable trust with a mission to advance social well-being. The Foundation funds research that informs social policy, primarily in education, welfare, and justice. It also funds student programmes for young people to develop skills and confidence in quantitative and scientific methods. The Nuffield Foundation is the founder and co-funder of the Ada Lovelace Institute and the Nuffield Council on Bioethics.

Family Justice Data Partnership

The Family Justice Data Partnership is a collaboration between Lancaster University and Swansea University, with Cafcass and Cafcass Cymru as integral stakeholders. It is funded by Nuffield Family Justice Observatory.

SAIL Databank

Cafcass Cymru data used in this study is available from the Secure Anonymised Information Linkage (SAIL) Databank at Swansea University, Swansea, UK, which is part of the national e-health records research infrastructure for Wales. All proposals to use this data are subject to review and approval by the SAIL Information Governance Review Panel (IGRP). When access has been granted, it is gained through a privacy-protecting safe-haven and remote access system, referred to as the SAIL Gateway. Anyone wishing to access data should follow the application process guidelines available at: www.saildatabank.com/application-process